Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 300
Mr. K. N. Prajapati
Vs.
The New India Assurance Co. Ltd.

Award Dated 04.10.2004

Complainant got admitted in a Hospital from 30.09.02 to 03.10.02 under the care of Dr. Doshi. Respondent repudiated the claim based on the opinion of their MR Dr. V. C. Parikh that the Complainant had Malarial Parasites 7 days before his hospitalisation because, the Pathological test done one 28.09.2002 did not show any blood parasites, and further that either Consulting Doctor or Treating Doctor had advised the Insurer for hospitalisation. It was the Complainant's argument that he consulted Dr. Doshi on 24.09.02, and Dr. Doshi diagnosed it as malaria Fever and under medical advice, urine and blood test were conducted. Documents perused. It is observed that the Complainant had consulted three more Doctors before consulting Dr. Doshi, and except Dr. Doshi, all other Doctors had prescribed medicines and recommended pathological tests. The pathological test conducted on 28.09.2002 did not show any Blood Parasite. It is also observed from the Discharge Card of Dr. Doshi's Hospital that the past history of the patient has noted as "No history of major illness, no fever, head - ache for 3 days, vomiting twice, giddiness". Further, no document could be found to establish that the hospitalisation was under advice of any Doctors and hence, the condition of the Complainant at the time of admission in the Hospital was such as not to warrant hospitalisation. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0001
Mr. Ashok B. Shah
Vs.
The New India Assurance Company Ltd.

Award Dated 04.10.2004

Complainant's son was hospitalised for back - ache problem. It was the Respondent' s argument that they repudiated the claim on 23.11.2001 under Clause 4.1 and the representation against repudiation was made by the Complainant only on 1.7.2003 and hence, the claim got time barred under Policy Condition 5.11. Form the Documents it is observed that the Complainant made his representation against repudiation of claim after 18 months, i.e. on 1.7.03, and Respondent gave a formal reply to it on 12.2.2004. The Complaint was filed with this office on 25.02.2004. During hearing also the Complainant could not explain the delay and no satisfactory pleading was put forward. Except a ploy, nothing could be found serious on the part of the Complainant. Hon'ble Supreme court judgement in National Insurance Company Vs. Ganesh Nayak & Anr. (AIR 1997 SC 2047) also referred to decide the case wherein the Hon'ble Supreme Court held that "if the Policy of insurance provides that if a claim is made and rejected and no action is commenced within the time stated in the Policy the benefits flowing from the Policy shall stand extinguished and any subsequent action would be time barred, such a Clause will fall

outside the scope of Sec. 28 of the Contract Act". Complaint dismissed without any relief to the complainant.

Ahmedabad Ombudsman Centre
Case No. NIC / 1 / 103
Shri Dinesh P. Vashisht
Vs.
National Insurance Co. Ltd.

Award Dated 07.10.2004

Complainant's wife underwent ear operation due to discharging from ear. Claim was repudiated under Exclusion Clause 4.1. Complainant submitted that the IP was covered under Mediclaim Policy from 2001 and hence the repudiation is unjustified on the ground of pre - existence of her problem. Respondent submitted that their MR opined that the Insured was suffering from Bilateral Chronoic Mastoiditis and that discharging from ear is a chronic problem. Documents and submissions perused. It is observed that the MR of the Respondent has endorsed all aspects of treatment except that he considered the disease to be pre - existing "in all likelihood" which is not a definitive opinion. The clinical history recorded in the Treating ENT Hospital as ear problem for 4 months is considered to be credible, particularly when there is no evidence is available to disprove it. Respondent to pay Rs. 12,542/- as FFS to the complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0049
Dr. Jaykumar C. Shah
Vs.
The New India Assurance Company Ltd.

Award Dated 04.10.2004

Claim under P.A. Policy. Complainant's wife sustained injury when she fell down from the staircase while climbing it. Respondent offered 3 weeks TTD initially, but revised it upto 5 weeks TTD. However, the Complainant demanded for 6 weeks TTD as recommended by the Treating Surgeon. Complainant pleaded that no reason was adduced by the Respondent for not settling the claim fro 6 weeks TTD. Respondent submitted that their MR recommended for 3 week TTD after physical examination of the insured. On representation from the Complainant they again referred the case to another MR who recommended 5 weeks TTD. Weightage was given to the treating Surgeon's recommendation. Allowed 6 weeks TTD.

Ahmedabad Ombudsman Centre
Case No. NIC / 1 / 100
Shri N. S. Patel
Vs.
National Insurance Company Ltd.

Award Dated 07.10.2004

Complainant met with an accident. Claim towards hospitalisation and medical expenses was lodged with the Respondent and also with TPA. TPA settled the claim of medical part fully, but Respondent, as PA part of Claim, paid 6 weeks TTD instead of 8 weeks recommended by the Treating Doctor. Complainant submitted during hearing that he has received the balance amount and his intention of appearing in the Hearing is to make the Respondent conscious towards the interest of customers and tone up their administration to avoid unnecessary delay and harassment as happened in his case. Respondent admitted the inordinate delay in making the balance payment to the Complainant. Complainant demanded no other monetary benefit. Therefore, an order is passed to the effect for closing

the case with a message to the Respondent's different level of offices for more sensitive to the needs of the Policyholders by effecting timely settlement of claim.

Ahmedabad Ombudsman Centre
Case No. UIC / 1 / 154
Dr. K. T. Patel
Vs.
United India Insurance Company Ltd.

Award Dated 08.10.2004

Smt. S. K. Patel underwent Laminectomy and Lateral Forminotomy. Claim was lodged after the prescribed time limit and hence it was repudiated. On exaplanation and representation to CRC, they examined the case on merit and sought expert opinion of their MR who in turn submitted his Report with the opinion that Spinal Canal Stenosis is a degenerative affection of Spinal Column that develops and progress slowly over a period of several years. Complainant submitted that though the disease might have started earlier, it was known recently when the symptoms manifested. Documents and submissions perused. It is observed that since the Respondent considered the case on explanation of the complainant the efflux of time was impliedly waived by them. Their MR concluded his Report by stating that if the Policy is only since Feb. 2001, then the ailment can be considered as pre - existing. Complainant produced a copy a Money Receipt dated 22.1.99 of payment of premium paid for Mediclaim Cover. From this, it is established that the policy was in force since 1999. The discharge summary of Treating Hospital also showed that the disease manifested before 6 months prior to surgery. Respondent to pay Rs. 76,450/-. Admission fee, Surcharge and other Hospital service expenses are to be deducted from the claim amount.

Ahmedabad Ombudsman Centre
Case No. 11 / 002 - 0027
Mr. Hasmukh M. Shah
Vs.
The New India Assurance Company Ltd.

Award Dated 08.10.2004

Complainant's wife underwent TKR. Claim repudiated under Clause 4.1. Complainant submitted that his Mediclaim Policy was in force from 1989 to 2002 - 03 without any break initially with United India and then with the Respondent since 1997. This was his first claim since inception and the claim amount is much lower than the actual expenses. Based on two X - Ray Reports taken in 1998, the core argument put forward by the Respondent was that osteoarthritis changes like reduction in joint space, tibia vara as early as 1988. Documents and submissions perused. It is observed that the subject surgery took place in 2002 after 14 years of inception of Policy in 1988 and the Respondent has no evidence of treatment in between 1988 and 2002. The complaint neither enhanced the SI nor made any claim during the period except the subject claim and the Policy has earned C.B,. as well. Further, the 1988 X - Ray Reports were submitted by the Complainant himself to the Respondent, otherwise they would not have opportunity to get a clue into these documents which they relied to repudiate the claim. No weightage has been given to these X - Ray Reports for denying the benefits to a loyal Policy Holder. Repudiation set aside. Respondent to pay Rs. 25,000/- to the Complainant as FFS.

Ahmedabad Ombudsman Centre
Case No. 14 - 002 - 0007
Smt. Hasumati J. Patel
Vs.
The New India Assurance Company Ltd.

Award Dated 11.10.2004

Repudiation of Mediclaim. Complainant's husband underwent Abdomen Rectopexy and repair of Right Inguinal Hernia. Claim Repudiated u / c 4.1 Complainant submitted that the disease was of 6 months old and it was detected by Treating Surgeon in course of examination. Respondent submitted that they referred the case to two Consulting Surgeons for their opinion since the claim was in the second year of the Policy. Both Doctors ascertained in their opinions that the disease was of 4 / 5 years. More over, one of the MRs obtained a statement from the Insured as well as from the Complainant stating that the Insured had bleeding P / R problem since 1992 - 93 and also problem of Inguinal Hernia since 4 to 5 years. Documents and submissions perused. It is observed that the treatment administered is in conformity with the disease diagnosed and the expenses incurred therein are not in dispute. The point for determination is whether the Respondent could prove that the disease was pre - existing vis - à - vis the inception of the Cover on 25.08.2000. Since the opinion of Treating Surgeon and the opinions of MRs were of vide difference, the statement obtained from the Insured and the Complainant by one of the MRs has been taken as important document to determine the issue of pre - existence of disease. Accordingly, it is establish that the disease was pre - existing. Repudiation sustained. Complaint dismissed without any relief.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 298
Smt. Abha N. Shah
Vs.
The New India Assurance Company Ltd.

Award Dated 11.10.2004

Complainant's 9 years old daughter underwent Appendectomy. Claim repudiated on the grounds of pre - existence of disease. Complainant submitted that due to severe abdominal pain, they consulted their family Physician who referred the case to Dr. A. P. Munshi. Dr. Munshi diagnosed the disease as Appendicitis and advised operation. Respondent submitted that according to their MR, who obtained a statement from the Complainant, the Insured was having the disease for last 2 years, and hence the disease existed prior to the inception of the Cover. During hearing, the Complainant submitted that she does not know the meaning of "Conservative treatment", and explained that the MR of the Respondent Dr. Y. C. Shah asked her whether the child had pain in the stomach ever and she recalled 2 years back there was some such pain and for that she consulted Dr. Desai who prescribed medicines and cured the pain. Documents and submissions perused. Explanation of the Complainant found convincing though she had signed the statement. Eventhough Dr. Desai's Chamber was very near to the house of the Complainant, Dr. Shah chose not to visit Dr. Desai and get clarification from him. It is also opined that a disease of potential danger to the life of a child was allowed for 2 years through conservative treatments is a difficult position of reconcile. Weightage has been given to Dr. Desai's certificate produced by the Complainant during hearing. Repudiation set said. Respondent to pay Rs.19088/- as FFS to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14 –004 - 0130
Mr. Nilesh B. Talati
Vs.
United India Insurance Company Ltd.

Award Dated 14.10.2004

Mediclaim – Complainant Claimed Rs. 150000/- Respondent offered Rs. 1,03,250/- Policy was in force from 1994 and accumulated 50% C.B. on S.I. of Rs. 65,000/-. Complainant

submitted that during 2002- 03, Respondent allowed 50% Bonus with increased S.I. of Rs. 1,00,000/- , but after the claim arose, they considered only 5% C. B. on erstwhile S.I. of Rs. 65,000/-. He claimed to have been entitled to Rs. 1.5 lac. Respondent submitted that there was a delay of 9 days in renewal of the Policy for the year 2001 - 2002 and hence, the Complainant is entited to only 5% Bonus on Rs. 65000/- and that 50% Bonus rate shown on Policy Bond was a mistake through oversight. Documents and submissions perused. It is observed that there is enough merit in the Complainant's argument that if the claim was not arisen, the Respondent would have been allowed 50% C.B. Further observed that the correction effected by the Respondent is not a one time lapse, but a continued lapsed and hence, the Complainant's claim acquires justification. Claim allowed with 50% C.B. on S.I. of Rs. 65000/- Respondent to pay Rs. 132500/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 131
Mr. Gunvant B. Shah
Vs.
Oriental Insurance Company Ltd.

Award Dated 25.10.2004

Complainant's wife was operated for Hysterectomy. Claim repudiated under Exclusive Clause 4.3 stating that Hysterectomy was due to Menorrhegia. Complainant submitted that after a long lapse of time the Respondent informed him that the claim file was missing at their end. During hearing, Respondent admitted that the claim file is not traceable and requested for adjournment of hearing for a week to find out the missing file. This request was not granted because Respondent had 2 years and 6 months to search it out and further, the letter fixing the hearing on 25 - 10 - 2004 was received by them on 10 - 10 - 2004. However, an opportunity was provided to them during hearing to study the case file. They could not come across any comment of the Treating/ Referee Doctors which stated the reason for Hysterectomy as Menorrhegia or any infirmity pointed out by them in the claim of Rs. 18870/-. The fact that neither in any treatment papers nor by any Doctors has mentioned that the reason for Hysterectomy operation was caused either by Menorrhegia or by Fibromyoma was brought to the notice of the Respondent. This fact as well as absence of defence by Respondent led to a position during hearing to admit the claim by them and they offered to pay Rs. 18870/- to the Complainant. Based on a joint statement to that effect submitted to this Forum, the complaint treated as resolved and directed the Respondent to pay Rs. 18870/- to the Complainant. No other relief.

Ahmedabad Ombudsman Centre
Case No. GIC / NIA / 1 / 268
Mr. Mahesh M. Pathak
Vs.
The New India Assurance Co. Ltd.

Award Dated 25.10.2004

Complainant's daughter was hospitalised and underwent surgery for correcting congenital deformity of Vagina. Respondent repudiated the claim under Exclusion Clause 4.8 Complainant submitted that the Treating Surgeon had clearly certified that the congenital deformity of vagina was revealed only during the Puberty" and hence, he or the Insured has no malafide intention to suppress any material fact of preexisting disease simply because the deformity was not known to the Insured. Respondent submitted that their MR in her Report certified that "the claim was for correction of Congenital External Anomaly" and hence claim is not payable under Clause 4.8. Documents and submissions perused. It is observed that both Doctors, the Treating Surgeon and the MR, have opined that the disease is congenital. Congenital Phenomena is governed by Rules under Clause 4.3 and 4.8 which speaks of congenital Internal and congenital external diseases respectively. If

the insured is aware about the existence of congenital internal disease / defects before inception of Policy it will be treated as pre - existing, while Clause 4.8 excludes from the scheme congenital External Disease or defect or anomaly. Hence, the critical issue taken for determination is whether “absence of Vagina” is to be treated as congenital external anomaly or congenital deformity. The Treating Surgeon termed it as congenital deformity without any categorical or implied attribute of its externality. According to Medical and English Dictionaries, “ visibility” is an essential attribute to “Externality”. The Treating Surgeon opined that because of the anatomical position of Vagina, the deformity is revealed only during puberty and when the patient does not get menstruate she consult Gynaecologist and then this deformity is diagnosed. It is also observed that patient had underwent “Pelvic Sonogram for the purpose of ascertaining inter alia non - identified uterus and cervix. Even after “Pelvic Sonogram, the Doctor advised for Laproscopic examination. Under the circumstances, the subject deformity in the present case has been taken as congenital deformity and not termed as external. The Law laid down by Hon’ble Supreme Court in the case of B. V. Nagarajan Vs. OIC [II (1996) CPJ 18 (SC)] also invoked for deciding the case. Respondent’s decision to close the claim as ‘No claim’ under Clause 4.8 is not sustained. Directed to pay Rs. 30280/- to the complainant.

Ahmedabad Ombudsman Centre
Case No. 11 - 004 - 0086
Mr. Dattretrey M. Shinde
Vs.
United India Insurance Co. Ltd.

Award Dated 28.10.2004

Complainant’s Wife fell down from the staircase. Respondent treated the Claim as No claim. Complainant submitted that diagnosis in the Hospital revealed fracture on Right Wrist and Left Leg injury and that admission in the Hospital and subsequent treatment was as advised by the treating Surgeon only. Respondent submitted that their MR opined that the Insured was only applied plaster cast without anesthesia and for such undisplaced fracture, hospitalisation was not necessary. Further, the hospitalisation was less than 24 hours and hence claim is not entertainable under Clause 2.3 Documents and submissions perused. It is observed that the hospitalisation of the Insured was as per the advice of the Treating Surgeon and hence, the operative part of the Mediclaim Policy has been fulfilled. As regards the reason cited by the Respondent in repudiation letter, it is opined that the Insured has no say in the matter when a Specialist Surgeon took the responsibility of the treatment. Referring to the plea of the Respondent that the claim is non entertainable under Clause 2.3, it is opined that the time of discharge from the Hospital has not been indicated and hence duration of stay in hospital in terms of hours is not possible. Further, if the Respondent was so desired to get the time, it was possible for them to avail it when the claim was lodged. But, they did not make any effort for it, but elicited the expert opinion and hence, after admitting the claim, and even not indicating the same in the repudiation letter, this plea cannot be permitted now. Respondent is to pay Rs. 5504/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 149
Mr. Ajay Kantilal Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 28.10.2004

Complainant underwent Surgery and treatment for internal Piles with bleeding and Ulcerative Colitis. Respondent repudiated the claim under Clause 2.1 of the Policy as the Hospital is having only 8 in - beds and Nurses are not qualified as reported by their MR

though he had concluded his report stating that the “case is admissible for mediclaim”. Complainant submitted a certificate from the Treating Surgical Hospital that the Hospital is meeting with all requirements stipulated to quality the claim. Respondent admitted that except status of Hospital, the claim papers submitted by the Complainant are in order. Documents and submission perused. It is observed that the bills, prescriptions of Treating Doctor, authenticity of the treatment and correlation of treatment with disease etc are of having no infirmities and the Respondent also took note of it. Therefore, in such cases, the Law laid down by the Hon’ble Supreme Court of India in B.V. Nagaraju Vs. OIC (II 1996 CPJ 18 SC) took as a guiding factor where the guiding principle is to give weightage to words and provision only to the extent that it is consistent with the main purpose of the Contract. As the main purpose of Policy is to provide support to the Policy Holder for treatment expenses when he needs it, and also the subject claim is fulfilled with the main purpose, the Respondent is directed to pay Rs. 20,534/- to the Complainant. No other relief.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 286
Mr. A. C. Parikh
Vs.
The New India Assurance Co. Ltd.

Award Dated 29.10.2004

Accidental injury sustained on the Complainant’s ankle while walking through his private garden and he was hospitalised and operated. Claim repudiated on the ground that ailment was arisen from diabetic condition which was an excluded disease from the Cover. The main points put forward by the MR of the Respondent was that in such a precarious condition the Complainant should not have gone for walking in the garden and secondly he was in a prolonged dressing to heal the wound linking with diabetic foot. From the documents it is observed that the Complainant had disclosed diabetes, IHD and Renal Disease and knowing these facts, the Respondent extended Mediclaim facility to him ever in his old age. Referring to the Respondent’s contention that the ambit of exclusions go beyond the specified diseases per se and extend to consequences attributable thereto or accelerated thereby or arising therefrom, it is opined that such diseases which escapes this vast network of relationship as noted to Diabetes Heart, Renal system and not connected to anyone of them in any way, will be very few and far between. Hon’ble Supreme Court’s directions in the case of Skandia’s (1987 ACJ 411 (SC) and B.V. Nagaraju Vs. OIC (AIR 1996 SC 2054) took as guidance to decide the case and held that application of this generic directive to subject claim means at the least that the injury sustained by the accident should not be brought into ramifications of specified exclusions, and hence the exclusions are to be read down at least clipping the ramifications out of keep the main purpose of the Mediclaim Cover alive. Respondent to pay Rs. 60,077/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. GIC / UIC / 1 / 135
Mr. Harshad C. Gandhi
Vs.
United India Insurance Company Ltd.

Award Dated 10.11.2004

Complainant’s wife underwent Hysterectomy for doubtful Cervix. Claim was in the first year of the Policy. Respondent’s Medical Referees, based on the case papers of Lion Tarachand Bapa Hospital & Research Centre, whrein it has been stated that Insured “had slight irregular periods + Leucorrhoea 2 years”, opined that the disease was pre - existing. Based on the MRs’ opinions and Exclusion Clause governing the Policy in its first year, Respondent repudiated the claim. Complainant submitted that slight irregularity of periods

and white discharge cannot be taken as indication of Cancer and that such phenomena is very much common. Documents and submissions perused. It is observed that the diseases excluded from the cover for the first year of the Policy is for Hysterectomy caused due to Menorrhagia or Fibromyoma. In this case, the hysterectomy was done for Hyperplasia as confirmed by the Treating Surgeon. As regards the pre - existence of disease, it is observed thats there is nothing on record as admissible evidence adduced by the Respondent to prove that the disease (Cancer) for which Hysterectomy was conducted was within the knowledge of the Insured prior to the inception of the cover. Repudiation set aside. Respondent to pay Rs. 50,356/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. GIC / UIC / 1 / 137
Mr. M. K. Jain
Vs.
United India Insurance Company Ltd.

Award Dated 16.11.2004

Mediclaim repudiation under Exclusion Clause 4.1. Complainant's father was admitted in Yashoda Hospital, Ghaziabad. Complainant submitted that the renewal Policy issued for 2002 - 2003 was without any exclusion. Examined the documentary evidences submitted by both the parties. It is observed that the Treating Doctor had given a certificate stating that the death of Insured was due to Non - diabetic Kidney Failure. According to the opinions obtained by the Respondent it was a case of Chronic Renal Failure. As the opinions from the Treating Doctor and from the Specialists were of confronting, relied on the Discharge Summary and Death Certificate from the Treating Hospital to arrive at a conclusion whether the ailment was CRF or not. Next point examined is that whether Diabetes is to be treated as an Excluded Disease from the Cover. It is observed that the Policy for the relevant period was issued without any Exclusions. In this regard, reference has been made to the judicial pronouncements of Apex Court in the case of United India Insurance Co. Vs. Mohanlal Agarwal (Volume 62 Part - 10 ACJ October 2004) wherein the Apex Court held that Exclusions incorporated at the time of inception of Policy will be excluded in the subsequent renewal Policies eventhough it was not incorporated in the subsequent Policies. Repudiation sustained.

Ahmedabad Ombudsman Centre
Case No. 14 / 004 / 0133
Mr. Indravadan Panchal
Vs.
United India Insurance Company Ltd.

Award Dated 18.11.2004

Complainant lodged Claim for his treatment on various dates from 21.1.03 which was repudiated on the ground of pre - existence of disease. Documents examined to ascertain whether the Respondent of Policy on 3.4.2000 It is observed that MR of the Respondent Dr. Shah though narrated in his opinion, these treatments administered to the Complainant by Dr. A. Naik, Dr. Shukla and Dr. J. Bhatt, Advised the Respondent to get probable duration of symptom from Dr. J. Bhatt and refer the case again to him. Though Dr. Nayak noted h / o multiple episode of Palpitation, the duration when the sickness started is not indicated by him. Respondent could not submit any consultation paper of Dr. Bhatt wherein the h / o Palpitation "since many years" reportedly noted by him. Medical Referee also could not come to any conclusion. Held that in absence of any cogent evidence led by the Respondent, the complaint succeeded of merit. Respondent to pay Rs. 55,318/- to the Complainant in FFS.

Ahmedabad Ombudsman Centre
Case No. GIC / NIA / 1 / 262

Mr. Jitendra M. Dalal
Vs.
The New India Assurance Co. Ltd.

Award Dated 19.11.2004

Complainant was operated for Incisional Hernia. Claim repudiated based on the opinions of the Medical Referees of the Respondent. It was the Complainant's pleading that his Appendicectomy operation was performed in 1997 and Incisional Hernia was conducted in 2001 and both being separate operations of different time, it should not be linked up each other in deciding the case. Documents and submissions perused. It is observed that the Hernia was developed on the scar of Appendicectomy Operation done in 1997 prior to the inception of Policy in 1999. The subject operation is related to the earlier Operation, the claim attracts Exclusion Clause 4.0 and 4.1 The Complainant did not disclose the fact of Appendicectomy Operation in the Proposal Form which vitiated the Contract of Utmost Good Faith. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 261
Mr. Sanjay B. Patel
Vs.
The New India Assurance Co. Ltd.

Award Dated 19.11.2004

Complainant's 2 years old son was operated for cataract. Claim repudiated on the ground of congenital problem based on the opinions of the Medical Referees of the Respondent. Complainant pleaded that he or his family was not aware of his child having cataract and even the Operating surgeon has not termed it as congenital. In this case the dispute was about congenitality of the Cataract. Documents perused. It is observed that MR of Respondent Dr. D. M. Desai in his Report concluded that the Claim is admissible and his Report did not contain any observation that termed Cataract as congenital. The second MR of the Respondent in his Report stated that both eyes Cataract is mostly due to congenital. He further mentioned that he will give his final opinion either after examining the patient or going through other case papers shown to other Doctors Congenitality of diseases is not established. Respondent to pay Rs. 24,034/-.

Ahmedabad Ombudsman Centre
Case No. 11 / 002 / 0127
Mr. Ajay V. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 22.11.2004

Repudiation of Mediclaim u / c. 4. 1. Complainant's son was hospitalised for Epilepsy treatment. Policy incepted with the Respondent from 1.8.01. Prior to that the Policy was with National Insurance Company since 1995. So the Complainant argued that the Respondent will have to prove that the disease was pre - exsting earlier to 1995. It is observed from documents that from 1995 the Complainant had individual Mediclaim Policy with National Insurance and from 2000.01 he had a Group Mediclaim Policy with Citi Bank / The new India Co. and thereafter from 2001 - 2002, Individual Policy with the Respondent. Individual and group Mediclaim Policies are being different products, the individual Mediclaim Policy with the Respondent for the period 2001.02 is intercepted by the Group Mediclaim Policy and hence, the continuity on renewal from 1995 is not sustained. Further, the Proposal papers submitted by the Complainant are all in conformity with the requirements for entering into a new Contract. As regards the contention of the Complainant that his intention was to transfer the Policy from Group to Individual Policy, it is opined that neither the Proposal Papers disclosed such intention nor such transfer is

permitted thereby, the Cover is to be taken as a new Policy. Complainant admitted that his son had Epilepsy since 1999. Considered the Policy as new one. Non - disclosure of disease established. No relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. GIC / NIA / 1 / 291
Mr. Suresh K. Kandhari
Vs.
The New India Assurance Co. Ltd.

Award Dated 24.11.2004

Respondent refused to renew the Mediclaim Policy for the period from 1.3.2003 - 2004 and refunded the premium. The premium was paid in time by the Insured. Documents and submissions perused. It is observed that the Respondent decided not to renew the Policy of complainant's wife without stating explicitly any reason. In this regard, reference had been made in the case of United India Insurance Co. Vs. Mohanlal Aggarwal decided by Hon'ble Gujarat High Court wherein it is held that "renewal of mediclaim insurance policy cannot be refused, despite timely payment of premium, on the ground that continuance of the Cover would become more onerous or burdensome for the Insurer due to the Insured contracting a covered disease during the period of the existing Policy". Referring to the Respondent's contention that they have filed a petition in Apex Court challenging the cited judgement, it is held that the Ruling against the type of refusal to renew the Policy becomes a binding judgement as of now since the Apex Court neither stayed the Ruling of Hon'ble High Court nor delivered any judgement quashing the Ruling. Respondent to renew the Policy in its totality for the relevant period on receipt of proper premium and compliance of any other existing procedural formalities from the Complainant - Insured.

Ahmedabad Ombudsman Centre
Case No. 11 / 002 / 0102
Mr. Vijay Bafna
Vs.
The New India Assurance Co. Ltd.

Award Dated 24.11.2004

Complainant met with an acident. He was first treated by Bone setter and then by Orthopaedic Surgeon. Based on the MR's opinion, Respondent repudiated the claim. Documents perused Factum of Fracture, genuineness of the bills and quantum of claim are not in dispute. It is observed that initial treatment was for 2 days without admission to Hospital, and thereafter complainant was admitted to Hospital. The hospitalisation was as per advice of the Doctor and nothing is on record contrary to it. As the operative provision of Mediclaim Policy stipulates that hospitalisation must be as per advice of a duly qualified Surgeon, no violation of said provision could be observed in the instant case. It is held that the factum of accidental injury and consequent treatment and hospitalisation under advice of Ortho - Surgeon are not in doubt, repudiation merely on the ground that it could have been treated conservatively fails to stand the taste of logic. Respondent to pay Re. 10,590/- to these Complainant as FFS.

Ahmedabad Ombudsman Centre
Case No. GIC / UIC / 1 / 155
Mr. Iqbal I. Tadha
Vs.
United India Insurance Co. Ltd.

Award Dated 25.11.2004

Mediclaim repudiations. Complainant's mother was hospitalised. Claim was repudiated under Exclusion Clauses 4.1 & 4.10. Documents perused It is observed that the Insured was covered under Medclaim Policy since 1991 and she had declared her diabetic problem while proposing for insurance, but the Respondent did not incorporate any such exclusions. As regards the second ground of repudiation u / c 4.10 it is observed that the Insured had consulted a number of Doctors, and underwent several tests before admitting into the Hospital under advice of Treating Doctor. Repudiation sets aside. Respondent to pay Rs. 11,400/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 144
Mr. Gunvant B. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 30.11.2004

Complainant underwent CABG. Claim repudiated on the ground of suppression of material information with regard to Personal Health History. Documents perused. Most of the other documents such as Medical Certificate, Hospital Reports, Pathological / Radiological Reports etc submitted by the Respondent were subsequent to inception of the Policy. The medical opinions were also found entirely not relevant. However, it is observed that the History Sheet dated 22.8.2000 of V. S. Hospital having noting of IHD, Diabetes etc that the Complainant was suffering from prior to inception of Policy is sufficient to establish suppression of material information. Complaint dismissed without any relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 004 / 0096
Mr. A. K. Roy
Vs.
United India Insurance Company Ltd.

Award Dated 9.12.2004

Repudiation of Mediclaim. Complainant's wife underwent operation for Incisional Hernia. Complainant pleaded that Incisional Hernia operation and Hysterectomy operation are two separate operations on different dates and should not be linked up in deciding the Claim. It is observed that the Hysterectomy conducted on the Insured in December 1999 had been declared in the Propsal Form. As Incisional Hernia has developed on the scar of Hysterectomy, the subject operation is in connection with the earlier Hysterectomy. Held that the subject claim attracts Exclusion Clauses although the two operations were on different dates. Repudiation sustained.

Ahmedabad Ombudsman Centre
Case No. 11 / 002 / 0160
Mr. Krishnakant S. Patel
Vs.
The New India Assurance Co. Ltd.

Award Dated 09.12.2004

Complainant's wife underwent Laparotomy for removal of Tubo Ovarian Mass. Respondent repudiated the Claim under Exclusion Clause 2.1 as the Surgical Hospital was not having 15 in - patient beds. Complainant submitted that the said Hospital was of having fully equipped operation theatre and qualified Doctors round the clock. The Claim is examined with reference to judicial pronouncements in similar cases. Cases referred to are [1987 ACJ 411 (SC) and (AIR 1996 SC 2054). No infirmity observed other than marginal short -

fall in number of beds which is not considered fundamental enough to deny the benefit to the Insured. Respondent to pay Rs. 13302/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14 / 004 / 0009
Mr. Suresh K. Jhaveri
Vs.
United India Insurance Co. Ltd.

Award Dated 13.12.2004

Wife of the Complainant was hospitalised for Right Knee Operation. Claim lodged for total expenses, but Respondent offered less than what is claimed. Respondent argued that the Insured had Osteotomy of Right Knee in 1995 and hence her TKR is to be treated as a fallout of Osteotomy and according to tabular benefits for different categories under Mediclaim Rules, maximum limit of the Policy was Rs. 83000/- at that time. Therefore the SI is restricted to Rs. 83000/- and when added 20% C.B. on it the total claim payable comes to Rs. 99600/-. It is observed that the offer made by the Respondent is not due to any infirmity with regard to actual expenses or the amount spent is disproportionate to the sickness. Hence, the point taken for determination is that whether the Respondent could establish by Law and by Logic, justification for offer of Rs. 99600/-. As regards the Osteotomy, it is opined that it is undertaken to see whether TKR can be avoided and neither of the two is caused by either. Insured had disclosed the Osteotomy Operation done in April 1995 and the Premium collected by the Respondent is corresponded to SI. But the Respondent issued Policy without any endorsement or restriction of benefits to the Insured under the Policy as per the erstwhile Tabular Benefits. Even Respondent's MR had advised the Respondent to consider the Claim. Held that when the Claim is not vitiated by any infirmity, Respondent's argument to correlate the subject surgery as a fall out of the previous surgery 8 years back and restricting the benefit of the current Policy is not tenable. Respondent to pay full claimed amount to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 003 / 0033
Mr. M. L. Khandwala
Vs.
National Insurance Co. Ltd.

Award Dated 16.12.2004

Mediclaim – Complainant underwent operation for Fistula in Anus. Claim repudiated under exclusion Clause 4.3. The point taken for determination is whether the subject Cover as it subsisted in the relevant period of treatment is to be considered as a renewal one or a fresh one. Documents and submissions perused. It is observed that after the expiry of Mediclaim Policy on 2 - 7 - 2002, the policy was renewed only on 13.9.2002 which resulted in 73 days gap in renewing the same. The ECG and other Test submitted at the time of renewal on 13.9.2002 also establish that the Policy was a fresh one the subject Operation was done in the first year of the Policy. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 252 (c)
Mr. Sharad G. Trivedi
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.12.2004

Wife of the Complainant sustained accidental fracture and was hospitalised. Claim lodged for Rs. 122564/-. Respondent initially offered Rs. 59,904/- and thereafter revised it upto

Rs. 89004/- In this case also the Respondent was not prepared to defend their case during Hearing. It is observed that the difference in claim amount and offered amount was due to duplicate bills for which affidavit was submitted by the Complainant, reportedly under instruction from the Respondent's Office, When asked, the Respondent submitted that the duplicate bills are admissible and the payment should be made against duplicate bills in view of Affidavit. There were 7 other excluded payments for which also the Respondent opined that the payments are warranted. Respondent to pay Rs. 122564/- to the Complainant alongwith 7% simple interest calculated from the date when the first Discharge Voucher was sent.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 252 (B)
Mr. Sharad G. Trivedi
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.12.2004

Complainant's daughter was hospitalised and underwent Surgery. Claim lodged with the respondent for Rs. 81408/-. Respondent, sent Discharge voucher for Rs. 67085/- but the same was refused. This Forum put on record that the Representative of the Respondent came for Hearing without proper study of the case. They had no defence for argument put forward by the Complainant or by this Forum and in fact, agreed to everything. During Hearing the Respondent was asked to explain the reason for admitting the claim which led to send Discharge Voucher after repudiating the Claim. They stated that the repudiation was wrong. It is observed that the Respondent's Investigator in their Report stated that "no document is available to establish that the disease of the Insured was pre - existing prior to March 1998. As regards the deduction made at the time of sending discharge voucher, the Respondent unequivocally informed that full amount should be paid. Directed to pay Rs. 81408/- to the Complainant alongwith 7% simple interest calculated from the date of discharge voucher was sent.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 252 (A)
Mr. Sharad G. Trivedi
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.12.2004

In connection with his hospitalisation and Surgery, the Complainant lodged a Claim with the respondent for Rs. 164370/-. Respondent, initially offered to settle the Claim at Rs. 79740/- which was increased to Rs. 88140/- and finally revised it upto Rs. 161270. This Forum put on record that the Representatives of the Respondent came for Hearing without proper study of the case, thought they carried with them a bunch of papers. They had no defence for argument put forward by the Complainant or by this Forum and in fact, agreed to everything. It is observed that Rs. 3100/- was disallowed by the Respondent because the voucher was issued on the Letter Head of the Hospital. Directed to pay Rs. 164370/- to the Complainant alongwith 7% simple interest calculated from the date of first discharge voucher was sent.

Ahmedabad Ombudsman Centre
Case No. 11 - 002 - 0029
Mr. J. R. Joshi
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.12.2004

Complainant was operated for PTCA and major OM lesion. Repudiation of Claim was on the ground of suppression of material facts and non - submission of documents concerning past treatments. Documents and Submissions perused. It is observed that the Respondent had obtained 3 Medical Reports one after another. The first Report was from an M. D. (Medicine), who inter alia opined that the hospitalisation was for unstable Angina of recent origin and recommended admissibility of the Claim. The second was from a General Surgeon who opined that the Claim is not Admissible, but recommended to take opinion from an M.D. Medicine to avoid injustice to the insured. The third one was from a Cardiologist based on which the respondent repudiated the Claim. It is noted that the information contained in the Report of the Cardiologist that the complainant had consulted for Cardiac Problem at Caroli Cardiac Centre, Delhi, was provided by the complainant himself and not brought up by investigation of the Respondent. It is further noted that the Complainant being beyond 45 years old, had under went ECG and other Tests before Proposal for insurance by an M.D. (Medicine) who was amongst the Panel of Respondent's Medical Referees. He had certified that the Complainant is free from Heart disease, Diabetes etc. Held that the inability of the Complainant to give Card number for medical examination at Caroli Hospital is not a tenable ground for non - payment of Claim; no evidence of treatment prior to the date of Proposal; the Panel Doctor's Report certifying the Complainant as free from heart disease is conclusive. Reference also made in the case LIC Vs. Channabasamma [I (1991) ACC 411 (DB)]. Repudiation set aside. Respondent to pay Rs. 139212/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 252(D)
Mr. Sharad G. Trivedi
Vs.
The New India Assurance Co. Ltd.

Award Dated 27.12.2004

This is a complaint against cancellation of Mediclaim Policy. Respondent sent a 15 days Notice of Cancellation without mentioning any specific reason for cancellation except reference to "as per condition agreed upon". It is observed that as per Clause 5.9 of Mediclaim Policy Prospectus, 30 days notice is to be sent, but the Respondent sent 15 days notice which is Bad in Law. The fundamental infirmity observed in the Notice is non - indication of any reason for cancellation of running Policy. Certain judicial pronouncements also referred in this regard wherein the Hon'ble Court barred the refusal of renewal of Mediclaim policy despite timely payment of Renewal Payment on the ground that continuance of the Cover would become more onerous or burdensome for the Insurer. In view of even refusal to renew a mediclaim Policy had been barred by the Hon'ble Court, cancellation of a running Policy by the Respondent taking recourse to Clause 5.9 of the Prospectus, it is held that the action of the Respondent is Bad in Law. Cancellation set aside. Respondent is directed to reinstate the Policy on continuing basis for the Complainant and his family.

Ahmedabad Ombudsman Centre
Case No. 11 - 002 - 0082
Mr. Subhashchandra M. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 30.12.2004

Disentomb and Laminectomy operation was performed on the Complainant's son due to backache. Claim repudiated on the ground of pre - existence of disease. The Claim was in

the first year of the policy. In this case, the subject disease, type of treatment administered or the reasonableness of expenses incurred were not in dispute. The only infirmity was with regard to pre - existence of disease. Documents perused. It is observed that the Respondent had obtained opinions from two Medical Referees. Amongst them, Dr. Pranav Shah gave a presumptive opinion rather than an assertive. The second opinion obtained from Dr. Y. Shah, clearly indicated that “any previous history of backache is not coming forth”. He concluded his Report stating that the benefit of doubt is to be extended to the Insured. Repudiation set aside. Respondent to pay claimed amount subject to limit of Sum insured.

Ahmedabad Ombudsman Centre
Case No. 11 - 005 - 0111
Mr. Ismail I. Modan
Vs.
Oriental Insurance Co. Ltd.

Award Dated 31.12.2004

Complainant’s son underwent surgery for Inguinal Hernia. Claim repudiated under Exclusion Clauses 4.1 & 4.8. It is observed that the Treating Surgeon in his certificate has clearly stated that the Insured had Congenital Inguinal Hernia though he retracted from his opinion later stating the disease as Inginal Swelling for 1 ½ months. Conclusion arrived at is that the condition of the insured was one of Congenital External (Protruding) Hernia and hence, Exclusion Clause 4.8 is operative. Repudiation sustained.

Ahmedabad Ombudsman Centre
Case No. 14 / 003 / 0079
Mr. Harshavardhan Shah
Vs.
National Insurance Co. Ltd.

Award Dated 31.12.2004

Wife of the Complainant underwent CABG following a chest - pain. The Policy was in force 1995 with Oriental Insurance Company and from 2002 with the Respondent without break. Claim repudiated on the ground of suppression of material information in the Proposal Form. On perusal of Proposal Form, it is observed that the Complainant and the insured replied in negative in respect of past previous Mediclaim Insurance, Claim received, and past history of ailment. Although the suppression of material information is proved, the case is viewed in a different context because the way in which the Respondent dealt with the Proposal and issuance of Policy proved otherwise. It is observed from the Policy issued by Oriental Insurance Company that 5% C.B. to the insured and 20% C.B. to the Complainant had been awarded by them for the period 2001 - 2002. The respondent Company awarded C.B. @ 10% and 25% to the Insured and the Complainant respectively when they insured the Policy for the period 2002 - 2003. This obviously means that the Policy was not treated as fresh Policy by the Respondent Company, but treated a continuation of Policy that the Complainant and the Insured held with Oriental Insurance Company. Held that though the Insured did not mention about the past insurance in the proposal Form, it is obvious that the Respondent was awere about it in issuance of the resulting Policy and hence, the Respondent is estopped from raising the issue at the point when Claim has arisen. Moreover, the MR. of the Respondent also opined in his Report that the Claim is admissible. Repudiation set aside. Respondent to pay Rs. 136358/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 004 / 0166

Mr. B. P. Parekh
Vs.
United India Insurance Co. Ltd.

Award Dated 7.1.2005

Mediclaim - Wife of the Complainant was hospitalised. Claim repudiated based on MR's opinion that the treatment administered on the Insured could be treated as OPD. Case examined with the provisions of Mediclaim Policy. It is observed that the hospitalisation was after OPD treatment of around 3 weeks. Further observed that opinion of the MR. is purely based on case papers, but the opinion of the treating Doctor was after his medical examination and treatment for a prolonged period on the patient. When asked to the Respondent, they confirmed that the Policy is in the 7th year with 20% and 30% C.B. for the Complainant and the Insured respectively. Repudiation set aside. Respondent to pay Rs. 9829/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 004 / 0066
Mrs. P. B. Hazari
Vs.
United India Insurance Co. Ltd.

Award Dated 17.1.2005

Complainant underwent TKR of Left Leg. Respondent repudiated the claim. In course of Hearing, Respondent informed the Forum that they have re - examined the case on the basis of duration of Cover since inception, and accordingly they are prepared to settle the Claim at Rs. 200639/-. Directed the Respondent to make this amount to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 004 / 0210
Mr. Vijay H. Tarpara
Vs.
United India Insurance Co. Ltd.

Award Dated 18.1.2005

Complainant was hospitalised for treatment of T.B. Panel Doctor of TPA, opined disease was pre - existing. Claim Repudiated U / c. 4.1. Examined the case in the context of documentary evidences. It is observed that neither the Panel Doctor's name nor his specialisation particulars are available on record or could it be brought out during oral submission. As regards the Consultant's Note dated 5 - 5 - 03, describing the patient as 'known case of LRTI', it is opined that since the duration of the sickness has not been indicated, the Respondent's argument duration must be taken back to a period prior to inception of the Policy is not an acceptable preposition. Referring to the Respondent's argument based on the Certificate of Dr. Nandkishor Shah that the Certificate is issued subsequent to the diagnosis of the Complainant and hence presumable distorted, it is opined that opinion from Specialists subsequent to the diagnosis of sickness is very much accepted, and hence the argument is untenable. Further observed that the Certificate issued by Dr. A. D. Abhayankar, Director, Interventional Cardiology in the Proforma of the Respondent, has not been taken into consideration by the Respondent, though it was convincing. The Respondent discarded the certificates of Dr. N. J. Shah and Dr. Abhayankar which are convincing, but approached the case in a priori presumption. No evidence that the disease was within the knowledge of the Complainant before inception of the policy. Held that the repudiation was done on presumption of duration of disease discarding the opinions of the Experts. Respondent to pay Rs. 35000/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 - 002 - 0108
Mr. Bhikhubhai Naik
Vs.
The New India Assurance Co. Ltd.

Award Dated 19.1.2005

Left Eye Cataract Operation – Due to non - disclosure of Right eye Cataract operation done in January 2000 in the Proposal Form at the time of proposing for Mediclaim Policy in March 2000, the Respondent repudiated the Claim. It is Observed that the answers to Q.No. 12(1) and 14 regarding dimness of vision / cataract and information about other illnesses were given negatively in the Proposal Form. Further, the Treating Surgeon confirmed in his Certificate that he had operated for Right Eye Cataract of the Complainant in January 2000. Suppression of fact established. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11 - 003 - 0052
Mr. B. M. Bhatt
Vs.
National Insurance Co. Ltd.

Award Dated 20.1.2005

Claim towards expenses for hospitalisation and treatment incurred by the Complainant in connection with CABG was repudiated. The reason behind repudiation by invoking Exclusion Clause 4.1 was that the Complainant's multi - vessel CAD is a direct complication of long standing and uncontrolled DM. Examined the case with reference to Proposal Form and its Annexure and observed that the Annexure was with respect to Questionnaire to be filled up for Diabetes and the other was an ECG Report. In the said Annexure, it had been mentioned that the complainant had uncontrolled Diabetes at the time of Proposal. But, the Respondent did not take into account the fact of uncontrolled Diabetes and issued the Policy without Exclusion. Held that the Respondent is estopped from denying liability in a claim when disclosed Proposal particulars had not been taken into account by them at the underwriting stage itself and the fetters / restrictions imposed at the inception is not communicated to the Insured. Respondent to pay Rs. 35000/- in FFS of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11 - 005 - 0173
Mr. Manharlal R. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 20.1.2005

P. A. Policy – Complainant sustained injury in a Scooter Accident. TTD Claim – Respondent offered 3 weeks TTD as advised by their MR instead of 6 weeks advised by the Treating Doctor. Complainant pleaded that he could not attend to his duties for 8 weeks. Case decided by applying the principle of Golden Mean. Accordingly, Rs. 4500/- for 4.5 weeks TTD is to be paid by the Respondent.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 272
Mr. J. M. Prajapati

Vs.

The New India Assurance Co. Ltd.

Award Dated 31.1.2005

Complainant suffered fracture on Right Neck Femur and was hospitalised for treatment. Based on the MR's opinion that the Complainant seems to be a handicapped person, Respondent repudiated the Claim. Respondent argued that Complainant being 60 years old and being handicapped, no Insurance Company would grant Mediclaim Cover to him. Further they stated that the Complainant is a disabled man and this fact was not disclosed by him. Documents and submissions perused. It is observed that the repudiation was entirely because the Complainant was handicapped and non - disclosure of this fact. Held that after granting Mediclaim Cover to an aged person and also after arising a Claim the contention of the Respondent is not acceptable particularly, the Respondent did not bring out any admissible evidence to prove the handicap or the Complainant deliberately sought to mislead the Respondent in extending the Cover.Respondent to pay SI of Rs. 10000/- to the Complainant.

Ahmedabad Ombudsman Centre

Case No. NIA / 1 / 295

Mr R. K. Jani

Vs.

The New India Assurance Co. Ltd.

Award Dated 03.2.2005

Wife of the Complainant underwent TKR. The reasons indicted by the Respondent for repudiating the Claim were delayed submission of claim papers, non - disclosure of Hysterectomy Operation 20 years back and treatment for Cervical Spondylosis in 1998. Documents and submissions perused. Respondent's core argument and agitation centered to the point of non - disclosure of treatment of Cervical Spondylosis and the other two reason were not pressed for during Hearing. Hence, the analysis restricted to the treatment for Cervical Spondylosis in 1998. It is observed that the Medical Referee of the Respondent opined that there was treatment for Cervical Spondylosis "since 1998". But the Treating Doctor narrated the history as pain in neck and right Periscapular region and certified it to be a case of early Carvical Spondylosis which was treated and cured by him "in 1998". Further, the Treating Surgeon noted that onset of osteoarthritis of Knee as 6 months. Held that Cervical Spondylosis which was treated and cured as certified by the Treating Surgeon cannot be a sole reason for repudiation of Claim of TKR after 4 years gap. Moreover, though Cervical Spondylosis was not disclosed in the Proposal form, the Respondent could not prove that this non - disclosure was material enough to sustain repudiation. Judicial precedents (I (1998) CPJ 45 (NC) also referred while deciding the case. Repudiation not sustained. Respondent to pay Rs. 309426/- to the Complainant.

Ahmedabad Ombudsman Centre

Case No. 11 - 004 - 0220

Mrs. Arti Modi

Vs.

United India Insurance Co. Ltd.

Award Dated 7.2.2005

Complainant was hospitalised. Claim repudiated based on the ground that hospitalisation was not necessary and the treatment could be given on OPD basis. Documents and submissions perused. It is observed that the hospitalisation was as per the advice of the

Treating Doctor and he had certified that the case of the Complainant was not a case to be treated on an OPD basis. Repudiation set aside.

Ahmedabad Ombudsman Centre
Case No. 11 - 004 - 0224
Mr. Balabhai S. Patel
Vs.
United India Insurance Co. Ltd.

Award Dated 07.02.2005

Complainant's wife was admitted in Hospital. Respondent repudiated the Claim on the ground that the hospitalisation was only for diagnostic purpose and no active treatment was offered to her. The point taken to determine the case is whether it is proved by evidences and opinion that hospitalisation was only for diagnostic purpose. And if so, is it non - admissible as per Policy Terms & Conditions ? It is observed from the Treatment Hospital's Certificate that except normal angiography and other Allied tests coupled with administration of some oral drugs, no treatment was extended. As per Clause 4.10 of the Policy, Claim towards Angiography expenses is not payable if hospitalisation is ended up in diagnosis only without recommendation of a qualified Doctor. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11 - 004 - 0207
Mr. Mukesh C. Gandhi
Vs.
United India Insurance Co. Ltd.

Award Dated 07.02.2005

Wife of the Complainant was hospitalised. Claim lodged against treatment expenses was repudiated on the ground that hospitalisation was not necessary and the treatment administered could been done in OPD. In this case, the issue taken for determination is whether in the context of the Policy conditions, the Respondent is justified in repudiating the claim on the ground that the treatment did not require any hospitalisation. It is observed that the hospitalisation was on the advice of a duly qualified Treating Surgeon as stipulated in the Policy Conditions. As regards the Respondent's pleading that the Complainant has written in his letter that hospitalisation was for diagnostic purpose, it is opined that it does not hold any ground because it is only a truncated version and further that the treating Surgeon reiterated in his Certificate that he had advised hospitalisation. The case also examined with reference to the Policy in force as well as Claim experience in the past. Repudiation set aside.

Ahmedabad Ombudsman Centre
Case No. 11 - 004 - 0233
Mr. Hiralal Kori
Vs.
United India Insurance Co. Ltd.

Award Dated 7.2.2005

Repudiation of Mediclaim under Exclusion Clauses 4.12. It is observed from the Discharge Certificate issued by the Treating Hospital that the ailment of the insured (Complainant's wife) was diagnosed as "Ruptured Ectopic Pregnancy. As the hospitalisation and treatment administered was in connection with and in respect of traceable to Pregnancy, it attracts Exclusion Clause 4.12 and hence repudiation of the Claim is upheld.

Ahmedabad Ombudsman Centre

Case No. 11 - 003 - 0135
Mr. Shailesh Mehta
Vs.
National Insurance Co. Ltd.

Award Dated 15.2.2005

Complainant's daughter underwent an Operation due to Ovarian Cyst and Appendicitis. Claim repudiated on the ground of pre - existence of disease as opined by the Medical Referee. Point taken for determination of the case is that the pre - existence of disease could be proved by evidence by the Respondent, when the Cover incepted. It is observed that there is a written statement given by the insured and her mother to the MR of the Respondent stating that the Insured was having the problem for last 2 years. To confirm the evidentiary validity of the said statement, the Complainant was asked in Course of Hearing, and he confirmed that it was in the handwriting of his daughter and that she is 20 years old having completed her graduation. Authenticity of the statement and its evidentiary value has been taken into consideration to decide the case. Repudiation sustained.

Ahmedabad Ombudsman Centre
Case No. 11 - 004 - 0092
Mr. Harshad V. Shah
Vs.
United India Insurance Co. Ltd.

Award Dated 15.2.2005

Claim for hospitalisation and treatment expenses incurred by the Complainant was admitted by the Respondent. Out of the Claim amount of Rs. 63791/- , Respondent paid Rs. 59199/-. The complaint was against balance amount not paid. Respondent submitted that their Medical Referee opinioned to deduct Rs. 4592/- , from the bill against certain items. Documents and submissions perused. It is observed that the same Medical Referee of the Respondent has issued a subsequent opinion advising the Respondent to release the payment against the items which were deducted earlier. Further observed that there is no justification either on record or in course of Hearing, for withholding the balance amount in view of their MR's subsequent opinion. Respondent to pay the balance amount.

Ahmedabad Ombudsman Centre
Case No. 14 - 005 - 0008
Mr. Ashok M. Vyas
Vs.
Oriental Insurance Co. Ltd.

Award Dated 15.2.2005

Complainant daughter was hospitalised due to ENT problem. Claim repudiated on the ground that domiciliary treatment was sufficient and also the Treating Hospital was not met with Policy Condition No. 2.1. The Hospital was unregistered situated in a 'C' Class Town treating only ENT Patients. Complainant submitted that as per G.R. from Government issued by Astt. Labour Commissioner, the Hospital had been exempted from registration. Respondent submitted that they were willing to settle the Claim subject to the Hospital / Nursing Home satisfying the provisions of Clauses 2.1 of the Policy. Documents and submissions perused. When asked, whether short - fall in number of beds will effect the quality of treatment, the Respondent admitted that if must not be necessarily so. As regards the genuineness of the Hospital, it is noted that the Treating Hospital has never

staked to have more than reality vis - à - vis its present status. Held that the infrastructural short - fall with regard to criteria stipulated in Clause 2.1 is not a tenable and acceptable position to repudiate a Claim. Respondent to pay Rs. 10082/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. NIC / 1 / 101
Mr. Mukesh P. Mehta
Vs.
National Insurance Co. Ltd.

Award Dated 23.2.2005

Repudiation of mediclaim under Clause 4.1 and also based on Medical Referees opinion that hospitalisation was not necessary. Complainant lodged Claim for two occasions of hospitalisation and treatment for Gouty Synovitis. Complainant submitted that the Mediclaim Policy was in force since last 15 years and he exhibited copies of 8 previous years policies. Documents perused. It is observed that the hospitalisation was under advice of Treating Surgeon which conformed to the relevant Policy provisions to qualify the Claim. During Hearing, the respondent confirmed that the mediclaim Policy of the Complainant was in force since last 15 years without break and the past claim experience was also satisfactory. No motivation on the part of the Complainant to force liability of hospitalisation on the insurer. Respondent to pay Rs. 14503/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. UIC / 1 / 130
Mr. Pankaj K. Shah
Vs.
United India Insurance Co. Ltd.

Award Dated 24.2.2005

Complainant's son was operated for Tonsilectomy. Claim repudiated. Complainant did not appear in Hearing. At the time of Hearing. Respondent informed this Forum that they have come into an amicable agreement with the Complainant to settle the Claim at Rs. 4856/- and the Complainant also consented it. Based on this submission, the Award pronounced.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 256
Mr. Seventilal H. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 28.2.2005

Due to back - ache, Complainant's wife was admitted in Hospital. Claim repudiated on the ground that hospitalisation was not necessary and no active line of treatment was given and it was for Rest and investigation as opined by the Medical Referees. Examined the issue with respect to the operative Clauses as laid down in the mediclaim Policy. It is observed that the hospitalisation was as per the advice of a Medical practitioner. Further observed that the Mediclaim Policy for the complainant and his family was incepted in 1990 and the Respondent has awarded 45% C.B. Although the Insured had back - ache for 5 to 6 years, it was not converted into claim for earlier hospitalisations. Held that taking a holistic view of the case and especially that the hospitalisation took place under medical advice, the complainant succeeded on merit. Respondnet to pay Rs.25019/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 - 003 - 0163
Mr. Madanlal Shah
Vs.
National Insurance Co. Ltd.

Award Dated 28.2.2005

Complainant underwent Right Knee Replacement on 31.7.2003 and Left Knee Replacement on 28.09.2003. Respondent settled the Claim lodged against Left knee Replacement, but repudiated the Claim for Right Knee Replacement. The Reason adduced for repudiation of Right Knee Claim was based on MR's opinion regarding pre - existence of disease as well as the Claim was in the 4th year of the policy period. The reason for settling the claim for Left knee Replacement was that the Claim was reported in the 5th year and also no evidence of pre - existence of disease to Left Knee is available, as opined by another MR. Documents and submissions perused. It is observed that there are no such blanket exclusions in the Policy Conditions that a Claim that arises in the 4th year of the Policy is not payable and if it is in the 5th year, it can be payable. Further observed that the MR of the Respondent never wrote that the osteoarthritis of Right Knee resulted in TKR was pre - existing. Respondent to pay Rs. 86500/- to the complainant in FFS of the Claim.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 305
Mr. Atulkumar S. Bhallani
Vs.
The New India Assurance Co. Ltd.

Award Dated 28.2.2005

Complainant's wife (Insured) underwent Vaginal Hysterectomy in November 2002. After her last delivery in 1989 / 90, miscarriages were happening in subsequent years. Respondent repudiated the Claim on the grounds that the Insured underwent D & E in August 2001 and the Fact of miscarriages was not disclosed in the Proposal Form. Documents and submissions perused. It is observed that there is nothing on record to prove that the two previous miscarriages were earlier to 1999 when the Policy incepted. Further, the MR of the Respondent in his Report observed that the Claim is admissible as history of pain since 2 to 3 months casting benefits of doubt. However, he retracted from his earlier stand and wrote a post - script that Claim is not payable. No weightage has been given to this post - script. Held that grounds adduced for repudiation are of having no factual or logical substance. Repudiation set aside.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 156
Mr. Bipin S. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 09.3.2005

Mediclaim – Complainant claimed Rs. 2407/- towards his hospitalisation and treatment expenses. This office through various letters requested the Respondent Company to sent their written compliance which was not complied with by them. However, on Hearing day the Representative of the Insurer submitted that they could not trace out the File and hence, they are not in a position to defend the case and requested further time which was not granted considering enormous delay and non - response from them. Directed the Respondent to pay Rs. 2407/- to the Complainant.

Ahmedabad Ombudsman Centre

Case No. NIA / 1 / 293
Mr. N. S. Thakkar
Vs.
The New India Assurance Co. Ltd.

Award Dated 09.3.2005

Complainant's wife was hospitalised for treatment for Aortic Stenosis and Rheumatic Heart Disease. When Claim lodged, Respondent sent the case papers to their Medical Referees for expert opinion. Based on their Medical Referees opinion that RHD is a disease affecting before the age of 40 years of a person, the Respondent repudiated the Claim on pre - existing ground. Policy was incepted in 1997 and the age of the insured at the time of hospitalisation for treatment of RHD was 64 years. Documents and submissions perused. It is observed that a person who takes a Mediclaim Policy after the age of 40 years and if he was treated for RHD, Policy benefits will be denied to him treating the Disease as pre - existing. Such Blanket Exclusion Clause is not applicable to RHD because, RHD has not been mention in the list of diseases falling under Blanket Exclusions. Hence, opined that to repudiated the claim on the basis of such generic position with regard to nature of illness vis - a - via age will amount to a hidden exclusion, any not be fair as a trade practice. As regards the words used such as "usually", "in the probability" in one of the medical opinions, it is opined that the repudiation cannot be on presumption or probability and it is required to be decided on examination of merit of such case, for which the Respondent seemed to have not seriously looked into. Respondent to pay full claimed amount with 8% simple interest.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 171
Mr. Nizar Samsudin Sohani
Vs.
Oriental Insurance Co. Ltd.

Award Dated 10.3.2005

Repudiation of Mediclaim. Policy incepted on 30.5.2000. While incepting the Policy Complainant's mother was not included in the Policy. She was included when the Policy renewed on 30.5.2001. Claim against her hospitalisation and treatment expenses on 19.12.2002 was repudiated by the Respondent under Exclusion Clause 4.1. Documents and submissions perused. It is observed that as per the Discharge Summary of the Treating Hospital, the Insured had history of CVA for past 2 years. This Hospital record has been accepted as an admissible evidence. The Complainant also could not put forward any evidence to rebut it. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11 / 002 / 0214
Mr. Kishor K. Doshi
Vs.
The New India Assurance Co. Ltd.

Award Dated 14.3.2005

Floater Mediclaim Policy - Complainant underwent Cataract Operation for Right Eye on 15.02.04 and for Left Eye on 27.2.04. Respondent paid the Claim for Right Eye Operation and treated the Claim for Left Eye Cataract Operation as 'No Claim because, the maximum limit for Cataract Operation had already paid to the Complainant towards the settlement of Right Eye Cataract Operation. Held that as per Policy Condition, no further amount is liable to pay to the Complainant since the limit is already exhausted in settling the earlier Claim.

Ahmedabad Ombudsman Centre
Case No. NIC / 1 / 99

Smt. Jyotsna R. Shah
Vs.
National Insurance Co. Ltd.

Award Dated 14.3.2005

Repudiation of Mediclaim - Complainant's husband was hospitalised for treatment for Cortical Sinus Thrombosis. Claim repudiated on the ground of pre - existence of diseases such as Hypertension, Hypercoauca, Recurrent Deep Vein Thrombosis. Respondent submitted that their repudiation decision was solely relying on their Medical Referee's opinion who listed the three diseases as aforementioned and commented that it is a case of pre - existence and hence the Claim is not payable. The point taken for determination is whether anyone of the pre - existing diseases was connected with Cortical Sinus Thrombosis and if so, the Respondent could establish the same with evidences to justify their repudiation decision. Documents and submissions perused. It is observed that the hospitalisation and treatment was for artical sinus Thrombosis, but the Medical Referee of the Respondent did not address himself to the question as to the connection between the aforesaid pre - existing diseases and Cortical Sinus Thrombosis. On the contrary, Treating Physician has very clearly mentioned that the subject illness of the Insured was for the first time and the subject illness has no relationship with either of the three diseases which has been taken into account for repudiation. Opined that the Respondent did not have any medical opinion to establish the pre - existence of disease for what the subject claim is lodged. Respondent to pay Rs. 1,07,474/- to the Compainant.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 163
Mr. Lilachand S. Modh
Vs.
Oriental Insurance Co. Ltd.

Award Dated 17.3.2005

Respondent refused renewal of Mediclaim Policy without Medical Tests at the time of renewal on 6.7.2003 alleging that there was delay in renewal. The Policcy was in force since 1999 to 5.7.2003 without break. Complainant submitted that he had sent a cheque dated 15.6.03 towards premium for renewal of Policy for the period from 6.7.03 to the Branch Office and the same was received by the Branch Office of the Respondent Company 30.6.03. But, instead of renewing the same they sent a Registered letter to the Agent and returned the Cheque pointing out that since there had been break in continuity, the Complainant would have to undergo different Medical Tests before considering renewal. The issue taken for determination is whether the Respondent could prove delay in renewal and whether they are justified in denying the continuity of the Policy. It is observed that the Respondent had received the Cheque for renewal of Policy on 30.6.2003 and then wrote a letter dated 16.7.2003 addressed to the Agent denying renewal. Nothing found to refuse the continuous renewal of the Policy effective from 6.7.03. Directed the respondent to renew the policy without break for the same Sum Insured for the period form 6.7.03 to 5.7.04 and 6.7.04 to 5.7.05 by collecting the premium as is quoted by the Respondent.

Ahmedabad Ombudsman Centre
Case No. 11 / 003 / 0280
Mr. Ushakant M. Sheth
Vs.
National Insurance Co. Ltd.

Award Dated 17.3.2005

Mediclaim Policy - Policy incepted in Oct. 1989. Complainant was operated for CAD on 14.10.2003 and within 45 days, he was again operated on 4.11.2003. In the Discharge Summary of the Hospital with respect to Operation on 14.10.2003, it was mentioned that

the Complainant had Diabetes for 19 years, but in the Discharge Summary for the Operation on 4.11.2003, it was noted as Diabetes for 7 / 8 years. The first Operation was in the Policy year 2002 - 2003 and the second one was during the Policy year 2003 - 04. Respondent took into account duration of disease as 19 years and repudiated the Claims Documents and submissions perused. It is observed that both the Discharge Summaries of the Treating Hospital were contradicting in durations of Diabetes noted therein. When asked to the Respondent that why did they specifically relied on one Report on duration of Diabetes and ignored the other of the same Hospital, and whether they had pursued the matter further with the Hospital, there was no satisfactory reply. As the evidence relied upon by the Respondent for repudiation of the Claims is not indisputably established, benefit of doubt cast in favour of the Complainant. As regards the respondent's plea that the claim is not payable since the second Operations took place within 45 days for relapsed disease, it is opined that it was during the Policy period for 2003 - 2004, and hence the Claim is payable. Respondent to settled the Claim in both the Operations and Awarded Rs. 2,61,000/-.

Ahmedabad Ombudsman Centre
Case No. 11 / 004 / 0218
Mr. Ronak P. Shah
Vs.
United India Insurance Co. Ltd.

Award Dated 18.3.2005

Complainant's son sustained severe injury on his left and right legs in a Hotel at Mt. Abu. After Emergency treatment with 80 to 85 stitches, he was brought back to Ahmedabad as advised by the Doctor and consulted Dr. P. B. Patel, M. S. who admitted the Patient in his Nursing Home for observation and treatment. The Respondent took the stand that as Dr. P. B. Patel himself certified that the hospitalisation was for observation, the Claim is not payable as per Exclusion Clause of the Policy. Documents and submissions perused. It is observed that the Doctor had treated the Child with I. V. Fluids and Antibiotics as well as tests also conducted on him and after examination of reports and condition of the child, the Doctor confirmed that there is no afters effect of shock or injury. As regards the stand taken by the Respondent, it is observed that the action was too rigid without taking into account the fact that the 8 year old Child who severely injured by an explosion at night in a far place, where only emergency treatment can be expected, and after that to ascertain whether there is any internal injury, the Child should have to be taken to a Surgeon as should have been done by any prudent father. Held that the steps taken by the Complainant is justified and claim could not be repudiated simply on strict literal meaning of the words written by the Doctor as 'admitted for observations'. Respondent to pay Rs. 2,629/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11 / 003 / 0139
Mr. Pankaj S. Shah
Vs.
National Insurance Co. Ltd.

Award Dated 18.3.2005

Mediclaim - Complainant's wife was hospitalised due to gynaecological problem. Resondent repudiated the Claim alleging that the Insured's Problem of Dysfunctional Uterine Bleeding (DUB) was pre - existing 15 to 20 years back Examined the documents to ascertain that whether the Respondent could indisputably prove that the disease was pre - existing 15 to 20 years back with unanimous evidences. It is observed that the Respondent totally relied on a noting on the reverse side of Dr. M. H. Doshi's consultation paper and the

Respondent's Medical Referee's opinion was also based on this noting. In the meantime, the Investigation Report of Dr. Y. Shah appointed by the Respondent to investigate into the case reported that the Insured had her D & C operation on 4.2.2002 prior to 8 months back of her Hysterectomy and prior to that she had no problem. Further observed that Dr. Anjana Shah, a very senior Gynaecologist and Treating Surgeon, certified that the duration of present disease as nearly 8 months, and it is Acute, but not Chronic. Held that since the documents available on record were not unanimous in duration of sickness, repudiation of the Claim under Exclusion Clause 4.1 is not justified and benefit of doubt cast in favour of the Complainant. Respondent to pay Rs. 45,971/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 303
Mr. Sanjay B. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 18.3.2005

Complainant submitted Claim papers on 18.2.2003 to the TPA of the Respondent for reimbursement of hospitalisation expenses of Rs. 21,252.00. On 5.10.2004, the Complainant received a Dscharge Voucher for Rs. 21,135/- which was not executed by him as a protest in delay as well as non - response either from TPA or from the Respondent till that time. Respondent submitted that when the Grievance Cell recevied representation from the Complainant in December 2003, they procured the documents from TPA and sent the discharge Voucher for Rs. 21,135/- to the Complainant. It is observed that there had been some problem faced by the Respondent because of submitting Claim papers to TPA by the Complainant, but at the same time, the Respondent was able to settle the claim within one month as soon as they came to know about such lapse on the part of the Complainant in December 2003. As regards the deduction of a nominal amount from the claimed amount of Rs. 21,252/- , the Respondent could not identify the voucher or to give reasons for the deductions. Claim allowed for Rs. 21252/- alongwith 8 % simple interest for the period from 1.1.04 to 5.10.2004.

Ahmedabad Ombudsman Centre
Case No. UIC / 1 / 145
Mr. Dineshchandra M. Jasani
Vs.
United India Insurance Co. Ltd.

Award Dated 21.3.2005

Mediclaim - Claim lodged towards hospitalisation and treatment expenses incurred by the Complainant, was repudiated. The reason for repudiation was that the Compainant had undergone Coronary Artery Bypass Surgery and that Cardiac disorder as well as a number of diseases were excluded from the Cover when it is renewed for the period from 18.9.02 to 17.9.03 after a break of 5 months although the Complainant had Mediclaim Policy since 1997. Complainant submitted that the Respondent had never issued him Policy Documents with Exclusions. In the meantime, the Policy Document issued to him with Exclusions was only after he lodged the Claim for the subject hospitalisation and treatment. Documents and submissions perused. It is observed that the Computer generated Policy Document in the possession of the Complainant was of having no exclusions. At the same time, Respondent forwarded Policy Document with number of Exclusions including Cardiac Disorder to the Complainant by Registered Cover on 20.2.03. Further observed that the Reports of Medical Referees were not found having evidentiary value. However, the Certificate of the Treating Surgeon dated 11.9.02 was convincing and having evidentiary value. The Claim history of the complainant in the past also been taken into consideration

while deciding the Claim. Repudiations set aside and directed the Respondent to pay Rs. 1,60,582/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. NIA / 1 / 304
Mr. Praful A. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 23.3.2005

Complainant took a Mediclaim Policy from the Respondent in 2003. Prior to that, he and his family was covered under Group Mediclaim Policy with National Insurance Company. The Respondent issued Policy with certain Exclusions and also without awarding any C. B. Complainant approached the Respondent for deletion of Exclusions and allowing C. B. which was not materialised. Documents and submissions perused. It is observed that the Respondent had passed an endorsement effecting cancellation of Exclusions in the first year Policy and the 2nd years Policy had been issued without any Exclusions. As regards the Complainant's pleading for C. B, it is explained to the Complainant, the difference between a Group Family Floater Policy and an individual Mediclaim Policy and why continuity of Policy could not be considered for granting C. B in individual Mediclaim Policy. It is also pointed out to him that the Respondent has allowed C. B. for the second year of the Policy with the Respondent. The Complainant expressed his satisfaction with the explainations given during Hearing. Thus, treated the complaint as resolved and disposed.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 148
Mr. Paresh L. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 30.3.2005

Mediclaim - Complainant's son suffered fracture on hand due to accident. Claim for hospitalisation and treatment expenses was repudiated invoking Policy Conditions in respect of eligibility criteria for a Hospital as a Medical Service Provider, for qualifying a mediclaim. Complainant submitted a statement from the treating Surgeon confirming that the Hospital is registered with local authorities. Although Respondent interpreted that the registration that they require was different from what had been submitted by the Complinant, they could not show any communication explicitly stating the type of Registration they required. On perusal of documents it is observed that a Major TPA of India had entered into a MOU with the Hospital as part of their Network of Medical Service Provider. Further observed that the Respondent had sent Discharge Voucher in October 2004, which was not executed by the Complainant as no compensation for delay in settlement was given. Directed the Respondent to pay Rs. 5370/- with 8 % simple interest.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 168
Mr. Jagdishchandra M. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 31.3.2005

Complainant held a Mediclaim Policy for himself and his family. Claim for hospitalisation and Operation performed on his daughter was repudiated by the Respondent. During Hearing Respondent submitted that they reconsidered their repudiation decision and on

admission of the Claim they had sent Discharge Voucher for Rs. 7000/- which was duly executed by the Complainant. It is observed from the record that the Complainant had received the Cheque. Closed the complaint as resolved.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 160
Mr. D. J. Shah
Vs.
Oriental Insurance Co. Ltd.

Award Dated 31.3.2005

Mediclaim – Respondent repudiated the Claim lodged for hospitalisation expenses incurred, on the ground that the disease was an excluded one as per Mediclaim Policy. Complainant moved his case to Grievance Redressal Cell and as a result, the Respondent reconsidered and admitted the Claim and sent a Discharge Voucher for Rs. 28,000/-. During Hearing, the Complainant submitted that he has executed the Discharge Voucher and received the payment of Rs. 28,000/-. He pleaded that the Respondent paid less amount than what is claimed and also he had not been compensated for delay in settling the Claim. Documents perused. It is observed that the Complainant has given a valid Discharge to the Company. Hence, it is ascertained that whether there was any coercion, undue influence, mis - representation on the part of the Respondent to force the Complainant to give the discharge. From the reply of the Complainant, it is ascertained that there was no such foul play on the part of the Respondent. Based on judicial precedents in such similar cases, it is held that no more relief is warranted to be extended to the Complainant.

Ahmedabad Ombudsman Centre
Case No. OIC / 1 / 158
Mr. Mahendrakumar Upadhyay
Vs.
Oriental Insurance Co. Ltd.

Award Dated 31.3.2005

Mediclaim – Complainant was hospitalised due to Tonsils. Claim towards hospitalisation expenses was repudiated on the ground that the Complainant was suffering from Tonsils since last 3 years i.e., prior to inception of Policy and the Respondent claimed to have been noted it by the Treating Doctor in his report. When asked for the said Report of Treating Doctor, the Respondent submitted it before the Fourm. On verifying the same, it is noted that there was no such mention of Tonsils in the said Report. As the ground of repudiation was on above ground, this office asked the respondent to submit the Proposal Form and Underwriting Sheet. But the Respondent stated that such documents were not available with them. Therefore, this office gave opportunity about 1 ½ hours to sort out relevant papers from the file to enable them to defend their stand of repudiation. But, the Respondent failed to lay their hands on the documents. Respondent to pay Rs. 20837/- to the Complainant.

Bhubaneshwar Ombudsman Centre
Case No. IOO / BBSR / 11 - 452
Mrs. Minati Ray
Vs.
Oriental Insurance Co. Ltd.

Award Dated 27.10.2004

Insured complainant, an employee of L.I.C. of India covered under the Group mediclaim Policy with Oriental Insurance Co. Ltd. Insured complainant underwent laparoscopic operation for “Infertility” due to blockage of fallopian tube and operation became

unsuccessful. Then insured complainant undergone IVF (In vitro fertilzation) procedure & claimed for the reimbursement of medical expenses. Insurer repudiated the claim as per policy condition 4.8 which excludes sterility. Sterility & infertility are defined synonymously. Insurance ombudsman upheld the repudiation as it specifically excludes “Sterility”.

Bhubaneshwar Ombudsman Centre
Case No. NL / NIA / 11 / 11 / 04 - 05 / GHY
Shri Prashanta Goswami
Vs.
New India Assurance Co. Ltd.

Award Dated 23.11.2004

Facts : Contention of the complainant is that due to serious cardiac attack on 9th august 03 he was rushed to GNRC Hospital, where an emergency Angioplasty was carried out. On release from the hospital, he submitted his claim but there was very poor response. That at the belated stage a sum of Rs. 1,71,477.43 was released in his favour and he received this sum on 06.01.2004. That no reason was shown for deducting an amount of Rs. 19,737.57 from his total claim amount of Rs. 1,91,215/-.
Issue : Whether partial repudiation of the claim by deducting a sum of Rs. 19737.57 from the original claim amount of Rs. 1,91,215/- could be justified by the opposite party.
Discussions : I have gone through the materials and records. No document is available in support of the partial repudiation of the claim.
Decision : It is hereby directed that the balance amount will be paid within 15 to 30 days from the date of receipt of copy of this Award alongwith in 6% simple interest p.a. w.e.f. 1st November, 2003 till the date of final settlement of this claim.

Bhubaneshwar Ombudsman Centre
Case No. NL / UII / 11 / 124 / 03 - 04 / GHY
Dr. Dipankar Banerjee
Vs.
United India Insurance Co. Ltd.

Award Dated 07.12.2004

Facts : The contentions of the complainant are that his wife (who had insurance cover) was admitted into the Jaslok Hospital for treatment of ‘osteoporosis’. That on recovery and discharge from the hospital the complainant submitted his bills for re - imbursement which had been repudiated on the ground that the ailment in question was ‘pre - existing’ at the time of submitting the proposal.
Contentions of the opposite party, however, are that the complainant proposed for medical insurance for the first time on 16th Sept. 99 covering self, wife Purabi Banerjee and his mother Maya Banerjee. That the policy was renewed till 20.09.01 and thereafter again opted for the same persons including self for the period 24.09.2002 to 23.09.03 with a declaration that none of the family members aforesaid had any pre - existing disease including diabetes, Hypertension etc. That when the hospital bills along with ‘discharge card’ were submitted preferring the medical re - imbursement it was revealed that she had been suffering from hypertension, hyperglycamia (diabetes), post menopausal osteoporosis. That the case being one of the pre - existing diseases it attracts the exclusion provisions 4.1 and 4.3 of the policy condition and accordingly fraud was played by the insured on the insurer willfully at the time of taking the policy with an intention to take undue advantage etc.
The issue involved here for the decision in this case is whether the view of the opposite party that the disease for which the insured had undergone treatment at Mumbai was pre - existing at the time of submitting the proposal form to policy. The policy copy forwarded shows that there was insurance cover from 24.09.02 till 23.09.03. But a photo – copy of the proposal form shows that the signature of the proposer was taken on 16.09.99. So, it is

difficult to say that it was a renewal policy. The insured was treated for Hypertension and Hyperglycemia alongwith Post Menopausal Osteoporosis and not for only Hyperglycemia (Diabetes) and Hypertension which find mention in the original proposal form dtd. 16.09.99 where the answer by the proposer was recorded as 'does not arise'. In the instant case the inception of policy appears (from the documents filed before me) to be in Sept. 99. Therefore, there was no scope for the proposer for mentioning of any disease from which insured was suffering from 16th Sept'99 till 24.09.02. Therefore, repudiation of the claim is neither appropriate nor logical. (Full discussion of evidence not reproduced)
It was a case of treatment of a new kind of ailment which developed after submission of initial proposal. It has no relation whatsoever with any pre - existing diseases.
Direction was given to settle the claim on actual voucher basis within prescribed time.

Bhubaneshwar Ombudsman Centre
Case No. I. O. O. / BBSR / 11 / 458
Shri Sudhakar Mohapatra
Vs.
United India Insurance Co. Ltd.

Award Dated 14.12.2004

Insured complainant, retired conservator of forest had taken a mediclaim policy for the period 17.05.2000 to 16.05.2001 for himself only. On 4 - 4 - 2001 the complainant underwent bypass surgery at Kalinga Hospital. Insured preferred a claim for the reimbursement of Rs. 111, 031 / of medical expenses incurred by him. Insurer repudiated the claim as the insured suppressed the material facts relating to the pre - existing of disease while making a proposal for insurance. The discharge certificate states that insured was suffering from chronic stable angina. More over investigator opined that insured had a mild stroke in 1995 - 96 while he was in service & had taken one month leave. During Hearing insured stated that he never suffered any heart stroke in 1995 - 96 nor was on leave for treatment of any disease during the said period. Ombudsman awarded Rs. 111,031/- in favour of insured complainant as the discharge certificate does not spell out the time since when the insured was suffering from angina & insurer has no leave particulars from the employer, report from treating doctor and had not made any correspondence with the former employer of insured.

Bhubaneshwar Ombudsman Centre
Case No. I. O. O. / BBSR / 14 / 446
Shri Prem Kumar Agrawal
Vs.
New India Assurance Co. Ltd.

Award Dated 5.1.2005

Insured complainant, had taken a mediclaim policy for sum insured of Rs. 320,000/-. The complainant was initially admitted in to Neelachal Hospital for appendicular perforation with multiple caecal perforation. Due to post operational complication he was admitted into Global Hospital, Hyderabad for hemicolectomy operation. Insured complainant lodged a claim of Rs. 4,69,156.85 towards medical expenses. Insurer delayed settlemed on the pretext of investigation as the expenses was exorbitant. So, the complainant preferred this complaint. Insurance ombudsman directed the insurer to pay Rs. 320,000/- to the complainant.

Bhubaneshwar Ombudsman Centre
Case No. I.O.O. / BBSR / 11 / 004 - 0004
Shri Smruti Ranjan Sarangi
Vs.
United India Insurance Co. Ltd.

Award Dated 29.03.2005

Shri Smruti Ranjan Sarangi had taken a mediclaim policy from United India Insurance Co.Ltd. for sum Insured of Rs. 200,000/- for the period 24 - 8 - 2001 to 23 - 08 - 2002. Insured complainant renewed the policy for one year commencing from 24.08.2002. During the currency of renewal policy complainant under went angioplasty at Apollo Hospital, Hyderabad and claimed Rs. 296,00/- towards reimbursement of medical expenses. Insurer repudiated the claim on the ground that the disease was pre existing. During the Hearing Insurer stated that Dr. J. P. Das, a retired professor of cardiology has opined that though the disease possibly could have existed before 24.08.2001 but there is no record to show that. It is not possible to comment as to how long the disease existed prior to 24.08.2001. Complainant stated that he is a regular mediclaim policy holder since 1989 and he did not suffer from any disease prior to 8 - 12 - 2002. Apollo Hospital discharge summery states that “patient a known case of hypertension (recently detected 2 months back). No history of DM / COPD / Asthma. Insurance Ombudsman directed the insured to pay Rs. 210,000/- which includes the bonus of 5% for free claim experience as the repudiation was arbitrary and unethical.

Chandigarh Ombudsman Centre
Case No.GIC / 61 / UII / 11 / 04
Shri Surendra Paul Singh
Vs.
United India Insurance Co.

Award dated 30.11.04

FACTS : Shri S.P. Singh had taken a Overseas Mediclaim Policy for US $ 250000 for the period 03.08.02 to 01.09.02. He fell ill in Dubai and got himself examined in Welcare Hospital. He underwent surgery on 28.08.02 for normal pressure hydrocephalus. He was informed by hospital authorities that since CORIS, Paris the service provider was not listed for credit with them, he should pay for treatment and get the expenses reimbursed. He lodged a claim for Dirham 29,418.28 with CORIS Paris, but did not get any response. He was informed by the Manager, H.O., UII on 12.3.2003 that CORIS Paris had denied the liability on the ground that he had past history of Parkinson’s syndrome and the treatment related to a pre - existing disease.

FINDINGS : Before taking the policy, the complainant underwent requisite medical tests. He admitted that he underwent brain surgery in 1960 after he fell while playing football. He, however, contended that the operation for the present ailment was not related to past surgery. The claim was however, repudiated on the ground that earlier open brain surgery was not notified. He also did not disclose that he was suffering from high B.P. for the last 20 years. Besides, normal pressure hydrocephalus for which he was treated could not have developed overnight. The claim was also not permissible under General condition no.10 (a) which stipulates that an overseas mediclaim policy is not a general health insurance policy and is intended for use by the insured person in the event of a sudden and unexpected sickness or accident outside the Republic of India.” The liability was disowned by CORIS before he underwent operation on the ground of past medical history and suppression of material facts.

DECISION : Held that the claim was not admissible as the insured suppressed material facts relating to past history of brain surgery and high BP. Besides, the claim was also not tenable, under general condition 10 (a) of the policy, since it was not an emergent surgery.

Chandigarh Ombudsman Centre
Case No. GIC / 37 / NIA / 11 / 05
Shri B.P. Singhal
Vs.
The New India Assurance Co.

Award dated 31.12.2004

FACTS : The complainant had taken a mediclaim policy for sum insured of Rs. Three lacs. He was hospitalised for two days from 26.02.03 to 28.02.03 for treatment of frozen shoulder at Ayurveda Kendra which was followed by OPD treatment for 19 days. He filed a claim for Rs. 21,000/- together with necessary bills and documents. He was informed that the claim was not payable as hospitalisation at Ayurveda Kendra was not justified.

FINDINGS : The complainant tried various allopathic remedies for treating his frozen shoulder, but nothing worked. Eventually, he consulted Dr. Sudha Ashokan of Ayurveda Kendra, who advised admission in her centre. The discharge report revealed that even after hospitalisation the pain reduced somewhat, but he was not fully cured. Before repudiating the claim the insurer sought the opinion of a doctor who expressed the view that hospitalisation was not necessary in this case. Since the insured felt that the opinion of an allopathic doctor was biased, another opinion of Dr. S.K. Sachdeva, Consultant Ayurvedic was taken, who opined that the therapy did not necessarily require hospitalisation. The complainant asserted that the hospitalisation was necessary as Dr. Sudha Ashokan wanted to finalise the treatment regime after subjecting him to various medicines and ascertain tolerance limits of certain medical applications.

DECISION : Held that it is not for the patient to determine or decide whether to be hospitalised or not. It is a matter on which judgement is exercised by the treating physician. In the instant case, Dr. Sudha Ashokan felt that hospitalisation was required for determining parameters of treatment subsequent to hospitalisation. Therefore, there was no merit in the contention of the insurer. Held that the claim was payable.

Chandigarh Ombudsman Centre
Case No. GIC / 91 / UII / 11 / 05
Shri Vishal Tandon
Vs.
United India Insurance Co.

Award dated: 31.12.2004

FACTS : The complainant has been a holder of mediclaim policy for the past many years. During the currency of the policy for the year 2003 - 04, after severe pain in the neck he suddenly fell on the floor on 1.2.04. The family doctor prescribed some medicines, which did not provide much relief. He was, therefore, admitted in the Arora Neuro Centre for observation. He filed a claim for Rs. 9,900/-. It was repudiated by DO - I Ludhiana vide letter dated 3.8.2004 on the ground that hospitalisation was primarily intended for investigation.

FINDINGS : The claim was repudiated by TPA on the ground that the claimant after fall remained lying on the ground for two minutes was hospitalised the next day. Had it been an emergency, he would have rushed to the hospital immediately. The complainant contended that the tests including MRI, were required for determining his treatment and that the liability could not be disowned in case hospitalisation was required for treatment of an ailment for which some tests were necessary.

DECISION : The tests were conducted subsequent to insured having fallen on 1.2.2004 and not on the basis of any suspicion. Besides, admission in the Arora Neuro Centre next day was on the advice of a specialist. Tests conducted subsequent to his fall could not be viewed as investigative. Held that the claim was payable.

Chandigarh Ombudsman Centre
Case No. GIC / 90 / UII / 11 / 05
Sh. R.P. Gupta
Vs.

United India Insurance Co.

Award dated: 24.1.2005

FACTS : The complainant had taken a mediclaim policy for self and family members effective from 9.2.04. His wife was taken ill on 25.2.04 due to acute gastroenteritis and had to be hospitalised in N.C. Jindal Institute of Medical Care and Research , Hissar. He submitted a claim for Rs. 1971 on 15.3.04, but was reimbursed Rs. 1781 only. A sum of Rs. 40 towards hospital admission fee and Rs. 150 for room service charges were disallowed. He was informed that these were not reimbursable as expenditure on these items did not fall under any of the specified categories listed in policy.

FINDINGS : It was contended that room service charges were rightly disallowed as it was not clear what these charges pertained to. The complainant gave a certificate dated 17.12.04 issued by N.C. Jindal Institute to the effect that Rs. 150 were charged for nursing services provided to the patient during her treatment in the private room for the period 25.2.04 to 27.2.04.

DECISION : Nursing charges are covered under the policy and hence Rs. 150 were reimbursable. Besides, admission fee is a valid charge for hospitalisation. Held that a sum of Rs. 190 disallowed earlier (Rs. 150 nursing charges and Rs. 40 admission fee) was payable to the complainant.

Chandigarh Ombudsman Centre
Case No. GIC / 131 / NIA / 11 / 05
Sh. Gopal Krishan
Vs.
The New India Assurance Co. Ltd.

Award dated 25.2.2005

FACTS: Shri Gopal Krishan had taken a family mediclaim policy for the period 18.2.03 to 17.2.04 for sum assured of Rs. 25000. The policy interalia included Aanchal his grand daughter. She was taken ill and diagnosed to be a case of post aural abscess of right ear. He filed a claim for Rs. 19,733 with the insurer which was repudiated by the TPA on the ground that it pertained to a pre - existing disease. The complainant admitted that as recorded in the discharge summary, she had a history of post auricular swelling of the right ear 5 - 6 years back. But after I and D she had fully recovered. He claimed that the repudiation of claim was not justified as the insured had not been suffering from the disease for the past 5 - 6 years.

FINDINGS : The insured had similar problem 5 - 6 years ago, but she had fully recovered as recorded in the Case Summary and Discharge Slip issued by the hospital authorities. The insured did not disclose in proposal form the fact of her having undergone I and D for treatment five years ago. The basic issue, however, was whether recurrence of a disease which is fully cured can be treated as the same thing as a pre - existing disease.

DECISION : Held that recurrence of a disease is not synonymous with a pre - existing disease. The insurer had, therefore, erred in disowning the liability. Ordered that the claim be paid.

Chennai Ombudsman Centre
Case No. 11.02.1082 / 2004 - 05
Smt. A. Ananthi Arvinth
Vs.
The New India Assurance Co. Ltd.

Award Dated 12.10.2004

The complainant, Smt. Ananthi Arvindth and her spouse Shri K. Arvinth were insured under mediclaim policy from 1.1.2003 onwards. Shri K. Arvinth was hospitalised from 10.10.03 to 27.10.03 for Coronary Artery Disease (CAD) and a Coronary Artery Bypass Graft (CABG) was done on him. His claim was repudiated by the insurer on the ground that the discharge

summary, as well as the attending doctor's certificate revealed that Shri Arvinth was suffering from DM for 12 years and Hypertension for 2 years and CAD, being a direct complication of hypertension, which was pre - existing, the claim was not payable.

The Complainant contended that only after the hospitalisation in October, 2003, it was revealed that Shri Arvinth was suffering from Diabetes and Hypertension and the history of DM and Hypertension was wrongly recorded in the discharge summary as per wrong information given by one of their relatives to the duty doctors.

In view of the insured's contention, the insurer was directed to obtain the indoor case records / records of earlier hospitalisation pertaining to angiogram done in July 2003. As per the records submitted by the insurer subsequently, it was observed that the discharge summary of July 2003 hospitalisation, medical certificate of attending doctor at that time and the ,medical certificate of the attending doctor in the claim form of the present hosptialisation stated that the insured had longstanding diabetes of 12 years duration and longstanding hypertension.

It was therefore, concluded that the contention of the complainant that DM and HTN was detected only during the hospitalisation in October 2003 was not accepted. Further, she also submitted a certificate from the attending doctor stating "Shri K. Arvinth was a .... standing diabetic and hypertensive" whereas the certificate originally read as "long standing diabetic and hypertensive". Hence, it was held that the complainant had misled the Forum with a tampered record and such being the case, the Forum was not inclined to give any relief. The complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.5.1121 / 2004 - 05
Shri Ganpath Kakde
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 18.10.2004

The complainant Shri Ganpath Kakde and his spouse, Smt. Suman Kakde were insured under mediclaim policy from September 1998 onwards. Smt. Suman Kakde was hospitalised from 22.07.02 to 24.07.02 for treatment of varicose veins. Her claim for reimbursement of medical expenses was repudiated by the insurer on the grounds that the hospital records revealed that she had been suffering from the said ailment for the past 12 years and hence, the ailment was pre - existing. In addition to repudiation of the claim, the insurer also cancelled the policy since the information regarding this ailment was not disclosed in the proposal form.

The complaint represented that his wife was having leg problem for the past 1 to 2 years only and she was taken to the Hospital for the present treatment only when she started developing ulcers in the legs The discharge summary also did not contain any mention of the said illness being 12 years old.

It was observed from discharge summary that the insured was suffering from Varicose Veins since 1 ½ years and this was also confirmed by the subsequent investigation done by the insurer. During the hearing also, the insurer accepted that the duration of the disease was 1 ½ years only and not 12 years as was construed by them earlier. It was, therefore, held that the disease was not pre - existing in view of which the cancellation of the policy was not justified since there was no suppression of material facts in the proposal form.

The insurer was directed to reimburse the admissible medical expenses and also revoke the cancellation and restore the policy from the date of cancellation. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.5.1142 / 2004 - 05

Shri S. Sivayogan
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 25.10.2004

The complainant, Shri S. Sivayogan was insured under mediclaim policy from 23.08.2000 onwards. He was hospitalised in Goodwill Hospitals, Chennai from 16.08.03 to 20.08.03 for "Chronic liver disease (Decompensated) HBV related, pedal edema". His claim was repudiated by the insurer on the ground that the discharge summary revealed that the disease was in existence for more than 2 years and hence was pre - existing.

It was observed that the insurer had based their conclusion of pre - existence of the disease on the Immuno Haeomatology test confirming HBSAG which had been done in June 2000 whereas the insured was covered from August 2000 only. However, it was pointed out to the insurers that the said report pertained to June 2001 and not June 2000 which the insurer had mistakenly made out to be. During the hearing, the insurer was directed to reconfirm the year of Immuno Haematology test. The insurer subsequently confirmed it to be June 2001 only. As per this confirmation and also since there was no other medical records to substantiate the existence of the disease prior to August 2000, it was held that the repudiation of the claim was not tenable and the insurer was directed to reimburse the admissible medical expenses. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.4.1306 / 2004 - 05
Smt. N. Rajalakshmi
Vs.
United India Insurance Co. Ltd.

Award Dated 05.11.2004

The complainant, Smt. N. Rajalakshmi and her husband Shri K. R. Narasimhan were insured under mediclaim policy. Shri Narasimhan was hospitalised in S. K. Hospital, Karur from 3.7.03 to 4.7.03 for hypertension and giddiness. Subsequently, on discharge, he moved to Bangalore where a number of diagnostic tests were done on him. His claim for reimbursement of medical expenses was repudiated by the insurer on the ground that the hospitalisation was for investigation and evaluation of the ailment only and hospitalisation was not necessary for the given treatment.

It was observed from the documents submitted in the case that no significant treatment was admitted on the insured in the hospital and also the investigative tests like the CT scan were done outside. Apart from a study report of the attending doctor stating that the patient was admitted for Hypertention and giddiness, and the bill of the hospital, no other medical records of the hospital in the form of discharge summary giving details of the investigations, diagnosis and course of treatment given during the hospitalisation was produced. The subsequent tests conducted at Bangalore was also done as an outpatient only. Under the circumstances, there being no necessity of hospitalisation, it was held that the claim did not fall within the ambit of the mediclaim policy and the complainant was not entitled to any relief. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.3.31233 / 2004 - 05
Shri Bharat C. Shah
Vs.
National Insurance Co. Ltd.

Award Dated 8.11.2004

The complainant, Shri Bharat C. Shah and his father Shri Chaman Lal Shah were insured under mediclaim policy from 24.4.1995 onwards. Shri Chaman Lal Shah was hospitalised from 15.3.2004 to 24.3.2004 for Chronic Obstructive Pulmonary Disease (COPD). The insured's claim for reimbursement of medical expenses was repudiated by the TPA's of the insurer on the ground that the patient was a diagnosed case of COPD since 1996 which was prior to inception of the first cover and hence the disease was pre - existing.

During the hearing, the insurer confirmed that the insured was covered under scheme 'B' for the period 1995 - 96 and for the period 1996 - 97, the sum insured was Rs. 60,000/- which was subsequently increased to Rs. 3 lakhs and hence the stand of the TPA that the disease was pre - existing was incorrect. They had also confirmed the date of commencement of the first policy (i.e. 24.4.95) to the TPA and directed them to settle the claim for Rs. 60,000/-. However, due to some procedural lapses, the TPA's had not settled the claim till the date of hearing.

Since the insurer, during the hearing, admitted their liability, they were directed to settle the claim upto a limit of Rs. 60,000/- which was the sum insured at the time of contracting the disease along with cumulative bonus, earned if any. It was also noted that despite the directions of the insurer to settle the claim, the TPAs had not complied with the same causing considerable hardships to the insured. Hence, the insured, in addition to the admissible claim amount, was also awarded 8 % interest from the date of repudiation of the claim, 13.5.2004, till the date of payment. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.5.1213 / 2004 - 05
Smt D. Saraswathi
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 9.11.2004

The complainant, Smt. D. Saraswathi and her family, including her mother Smt. Menaka were insured under mediclaim policy from 24.12.2001 onwards. Smt. Menaka was hospitalised in Kannan Hospital, Pudukottai from 22.11.2003 to 25.11.03 for right Hemiplegia. Her claim was repudiated by the insurer on the ground that Smt. Menaka was a diabetic for the past 15 years and pre - existence of diabetes had led to the right side Hemiplegia. Further the fact that she was suffering from diabetes was also not disclosed in the proposal form. The complainant contended that they became aware that Smt. Menaka was suffering from diabetes only during the present hospitalisation and that the present ailment was not contracted due to diabetes.

The documents submitted in the case revealed that Smt. Menak was admitted for "Right Hemiplegia - Known DM" and the internal case papers of the hospital confirmed the risk factor for right hemiplegia as Hypertension / DM and her blood sugar was 411. There was also a certificate from her family doctor stating that Smt. Menaka had diabetes for the past 15 years.

Since the nexus between a stroke and Diabetes / Hypertension was medically acknowldeged and there had been suppression of material facts by the insured while proposing for insurance, it was held that the insurer could not be faulted for repudiating the claim. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.3.1099 / 2004 - 05
Shri T. Sekar
Vs.
National Insurance Co. Ltd.

Award Dated 12.11.2004

The complainant, Shri T. Sekar was insured under mediclaim policy from 30.9.1997 onwards. He was hospitalised from 4.4.04 to 7.4.04 for Coronary Artery Disease (CAD) for which a coronary angioplasty (PTCA) with stenting was done. His claim for reimbursement of medical expenses was repudiated by the insurer by invoking exclusion clause 4.1 of the policy on the ground that the disease pre - existed to the date of inception of the first cover, i. e. 30.9.1997.

It was noted from the history recorded in the discharge summary of the present hospitalisation that Shri Sekar had Myocardial Infarction in the past for which he underwent POBA to distal LAD and distal Circumflex in 1996. The discussion recorded in the discharge summary also mentioned that Shri Sekar was a known Ischamie Heart disease (Old Inferior Wall Myocardial Infarction) with POBA to distil LAD and LCS in 1996. A copy of discharge summary dated 16.2.96 of the hospital, where the insured took the treatment in 1996, was also produced to this Forum. Hence, it was held that the disease being pre - existing the insurer could not be faulted for repudiating the claim. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.3.1151 / 2004 - 05
Shri K. S. Sivakumar
Vs.
National Insurance Co. Ltd.

Award Dated 15.11.2004

The complainant, Shri K. S. Sivakumar and his wife were covered under mediclaim policy from 28.04.02 onwards. Smt. Gomathi was hospitalised in Ganga Hospital, Coimbatore from 11.11.03 to 12.11.03 for split ear lobule (L) and Depressed Scar ® ear lobule and repair of both ear lobules was done. The insured's claim for reimbursement of medical expenses was repudiated by the insurer on the ground that the treatment undergone was not necessitated due to any illness or disease but was for cosmetic purposes and the same was an exclusion under the policy.

The documents submitted before the Forum included certificates from the doctors who had attended on the insured not only during the present hospitalisation but also during the earlier treatment taken by the insured for the same problem in the year 2002. As both the certificates did not indicate any accidental happening leading to the tear of the ear lobe, it was concluded that the hospitalisation was for cosmetic reasons only and was not necessitated due to any disease or injury caused by accident. The repudiation of the claim was upheld and the complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.2.1229 / 2004 - 05
Shri K. Sripath
Vs.
The New India Assurance Co. Ltd.

Award Dated 16.11.2004

The complainant, Shri K. Sripath was insured under mediclaim policy for the past 4 years. He was hospitalised from 3.1.04 to 4.1.04 and was diagnosed to have Chronic Sinusitis / Deviated Nasal Septum for which FESS / Septoplasty with Inferior Turbinectomy Right was done. His claim for reimbursement of medical expenses was repudiated by the insurer on the ground that the insured had been suffering from the problem and symptoms of Sinusitis for the past 15 years and hence the claim was not payable.

It was observed from the medical records submitted in the case that the insurer had repudiated the claim on the basis of a noting in the discharge summary about history of "15

years" of nose block. However, the insured submitted another discharge summary correcting the history of the nose block as "1 year" which the insurer did not accept. It was noted that the discharge summary in which the history of the complaints was corrected as "1 year" was initialed by the attending doctor. Further, the medical certificate, forming part of the claim form and filed in by the attending doctor, also revealed that the insured was suffered from the said complaints "On and Off for the past 1 year", there was no significant past history and also the present ailment was not a complication of any pre - existing disease. The attending doctor had also certified that the diagnosed ailment was not congenital in nature.

In view of the correction regarding the history of the ailment having been duly certified by the attending doctor and also his certificate in the claim form, as explained in the preceding para, it was concluded that the contention of the insurer that the disease was pre - existing was found not tenable and the insurer was directed to entertain the claim and pay the admissible medical expenses. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.3.1338 / 2004 - 05
Shri S. Ranganathan
Vs.
National Insurance Co. Ltd.

Award Dated 24.11.2004

The complainant, Shri S. Ranganathan was insured under mediclaim policy for the period 4.4.03 to 3.4.04. He was hospitalised in Vijaya Health Centre, Chennai from 3.6.03 to 6.6.03 and the diagnosis was "Acute Posterior Fissure in Ano with Grade I BPH / Hammorrhoids Grade - III / DM / HTN / Gastric Ulcer / Gastritis". His claim for reimbursement of medical expenses was repudiated by the insurer on the grounds that DM was an exclusion under the policy, HTN was pre - existing for the past 4 years and IIIrd degree Haemorrhoids being a late manifestation of Haemorrhoids, would have been pre - existing and hence the claim was not payable.

It was observed from the medical records submitted that the insured had been suffering from hypertension for the past 4 years and DM was specifically excluded from the scope of the cover. Further, Exclusion clause 4.3 of the policy also excluded BPH and Piles (Haemorrhoids) from the scope of the cover during the first year of insurance. It, therefore, emerged that the expenses incurred for treatement of DM, HTN, BPH and Haemorrhoids were not payable under the policy.

It was, however, noted that the insured was also afflicted fissure in ano and gastric ulcer / gastritis and received treatment for the same. Since the same were independent of the excluded diseases, the insurer were liable for any expenses incurred towards investigations and treatment for the same. Hence, it was held that the insurers were not justified in repudiating the entire claim and were directed to reimburse the admissible medical expensess for treatment of fissure in ano and gastric ulcer / gastritis. The complaint was party allowed.

Chennai Ombudsman Centre
Case No. 11.3.1023 / 2004 - 05
Shri Kaushik R. Thakkar
Vs.
National Insurance Co. Ltd.

Award Dated 29.11.2004

The complainant, Shri Ramesh M. Thakker was insured under mediclaim policy with National Insurance Co. Ltd. from 9.10.2000 onwards Earlier, he was insured with the Oriental Insurance Co. Ltd. from 9.10.1998 to 8.10.2000. The sum insured under the

policies for the period 1998 to 2000 was Rs. 65,000/- , which was increased to Rs. 1,00,000 for the policy periods 2000 - 2003 and further to Rs. 2,00,000/- from October 2003 onwards.

The insured was hospitalised from 27.10.2003 to 06.11.2003 in Apollo Hospitals and was diagnosed to be suffering from CAD for which he underwent Coronary Artery Bypass Graft. His claim for reimbursement of medical expenses for Rs. 2,63,430/- was settled by the insurer for an amount of Rs. 1,10,000/- only on the ground that the insured was suffering from chest pain since September 2003, i.e. one month before the sum insured was increased from Rs. 1,00,000/- to Rs. 2,00,000/- under the policy effective from 11.10.2003.

From the documents submitted before the Forum, it was observed that the insured was admitted on 18.10.2003 for coronary angiongraphy followings a TMT taken on 17.10.2003 and the complaints at this point of time was retrosternal chest pain for the past 20 days. The discharge summary of Apollo Hospitals contained the noting that the insured was admitted with history of class II Angina since 1 month and with a positive TMT for further cardiac evaluation. Hence, it followed that angina / restrosternal chest pain which manifested in the insured was an indication of his having been afflicted by ischaemic heart disease as early as the end of September, 2003. Since the sum insured was increased to Rs. 2,00,000/- under the policy period 11.10.2003 to 10.10.2004 and the sum insured under the previous policy was Rs. 1,00,000/- only, by the tenet of insurance, the insurer's liability for the particular disease that was existing prior to increase in sum insured stood restricted to the preincresed sum insured.

It was therefore, held that the settlement of the claim for Rs. 1,10,000/- + CB of Rs.10,000/- was in order and the complaint was not entitled to any further relief. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.4.1246 / 2004 - 05
Shri S. Ramesh
Vs.
United India Insurance Co. Ltd.

Award Dated 30.11.2004

The complainant, Shri S. Ramesh and his wife Smt. Jagadeeswari were covered under mediclaim policy with United India Insurance Company Ltd., Branch Office, Egmore from 29.8.2003 to 28.8.2004. Smt. Jagadeeswari was hospitalised in Shri Ganesans Hospital, Chennai from 20.10.03 to 21.10.03 for Bilateral Ovarian Cyst. A laproscopy was done on her along with D & C and Chromotubation Her claim for reimbursement of medical expenses was repudiated by the TPA's of the insurer, Family Health Plan Ltd. on the grounds that the hospitalisation was related to the diagnosis / treatment of infertility and the same was not covered under the mediclaim policy. The insured represented for reconsideration of the claim and submitted a certificate of the attending doctor stating that the laprascopic surgery was done only to remove the Bilateral Ovarian Cyst and had nothing to do with treatment for infertility. Since the insurer did not respond to this represntation, the complainant approached this Forum for relief.

From the discharge summary, it was observed that the Diagnosis was "Bilateral Ovarian Cyst". The procedure done was "Laprascopy, Left Ovary haemorragic fluid aspirated cyst wall excised, D & C and Chromotubation". The sonogram report gave the impression that both ovaries were enlarged and cystic and the biopsy report gave the impression as "Endometrium - Proliferative phase, Rt. & Lt. Ovaries - Multiple Cystic Folicles with Corpus Albicantes". The attending doctor had certified that the treatment administered was for Bilateral Ovarian Cyst. This Forum also obtained the opinion of the medical specialists, according to which the surgery done was primarily for ovarian cyst which was a pathological condition by itself and was not in any way treatment pertaining to infertility. The infertility treatment, i. e. Chromotubation was a procedure done incidentally only.

Under the circumstances, the repudiation of the claim by the insurer was set aside and the insurer was directed to entertain the claim and reimburse the admissible medical expenses to the insured. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.5.1184 / 2004 - 05
Shri K. Muthusamy
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 06.12.2004

The complainant, Shri K. Muthuswamy had availed a mediclaim policy with the Oriental Insurance Company Ltd., Branch Office, Rajapalayam for the period 11.10.2001 to 10.10.2002. Subsequently after a lapse of more than 5 months Shri K. Muthuswamy took a fresh policy from 19.3.2003 to 18.3.2004 on the basis of fresh proposal form. Shri Muthuswamy was hospitalised from 22.01.2004 to 27.01.2004 in Apollo Hospitals, Madurai and the diagnosis was “Left UV Junction Calculus and Lower Ureteric Calculi, Right UV Junction Calculus” Shri Muthuswamy underwent Intra Venous Pyelogram followed by Bilateral Uteroscope and Intracarponeal Lithotripsy and Left DJ stenting was done. The TPA of Insurer, M/s. Medicare services repudiated the claim on the ground that the patient had multiple calculi ranging from 6 MM to 12 MM and it was not possible that these developed over just 10 months of policy inception. Hence the ailment was pre - existing and therefore noy payable.

From the records submitted before the Forum, it was observed that the policy was taken on 19.03.2003 and the insured was hospitalised on 22.01.2004, i. e. after 10 months of availing the insurance cover. The discharge summary of Apollo Hospitals mentioned that the insured was admitted with the complaints of lower abdominal pain on and off since 2 months and the diagnosis was Left UV Junction Calculus and Lower Ureteric Calculi, Right UV Junction Calculus. It followed that the earliest symptoms of the ailment, which the insured had, appeared 8 months after inception of the policy. Apart from this, no evidence of any earlier symptoms of the ailment exisitng prior to the inception of the policy was produced. Further, the attending doctor had certified that it was quite possible that multiple calcculi ranging from 6 mm to 12 mm could have been formed, developed and created obstruction within the span of 5 to 6 months. The policy exclusion cluase 4.1 warrrant that the disease should have been in existence prior to inception of the policy and further, awareness of the disease should be established. Apart from the conclusion of the TPA’s doctor, there was no evidence of the actual diagnosis of the ailment or any symptoms or any treatment having been rendered for the same prior to the inception of the policy. Under the circumstances, It was held that there were no sufficient grounds for concluding pre - existence of the disease or its symptoms and awareness of the same. Hence, invoking of clause 4.1 by the insurer was not justified. The complaint was allowed and the insurer was directed to reimburse the admissible medical expenses.

Chennai Ombudsman Centre
Case No. 11.3.1201 / 2004 - 05
Shri S. Balaguru
Vs.
National Insurance Co. Ltd.

Award Dated 06.12.2004

The complainant, Shri S. Balaguru was insured under mediclaim policy since 22.11.2001 onwards. He was admitted in Sundaram Medical Foundation, Chennai from 26.4.04 to 03.05.04, for Hemoptysis and subsequently was referred to Ramachandra Medical Centre, Ramavaram, since he was found to have severe Aortic Stenosis and the same needed

further evaluation and hence was hospitalised in Ramachandra Medical Centre from 5.5.04 to 12.5.04. He lodged a claim with the insurer for reimbursment of medical expenses for Rs. 64,314/- , comprising of expenses incurred for both the episodes of hospitalisation. The claim was repudiated by the TPA's, Family Health Plan Ltd. on the ground that the hospitalisation was for the management of an illnesss which related to a pre - existing condition, i.e. Tuberculosis.

The records submitted before the Forum were perused. As per the discharge summary of Sundaram Medical Foundation, the diagnosis was "Massive Hemoptysis" and the secondary diagnosis was "Severe Aortic Stenosis, Diabetes Mellitus, Systemic Hypertension". The clinical summary showed that Shri Balaguru presented with history of coughing out of fresh blood, 5 episodes amounting to about 1 litre of blood. The insured had history of complete treatment for sputum positive Pulmonary TB in 1998. The discharge summary of Ramachandra Medical Centre, gave the final diagnosis, amongst others, "Severe Aortic Stenosis, Bilatral Carotid Artery disease, Coronary Artery Disease - Single Vessel Disease (80 - 90%) Distral RCA Stenosis), Successful Bronchial Artery Embolisation".

This Forum also referred the case to a medical specialist for opinion. From the medical opinion so obtained and the records of Sundaram Medical Foundation and Ramachandra Medical Centre, it emerged that Hemoptysis for which Shri Balaguru was Primarily admitted in Sundaram Medical Foundation was a sequel to the earlier TB infection which he had in 1998, and therefore, there being a nexus between the disease of Tuberculosis, suffered prior to inception of the policy and Hemoptysis, the invoking of exclusion clause 4.1 was justified and the complainant was not entitled to reimbursement of expenses pertaining to treatment of Hamoptysis. However, It was noted that the insured had also undergone treatment of Hemoptysis. However, it was noted that the insured had also undergone treatment in the form of evaluation and management of problems related to Aortic Stenosis and Coronary Artery Disease. Since these disease were not in any way related to the illness of Tuberculosis, and were not pre - existing, the invoking of clause 4.1 so far as reimbursement of expenses for treatment of these disease were concerned, was not tenable. Hence, the insurer was directed to reimburse the admissible medical expenses incurred by the insured in respect of the evaluation, diagnosis and treatment connected with Aortic Stenosis and Coronary Artery Diseases besides any other medical expenses incurred which were not attributable to Pulmonary Tuberculosis. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. 11.4.1235 / 2004 - 05
Shri B. Ramesh
Vs.
United India Insurance Co. Ltd.

Award Dated 14.12.2004

The complainant, Shri B. Ramesh and his spouse Smt. Lavanya Ramesh were covered under mediclaim policy. Smt. Lavanya Ramesh was hospitalised for Cervical Cerclage from 27.9.03 to 1.10.03. Her claim for reimbursement of medical expenses was repudiated by the insurer on the ground that treatment arising from or traceable to pregnancy or childbirth was not covered as per the given standard mediclaim policy.

From the documents submitted in the case, it was observed that the case sheet of the hospital gave the admitting complaint as : 1) Early 2 Pregnancies loss and 2) Bleeding PV - Suggestive of Cervical Incompetence. The procedure done was McDonald's Cervical Cerclage.

This Forum referred the case to a Gynaecologist who opined that “McDonald’s Cervical Cerclage” is done for cervical incompetence. This procedure is done to prevent abortion and sustain the gestation so that pregnancy continues beyond second trimester.

It, therefore, emerged that the hospitalisation and treatment was primarily for maintenance of pregnancy. As per the mediclaim policy, exclusion clause 4.12 excludes treatment arising from or traceable to pregnancy, childbirth including caesarian section. Under the circumstances, it was held that the insurer could not be faulted for repudiating liablity in this claim. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.5.1150 / 2004 - 05
Shri Chandubhai Patel
Vs.
The Oriental Insurances Co. Ltd.

Award Dated 15.12.2004

The complainant, Shri Chandubhai Patel was insured under mediclaim policy from the year 1993 onwards. He was hospitalised from 02.01.2004 to 05.01.2004 and diagnosed to have Ischaemic Heart Disease for which Adhoc Percutaneous Transluminal Coronary Angioplasty (PTCA) was done. His claim for reimbursement of medical expenses was repudiated by the TPA’s of the insurer, on the grounds that the insured was a known case of hypertension for the past 15 - 20 years and hypertension, being a known risk factor for Coronary Artery Disease (CAD), the present illness was a complication of a pre - existing hypertension. The insured contended that the discharge summary revealed that there was no indication of any existing disability on account of hypertension and if there was a mention of hypertension of 10 to 15 years, it was a statement made on presumption and not really based on details furnished by him. He further added that if the claim was repudiated solely on the grounds that hypertension was existing for a long time, the very purpose of this mediclaim scheme was being negated.

The discharge summary of Apollo Hospitals in respect of the hospitalisation, for which the present claim was preferred, mentioned the diagnosis as “DM, Systemic Hypertension, Bronchial Asthma and Coronary Artery Disease”. The history of hypertension was mentioned as 15 to 20 years. There were also Master Health Checkup Report of March 1997 giving the existences of hypertension for past 10 years and TMT of March 1997 which also gave a history of hypertension for 10 years. In the proposal for insurance, the hypertension questionnaire of these complainant also revealed that he was on medication for blood pressure and his blood pressure reading was 95 / 150. It was clear that the complainant was afflicted by hypertension prior to inception of these policy. It, therefore, followed that there were sufficient documentary evidences to establish the pre - existence of hypertension. It is well established in medical science that hypertension is a risk factor for cardiac disease and coronary diseases are more frequent in those who have elevated BP than in those who are normotensive. The nexus between hypertension and ischaemic heart disease having been well established, it can be held that hypertension, which had been proved to be pre - existing, was proximate cause of coronary artery disease in Shri Chandubhai A. Patel. As the proximate cause, namely Hypertension, was a pre - existing ailment, the claim did not become payable. Hence, the repudiation was upheld and the complaint dismissed.

Chennai Ombudsman Centre
Case No. 11.5.1118 / 2004 - 05
Shri V. Sathiamoorthy
Vs.
The Oriental Insurace Co. Ltd.

Award Dated 15.12.2004

The complainant, Shri V. Sathiamoorthy was covered under mediclaim policy with The Oriental Insurance Company Ltd., City Branch Office X, Chennai from 01.06.93 onwards. Shri Sathiamoorthy was hospitalised from 4.8.2002 to 15.8.2002 in Aysha Hospital, Chennai, for Portal Hypertension, Hepatic failure, Diabetes Mellitus (DM), Haematemesis / Meglablastic Anaemia".

Shri Sathiamoorthy's claim for reimbursement of the medical expenses was repudiated by the Insurer, vide letter dated 06.03.03, on the grounds that the insured was a known user of ethanol and the ultrasound report clearly mentioned Cirrhotic liver with mild splenomegaly and consumption could have been the causative factor - policy excluded any disease arising out of consumption of alcohol. The complainant contested the stand of the insurer by stating that in the discharge summary of Aysha Hospital, it was not stated anywhere that he was suffering from Cirrhosis of Liver and Portal Hypertension was not synonymous with Cirrhosis and the word ethenol had been mentioned only in relevance to the past history.

It was observed from the indoor case records of Aysha Hospital, that Shri Sathiamoorthy was having a cirrhotic liver and further that he was a "known alcoholic" and that he had "alcoholic liver disease". There was also a scan report of August 2002 which gave the impression of a cirrhotic liver. Hence, the contention of the complainant that he did not have cirrhosis of liver was not found teneble. He had cirrhosis of liver for which he was hospitalised in 2002 and consumption of alcohol or ethanol has contributed to the same. Exclusion No. 4.8 of the policy excludes diseases arising out of the use of intoxicating drugs / alcohol. It was, therefore, held that the insurer's decision in repudiating the claim could not be faulted. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. 11.4.1198 / 2004 - 05
Shri M. Murali
Vs.
United India Insurance Co. Ltd.

Award Dated 15.12.2004

The complainant, Shri M. Murali was insured under Universal Health Insurance Policy, from 12.1.2004 to 11.01.2005. He was admitted on 18.4.2004 in SKS Hospital, Chennai and diagnosed to have "Right Lower Ureteric Calculus with UTI". His claim for reimburesement of medical expenses was repudiated by the insurer, on the ground that as per the discharge summary, the present admission was for an ailment which was in existence for more than one year.

On perusal of the medical records submitted before the Forum, it was observed that there was a noting of "history of previous episode one year back, collicky in nature radiating to the front" and based on this noting of "previous episode one year back", the insurer had concluded pre - existence of the disease since the policy incepted only on 12.1.2004. As per the discharge summary, the patient was disgnosed to have right lower Ureteric Calculus with UTI. The case history given in the discharge summary stated that the patient was admitted with history of pain in the right loin since 2 days as on the date of admission on 18.4.04. The indoor case papers of the hospital also contained the remarks" "Complaints of pain right loin since 2 days. Pain is collicky in nature, radiating to loin". Apart from these notings, there were no other notings indicative of a history of the disease. It, therefore, emerged that the only indication of the "pre - existence" of the disease, as construed by the insurer, was that of the noting of "Previous episode one year back". However, there was nothing to evidence that previous episode was an indication or a

symptom of the existence of the present illness and it therefore, emerged that pre - existence of the disease did not stand conclusively established by the insurer. Under the circumstnaces, invoking of exclusion clause 4.1 was found not tenable.

The insurer, based upon investigation conducted by them subsequent to hearing, also contended that the hospital where the insured took treatment did not meet with the policy conditions of minimum of 15s beds and a certificate issued by the hospital confirming the existence of only 10 beds was submitted. During the hearing, the insured stated that he was not aware of this particular condition since the terms and conditions were not given to him along with the policy and further, due to the urgency of the situation only, he was forced to go to that particular hospital which was near his resident. It was noted that the insured had been covered under a universal Health Insurance Policy which was intended for people of the lower income group. From the documents submitted, it appeared that only a pamphlet containing the basic details of the scheme and a policy schedule were issued to the insured. Both did not contain the specific condition regarding the necessity for the hospital meeting with the minimum number of beds in order to be eligible for reimbursement under the policy. Considering that the policy has been devised at a subsidised premium, as a welfare measure, to meet the medical needs of the lower income group, and a member of this strata of society cannot be expected to be aware of the specific conditions of the policy unless so informed, it was held that a violation of the policy condition such as number of beds did not warrant total repudiation of the claim and hence, in order to meet the ends of justice, it was deemed fit to allow the claim on ex - gratia basis to the extent of 75 % of the admissible claim amount. The insurer was directed to pay the claim at 75 % of the admissible claim amount. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. 11.5.1256 / 2004 - 05
Shri M. Vijaya Chandran
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 20.12.2004

The complainant, Shri M. Vijaya Chandran was covered under mediclaim policy with The Orietal Insurance Company Ltd., Branch Office 411702, Chennai. He was hospitalised at Malar Hospitals, Chennai from 26.4.2004 to 27.4.2004 with a minor head injury and right clavicle fracture arising out of road accident on 25.4.2004.

The insured's claim for reimbursement of medical expenses was rejected by the insurer, invoking exclusion clause 4.8 of the mediclaim policy, which disallowed claims arising out of use of alcohol. The insured represented for reconsideration of his claim on the grounds that though he had consumed alcohol while trevelling on the two - wheeler, it was not to the extent of inebriation whereby he had no control over his senses and wit and further, he was only a pillion rider, and therefore, did not contribute to the accident. However, since the insurer did not respond to the insured's appeal, Shri Vijaya Chandran has approached this Forum for redressal of his grievance.

From the documents submitted, it was observed that Shri Vijaya Chandran was a pillion rider when the accident happened and he sustained injuriess. Though the records also indicated that he was under the influence of alcohol, the fact remains that he was only a pillion rider and hence the contention that his inebriated condition had primarily caused the accident resulting in injury, had not been established. Exclusion clause 4.8 excludes medical expenses arising out of the use of alcohol. In the said case, the hospitalisation was for treatment for injuries sustained in the accident. Shri Vijaya Chandran being under the influence of alcohol and hence causing the accident or for that matter the cause of the accident itself has not been established by way of any documentary evidence. Under the circumstnaces there does not appear to be any substantial grounds for the applicability of

exclusion clause 4.8. The insurer was directed to entertain the claim and pay the admissible medical expenses to the complainant. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.5.1313 / 2004 - 05
Shri A. A. Naggaraj
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 22.12.2004

The complainant, Mr. A. A. Naggaraj and his family, including his daughter, Soundharyaa, were covered under mediclaim policy with The Oriental Insurance Company Ltd., Divisional Office - V, Chennai from 2.12.2002 onwards. Ms. Soundharyaa, aged 7 years, was hospitalised from 20.12.2003 to 21.12.2003 in Kanchi Kamakoti Childs Trust Hospital, Chennai for Chronic Adeno Tonsilitis. The insured's claim for reimbursement of medical expenses was repudiated by Medicare Services, the TPAs of the insurer on the grounds that as per their panel doctor's opinion, the patient was symptomatic within 8 months of policy inception and it was unlikely that chronic Tonsilitis developed over such a short time so as to need operative interference. Therefore, it was concluded by the TPAs that the disease was pre - existing and hence, the claim not payable, The insured contested the stand of the TPAs and approached this Forum.

It was observed that there was a record dated 4.5.2003 of National Hospital, wherein, Ms. Soundharyaa had been diagnosed to have Posterior Cervical Adenopathy and a regime of medication was prescribed to her. There was also a prescription of Dr. K. Balakumar, ENT Surgeon, also dated 3.5.2003 in which the diagnosis has been mentioned as Post Cervical Adenitis, JD Adenitis, Tonsilitis and Adenitis with Obstructive Symptoms. There was a discharge summary of August 2003 when she was admitted in Kanchi Kamakoti Childs Trust Hospital, which mentioned the diagnosis as "Posterior Cervical Node Right side Excision Biopsy". The complaints and findings were mentioned as "Swelling Right side of the neck for one week, History of Recurrent Cough and Cold". The discharge summary of Kanchi Kamakoti Childs Trust Hospital for the present hospitalisation gave the diagnosis as "Chronic Adeno Tonsilitis" and the History and findings were mentioned as "H / o recurrent attack of cough and cold, H / o Swelling in (Rt) side of neck 4 months back. The course in the hospital states that an Adeno Tonsilectomy was done.

From the documents mentioned above, the first symptoms of the disease appeared to have manifested in May 2003 when Dr. C. Satheesh and Dr. K. Balakumar were consulted and she was diagnosed for Tonsilitis and Adenitis only as early as 3.5.2003 and was on medications since then. However, when the medication did not give relief, Ms. Soundharyaa underwent excision of the cervical node in August 2003 which was followed by Adeno Tonsilectomy in December 2003.

It, therefore, became clear that medical records traced the symptoms of the disease only to May 2003 whereas the insured was covered under the policy form 02.12.2002. There were no medical records that established any symptoms of the disease prior to December 2002. The invoking of exclusion clause 4.1 warrants there be conclusive evidence of the existence of the disease prior to inception of the policy and further the insured be aware of the same. In the case on hand, the conditions for invoking of exclusion clause 4.1 not having been established and the medical records tracing the earlist signs of the disease only to May 2003, it was held that the insurer was not justified in repuduating the claim. Hence, the insurer was directed to entertain the claim and reimburse the admissible medical expenses to the complainant. The complainant was allowed.

Chennai Ombudsman Centre

Case No. 11.2.1246 / 2004 - 05
Shri D. N. Mittal
Vs.
The New India Assurance Co. Ltd.

Award Dated 31.12.2004

The complainant, Shri D. N. Mittal and his wife Smt. Susheeela Mittal were covered under mediclaim policy from February 1998 onwards. Smt. Susheela Mittal was admitted in Escorts Heart Institute and Research Centre, New Delhi from 03.07.2002 to 19.07.2002 for Coronary Artery Disease (CAD) and a Coronary Artery Bypass Graft (CABG) was done on her. Her claim for reimbursement of the medical expenses was repudiated by the insurer invoking exclusion clause 4.1 of the policy, on the ground that the insured person was suffering from CAD since 1990.

The insured represnted to the insurer for reconsideration of the claim stating that in the discharge summary, it has been stated by mistake, that his wife has had TIA / MI since 1990 and the attending doctor had subsequently issued a certificate clarifying that Smt. Susheela Mittal had no previous history of TIA / MI and the same had been mentioned due to oversight in the discharge summary. However, the insurer continued to uphold the repudiation of the claim. The insured has subsequently approached this Forum for redressal of his grievance.

In view of the insured denying the previous history of TIA / MI, the insurer was directed to investigate and ascertain the required information and submit the same to the Forum. Accordingly the insurer arranged for further investigation and the investigation report along with indoor case records pertaining to the hospitalisation of Smt. Susheela Mittal in April 1995, July 2002 and an ECG taken in March 1999 were submitted.

From the medical records produced before the Forum, it emerged that Smt. Susheela Mittal was hypertensive since 1980, as diabetic since 10 years an in 2002, had a history of TIA in 1990. The patient herself had mentioned in the patient history questionnaire form that she had suffered from Slight ST Depression (? due to angina) in 1992, which was an indication of coronary artery disease.

It was observed by the Forum that an episode of TIA was a neurological problem and hence the materiality of the TIA attack in 1990 was not of considerable significance in the present case. However, it was noted that Smt. Susheela Mittal has been hypertensive since 1980. It is well established in medical science that hypertension is a risk factor for cardiac disease and coronary diseases are more frequent in those who have elevated BP than in those who are normotensive. The nexus between hypertension and ischaemic heart disease having been well established, it was concluded that hypertension, was the proximate cause of coronary artery disease in Smt. Susheela Mittal. As the proximate cause, namely Hypertension, was a pre - existing ailment, the claim did not become payable. Further there was an ECG report of Smt. Susheela Mittal pertaining to March 1992 which was suggestive of the presence of Coronary Artery disease itself. Hence, it was held that the Insurer could not be faulted for invoking exclusion clause 4.1 and repudiating the claim. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.2.1230 / 2004 - 05
Shri M. R. Narayanaswamy
Vs.
The New India Assurance Co. Ltd.

Award Dated 31.12.2004

The complainant, Shri M. R. Narayanaswamy was insured under mediclaim policy since 1989. Shri Narayanswamy was hospitalised from 27.10.2003 to 20.11.2003 in Apollo

Hospitals, Chennai, for Coronary Artery Disease for which he underwent Coronary Artery Bypass Graft (CABG). His claim for reimbursement of medical expenses was repudiated by the TPA's of the insurer on the ground that the cliamant was admitted for Acute Myocardial Infarction and Cardiogenic Shock and documents clearly indicated Old Anterior Wall Myocardial Infarction (AWMI) 20 years ago, which made the ailment pre - existing and hence the claim was not payable.

The insured represented that he never had any problem before the attack in 2003 and his health check - up in 1987 and 1989 showed that the manuscript report stating that he had an MI 20 years ago was not correct. Further, he undewent an operation for multiple fracture in 2000 and then too, it was observed that there was no heart problem. However the insurer continued to uphold the repudiation following which the complainant approached this forum.

It was observed from the documents submitted before the Forum that the notings on the schematic diagriam of the stenting done in the heart on 11.11.2003 on Shri Narayanaswamy indicated an AWMI 20 years. It had also been mentioned by the attending doctor, Dr. Girinath in the claim form that Shri Narayanaswamy had a chest pain 20 years ago. However, Dr. Girinath had also gone on to confirm that the pain was of insignificant nature and that Shri Narayanaswamy remained asymptomatic for 20 years since then and was not on cardiac medication. The fact that shri Narayanaswamy did not have any further symptoms or attacks of the ailment subsequently was also evident from the Master Health Checkup done at Apollo Hospitals in May 1987. All the subsequent medical records did not reveal any heart problem. Hence, it was reasonable to conclude that Shri Narayanaswamy, not being on medication after an episode of chest pain 20 years back and the subsequent ECG of 1987 being within normal limits, was not suffering from any heart ailment at the time of inception of the policy 1989. In the facts and circumstancees of the case, the repudiation of the claim by invoking exclusion clause 4.1 was found not tenable and the insurer was directed to entertain the claim and reimburse the admissible medical expenses. The complaint was allowed.

Chennai Ombudsman Centre
Case No. IO (CHN) 11.3.1148 / 2004 - 05
Mr. Ekambaram
Vs.
National Insurance Co. Ltd.

Award Dated 23.2.2005

Mrs. Shantha Ekambaram, aged 64 years availed Overseas Medical Policy for the period from 14.7.2001 for a period of 109 days for her trip to USA. She was hospitalised at USA on 29.7.2001. She spents around US$ 1147.59. It is reported that the Insurer's claim settling agent M/s. Mercury International in abroad settled the sum of US$ 763.59. The unsettled portion works out to US$ 384. After returning to India, the insured taken up the matter with M/s. Tower Assistance, Mumbai - the Indian agent of Mercury International. They informed the insured that due to some funding problem with the Insurer Company, they are not receiving any communication from Mercury for any claims. The insured taken up the matter with the Insurer and claim settling agent again but of no use.

It is the basic responsibility of the Insurer to settle the claim and they cannot postpone its decision by passing the buck to the claim settling agent. Inspite of conducting two hearings, the Insurer expessed their inability in getting the details from claim settling agent. Hence, Ombudsman directed the Insurer to settle the claim for the balance amount immediately subject to the other policy conditions.

Delhi Ombudsman Centre
Case No. GI / 230 / UII / 04
Shri. J. C. Sharma

Vs.

United India Insurance Company Limited

Award Dated 29.10.2004

The Insurance relates to repudiation of claim of the complainant under 'Overseas Mediclaim Policy'. The settling agent in USA had repudiated the claim under prexisting condition, because, as per the medical report the complainant had similar episode in the past (chest pain), one five years ago and and another three years ago. Hence, the present claim is related to past history of chest pain.

After careful consideration of the facts of the case, no substance was found in the reasons for repudiation. The claim is not a claim under the usual mediclaim policy. That was a claim under an overseas mediclaim policy, which is governed by different terms and conditions. In the overseas mediclaim policy, the expression 'pre - existing condition' has been defined as any sickness for which the insured person has sought medical advise or has taken medical treatment in the proceeding 12 months prior to the commencement of travel.

It was held that in the present case, there was no evidence to show that the insured person had taken any treatment during the 12 months preceding the commencement of travel for chest pain. What happened three years ago or five years ago us just not relevant. The insurance company should have clarified to their setting agent that there was no pre - existing condition by definition in this case. The insurance company to pay the admissible claim amount in the prescribed manner as per the policy terms.

The complaint was dismissed.

Delhi Ombudsman Centre

Case No. GI / 354 / OIC / 04

Shri. M. P. Sehgal

Vs.

Oriental Insurance Company Ltd.

Award Dated 20.01.2005

The grievance of the complainant is that the Insurance Company has refused to renew his mediclaim policy. The complainant is medically insured for long yeaRs. He has been continuously insured without any break form 1992 to the year 2004. He was insured with another Insurance Company and switched over to this company, a few years ago. There is no break is continuity of the policy.

The Insurance Company refused to renew the policy on the ground that the claim experience is this case is bad regarding claim taken and no reliable information was provided by the Insurance Company. The mentioned that claims for Rs. 16,948/- and Rs. 6,638/- were made.

After careful consideration of the facts of the case, Hon'ble Ombudsman held that:

(1) The refusal of the Insurance Company to renew the mediclaim policy of the complainant is an arbitrary exercise of authority;

(2) The facts that the complainant has made two or three small claim is not a good and sufficient reason to refuse to renew the policy;

(3) There is no approved definition of "bad claim experience". in the absence of an approved definitions all refusals to renew mediclaim policies become arbitrary;

(4) A Public Sector Insurance Company is an authority or instrumentality of the state within the meaning of Article 12 of the Constitution; it cannot seek refuge in condition No.5.9 of the contract; its actions must be transparent and based on sound reasons; and

(5) In the present case, the refusal of the Insurance Company to renew the mediclaim policy of the complainant is against all principles of equity and fair play.

Award was passed by Hon'ble Ombudsman to renew the mediclaim policy on payment of the requisite premium by the insured.

The complaint was dismissed.

Delhi Ombudsman Centre
Case No. GI / 375 / UII / 04
Shri. Vishal Mahajan
Vs.
United India Insurance Company Limited

Award Dated 19.01.2005

The complainant was covered under mediclaim policy. The claim was paid but the Insurance Company had disallowed a sum of Rs.7,000/- on account of the Ceramic Crown that was fixed for the protection of the complainant's teeth which had been injured as the result of a road accident.

It was held that it is absured to suggest that the Ceramic Crown was fixed for cosmetic reasons. It is quite clear that the Ceramic Crown was necessitated by an accident. There is no element of cosmetic about it. Exclusion No.4.5 of the Insurance contract has no applicability at all in this case.

The Insurance Company was asked to pay Rs. 7,000/- being the cost of the Ceramic Crown.

Delhi Ombudsman Centre
Case No. GI / 233 / NIA / 04
Shri. B.M.Anand
Vs.
New India Assurance Co. Ltd.

Award Dated 08.11.2004

The complainant's 68 years old mother was hospitalized for undergoing an operation for hidradenitis (Left axilla). The Insurance Company repudiated the claim, as the patient was hospitalized for less than 24 hours (the minimum period of hospitalization as provided in the mediclaim policy).

It was held that it is not a case to which the minimum period of 24 hours hospitalization should be applied. The patient was operated upon under general anesthesia. This operation could not have been carried out on OPD basis. The operation could have been carried out only in a proper operation theatre. It was not necessary to confine her to the hospital for more than 24 houRs. The case should be treated as an exception to the general rule of minimum 24 hours hospitalization. Certain specific ailments are mentioned in the mediclaim Insurance Policy to which the minimum period of 24 hours is not applied and the list given in the policy cannot be regarded as exhaustive.

The claim of the complainant was allowed.

Delhi Ombudsman Centre
Case No. GI / 311 / UII / 04
Shri. Surendra Sarin
Vs.
United India Insurance Co. Ltd.

Award Dated 29.12.2004

The complaint's claim under mediclaim was repudiated by the Insurance Company. After careful consideration of the facts of the case it was held that the decision of the Insurance Company was correct. As per the discharge summery, the wife of the complainant was admitted for the purpose of investigation only. Neither the tests conducted in the hospital nor the treatment procedure adopted in the hospital required confinement in a hospital. The same could have been done on OPD basis. The decision of the Insurance Company is, therefore, justified.

Guwahati Ombudsman Centre
Case No. 11 / 005 / 0049
Shri Prasanta Das
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 14.03.2005

Facts : Complainant preferred a claim of Rs. 7038.44 against the Oriental Insurance Co.Ltd. The claim was processed through TPA which recommended for payment of Rs. 969/- only which was not acceptable to the complainant.

The contention of the insurer / opposite party is that amount recommended by TPA was refused by the insured and on enquiry it has been revealed that the amount, which was deducted by TPA from bill was incurred by the complainant at pre - natal stage 'for which there was no insurer cover' as per the policy condition of maternity benefit.
I find that the TPA had settled the payment on the basis of actual expenses for hospitalisation at B.P. Hospital, Nagaon and balance of claim was rejected on the ground that the said amount do not come under category of hospitalisation. The discharge slip issued by B. P. Hospital, Nagaon show that the insured's wife was hospitalised with effect from 15.03.04 till 16.03.04. The list of medicines purchased, given by the claimant shows that he purchased medicines on 15.03.04 and 16.03.04 worth Rs. 632/- , Rs. 337 and Rs. 572.32. The TPA has however overlooked the purchasing medicines on 16.03.04 amounting to Rs. 572.32 and admission for fee of Rs. 50/- and allowed only those medicines purchased on 15.03.04 amounting to Rs. 969.00 in total.

The relevant policy conditions are not before me. But it is understood that experneses other than those incurred during hospitalisation are not liable to be reimbursed. (Evidence discussed).

The case is disposed of with observations directing to pay amount left out by mistake etc. and with interest as suggested.

Kolkata Ombudsman Centre
Case No. 279 / 7 / NL / 2003 - 04
Shri Dibasunder Sur
Vs.
The National Insurance Co. Ltd.

Award dated 18.10.2004

Facts / Submissions : The complainant's mother Smt. Bandana Sur aged 56 years had taken Mediclaim Policy effective from 15.5.2001. She was admitted in Missionary Hospital in Charttisgarh. The physician first expressed his doubt about the function of her heart and advised angiography and she was released from the Hospital on 16.07.2001. Again she was admitted in SSKM Hospital, Kolkata for treatment in Cardiology Department.Subsequently, angiography was conducted and detected 3 blockages in her heart and immediate By - pass surgery was conducted on 10.09.2001 at Rabindra Nath Tagore International Institute of Cardiac Sciences, Kolkata. A Claim for Rs. 40,000/- was filed on 16.11.2001.The Insurance Company repudiated the claim on 30.05.03. on ground of pre - existing disease.

National Insurance stated that the complainant took a Mediclaim Policy on 15.05.2001 covering his wife, daughter and mother, Smt. Bandana Sur for the risk comencing from 15.05.2001 to 14.05.2002 but the same was not renewed on its expiry. The Insured was admitted in The Chattisgarh Hospital and discharge summary issued by the Hospital on 14.07.01 stated that the patient was a known case of HTN / DM with Ischemic Heart Disease The Panel doctors examined the papers and opined that the disease was pre - existing. Again the Insured submitted a representation on 13.06.03. However, the decision

remained unchanged. The Insurance Company also sought some Clarifications from the Insured which remain un - replied.

Held : Considering the facts it was found that the ailment was detected within two months from the commencement of the Policy. The Medical Report of Chattisgarh Hospital confirmed prior knowledge of HTN / DM. It also confirmed that the patient was on regular T / F. Physical illness was not declared in the Proposal Form. It is held that such information of existing ailment was material enough to influence the decision of the insurance company about underwriting decision had it been declared in the Proposal Form.

In view of the above findings, the decision of the Insurer in repudiating the claim is justified.

Kolkata Ombudsman Centre
Case No. 179 / 2 / NL / 2003 - 04
Shri Manoj Kumar Nandi
Vs.
National Insurance Company Ltd.

Award dated 24.02.2005

Facts / Submissions : The complainant's daughter was covered under a mediclaim policy. She was diagnosed for abscess behind left knee and was hospitalised for operation under general anesthesia. The patient was released at the earliest opportunity which was possible due to techological development in medical science. The claim filed under mediclaim policy was repudiated invoking condition 2.3 which stipulated minimum 24 hours confinement in the hospital The complainant's main argument was the surgical procedure could not have been done in an outpatient unit. He argued that the patient could have been kept in the hospital for few more hours to meet the policy condition, which would also have enhanced Insurers' liability

Held : There has been a tremendous improvement in medical science over the last few years has resulted in faster treatment and shorter stay at the hospital. It was felt that the various provisions and rules and regulations under mediclaim policy required a review in the light of improvement in Medical Science. Pending review and necessary modification in the policy, the complaint was processed based on the exisiting conditions, which included condition 2.3 relating to minimum 24 hours hospitalisation for claiming reimbursement. The Insurance company, therefore, was not unjustified in invoking this condition for the purpose of repudiating the claim. It was also observed that the complainant has not spoken of any particular technological development, which reduced the period of stay in the hospital. The technological developements like laser surgery have vastly reduced the duration of stay in the hospital. It is not clear which type of application of technology made the stay shorter in this case

In view of the above, the decision of the insurance company to repudiate the claim was upheld.

Kolkata Ombudsman Centre
Case No. 173 / 2 / NL / 2003 - 04
Shri Susanta Kumar Bagchi
Vs.
United India Insurance Company Ltd.

Award dated 25.02.2005

Facts / Submissions : The complainant's wife was admitted in a nursing home due to Raptured Ectopic Pregnancy as per the advice of attending physician who, after opening

her abdomen, diagnosed the disease to be a case of Cornual Pregnancy. The patient's uterus was removed not due to any disease of the uterus but due to complication of pregnancy which threatened her life. The Insurers panel doctor, a Specialist Gynaecologist and Obstetrician, opined that the hysterectomy was done neither for menorrhegia nor for fibromyoma but for Raptured Ectopic Preganancy. The insurance company repudiated the claim on the ground that the discharge summary revealed the contigency to be linked with pregnancy, which is an exclusion under the standard Mediclaim Policy.

Held : The repudiation was based on the ground that proximate cause of hysterectomy was pregnancy which was excluded under the policy. The complainant claimed that the patient was bleeding profusely. But the Operation was performed one day after the admission in the Nursing Home. This raised doubt about his statement that she was bleeding profusely. The complaint also did not produce any material to rebut the finding of the panel doctor except for what he stated in the representation, which again was not convincing. In the circumstances, the repudiation was upheld.

Kolkata Ombudsman Centre
Case No. 201 / 2 / NL / 2003 - 04
Shri Swarup Banerjee
Vs.
The Oriental Insurance Company Ltd.

Award dated 28.02.2005

Facts / Submissions : The complainant took a mediclaim policy and suffered from chest pain after 38 days from inception of cover. Based on the ultrasonography the attending physician diagnosed that the complainant was suffering from gall bladder stone. The complainant underwent operation in hospital and filed a claim, which was repudiated on the ground of suppression of pre - existing disease. According to the opinion of Insurers panel doctor, the complainant was suffering from chronic abdominal pain and indigestion. The USG indicated chronic cholecystitis and cholelithiasis. According to the panel doctor, this was a very chronic disease from which the complainant was suffering for last 1 to 2 years. The complainant contested the repudiation claiming that he could not have known about the disease while taking the cover as same was detected only after the sonography test was conducted.

Held : The ultrasonography report dated 09.09.2002 recorded that the patient was suffering from (a) Chronic calculus cholecystitis with single cholelithiasis and (b) Borderline hepatomegaly with mild & diffuse towards chronic disease. The opinion of the panel doctor was also quite categorical that the patient was suffering from last 1 to 2 years prior to the inception of the policy. Accordingly, it was held that the disease existed prior to inception of the policy and repudiation was uphled.

Kolkata Ombudsman Centre
Case No. 158 / 1 / NL / 2003 - 04
Shri Pradeep Kumar Agarwal
Vs.
The Oriental Insurance Company Ltd.

Award dated 28.02.2005

Facts / Submissions : The complainant was covered under a mediclaim policy. He suffered from abdominal pain and was advised hospitalisation. Following discharge, the claim was filed with the insurance company, but the latter repudiated the claim after 1 ½ year on the ground that there was no specific diagnosis. The insurance company contended the Discharge Certificate, hospital document, etc. revealed that the complainant was

suffering 'Porphyria' and he was dischanged from the hospital on request. It was observed from the hospital treatment sheet that only investigations were conducted but no specific treatment was provided to the complainant. In the circumstances, the insurance company repudiated the claim unde exculsion clause 4.10 based on their panel doctor's opinion that none of the tests conducted were for porphyria. The complainant, on the other hand, contested that the Discharge Certificate mentioned about porphyria treatment.

Held : The complainant was sent or admission to the Institute of Laparoscopic Surgery by the physician whom he consulted first. The complainant however, was admitted under another doctor, whose advice was not in the file. On the date of admission the consulting physician recorded that there was a severe pain in chest but the complainant stated that he had pain in abdomen. The Discharge Certificate did not mention anything about history or the possible diagnosis. The patient was discharged on request although he was supposedly having severe pain in chest / stomach. In a matter of 6 days the complainant consulted 4 different doctors. There was no ECG test report in the file at the time of admission in the hospital, although the patient was suffering from severe chest pain as recorded by the consulting physician. The panel doctor of the insurace company recorded that there was no report for Porphyria.

In the circumstances, it was held that the complainant was admitted for the purpose of investigation / test and not for the treatement as claimed by him and the repudiation was upheld.

Kolkata Ombudsman Centre
Case No. 160 / 1 / NL / 2003 - 04
ShriJ. C. Dhar
Vs.
The New India Assurance Co. Ltd.

Award dated 28.02.2005

Facts / Submissions : The complainant along with his wife was insured under a mediclaim policy which was running for 14 years. For last few consecutive years, the complainant preferred about5 claims for both the persons covered. While renewing the policy for the period 2004 - 05, the insurance company imposed a compulsory excess of Rs. 5,000/- for each claim against a sum insured of Rs. 20,000/- , on the ground of high claim ratio. Appeal to higher authorities yielded a concession of promise of withdrawal of the excess, if there was no claim for 3 years. However, the complainant sought withdawal of excess Clause altogether contending that the ailments for which the claims were lodeged related to old age and not due to any vital organic failure or ailment involving heart, kidney, lungs, stomach, etc. The Insurance company only relied on recent spurt of claim to impose the excess.

Held : Though the complainant's policy was found to have become some what prone in the recent years, but at the same time the following issues were considered : -

i) The policy has been running for 14 days. Therefore, there was no selection against the Insurers;

ii) The Mediclaim coverage issued to Shri & Smt. Dhar were for already aged person who were known to bevulnerable at such mature age. Thus, the insurance company granted mediclaim cover fully knowing risk of the Insureds.

iii) The essence of Mediclaim insurance is to assist people in case of medical expenditure. Notwithstanding the Insurer's prerogative in deciding the risk acceptance, imposing an excess as high as 25 % of the sum insued was not reasonable and justified particularly considering that the complainant was a senior citisizen.

iv) By imposing an excess of Rs. 5,000/- over a sum insured of Rs. 20,000/- , the insurance company was also penalizing the complainant by charging premium towards this Rs. 5,000/- component of the sum insured, though coverage was extended for the said

amount. Effectively, thecomplainant was enjoing a sum insured of Rs. 15,000/- by paying premium for Rs. 20,000/- sum insured.

In view of the above, it was held that it would be reasonable and proper on the part of the insurance company to impose a small and token excess to weed out small claims below, say Rs. 500/-. This excess would be made applicable for renewals after expiry of the policy for the period 2004 - 05. With this small excess charged, the interest of the policy holders as well as that of the Insurer would be protected.

Kolkata Ombudsman Centre
Case No. 231 / 3 / NL / 2003 - 04
Smt. Navita Bihani
Vs.
National Insurance Company Ltd.

Award dated 24.03.2005

Facts / Submissions : The complainant was diagnosed suffering from an infection of retro - intro ovarian cyst for which she had to undergo laparatomy along with Ruptured Appendix operation performed under general anesthesia. The claim filed with the insuance company under mediclaim policy was repudiated on the ground of pre - existing disease. The insurance company contended that the date of first detection of the illness was two months since inception of cover but prescription recording that the complainant had pain and fever before that was available. Replying to a reference by the insurance company, the attending physician stated that the complainant had undergone laparoscopy four years back for removal of fibroid in the uterus and subsequently she had a right ovarian cystectomy about 5 months before commencement of the present cover. According to the attending physician, in the instant case, the complainant was admitted with Ruptured tubo ovarian abscess and Ruptured Appendix requiring emergancy operation.

Held : According to the panel doctor's opinion, despite provisional diagnosis of acute abdomen, institution of domiciliary treatment was rather unusual. The patient did not take the medicines she was advised to. The second doctor consulted by the complainant suspected right - sided tubo ovarian mass and the pelvis USG suggested normal right ovary in addition to a space occupying lesion. Though the doctor's clinical findings did not corroborate the USG report, in spite of such contradiction, the complainant had accepted a mojor surgery ignoring the USG report. There was no evidence of Ruptured Appendix either in the operative or pathological note. From the medical view point, it was very much unlikely for an ovarian cyst to be of such huge size within a span of 2 months unless, of course it was malignant or there was intracystic hemorrhage. However, none of such possibilities was evident. Eventually, the panel doctor concluded that the disease was pre - existing.

In the circumstances, the panel doctor's opinion was accepted and repudiation was upheld.

Kolkata Ombudsman Centre
Case No. 225 / 3 / NL / 2003 - 04
Shri Rajesh Kumar Saraogi
Vs.
The New India Assurance Co Ltd.

Award dated 28.03.2005

Facts / Submissions : The complainant's wife was admitted to hospital for treatment of Rheumatic Heart Disease. Some other tests were done on the advice of attending surgeon which was necessary for proper treatment. The claim filed by the compainant under mediclaim policy was repudiated by the isnurance company on the ground of pre - existing disease. The complainant also had a claim for treatment of dental disease which was turned down because the patient was not hospitalised. The complainant represented

against the decision along with the certificate of the attending physician which indicated that the patient was not having any heart related problem until two months before admission to hospital and hence it could be concluded that the disease was only 8 to 10 months old. The attending doctor also stated that many diseases e.g., heart disease, lung disease, kidney disease, gall stone or cancer exist in the body for many years before being diagnosed. But the patient did not knowingly conceal any fact when taking the policy. On the other hand, the insurance company contended that as per the opinion of their panel doctor Rheumatic Heart Disease was certainly pre - existing in our country as, in our country, the disease normally started around the age of 15 to 20 years and take at least 10 years to attain the stage of valve involvement. Since the ailment was reported the 3rd year of the policy it was pre - existing. Refuting the certificate of the attending physician, the panel doctor opined that such remarks were not necessarily accurate. In cases of Rheumatic Fever, many people often ignore and not bother to treat the initial symptoms of fever, sore throat and joint pain, which eventually leads to valve disease.

Held : It was found that although the admission to the Nursing Home was for the treatment of Rheumatic Heart Disease, the stay in the Nursing Home was for one day only, during which time she had an echocardiogram, thyroid function test and a few other tests. These tests did not come under the treatment of Rheumatic Heart Disease. The question considered was whether the expenses for the treatment of disease, different from the disease for which admission was taken, are at all allowable. The answer was clearly in the negative. If it was accepted that expenses were incurred for the disease for which admission was taken, then also the claim was found not payable for the reason that Rheumatic Heart Disease was definitely pre - existing. Accordingly, repudiation was upheld.

Kolkata Ombudsman Centre
Case No. 197 / 2 / NL / 2003 - 04
Shri Asit Kumar Mitra
Vs.
National Insurance Company Ltd.

Award dated 31.03.2005

Facts / Submissions : The complainant filed a claim for Rs. 29,493/- in respect of treatment of his wife Smt. Gopa Mitra in the hospital. Family Health Plan Ltd., TPA of National Insurance Company settled the claim after deducting Rs. 2,400/- stating that payment for 'home visits' were not payable under the policy. The complainant represented against the decision on the ground that nowhere in the policy condition was it mentioned that payment for home visits were not allowed. But there was no response from the Insurance Company.

Nationlal Insurance Company stated that the claim wa settled after deducting Rs. 2,469/- on valid ground. TPA had sent voucher to the insured and the insured acccepted the payment without any condition. The complainant agreed and received Rs. 27,024/- and therefore, the claim stood settled.

Held : Ordinarily, complaint against partial settlement of claim is not entertained by this forum, where the payment has been received by the complainant after signing a pre - receipted voucher towards full and final settlement of the claim. But in the instant case, it was not clear whether the insurance company sent any discharge voucher, which was signed by the insured towards full and final settlement of the claim. According to the insurance company, the TPA sent the cheque along with a voucher to the insured and the insured accepted the payment without any condition. The complainant nad enclosed a letter from Family Health Plan enclosing a cheque dated 17.12.03 for Rs. 27,024/-. In the letter it was mentioned that Rs. 2,400/- on account of Home Visits was not payable. There was nothing in the letter to indicate that the complainant was required to sign discarge voucher

accepting the payment. Therefore, in this case the complainant could not be held to have accepted the payment by signing the voucher towards full and final settlement of the claim and thereby forfeiting his right to claim the balance amount. As the insured was not given any opportunity to raise his objection to the deductions made, the grievance of the compainant was admitted for consideration on merit.

As regards merit, the insurance company did not furnish copy of the policy to confirm whether the reimbursement of "Home visitis" was excluded under the policy. On the contrary, there might be cases where treatment in the hospital also covers pre and post hospitalisation, covering doctors visit at home in relation to the same treatment. Therefore, the nature of the 'home visit', visit by whom, purpose of the visit, number of visitis, etc. were relevant factors to be taken into consideration before deciding the allowability of the claim. The TPA could not disallow a claim suo moto without referring to the policy issued by the parent company laying down the policy conditions. Since the insured was not given an opportunity to represent against such deduction before the payment was made to him, the insurer was directed to consider the claim again in the light of the policy conditions. The insurance company could not run away from the responsibility of reexamining the deductions made by the TPA keeping in view the facts of the case and the relevant terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 194 / 2 / NL / 2003 - 04
Shri Raja Ghoshal
Vs.
National Insurance Company Ltd.

Award dated 31.03.2005

Facts / Submissions : The complainant's wife Smt. Sudeshna Ghoshal was suffering from Tumor in the Ovary and deposit of urine in UrinaryTract. She was treated by Dr. Mitrasree Dasgupta, who advised her on 07.04.2003 to undergo Urinary dilatation at South Calcutta Clinic. She was then treated at the hospital. He submitted the claim papers on 01.05.03 but the insurance company did not settle the claim in spite of reminder.
National Insurance Company vide their letter dated 23.04.04 requested Family Health Plan Ltd. about the present status of the claim and return the entire claim file with their comment as to why claim had not been settled and if rejected, stating reason thereof. The insurance company reminded the TPA again on 23.04.04. They sent the underwriting particulars to Family Health Plan, TPA on 03.06.04, as required by them vide letter dated 14.05.04.TPA informed the insurance company verbally that the claim file had been forwarded to their Hyderabad Office for processing and necessary action.

Held : There was no reason way the insurance company did not settle the claim when all the necessary details were available with them and what administrative control the insurance company had over their TPA i.e., Family Health Plan Limited. Further, why no action was taken by the National Insurance Company against such callous and careless attitude of the TPA in settling a very paltry claim of Rs. 10,080/- with no particular complication in the claim requiring detailed verification and investigation. This was a case of reckless irresponsibility of the TPA in dealing with the claims of the policyholders, aided and abetted by the parent company, i.e., National Insurance.

The insurer was directed to settle the claim and also to take administrative action against their TPA for harassing policyholders.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / UII / 101 / 2003 - 04

Shri V. Joseph
Vs.
United India Insurance Company Ltd.

Award dated 1.10.2004

The Complaint under Rule 12 (1) (b) read with Rule 13 of the RPG Rules, 1998, was an off - shoot from the repudiation of a mediclaim by the insurer for non - renewal of the policy during the grace period of the previous policy. As there was a break in insurance, the hysterectomy operation expenses of the complainant's wife were not paid by the insuer as the policy was a fresh contract and the treatment expenses coming under the first year, it was hit by Exclusion Clause No. 4.3 of the mediclaim policy. The earlier claims of the claimant were duly considered and paid by the insurer and denial of the disputed claim was found to be in order as there was a break in the contract. The complaint was, therefore, dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIA / 07 / 2004 - 05
Shri P. K. Raveendran
Vs.
New India Assurance company Ltd.

Award dated 6.10.2004

The complaint under Rule 12 (1) (b) read with Rule 13 was as a result of repudiation of a mediclaim preferred by the complainant under Policy No. 2001 / 47 / 76055 / 85611 issued by the insurer alleging suppression of material facts at the time of taking the policy. The complainant was working at Sultanate of Oman when the disputed PSKA policy was taken. The complainant had felt chest pain on 01.06.2003 and consulted the doctors at the Royal Hospital, Sultanate of Oman. For expert treatment, he came down to India and took treatment from Amritha Institute of Medical Sciences, Kochi from 11.06.2003 to 20.06.2003. The treatment expenses including Angioplasty came to be Rs. 1,39,681.40. However, in the discharge summary, it was mentioned that the complainant was hypertensive for "30 years" and according to the insurer, the long duration of hypertension was not mentioned in the proposal The complainant clarified that he was a manual worker at Sultanate of Oman where they are subjected to Compulsory medical check ups every six months and that he had no problem of hypertension earlier. According to him, it was only a clerical error, in that, instead of writing "30 days", it was mentioned as "30 years" of hypertension in the discharge summary. The insurer being unable to prove its case with any other confirmatory evidences, it was impossible to brand a person as hypertensive for 30 years particularly because he was working as a manual worker abroad with compulsory medical check ups every six months. Therefore, the possibility of a clearical error of writing the duration as "30 years" instead of "30 days" could not be ruled out and the insurer was found to be wrong in relying upon a single bland statement - most probably, a clearical error - while repudiating the claim.

The Sum Insured under the Policy being limited to Rs. 1 lakh, the insurer's decision was set aside and the complainant was allowed for a sum of Rs.1 lakh in full and final settlement of the claim.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 05 / 2004 - 05
Shri K. Venugopal
Vs.
National Insurance Co. Ltd.

Award dated 6.10.2004

The complaint under Rule 12 (1) (b) read with Rule 13 of the RPG Rules 1998 came up due to repudiation of a mediclaim preferred before the insurer by the complainant under Policy No. 2002 / 8200986 for alleged non - disclosure of material facts. The complainant was hospitalised at PVS. Memorial Hospital at Kochi during 18.02.2003 to 22.02.2003 for de - compensated cirrhosis of liver with hypertension. The insurer had rejected the claim as the previous history of diabetes mellitus was undisclosed in the proposal. The complainant was also on medical leave from M/s Indian Express where he was employed. During the hearing the complainant had plainly admitted that he had liver cirrhosis even in 2000 whereas the policy commenced only in February 2003. He said that he was not in good health and in good comprehension even while the proposal was filled up or when the investigator of the company met him after the claim form was submitted. He maintained that the suppression of information was not intentional and that it occurred due to his general indisposition. Under the circumstances, the repudiation of the claim by the insurer, though upheld, the Insurance Ombudman awarded an ex - gratia of Rs. 8,000/- to the complainant considering his impecunious situation and depleted health conditions.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 03 / 2004 - 05
Shri P. M. Abdul Shukoor
Vs.
National Insurance Co. Ltd.

Award dated 7.10.2004

The complainant under Rule 12 (1) (b) read with Rule 13 of the RPG 1998 came up consequent on the repudiation of a mediclaim preferred by the complainant before the Insurer under Pol No. 570704 / 42 / 2002 / 8201006. The complainant had undergone operation for left Inguinal Hernia on 25.09.2003 and preferred a claim for Rs. 18,961 before the Insurer. On going through the discharge summary issued by the hospital the Insurer found that the complainant had a previous history of right Inginal Hernia repair four years back.

The Insurer had therefore repudiated the claim invoking exclusion clause 4.1 of the mediclaim policy and cancelled the policy invoking clause 5.9. However as the Insurer had cancelled the policy without giving due notice as per policy conditions and has not refunded the pro - rata premium for the unexpired period - the Ombudsman directed the Insurer to refund the pro - rata premium plus one month's premium in lieu of notice) to the party.

The repudiation and cancellation by the insurer are upheld and the case is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / OIC / 87 / 2003 - 04
Shri P. C. Varghese
Vs.
The Oriental Insurance Company Ltd.

Award dated 12.10.2004

The complaint under Rule 12 (1) (b) read with Rule 13 of the RPG Rules 1998 stems out of repudiation of a mediclaim preferred by the complainant. The complainant was an employee of Appollo Tyres and reportedly he had sustained a fall in the bathroom on 12.12.2002. When the claim was preferred, the insured had rejected it for the reason that there was no visible injury arising out of the alleged fall and that the treatment was for a long lasting diseases and, therefore, it was out of purview for an accident claim. From the records, it was found that the complainant was under treatment of Dr. P. G. Mangalanandan of Government Ayurvedic College, Kodakara from 12.12.2002 to 03.01.2003 for the disease called BHAGINA VATHAM and not for any visible accidental

injury. During the hearing, the complainant had in fact admitted that between1994 and 1998, he was in the same hospital and under treatment of the same Doctor for rheumatic complaints. In any case, as per the Discharge Summary issued by the above Ayurvedic hospital, the treatment availed of by the complainant was for BHAGINA VATHAM and not for any visible accidental injury. Finding no merits in the case, the compainant was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 107 / 2003 - 04
Shri T. M. Paulose
Vs.
National Insurance Company Ltd.

Award dated 13.10.2004

The complaint under Rule 12 (1) (b) read with Rule 13 of the RPG Rules, 1998, stems from rejection of a mediclaim by the insurer relating to the surgical treatment to the daughter of the complainant, Ms. Melvi Paul stating that the surgery was correction of a congenital disorder and, therefore, excluded from the scope of the policy. In fact, on examination of the facts, it was revealed that the problems started only two months before the sugical intervention and other than usual ailements, the insured had no previous history. The insurer's third party administrator had called for another opinion from a doctor who had neither seen nor treated the patient. The doctor who attended on the complainant's daughter was a competent specialist and his opinion would naturally prevail over the opinions expressed by other doctors who had seen only the papers. Moreover, the exclusion clause concerned in the mediclaim policy meant only congenital external disorders. Deflected Nasal Septrum did no come under this definition in as much as there was no external deformity. In the above circumstances, the insurer's action was not found in order and therefore, the insurer was asked to pay off the expenses incurred by the complainant.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 106 / 2003 - 04
Shri V. J. Kurien
Vs.
National Insurance Company Ltd.

Award dated 13.10.2004

The complaint under Rule 12 (1) (b) read with Rule 13 of the RPG Rules 1998, is as a consequence of inordinate delay amounting to injustice in settling the mediclaim of the complainant by the insurer under Policy No. 570700 / 46 / 2002 / 8500232 covering the period from 21.10.2002 to 12.11.2002. The minimum sum insured under such policies was sue motto raised by the insurer from April 2002 to Rs. 25,000/- , although, originally, it was only Rs. 15,000/- and the corresponding premium was also charged. The complainant submitted that at the time of the original proposal, he had no illness. It is said that the complainant noticed a while leucoderma on his tougue in June 2002 and consulted Dr. Prameela of the Seventh Day Adventist Hospital at Ottapalam where he was himself working and his wife Mrs.Jessy Kurien was a staff nurse. Although the doctor prescribed certain tablets, as the situation did not improve, a biopsy was advised and thereafter, he was referred to Amala Cancer Institute, Thrissur, as it was a case of carcinoma. In the meantime, it is reported that the investigator of the insurer visited the Hospital at Ottapalam and obtained a letter from the wife of the complainant to the effect that her husband's disease was in existence for 1 ½ years, which statements, she immediately

controverted and wrote to the insurer. As per the records or in the oral examination of the complainant and the insurer's representative, there was nothing to prove that the complainant's disease was pre - existing and there was no misrepresntation. In the circmstances, the complaint was allowed and the insurer was asked to pay off the claim i.e. Rs. 25,000/-.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 14 / UIIC / 09 / 2004 - 05
Shri James Martin
Vs.
United India Insurance Co Ltd.

Award Dated 14.10.2004

Shri James Martin has filed this complaint against the respondent for the inordinate delay in taking a decision on his claim reimbursement of medical expenses. His wife had undergone treatment at a hospital at Vyttila during March 2003 and had preferred the claim on 09.05.2003. Despite repeated requests and enquiries, the claim was kept pending. The complainant prays an early disposal of the claim.

The Insurer contented that the treatment administered on Mrs. James on both the occasions are for the diseases connected to the conditions of Pregnancy. These expenses were not covered under this policy and the insurer is not liable to reimburse the expenses relating thereto. The decision of the Insurer in rejecting the claim invoking Clause 4.12 of the policy is correct and does nor require any modification.

Taking into considerations all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the treatment given to Mrs. James was for the conditions attributable to pregnancy and this is explicitly excluded in the policy. His version of an accidental fall may be a concoction and is hardly believable. The decision of the Insurer is judiciously made and does not require any intervention at the hands of this Authority. The insurer is directed to communicate their decision to the parties as soon as it is made.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIA / 115 / 2003 - 04
Shri M. D. Sasidharan Pillal
Vs.
New India Assurance Co. Ltd.

Award Dated 14.10.2004

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose from repudiations of Mediclaim under Policy No. H003072143 / 2001 - 02 issued by the Insurer. The complainant's son Master Vysakh had developed a disease called Osteo Sarcoma in Nov. 2001 and the left leg of the child was amputated and the treatment was still continuing. The Insurer contested the claim on the ground that the child had a history of illness about 8 months prior to the inception of the policy and citing suppression of material facts at the inception of the policy, the claim under PSKA Policy was repudiated. However, there was clear evidence from the medical records that the symptoms appeared only about two months back from January 2002, in other words from November 2001 or so and it was also found that "November 2001" was wrongly or through an inadvertent mistake. Written as November 2000. When the medical records were read together, there was nothing to prove the theory of suppression of material facts. The complainant had already spent Rs. 10 lakhs for the treatment of the child and the treatment was still continuing. The sum insured under the disputed PSKA Policy was only Rs. 1 lakh. Since the Insurer had not proved the case of misrepresentation or suppression of material facts, the complaint was

allowed and the Insurer was asked to pay the claim amount of Rs. 1 lakh to the complainant.

In the above premises the complaint disposed of as above.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 105 / 2003 - 04
Shri K. J. Thomas
Vs.
National Insurance Co. Ltd.

Award Dated 15.10.2004

The complaint before the Insurance Ombudsman arose against the partial repudiation of the mediclaim preferred by the complainant before the insurer towards his treatment at HGM hospital Muttuchira on 20th and 21st August 2002. He was ill treated by the Insurer when contracted to know the fate of his claim. The complainant prays to reopen the case and to award the medical expenses besides a compensation of Rs. 5,000/- for the mental agony.

The insurer contented that a sum of Rs. 1,578/- has already been sanctioned to the insured towards medical expenses in final settlements of his claim. The expenses claimed for the treatment in August was rejected for the chronic and preexisting nature of the disease. The Insured was suffering from the chronic and preexisting nature of the disease. The Insured was suffering from Diabetes mellitus for the past 5 years and there was no mention about the disease in the proposal form for insurance. As such the rejection of the claim invoking Clause 4.1 of the Policy is in order.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the Insured was under treatment for Diabetes Mellitus for the past 5 years. It is evident that he was hospitalised for Seborrhic Dermatitis. This shows the preexisting nature of the disease and the decision of the Insurer to reject the claim invoking Clause 4.1 is in order. Cancellation of the policy by giving 30 days notice is also correct and does not warrant interference by this Authority. Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / UIIC / 104 / 2003 - 04
Shri G. Govindan
Vs.
United India Insurance Co Ltd.

Award Dated 19.10.2004

The complaint before the Insurance Ombudsman arose against the repudiation of the mediclaim preferred by the complainant before the Insurer towards reimbursement of the medical expenses incurred by him in connection with the treatment of his son Mr. Gopalkrishnan invoking Exclusion Clause 4.1 of the Policy. The complainant refutes the allegation and prays to reopen the case with an award a compensation of Rs. 40,000/-.

The insurer contented that they had repudiated claim for the medical expenses due to the pre - existing nature of the disease. The patient was suffering from Recurrent Urinary Tract Infection for a long period; the child was taken for treatment to various hospitals and that kidney problems was there much prior to the date of commencement of the policy. The policy had become void ab initio for misrepresentation of material facts and nothing is payable under this policy. The repudiation of the claim invoking Exclusion Clause 4.1 of the policy is in order.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the Insured was under treatment for Urinary Tract Infection and the version of the complainant that he was having the disease after the date

of commencement of policy is rather untenable. The claim is hit by the Exclusion Clause 4.1 of the policy for the pre - existing nature of the disease. The decision of the Insurer to repudiate the claim does not warrant any intervention by this Authority. The complaint is unsustainable in law as well on facts. Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 118 / 2003 - 04
Shri P. A. Sageer
Vs.
National Insurance Co. Ltd.

Award Dated 19.10.2004

The Complaint before the Insurance Ombudsman arose against the repudiation of the mediclaim preferred by the complainant before the Insurer towards reimbursement of the medical expenses incurred by him in connection with the treatment of his father Shri P. M Aseez invoking Exclusion Clause 4.1 of the Policy. The complainant prays to reopen the case and to award a compensation of Rs. 10,000/-.

The insurer contented that they had repudiated claim for the medical expenses due to the pre - existing nature of the disease. The patient was suffering from diabetic problems before the inception of the policy. The complainant had concealed these facts while proposing for insurance. He managed to secure this policy by wilful misrepresentation of material facts. As such the decision of the insurer to reject the claim invoking Exclusion Clause 4.1 is quite in order.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the Insured was under treatment for Diabetes Mellitus and the version of the complainant that he was not aware of the disease of his father is hardly believable. The claim is hit by the Exclusion Clause 4.1 of the policy for the pre - existing nature of the disease. The decision of the Insurer to repudiate the claim does not warrant any intervention by this Authority. The complaint is untenable and being devoid of merits, dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / UIIC / 122 / 2003 - 04
Shri M. A. Mohammed
Vs.
United India Insurance Co Ltd.

Award Dated 20.10.2004

Shri M. A. Mohammed had filed this complaint challenging the decision of the Insurer in repudiating his Mediclaim under policy No. 100200 / 48 / 02 / 00585 on the grounds that the patient was under medication for the last 5 years and this fact was not disclosed while proposing for insurance. Aggrieved by the decision of the respondent he has approached this authority for redressal of his grievances.

The Insurer reiterated their plea that the patient was under medication for the last 5 years. The patient was admitted at the hospital purely for investigation and complete health check up and not for any disease and only a sum of Rs. 83/- was incurred for purchase of medicine. The remaining bills were in respect of spectacles, investigation charges, etc. The decision of the insurer to repudiate the claim is in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that in the absence of any concrete evidence to prove that the patient was under medication for the past 5 years, the contention of the respondent is untenable. The actual expenses incurred as per the bills towards the cost of medicines prescribed by the doctor is payable to the complainant. The Insurer is directed to pay the said amount. The complaint is partially admitted as above.

The complaint is thus disposed of on merits as aforesaid.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / OIC / 125 / 2003 - 04
Smt. M. A. Dhanya
Vs.
Oriental Insurance Co. Ltd.

Award Dated 21.10.2004

Smt. M. A. Dhanya had filed complaint challenging the decision of the Insurer to close her Mediclaim under Policy No. 441106 / 48 / 2002 / 01630 invoking Exclusion Clause 4.1 of the Policy. The complainant maintains that she had consulted the doctor only on 05.03.2002 and never before was having the ailment. The decision of the Insurer to repudiate her claim was untenable and prays to reopen the case and award an amount of Rs. 55,000/- as compensation.

The insurer contented that they had repudiated the claim invoking Exclusion Clause 4.1 of the Policy. She obtained the Insurance cover concealing material facts as to the state of her health at time of proposal. Actually she had gone for insurance only after having the knowledge of her disease as proved by the reference letter - dated 28.01.2002 of Dr. P. P. Mohanan of West Fort Hospital. The proposal for insurance was routed through the said hospital. As such the decision of the Insurer to repudiate the claim is quite in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the respondent has acted judiciously. The complainant was well aware of her disease at time of proposal and she had deliberately misrepresented the facts in the proposal papers thereby committing the Insurer to issue the policy on the basis of the proposal. The Insurer would have never undertaken the risk if only the facts were disclosed in the proposal for insurance. No contract is valid unless the parties are of the same mind. **The complainant is not entitled to any compensation as she had committed fraud by deliberately concealing the material facts from the Insurer.**

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIA / 130 / 2003 - 04
Shri P. P. Raphel
Vs.
New India Assurance Co. Ltd.

Award Dated 26.10.2004

Shri P. P. Raphel has filed this complaint challenging the decision of the Insurer in repudiating his Mediclaim invoking Exclusion Clause 4.1 of the policy. The complainant states that the decision to reject the claim is highly illegal and prays for an award of Rs. 44,752/- as compensation being the reimbursement of medical expenses incurred by him for the treatment of his wife Ms. Alice Raphel.

The Insurer contented that the wife of the complainant Ms. Alice Raphel had the symptoms of cancer from inception of the policy. The complainant had not disclosed this at the time of proposal and as such Exclusion Clause 4.1 of the policy attracts. The decision to repudiate the claim was made on the basis of the reports from Dr. Anilkumar, the panel doctor of the Insurer. The repudiation of the claim for supporession of material facts invoking Exclusion on clause 4.1 of the policy is genuine and in order.

Taking into consideration all the records available in the file and also the contentions of the concerned, the Ombudsman ruled that the Exclusion Clause 4.1 of the policy would be operative only if two conditions are fulfilled.

1. The ailment should be pre - existing.

2. The Insured / Proposer must have been aware of the disease at the time of proposal. The question of wilful suppression of material facts arises only in case of proposer's knowledge of existing ailments.

The report of the panel doctor is too scanty to arrive at a conclusion that the symptoms were prevailing as on the date of proposal, in July 1999. It is unusual that any person of a normal prudence will wait for such a long period of 3 years to be eligible for mediclaim benefits, once the disease is diagnosed as carcinoma. As such the decision of the respondent to reject the claim invoking Clause 4.1 of the policy is illegal and unsustainable and therefore set aside. The respondent is directed to honour the claim as per the bills.
The above complaint is thus disposed of on merits as aforesaid.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 131 / 2003 - 04
Shri K. K. Sunilkumar
Vs.
National Insurance Co. Ltd.

Award Dated 26.10.2004

The complaint before the Insurance Ombudsman arose against the partial repudiation of the mediclaim preferred by the complainant before the Insurer towards his treatment at KIMS during the period 28.05.2002 to 04.062002. He was insured for Rs. 50,000/- and later the sum insured was enhanced to Rs. 2,00,000/-. His claim for reimbursement was rejected invoking Clause 4.3 of the policy. The complainant prays to reopen the case and to award the medical expenses incurred by him in full.

The insurer contented that a sum of Rs. 46,100/- has already been paid to the insured in full and final satisfaction of the claim and he has received the payment. The claim was settled taking into account the sum insured as 50,000/-. Piles was not a disease of sudden onset and from the available data he was suffering from this disease for the last more than one year and so enhancement of sum assured would not apply for the treatment. As such the rejection of the claim invoking Clause 4.3 of the Policy is in order.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the Insured had already accepted the amount of Rs. 46,100/- in full and final settlement of the claim. The sum assured during the period of treatment was only Rs. 50,000/- enhancement of sum assured will be in operation one year after enhancement. Claim for reimbursement of surgical expenses falls within the Clause 4.3 of the policy. The decision of the Insurer to rejects the claim invoking Clause 4.3 is in order and does not warrant interference by this Authority.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 129 / 2003 - 04
Shri K. A. Unnikrishnan
Vs.
New India Assurance Co. Ltd.

Award Dated 26.10.2004

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose from repudiation of Mediclaim under Policy No. 760702 / 48 / 02 / 01087 issued by the Insurer. The complainant sustained injury due to an accidental fall at his residence on 17.07.2003 and he was under treatment at Cochin Hospital. The plaster was removed after 28 days and he was advised rest for a further period of one week He preferred a claim for reimbursement of medical expenses, but the respondent in voking Clause 4.10 of the policy

rejected the same. Aggrieved by the decision of the respondent he had approached this Authority to reopen the case.

The Insurer contested the claim on the ground that the policy covers reimbursement for hospitalisation / domicilians expenses for illness / disease or injury sustained and where confinement is required at hospital / nursing home. They contented that the treatment given was for fracture of 5th Metatarsel ® and it did nor require any hospitalisation. The confirnement was only for claiming reimbursement. Being devoid of merits, the claim was rejected.

Taking in consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the complainant was under plaster for 28 days and he was advised rest for another one week after removal of plaster. Admittedly his movements were restricted for 5 weeks. He could not earn his living due to this injury and treatment. He is eligible for the reimbursement of the bills, setting aside the orders of repudiation this Authority directs the respondent to pay an amount of Rs. 1994/- subject to compulsory deductions to the complainant.

In the above premises the complaint is disposed of as above.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 134 / 2003 - 04
Shri P. Vijayan
Vs.
National Insurance Co. Ltd.

Award Dated 27.10.2004

The complaint under Rule 12(1)(b) read with Rule 13 days RPG Rules, 1998 arose from repudiation of mediclaim under Policy No. 570704 / 48 / 02 / 8501485 issued by the Insurer. The complainant was under treatment from 24.02.2003 to 01.03.2003 for Disc Derangement syndrome. His claim for reimbursement of hospital charges was turned down by the respondent for the reason that the disease for which he had undergone for treatment was a pre - existing one to the date of proposal for insurance. His reminder to the Grievance Cell of the Insurer also met the same fate. Aggrieved by the decision of the respondent he had approached this Authority to reopen the case.

The Insurer contested that the medical reports reveal that the complainant was suffering from ‘pain on lower back’ for the past 2 years. Definitely it is a forerunner of Disc Derangement. The repudiation of the claim invoking Clause 4.1 of the policy is in order and does not warrant any modification.

Taking consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the Senior Branch Manager could have condoned the delay of 9 days in renewing the policy. Moreover no fresh proposal was obtained while renewing the policy. The existence of any illness can be divulged only if a fresh proposal is obtained. As such the acceptance of the premium without a fresh proposal amounts to the renewal of the existing policy. The decision of the Insurer to repudiate the claim is untenable in law as well as on facts. Setting aside the decision of the respondent, this Authority directs the Insurer to release the amount claimed by the complainant as per the bills and computation afresh.

In the above premises the complaint is disposed of as above.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 14 / OIC / 136 / 2003 - 04
Shri K. Rahdhakrishna Menon
Vs.
Oriental Insurance Co. Ltd.

Award Dated 28.10.2004

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose from repudiation of Mediclaim under Policy No. 2002 / 820 Ren No. 2003 / 751 issued by the Insurer. The complainant was under treatment for dental ailments at Arumana Hospital, Trivandrum. As against his claim for Rs. 34,943/- towards reimbursement of hospital charges, the respondent had sent a voucher considering his claim for Rs. 3,200/- only. The complainant refused to accept the same and returned the voucher unsigned. His appeal to consider his claim in full to the Grievance Cell of the Insurer was of no use. Aggrieved by the decision of the respondent he had approached this Authority to reopen the case and award the amount in full.

The Insurer contented that the amount offered by them was as per the expert opinion they had sought from Dr. Ramachandran. They had some suspicion as regards the sequence number of the bills submitted by the complainant and according to the recommendation of their investigator. The complainant is not eligible for any further amount. The partial repudiation of the claim is in order and does not warrant any modification.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the Insurer could have verified the veracity of the claim with Arumana Hospital or with Dr. C. P. John who had treated the complainant. Dr. Ramachandran had not taken into account the other treatment given to the complainant, besides Route Canal Treatment. There is no reason to disbelieve the contentions of the complainant, who was a senior Central Government Officer. The decision of the Insurer to partially repudiate the claim is untenable in law as well as on facts. Setting aside the decision of the respondent, this Authority directs the Insurer to release the amount of Rs. 34,943/- as claimed by the complainant supported by the bills.

In the above premises the complaint is disposed of as above.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 004 / 010 / 2004 - 05
Shri Fancis K. George
Vs.
United India Insurance Co. Ltd.

Award Dated 02.11.2004

Shri Francis K. George had filed this complaint challenging the decision of the Insurer to repudiate his claim for the reimbursement of medical expenses incurred for his treatment and for that of his mother Smt. Mary Francis. His claims for reimbursement of medical expenses were rejected by the respondent for suppression of material facts at the time of Proposal / Revival. The complainant refutes this allegation and approached this Authority with a prayer to re - open the case and award Rs. 50,000/- + interest as compensation.

The insurer contented that Smt. Mary Francis was suffering from Hypertension and Periarthritis and was intermittently under treatment since 1999. While proposing for insurance in 1999 or at the time of revival in 2002, he had not mentioned anything about the disease or treatments. The relevant questions in the forms were either left blank or answered in Negative. The policy was issued on the basis of the answers and declarations in the proposal forms. He managed to secure the policy by suppressing material facts from the Insurer. He had violated the principle of “utmost good faith”, the very basis of Insurance contract. The decision of the Insurer to repudiate the claim is quite in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the respondent had acted judiciously. The complainant was well aware of her disease at the time of proposal and he had deliberately

misrepresented the facts in the proposal papers thereby committing the Insurer to issue the policy on the basis of the proposal. The Insurer would have never undertaken the risk if only the facts were disclosed in the proposal for insurance. No contract is valid unless the parties are of the same mind. The complainant is not entitled to any compensation as he had committed fraud by deliberately concealing the material facts from the Insurer.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / UII / 13 / 2004 - 05
Shri K. P. Unnikrishnan
Vs.
United India Insurance Co. Ltd.

Award Dated 02.11.2004

Shri K. P. Unnikrishnan has filed this complaint challenging decision of the Insurer in repudiating his Mediclaim invoking Exclusion Clause 4.1 & 4.2 of the policy. The complainant states that the decision to reject the claim is highly illegal and baseless and untenable and prays for an award of Rs. 15,497/- as compensation being the reimbursement of medical expenses incurred by him for his treatment.

The Insurer contented that the complainant had the symptoms of Hernia since 5 years and that the patient was fully aware of the same at the time of proposing for Insurance. The complainant had not disclosed this at the time of proposal and as such Exclusion Clauses 4.1 & 4.2 of the policy attract. The decision to repudiate the claim was made on the reports from Dr. C. Gopalakrishnan Nair of AIMS Edappally. The repudiation of the claim for suppression of material facts invoking Exclusion clauses 4.1 & 4.2 of the policy is genuine and in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the Exclusion Clause 4.1 of the policy would be operative only if two conditions are fulfilled.

1. The ailment should be pre - existing

2. The Insured / Proposer must have been aware of the disease at the time of proposal. The question of wilful suppression of material facts arises only in case of Proposer's knowledge of existing ailments.

Moreover, the complainant was an employe of Central bank of India, where he was eligible for full refund of medical expenses. If that were so, he would have undergone the operation while in service itself, once the ailment is detected. It clearly indicates that he was not aware of the disease earlier. As such the decision of the respondent to reject the claim invoking Clause 4.1 of the policy is illegal and unsustainable and therefore set aside. The respondent is directed to honour the claim as per the bills within 10 days from the date of receipt of this order.

The above complaint is thus disposed of on merits as aforesaid.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 04 / 016 / 2004 - 05
Shri D. Subramanyam
Vs.
United India Insurance Co. Ltd.

Award Dated 03.11.2004

Shri D. Subramanyam had filed this complaint challenging the decision of the Insurer to partially repudiate his claim for the reimbursement of medical expenses incurred for his treatment against his claim for Rs. 37,497/- the respondent had allowed only Rs. 10,631/- for the reason that the expenses for the period beyond 30 days of pre - hospitalisations

and 60 days of post hositalisation was not grantable. His appeal to the higher authority was also turned down citing the same reason. Aggrieved by the decision of the Insurer, the complainant has approached this Authority and prays for reopen the case and award a compensations of Rs. 26,000/-.

The insurer contented that they had acted only as per the rules. The expenses for the treatment beyond 30 days of pre - hospitalisation and 60 of post hospitalisation are not allowable. As such the amount allowed is correct. By an over sight they had paid Rs. 6,866/- in excess and the complainant is requested to refund that amount.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the respondent had acted judiciously. The complainant had submitted a bill for Rs. 14,000/- being the professional Fee. Since it was not submitted in time, and its credibility being at stake, as it was a hand written one, it could not be reimbursed. The Insurer had reimbursed Rs. 5,000/- towards domiciliary treatment. The complaint is not sustainable. And the complainant is not eligible for further reimbursement.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / OIC / 19 / 2004 - 05
Shri Padmanabhan Nair
Vs.
Oriental Insurance Co. Ltd.

Award Dated 04.11.2004

Shri Padmanabhan Nair has filed this complaint challenging the decision of the Insurer to repudiate his claim for the reimbursement of medical expenses incurred for the treatment of his wife Smt. Thankamani during the period 18.09.2002 to 08.10.2002 citing pre - existing nature of the disease. The complainant states that he was having 12 more policies also with the respondent company and he had not preferred any claim on those policies except the one in question. The decision of the Insurer to repudiate her claim was untenable and prays to reopen the case and award an amount of Rs. 60,000/- as compensation.

The insurer contended that they had repudiated the claim invoking Exclusion Clause 4.1 of the Policy. The patient was suffering from Rheumatoid Arthritis for the past so many years and he had not disclosed the same while proposing for Insurance. As such he had suppressed vital information from the Insurer, thereby he had violated the principle of “utmost good faith”, the very basis of Insurance contract. The decision of the Insurer to repudiate the claim is quite in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the respondent has acted judiciously. The complainant was well aware of her disease at the time of proposal and he had deliberately misrepresented the facts in the proposal papers thereby committing the Insurer to issue the policy on the basis of the proposal. The Insurer would have never undertaken the risk if only the facts were disclosed in the proposal for insurance. No contract is valid unless the parties are of the same mind. The complainant is not entitled to any compensation as he had committed fraud by deliberately concealing the material facts from the Insurer.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIA / 113 / 2003 - 04
Shri K. U. Mohammed Salih
Vs.
The New India Assurance Co. Ltd.

Award Dated 05.11.2004

Shri K. U. Mohammed Salih has filed this complaint challenging the decision of the Insurer to repudiate his claim for the reimbursement of medical expenses incurred for the treatment of his wife Smt. Laila Salih during the period 23.07.2001 to 28.07.2001 for “Incisional Hernia Posts Hysterectomy”. His claim for reimbursement was rejected by the respondent for the reason that the treatment in question was in continuation of a pre - existing problem and therefore, non - entertainable under this policy. Aggrieved by the decision of the Insurer, the complainant had approached this Authority and prays for reopen the case and award compensation of Rs. 24,923/-.

The insurer contented that they had repudiated the claim for the pre - existing nature of the ailment. The very term “Post Hysterectomy” suggests that the patient had undergone “Hysterectomy” previously. The treatment undergone by the patient now is in continuation of her previous treatment. The certificate from the treating Doctor clearly indicates that she was suffering from the said complaints for 4 years from the date of first consultation. He had not disclosed the same while proposing for Insurance. As such he had suppressed vital information from the Insurer, thereby he had violated the principle of “utmost good faith”, the very basis of Insurance contract. The decision of the Insurer to repudiate the claim is quite in order.

Taking into consideration all the records available in the file and also the contentions of the parties concerned, the Ombudsman ruled that the respondent had acted judiciously. The complainant was well aware of her disease at the time of proposal and she had deliberately misrepresented the facts in the proposal papers thereby committing the Insurer to issue the policy on the basis of the proposal. The Insurer would have never undertaken the risk if only the facts were disclosed in the proposal for insurance. No contract is valid unless the parties are of the same mind. The complainant is not entitled to any compensation as he had committed fraud by deliberately concealing the material facts from the Insurer.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 004 / 023 / 2003 - 04
Smt. K. R. Anithakumari
Vs.
United India Insurance CO. Ltd.

Award Dated 05.11.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 was is relation to the repudiation of a Mediclaim by the Respondent Insurer. The complainant had undergone a surgery on her left ear on 05.04.2003 at Vikram Hospital, Coimbatore and the claim preferred therefore was turned down by the Insurer citing pre - existing nature of the disease. The policy was for the period 14.11.2002 to 13.11.2003. The discharge summary from the hospital cited pain and block in the ear for the complainant over a period of 4 months which would mean that the problem existed at least as far back as 04.12.2002 reckoning the period of 4 months from the date of admission in the hospital i.e. 04.04.2003. Policy condition 4.2 explicitly excludes treatment during the first 30 days of the policy. Therefore, evidently, the treatment of the claimant was hit by the Exclusion Clause and hence the action of the Insurer in repudiating the claim was just and proper. In the said circumstances, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 041 / 2004 - 05
Smt. Omana
Vs.
National Insurance Co. Ltd.

Award Dated 09.11.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG, Rules 1998 is as a result of repudiation of the mediclaim of the complainant under Policy No. 570700 / 46 / 02 / 8501149 / 5252 issued by the respondent Insurer. The claim pertained to the treatment of the complainant's son Master Anoop at Sevanam Hospital, Edakkara for Acute Glomenulo Nephritis & Acute Gastro Enteritis. The respondent's contention is that by the nature of the disease, it should be a longstanding problem and the word "Acute" was incorporated in the discharge form instead of "Chronic" only to accommodate the claim settlement. The amount involved in this case was only Rs. 2,804.70 and the complainant was a housemaid. From the circumstances and the documentary evidences on the file, the Respondent Insurer had not established their contention that it was a longstanding problem. The Insurer was unjustified in rejecting the claim based on conjectures and surmises. No merit could be attributed to the arguments of the Insurer and, therefore, the claim for Rs. 2,804.70 was allowed in favour of the complainant.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 028 / 2004 - 05
Shri K. Aravindakshan
Vs.
National Insurance Co. Ltd.

Award Dated 17.11.2004

The complaint under Rule No. 12(1)(b) read with 13 of the RPG Rules, 1998 is as a result of repudiation of the mediclaim of the complainant by the respondent Insurer on the allegation that the listed disease was pre - existing as on the date of commencement of the policy and, therefore, it attracted the mischief of Exclusion Clause 4.1 and 4.8 of the Mediclaim Policy. The Insurer's contention was that the complainant had preferred a claim just 2 months after taking the policy and the hospitalisation was for "Acute Angle Closure Glaicoma", "Headache" etc. and that such diseases could not be a matter of sudden development. The hospital records however revealed its only as a sudden development. In fact, the hospital records showed it as symptomatic "since one day". Another hospital termed it as of "2 - 3 days only". Under these circumstances, the Insurer's arguments were found to be a wrong footing and the claim amounting to Rs. 10,042.48 was allowed by Ombudsman.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 029 / 2004 - 05
Shri M. K. Hariharan
Vs.
Oriental Insurance Co. Ltd.

Award Dated 17.11.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is an offshoot from rejection of a mediclaim preferred by the complainant under Policy No. 296 / 2004 issued by the respondent Insurer on the alleged misrepresentation of material facts. The complainant had some ailments on his left foot and so was he hospitalised between June 2003 and August 2003 incurring an expenditure of Rs. 25,332/-. The complainant's version was that he had no such pre - existing problems and that Diabetes Mellitus as would not cause swelling on the foot. The Insurer citing from the Medical Trust Hospital records submitted that the complainant was a Diabetes patient for the past 23 years and the medical opinion also being Diabetic Foot, the Insurer had no doubt about the pre - existing nature of the disease.

On the whole, the Insurer had conclusively proved its case that the complainant had suppressed a variety of material facts while taking the mediclaim policy and hence the Ombudsman, as being devoid of merits, dismissed the complaint.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 036 / 2004 - 05
Smt. Rachel George
Vs.
National Insurance Co. Ltd.

Award Dated 19.11.2004

The Complaint before the Insurance Ombudsman arose against the repudiation of the mediclaim preferred by the complainant before the Insurer towards the treatment of her husband Mr. George at Bangalore Heart Hospital & Research Centre during the period 03.01.2003 to 27.01.2003. Her claim for reimbursement was rejected invoking Clause 4.1 of the policy. The complainant prays to reopen the case and to award the medical expenses incurred by her in full.

The insurer contented that the complainant was having a mediclaim policy covering her spouse from 02.07.1999 to 01.07.2002. The cheque tendered by her towards renewal of policy from 02.07.2002 had bouned. The respondent on 17.07.2002 received fresh premium by cash and they had issued a new policy commencing from 17.07.2002. Mr. George was under treatment at Bangalore Heart Hospital & Research Centre from 03.01.2003 to 27.01.2003. The discharge summary produced by the complainant clearly indicates that he was suffering from the disease since 2 years. If the period is calculated regressively, he was suffering from 2001 onwards. The new policy commenced only on 17.07.2002. As such rejection of the claim in view of the pre - existing nature of the disease is in order.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the Insured had at fault in allowing the cheques tendered by her towards the renewal premium to bounce. The break in continuity of the insurance coverage had rendered the contract a fresh one and the respondent had acted only as per the policy conditions. The insurer admits that the allowance cumulative bonus is an inadvertent mistake on their part. One should not benefit by an inadvertent mistake committed by the other party. “Two mistakes do not make a right decision as a third Intermediary proposition”. The decision of the Insurer to reject the claim invoking Clause 4.1 of the policy is in order and does not warrant interference by this Authority.

Being devoid of merits, this complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 048 / 2004 - 05
Shri Philip Abraham
Vs.
The New India Assurance Co. Ltd.

Award Dated 30.11.2004

The complaint under Rule No. 12(1)(b) read with Rules 13 of the RPG Rules, 1998 is the aftermath of repudiation of a PSKA Claim by the Respondent Insurer. The complainant had claim for medical expenses reimbursement in relation to the treatment fo his wife Smt. Shirley Philip. She had undergone a surgery for Incisional Hernia on 20.05.2003. The Insurer had repudiated the claim citing pre - existing health problems. From the records, it was evident that Smt. Shirley Philip had undergone a Caesarian Section 6 years back and the hernia had developed at the very site of operation and therefore it was also rightly claissified and documented as Incisional hernia. As per conditions of the PSKA Policy, all pre - existing illness or complications arising out of pre - existing medical history are clearly excluded under Part III of the Policy. The case being very clear and the past history of Caesarian Sections before the commencement of the policy having been proved beyond

doubt, the action of the Insurer in repudiating the claim was found justifiable and hence upheld.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 049 / 2004 - 05
Smt. D. Sarojini Amma
Vs.
National Insurance Co. Ltd.

Award Dated 01.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 was in consequence of Repudiation of a mediclaim preferred before the Insurer by the complainant under Policy NO. 570201 / 48 / 2002 / 8500131. Late Ramchandran Nair had taken the policy in 1995 and the same is got renewed in 1996. The next year there was a gap of 9 days in renewing the policy. A new policy was issued obtaining a fresh proposal form dated 29.04.1997 from the party. He had to undergo hospitalisation and treatment for cardiac diseases during the period March - May 2002. He died of heart disease. The Insurer invoking Exclusion clause 4.1 of the policy rejected the claim preferred by the complainant The deceased was suffering from the heart diseases from 1995 and he received reimbursement of hospital charges from the Respondent Insurer. However, these facts were not disclosed in the fresh proposal. The Insurer was able to prove the case of suppression of material facts beyond all reasonable doubts. The complainant was well educated and was serving as professor as seen from the propsal papers of 1997 and was certainly aware of the seriousness of what he had written in the proposal form. Insurance being a contract of utmost goof faith, the intentional suppression of material facts had vitiated the contract and finding no merits / substance in the complaint, the same was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 14 / NIC / 52 / 2004 - 05
Shri K. J. Mathew
Vs.
National Insurance Co. Ltd.

Award Dated 03.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 was in consequence of non - settlement of a mediclaim preferred before the Insurer by the complainant under Policy No. 570704 / 42 / 2001 / 8204755. The claim was amounted to Rs. 20,000/- in terms of the sum insured restriction, although the actual expenditure was Rs. 21,402/-. The insurance was through a local Health Club and while submitting the proposal for the said mediclaim insurance, the complainant had declared himself hale and healthy. The claim now in dispute was for treatment of Inguinal Hernia and it was found out by the Insurer that the treatment - history of the related problems was traced to April 1998. The insurance policy was for the period 15.03.2002 to 14.03.2003. By his own statements, the complainant had treatment in other hospitals. Other than hernia related problems, the complainant was also suffering from kidney ailments. The Insurer was able to prove the case of suppression of material facts beyond all reasonable doubts. The complainant was a graduate and he was certainly aware of the seriousness of what he had written in the proposal form. **Insurance being a contract of utmost good faith,** the intentional suppression of material facts had vitiated the contract and finding no merits / substance in the complaint the same was **dismissed.**

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 055 / 2004 - 05
Dr. B. Sasikumar
Vs.
The New India Assurance Co. Ltd.

Award Dated 06.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a mediclaim prefered by the complainant with the Respondent Insurer. The complainant had a problem of low back ache with radiating pain to left lower limbs and he was hospitalised during the period 25.02.2004 to 03.03.2004. The Insurer's contention was that there was contradiction relating to the duration of illness mentioned in the Discharge form and company's medical certificate form issued by the Doctor. The facts, as turned out to be one that, on the Insurer's pointing out the discrepancy, the Doctor had issued a corrected Discharge summary and not being prepared to accept the same, the Insurer had repudiated the claim However, the Insurance Ombudsman found nothing wrong in what the complainant had done. A Junior doctor who had not attended the patient wrote the form. On pointing out the lacuna, it was got rectified by the Doctor concerned. And besides, the complainant is a Senior Scientist by profession and his version was simple, straightforward and acceptable. The Insurer had repudiated the claim on wrong premises and therefore the order of repudiation was interfered with and the claim was allowed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 057 / 2004 - 05
Shri K. P. Prasannakumar
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 07.12.2004

The complaint under Rule No. 12(1)(b) read Rule 13 of the RPG Rules, 1998 was in relation to the repudiation of a mediclaim preferred by the complainant in relation to the treatment of his father Mr. Purushothaman who was covered under the Group Mediclaim Policy of the complainant, who is an employee of M/s Appollo Types, Ltd. Perambra. On scrutiny of the papers, the Insurer found out that the complainant's father was on treatment for portal hypertension, Cirrhosis etc. for about 8 years and the policy had commenced much later i.e. in 2000 only. Therefore citing pre - existing diseases, the claim was repudiated. The case of the Insurer was well documented and there was no doubt about the contention of the pre - existing nature of the diseases. However, the complainant was in a very precarious condition finacially and he was heavily depending on the reimbursement of the treatment expenses from the Respondent. It was a family benefit scheme floated by the employer of the company and considering the peculiar nature and circumstances of agony in which the complainant was placed, while upholding the orders of repudiation; an ex - gratia of Rs. 6,000/- was sanctioned to the complainant.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / OIC / 64 / 2004 - 05
Dr. K. P. Janardhan
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 09.12.2004

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose from repudiation of a mediclaim under Pol. No. 141602 / 2003 / 673 by the insurer. The

complainant's wife had preferred an earlier claim in 1995, which was settled by the insurer. However, the second claim for renal transplantation was rejected by the T. P. A. of the insurer citing pre - existing illness. When the facts were represented, the T. P. A. had considered the claim and sent an advance receipt to the complainant for the sum insured of Rs. 1,50,000/-. However, since the claim amount exceeded the limits of the T. P. A. the papers were sent in the meantime to the Head Office of the insurer who took the decision to repudiate the claim on the plea that the illness was pre - existing. However, it is found from records that the T. P. A. had based their original finding on a bland statement in care record of one Devaki Hospital that the patient had problems for about 10 years. Other than this unqualified statement, there was no medical evidence to prove that the complainant's wife had suffered from kidney ailments any time before March 2003. Therefore, since the complainant had enjoyed continous mediclaim coverage and the fact of pre - existing illness was not proved with supporting medical evidences, the conclusion drawn by the insurer was found legally infirm and invalid. In the said circumstances, the complaint was allowed and the insurer was directed to settle the claim for Rs. 1.5 lakhs.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 062 / 2004 - 05
Shri G. K. Nair
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose due to repudiation of a PSKA claim (Pol. No. 1999 / 47 / 760505 / 81888) by the insurer. The complainant had preferred a claim for his medical treatment at Pandya Hospital at Mombassa, Kenya and thereafter, on return to his native palce, at Medical College, Trivandrum. However, as per the policy conditions, reimbursement was permissible only in relation to inpatient hospital treatment in India. In the case on hand, the complainant had received in - patient treatment at Mombassa Hospital in Kenya and therefore the claim was not admissible. Besides, the treatment at Medical College, Trivandrum was only at out - patient treatment and, therefore, again, it did not come within the purview of the policy. The conditions of the policy being very strict and pronounced within the knowledge of the complainant, the repudiation of the claim by the insurer was upheld by this Forum.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 078 / 2004 - 05
Shri P. V. George
Vs.
National Insurance Co. Ltd.

Award Dated 17.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of a mediclaim by the respondent insurer. The complainant had undergone a thyroid gland surgery in February 2004 and the claim was repudiated by the insurer on the plea that the disease was pre - existing. As pointed out by the insurer and also as per the medical records available, the surgery was for sub - total thyroidectomy which suggested that the ailment was certainly pre - existing. The investigations concluded by the insurer also revealed that the complainant was suffering from Asthma and goiter problems for over four years and he was under treatment for the same from a different hospital. In fact it was a case of two - lobes sub - total thyroidectomy with dimensions of 6.5 cms and 5.5 × 2.3 cms and from the very size, it was clear that the ailment was existing for several years. The complainant stated that he had no pre - existing problems but the records proved the

case otherwise and the insurer was found right in repudiating the claim invoking Exclusion Clause No. 4.1 of the mediclaim policy. In these circumstances, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 082 / 2004 - 05
Shri K. X. Mathews
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 21.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of a claim for medical reimbursement by the insurer. The complainant is an employee of M/s. Apollo Tyres and his wife had sustained an injury due to fall from a two wheeler. The complainant's wife was treated at Sanjeevani Panchakarma. Institute, Trichur. As per the insurer, the said Nursing Home did not conform to the definition of a hospital as mentioned in the policy. In the policy, the hospital / nursing home is defined as "an Institution in India established for indoor care and treatment for sickness and injuries and which has been registered as a hospital / nursing home with local authories". The complainant states that he was not aware of this condition and so also his employer - M/s. Apollo Tyres too did not know of it. However, the insurer's contention was found correct and the hospital from where the treatment was availed of by the complainant's wife did not answer the definition as contained in clause 2.2 of the Group Mediclaim policy. Under these circumstances, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / NIC / 81 / 2004 - 05
Shri M. V. Sreekumar
Vs.
National Insurance Co. Ltd.

Award Dated 21.12.2004

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of a mediclaim by the respondent insurer. The complainant's wife, who was covered under the policy, had undergone an operation for abortion due to severe bleeding. Although pregnancy related complications are excluded under the mediclaim policy, the complainant submitted that it was a case of critical abortion to save the life of the patient and hence it came under the purview of the policy. However, the records did not reveal that it was a life saving operation either. In any case, critical or otherwise, it being a pregnancy related complication clearly excluded by the policy under cl. 4.12, the complainant's case was not tenable and hence it was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 090 / 2004 - 05
Shri C. P. Gabriel
Vs.
National Insurance Co. Ltd.

Award Dated 06.01.2005

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is as a result of repudiation of a mediclaim by the Insurer in respect of a Jana Seva Insurance Policy No. 570704 / 42 / 2001 / 8204844 issued by the respondent insurer. The complainant was under treatment at Irinjalakuda Co - Operative Hospital Ltd., from 14.03.2004 to

19.03.2004. The respondent citing the pre - existing nature of the disease rejected his claim for reimbursement of medical expenses. The dispute was compromised as between the parties at the instance of the Insurance Ombudsman and the Insurer agreed to pay an amount of Rs. 1,500/- to the complainant in full and final settlement of the claims. The compromise was duly recorded and thus the dispute was amicably resolved.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 083 / 2004 - 05
Shri C. Kochukrishnan
Vs.
The New India Assurance Co. Ltd.

Award Dated 06.01.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 stems out of the inordinate delay in settling claim under his Mediclaim Policy by the respondent Insurer. The wife of the complainant had undergone medical treatment at Fort Hospital Palakkad from 05.04.2004 to 07.04.2004 and his claim for reimbursement of medical expenses was referred to M/s Medi Assist, the TPA of the of the Insurer. The TPA had settled the claim for Rs. 4,722/- with a delay of more than 100 days from the date of claim. The complainant has approached this Authority to compensate him for the mental agony he had undergone and the expenses he had to incur towards traveling expenses and telephone charges.
Taking into consideration the status of the complainant, he being a senior citizen and a retired official of Grasim Industries, This Authority has allowed Rs. 500/- towards travelling expenses and an interest for 20 days at 6 % to the claim amount of Rs. 4,722/-. The respondent is directed to pay the amount as aforesaid.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 091 / 2004 - 05
Shri P. Sunderdas
Vs.
The New India Assurance Co. Ltd.

Award Dated 07.01.2005

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPGs Rules, 1998 was in consequence of Repudiation of a mediclaim preferred before the Insurer by the complainant under Policy No. 761300 / 48 / 2003 / 0269. The complainant had undergone Coronary Artery byepass Surgery at MIOTS Hospital, Chennai where for he was an inpatient from 16.09.2003 to 6.10.2003. The Insurer invoking Exclusion clause 4.1 of the policy rejected the claim for Rs. 1,98,602/- preferred by the complainant The complainant was suffering from the disease while proposing for insurance and he had not disclosed these facts in the proposal form. The Insurer was able to prove the case of suppression of material facts beyond all reasonable doubts. The discharge summary issued to him clearly indicates that he was having these illnesses before the inception of the policy. The complainant was cetainly aware of the seriousness of what he had written in the proposal form. **Insurance being a contract of utmost goof faith,** the intentional suppression of material facts had vitiated the contract and finding no merits / substance in the complaint, the same was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 101 / 2003 - 04
Smt. Susamma Mohan
Vs.
The New India Assurance Co. Ltd.

Award Dated 25.01.2005

The Complaint under Rule No. (1) (b) read with Rule 13 of the RPG Rules, 1998 was in consequence of Repudiation of a mediclaim preferred before the Insurance by the complainant under Policy no. 760905 / 48 / 2003 / 03135. The complainant had undergone Abdominal Hysterectomy on 14.05.2004. The Insurer rejected her claim for reimbursement of medical expenses for the reason that the operation was during the exclusion period of the policy. Aggrieved by the decision of the Insurer she had approached this authority.

During personal hearing the complainant had expressed her willingness to withdraw the case as she was now realize that the claim was rejected invoking Exclusion Clause 4.3 of the policy. As such the complaint stands **dismissed.**

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 029 / 2004 - 05
Shri K. Mohanachandran
Vs.
The New India Assurance Co. Ltd.

Award Dated 27.01.2005

The complaint under Rule No 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 is an offshoot from rejection of a mediclaim preferred by the complainant under the Policy No. 760502 / 48 / 0201180 issued by the respondent Insurer on the alleged misrepresentation of material facts. The wife of the complainant had undergone 'abdominal surgery - hysterectomy' 7 years back and the hernia in question was at the upper end of the previous incision. The present operation was the after effects of the operation held 7 years back. The previous operation was before the issue of the policy and the proposal was silent about the operation. The decision of the insurer in repudiation the claim invoking Exclusion Clause 4.1 of the policy is perfectly in order. Though this authority does not want to interfere with the judiciously made decision of the insurer, taking into consideration that he is an ex - service man burdened with heavy financial difficulties and that he had managed to raise funds by personal loans and such other means, in order to leave the complainant in a less unhappy situation, an amount of Rs. 5000/- is awarded as ex - gratia. The Insurer is directed to pay the amount within 15 days from the date of receipt of consent from the complainant.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 004 / 093 / 2004 - 05
Shri C. R. Shasikumar
Vs.
United India Insurance Co. Ltd.

Award Dated 01.02.2005

The complaint under Rule No 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a mediclaim preferred by the complainant with the Respondent Insurer. Ms Deena, daughter of the complainant was got admitted at Don Bosco Hospital from 23.09.2003 to 27.09.2003 and again from 30.09.2003 to 01.10.2003. The diagnosis was Oesophagitis and Sinusitis. The respondent on the plea that hospitalisation was not required for the disease rejected the complainant's claim for reimbursement of medical expenses. Upholding the decision of the TPA, his appeal to the Grievance Cell of the Insurer was also turned down. Aggrieved by the decision of the respondent, he has approached this authority with a prayer to reopen the case and compensate him suitably.
Taking into consideration all the records available in the file and also the contentions of the parties concemed, the ombudsman ruled that it was at the instant of some colleagues that Ms. Deena was hospitalised and the version of the Insurer that it was for claiming Medical benefits can be taken only with a pinch of salt. As the complainant has followed bigamy against the law of the land, this policy is issued opposed to the public policy, rendering this policy void. Nevertheless, taking into consideration the impecunious condition of the complainant this authority awards Rs. 4045/- , the hospital charges as EX - gratia.

The complainant is thus disposed of on merits as aforesaid.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 004 / 093 / 2004 - 05
Smt Usha Susan Jacob
Vs.
United India Insurance Co. Ltd.

Award Dated 01.02.2005

The complaint under Rule No 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a mediclaim preferred by the complainant under Policy no. 100782 / 48 / 03 / 00243 renewed continuously for a period of two years, from 22.02.2003 to be precise. The complainant, Smt. Usha Susan Jacob had undergone surgical treatment at the Eye Foundation, Coimbatore, for High Myopia Astigmatism and the repudiation of the claim was for the reason that the condition was far too long pre - existing. Dr. Chitra who had attended on the patient had also mentioned that the exact duration of the complaint could not be predicted. But the complainant's father had made it clear that the girl was using spectacles for the said complaint from her age 14. Therefore, the case was clear enough that the eye disease of the complainant was in existence right from her childhood and obviously pre - existing as far as the Insurance Policy is concerned. In these circumstances, the repudiation of the claim by the Insurer was found substance on law as well as on facts and the complaint was **dismissed.**

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 098 / 2004 - 05
Shri S. K. Vijayan
Vs.
National Insurance Co. Ltd.

Award Dated 03.02.2005

The complaint under Rule No 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 is as a result of partial repudiation of the mediclaim of the complainant by the respondent Insurer on the allegation that the listed disease was pre - existing as on the date of commencement of the policy. The complainant had two policies – one regular mediclaim policy and the other Sampoorna Suraksha Bima. The complainant had undergone Coronary Angiogram and By - pass surgery at Sree Chithra Thirunal Institute of Medical Sciences in April 2004. The insurer had allowed a sum of Rs. 12688/- and the rest of the claim was disallowed by them citing pre - existing problems. It was also mentioned in the hospital records that the complainant was a diabetic for 5 years and that he had a history of TURP 4 years back which were reportedly not mentioned in the proposal for insurance. However, the Insurer's stand was found arbitrary and the reasoning was not on sound logic or clear medical evidence. The circumstances narrated by the complainant for the mention of Diabetic etc. could not be disbelieved for many reasons. In these circumstance the Insurer was asked to pay the sum insured of Rs. 5000/- to the complainant under the Sampoorna Suraksha Bima.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 076 / 2004 - 05
Shri U. P. Rajan
Vs.
Oriental Insurance Co. Ltd.

Award Dated 03.02.2005

The complaint under Rule No 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 stems out of the partial repudiation of his claim under his Mediclaim Policy by the respondent Insurer. The complainant had taken a Mediclaim Policy No. 2004 / 48313 from National Insurance Co. On 20.02.2003 he had a massive heart attack. He was hospitalised and undergone treatment. Again on 31.07.2003 he had another attack and he was advised to undergo Angiogram. His claim for full reimbursement of medical expenses was not honoured in full. The complainant had approached this Authority to reopen the case and compensate him with the actual expenses incurred.

The Insurer contented that the policy covers the post hospitalisation expenses up to 60 days. The expenses incurred beyond this period are not allowable under this scheme. The amount disallowed is perfectly in order as these amount pertains to the period beyond 60 days.

Taking into consideration the pleadings of the parties and the records, Insurance Ombudsman ruled that the respondent had acted strictly as per the conditions of the policy. The complainant had purchased the medicines for the period beyond 60 days and this authority does not incline to interfere in the decision of the Insurer.

Being devoid of merits this complaint stands **dismissed.**

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 002 / 114 / 2004 - 05
Shri Thomas Varghese
Vs.
The New India Assurance Co. Ltd.

Award Dated 08.02.2005

The complaint under Rule No. 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 relates to the repudiation of a Mediclaim under the Pravasi Suraksha Kudumba Arogya Scheme floated by the Insurer. The complainant's wife, member of the scheme had developed Motor Neoron Disease and was treated at various hospitals including NIMHANS, Bangalore. From the various medical records and investigation, the Insurer concluded that the disease existed in the insured for at least 6 - 8 years. However, it was seen that the initial treatments were all for Neck pain and not for Motor Neoron problems by the insure. The Neck pain and Spondylosis treatment at one of the hospitals was prior to the commencement of the policy and hence the repudiation of that the claim was upheld. However, the Motor Neoron Disease, which started subsequently, was right during the policy coverage and hence repudiation of those claims was found unjust and unfair. Therefore the Insurer was asked to pay the claim for the treatments relating to the Motor Neoron Diseases taken from three hospitals, viz. Medical Trust Hospital, CMC Vellore and NIMHANS Bangalore. The claim allowed amounted to Rs. 43412/-

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 106 / 2004 - 05
Dr. B. Jayaprasad
Vs.
National Insurance Co. Ltd.

Award Dated 09.02.2005

The complaint before the Insurance Ombudsman arose against the repudiation of the mediclaim preferred by the complainant before the Insurer towards the reimbursement of hospital expenses in connection with the delivery of his wife. The Insurer rejected the claim on the plea that the policy is hit by Clause 5.18.3 of the Group Mediclaim policy which reads as follows." claim in respect of delivery for only the first two children and / or operation associated therewith will be considered in respect of any one insured person covered under the policy or any renewal thereof. Those insured persons who are already having two or more living children would not be eligible for this benefit". The complainant

contended that this condition was on amendment to the original conditions and the same is not applicable to his case.

Taking into account the records available in the files and also the contentions of the parties, the Ombudsman held that the policy terms are very clear to the effect that only the first two deliveries are covered under this policy. There was no amendment to the original conditions as put forth by the complainant. As such the delivery in question being her third one no reimbursement of medical expenses is allowable. The decision of the respondent is upheld and the complaint being devoid of merits, **dismissed.**

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 - 022 / 113 / 2004 - 05
Shri C. S. Victor
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.02.2005

Complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 relates to repudiation of a mediclaim by the insurer stating that dental treatment without hospitalisation was an exclusion in the policy. It was a group mediclaim policy of the LIC for the benefit of its employees. The complainant's wife Ms. Merina Victor had undergone Root Canal treatment for her defective teeth and there was four sittings in all with the Dentist. There was no hospitalisation in the case, and the Exclusion under cl.no. 4.7 of the mediclaim policy was very clear about the position. There being no merits in the case, the repudiation was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 029 / 2004 - 05
Shri Sethumadhavan
Vs.
National Insurance Co. Ltd.

Award Dated 23.02.2005

Complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is an offshoot from the repudiation of a mediclaim preferred by the complainant under Policy No. 570700 / 46 / 2002 / 8501075 issued by the respondent Insurer in favour of the members of Healing Touch Health Care Club, Trichur invoking Exclusion Clause 4.1 of the policy. The wife of the complainant had undergone treatment at had Sanjeevani Hospital and M/s Healing Touch Health Care Club Had already met the medical expenses. The complainant had categorically submitted that he had not paid any amount to the hospital. The insurer had rejected he claim invoking Exclusion Clause 4.1 of the policy. But it would have been more appropriate if the claim were rejected for the reason that the complainant had not incurred any expenses. Since the complainant had not incurred any expenses in connection with the treatment of his wife, upholding the decision of the Insurer, this complaint **stands dismissed** being devoid of merits.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 029 / 2004 - 05
Shri M. Rajan
Vs.
National Insurance Co. Ltd.

Award Dated 24.02.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is an offshoot from the partial repudiation of a mediclaim preferred by the complainant under Policy No. 570700 / 46 / 2002 / 8500295 issued by the respondent Insurer in favour of the

members of Healing Touch Care Club, Trichur on the plea that sterilization had been excluded in the policy. The wife of the complainant had undergone caesarian and sterilization on 31.12.2002 and his claim for Rs. 10,473/- was settled for a reduced sum of Rs. 6375/- only. This amount was directly settled in favour of the Club and no further amount was required to be paid by the complainant. Since the complainant had not incurred any expenses in connection with the treatment of his wife, upholding the decision of the Insurer, this complaint stands dismissed being devoid of merits.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 005 / 118 / 2004 - 05
Mr. Sony Abey
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 24.02.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is as a consequence of partial repudiation of a mediclaim preferred by the complainant in relation to the Cancer treatment of his father at Amala Cancer Institute, Trichur. The complainant was a member of the Group Mediclaim policy for LIC employees and the complainant's father Sri Abraham Antony was one of the beneficiaries. Earlier, the sum insured was Rs. 50,000/- and the same was enhanced to Rs. 1 lakh with effected from 1.10.2002. However, prior to the enhancement of the sum insured to Rs. 1 lakh, the complainant's father had a health check up at Century hospital, Chengannur and his admission at Amala Cancer institute was from 17.10.2002 to 8.10.2003. Since the disease was detected while the sum insured was Rs. 50,000/- (August 2002), the insurer restricted the claim to Rs. 50,000/- and the rest of the claim was disallowed on the plea that the enhanced sum insured was not applicable to pre - existing diseases. In fact, the agreement between LIC and the Oriental had specified that pre - existing diseases as on the date of enhancement will not be eligible for the enhanced sum insured. Under these circumstances, the action of the insurer in restricting the claim to the pre - enhancement sum insured was found fair and proper and therefore the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 119 / 2004 - 05
Ms. K. K. Rabia
Vs.
National Insurance Co. Ltd.

Award Dated 24.02.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is an off - shoot from repudiation of a medi claim by the insurer. The complainant's mother was covered under a floater group mediclaim insurance policy issued in favour of M/s. Healing Touch Health care club, Trichur and as per medical records, the complainant's mother was treated at Sanjeevani Hospital for chronic bronchitis and pharyngitis. The insurer had repudiated the claim under exclusion clause 4.1 of the medi claim policy citing pre - existing health problems undisclosed at the time of joining the scheme. Moveover, it was found from the records that the medical expenses for the treatment were reimbursed to the hospital by the promoter Health Club and not by the complainant. The insurer also stated before this Forum that the insurance arrangement with M/s Healing Touch Health care club was also cancelled by them for raising ever so many bogus claims. As far as the present case is concerned, the complainant had not incurred any expenses for the treatment and the medical records also proved that the diseases were chronic and preexisting at the time of taking insurance and, therefore, the repudiation was upheld.

Kochi Ombudsman Centre

Case No. IO / KCH / GI / 11 / 003 / 124 / 2004 - 05
Shri George Varghese
Vs.
National Insurance Co. Ltd.

Award Dated 25.02.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arises from repudiation of a mediclaim. The complainant – a retired officer of the respondent insurer – was member of the staff mediclaim scheme. Originally, the sum insured was Rs. 70,000/-. It was enhanced to Rs. 2 lakhs with effect from 1.4.2000 and further enhanced to Rs. 3 lakhs from 1.4.2001. The complainant had suffered a myocardial infarction on 5.3.2000 and he had undergone a graft in Oct. - Nov. 2004. As the disease was detected on 5.3.2000 (the date of mycardial infarction) and the prevailing sum insured upto 31.3.2000 was only Rs. 70,000/- , the insurer had limited the claim to Rs. 70,000/- only although the total claim for the graft in Oct. - Nov. 2004 was to the tune of over Rs. 1.9 lakhs. The insurer's stand was found to be on solid grounds and the terms of the mediclaim insurance policy in question were also clear on this. Therefore, the partial repudiation of the claim by the insurer was upheld.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 121 / 2004 - 05
Ms. Sarala Devi
Vs.
National Insurance Co. Ltd.

Award Dated 01.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a medi claim by the insurer. The complainant and her family were covered under a Group mediclaim policy (floater policy) taken through M/s Healing Touch Healthcare Club, Trichur and the coverage was for Rs. 25,000/- per member. The relevant policy year was from 18.11.2002 to 17.11.2003. A claim was intimated to the insurer on 22.10.2002 in relation to the hospitalisation of the complainant's mother at Sanjeevani Hospital, Shornur for treatment of prolapse of uterus. The hospital record had shown the past history of illness as "more than one year". The investigator of the of the insurer had also contacted the mother of the complainant who gave certain details of her treatment form 25.02.2002. However, the insurer alleges that the complainant who was an employee of the hospitals at the relevant time had obstructed the way and the investigator could not get at the records. Although the insurer wrote to the complainant asking for the details duly quoting the O.P. ticket number etc., no information was supplied and the insurer had closed the file as "NO Claim". Moreover it was found from the records that the treatment expenses were paid to the hospital by the Health Club and not by the complainant. In such circumstances and the fact of pre - existing diseases and suppression of material facts being apparent on the face of records, the action of the insurer in repudiating the claim was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 125 / 2004 - 05
Shri A. V. Jose
Vs.
National Insurance Co. Ltd.

Award Dated 03.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arise from repudiation of a mediclaim by the insurer. The complainant and his family were covered under mediclaim insurance for a sum insured of Rs. 25,000/- per member for the

period 9.7.2002 to 8.7.2003. While the terms, conditions and scope of the policy conformed to regular mediclaim policies, due to varying underwriting instructions, the insurer had restricted coverage in certain categories by affixing a rubber stamp. In the relevant policy, the insurer had included " Ayurvedic Treatment" by affixing a rubber stamp. When the policy was renewed for the subsequent year, as per Ex. Clause 4.3, apart from excluding Ayurvedic treatment, the exclusion for certain diseases extended for a period of 2 years from the date of issuance of renewal and the complainant had accepted the same. However, the complainant was hospitalised for inguinal hernia during the period 29.1.2004 to 7.2.2004 and the claim was repudiated by the third party administrator for the reason that the exclusion for the said diseases extended for a period of two years from the date of renewal. The contentions of the insurer were found correct in as much as that each policy had certain inherent and proclaimed exclusion and having accepted the said conditions suo - motto, the complainant could not dispute the same subsequently. In the circumstances, there was no merit in the complaint and the same was dismissed.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 129 / 2004 - 05
Ms. Anitha
Vs.
National Insurance Co. Ltd.

Award Dated 15.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 was as a result of rejection of a mediclaim by the insurer pertaining to the treatment of the complainant's father. The complainant had originally insured herself and family members through a Group mediclaim policy through the Sanjeevani Health Club for the period 6.05.2005 to 5.5.2003 In October 2002, the insurer had discontinued the insurance arrangement with the above club and since then, the complainant had availed of an individual mediclaim policy with the same insurer for the period 6.5.2003 top 5.5.2004 with the exclusion of the known diseases / disabilities like thumb amputation and Diabetes of her father. In other words, the new policy had clearly excluded that existing health problem and the complainant's father had problems of Diabetes and Hypertension form February 2002 itself. Although the group medi claim policy would have served the requirement of continuous coverage, the pre - existing diseases clearly excluded from the ambit of the new policy, would not confer any benefits under the said category to the complainant. Since the facts of the case are very clear and were also known to the complainant, the rejection of the claim was neither ambiguous nor unjustified. Therefore, it was found that the insurer's decision to reject the claim was on strong footing and hence the same was upheld dismissing the complaint.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 126 / 2004 - 05
Shri Radhakrishnan Potti
Vs.
National Insurance Co. Ltd.

Award Dated 16.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is in relation to repudiation of a claim under the medi claim policy issued by the insurer favouring employees of M/s Bhima Jewellers, Ernakulam. There was a claim for a coronary Angiogram from the complainant. The complainant had an inferolateral MI in 2003. The angiogram revealed Tripple Vessel Disease for which By pass surgery was conducted. The insurer / third party administrator felt that the disease must have been pre - existing and the claim was rejected. The Doctor had also committed an inadvertent error in describing the commencement of ailment as 1993 instead of Nov. 2003 which, of course, was set right later on. Even then, going by the records available, the consultant Doctors of the TPA

concluded that the heart ailments must have stared somewhere around 1999 or 1998. However, there was no evidence to suggest that he had any heart ailment at or before the commencement of continuous insurance coverage from 1998 and only the angiogram for which the claim was preferred revealed everything. The insurer's action in accepting the TPA's recommendation was found baseless and there was nothing to suggest what the heart ailment existed at or prior to the commencement of the policy. The claim for By pass was not preferred by the complainant as the claim for the angiogram itself was rejected. The complainant had claimed only Rs. 30,000/- for the angiogram and the insurer was asked to settled the same.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 130 / 2004 - 05
Smt. Sudha Krishnan
Vs.
National Insurance Co. Ltd.

Award Dated 18.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arisen from repudiation of a mediclaim of the complainant by the insurer. The complainant, her husband and mother were covered under a group mediclaim policy for the period 28.03.2002 to 27.03.2003. The complainant was hospitalised during the period 20.3.2003 to 15.4.2003 for caesarian section at Aswini Hospital, Trichur. The Doctors had described her condition as IUGR, Multiple Fibroid and Oligo Hydramious,. As per the complaint, the Fibroid was detected only when she was hospitalised for the caesarian section. The investigator of the insurer said that the scanning done on the complainant on 20.7.2002 was positive for fibroid and Fibroid in uterus is expressly excluded during the first year of the policy. The insurer also said that the complainant who is only 28 years old is Diabetic and hypertensive. It was infact pregnancy related Diabetes and hypertension. While the complainant had spent a little over Rs. 20,760/- for the operation, she was fair enough to claim only Rs. 15,000/- for the caesarian section only. The insurer's action was found arbitrary and the order of repudiation was set aside. The complainant was awarded Rs. 15,000/- for the caesarian section and the complaint was disposed of.

Kochi Ombudsman Centre
Case No. IO / KCH / GI / 11 / 003 / 132 / 2004 - 05
Shri K. Manesh
Vs.
National Insurance Co. Ltd.

Award Dated 22.03.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 is an offshoot from repudiation of a maternity claim by the insurer. The complainant had a mediclaim policy with the insurer commencing from 24.02.2003 and a waiting period of 9 months from the date of commencement was prescribed for entertaining any claim there under. The complaint's wife delivered a baby in the hospital on 24.11.2003 and the insurer rejected the claim stating that the delivery was within 9 months or 270 days from the date of commencement – short by one day. However, on a close scrutiny, it came to light that the 9 months; period had expired by midnight of 23.11.2003 and therefore the delivery on 24.11.2003. did not come under the exclusion. In the aforesaid circumstances, the order of repudiation was set aside and the expenses amounting to Rs. 4671/- was admitted in favour of the complainant.

Mumbai Ombudsman Centre
Case No. GI - 450 of 2003 - 2004

Shri Rajkumar Bhattad
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 04.10.2004

Shri Rajkumar Bhattad, alongwith his family members were covered under Mediclaim Policy No. 161900 / 007 / 48 / 2003 / 01057 of the Oriental Insurance Co. Ltd., Mumbai from 16.7.2002 to 15.7.2003. He lodged a claim for reimbursement of hospitalisation expenses incurred for his mother, Smt. Taramani S. Bhattad's disease, Prolapsed Intervertebral Disc (PID) at Dhanraj Girji Hospital from 12.05.2003 to 8.5.2003. The company by their letter dated 3.9.2003 repudiated the claim under Policy Exclusion No. 4.1 pre - existence of the disease and breach of Policy condition No. 5.7. Not satisfied with the decision of the Company and not receiving any response to his representation Shri Rajkumar Bhattad, approached the Ombudsman on 29.10.2003. Parties to the dispute were called for hearing on 28th September, 2004.

The claimant's contention is that any back pain would not result into PID and that the diagnosis was made only after a through investigation both in Sarda Nursing Home and later in Mumbai. It is seen from the certificate issued by Dr. S. Sarda, who treated Smt. Bhattad that she attended his clinic from 23rd September, 2000 to 3rd September 2002 for various complaints viz. for back ache and leg pain frequently. She was treated for these ailments and was specifically advised to get further opinion of Orthopaedic Surgeon for complete evaluation of the Complication. He further stated that the diagnosis of PID with Lumbar Stenosis corelates with her previous complaints when she was under his treatment. The same view was experessed by Dr. A. V. Nehatrao, the Panel Doctor of the company, who felt that the progress of the disease as is evident from MRI Report and other investigations clearly point out that the Insured was having these ailments for quite sometime. The MRI Reports findings were "degenerative change in the form of Endplate Osteophytes coupled with L4 Nerve Roots being compressed with other bilateral subarticular and foraminal extrusion alongwith degenerated discs".

The Insured's policy was in operation for two years and the claim has been preferred in the second year of operation for hospitalisation form 12.5.2003 to 18.5.2003. Going by the specific evaluation and certification made by Dr. Sarda about effective treatment being received from his clinic by Smt. Taramani Bhattad, is would be difficult to admit the contention of the claimant that without the diagnosis, they were not knowing that nature of ailment and therefore, no declarations was made. On the contrary, the very fact that the treatment was received and the Doctor specifically advised for further evaluation by a Orthopaedic Surgeon goes to show that the company's contention that is was suppressed at the time of making the proposal is sustainable.

In the facts and circumstances, the claim of Shri Rajkumar Bhattad, for reimbursement of hospitalisation expenses incurred for his mother Smt. Taramani Bhattad's disease, Prlapsed Intervertebral Disc (PID) at Dhanraj Girji Hospital from 12.5.2003 to 8.5.2003 is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 342 of 2003 - 2004
Shri Eruch E. Fanibanda
Vs.
National Insurance Co. Ltd.

Award Dated 04.10.2004

Shri Eruch E Fanibanda, approached that Office of the Insurance Ombudsman by a complaint dated 26.08.2003 against partial settlement of claim by the National Insurance Company Limited, Divisional Office IV, Mumbai. It is reported that Shri Eruch E Fanibanda alongwith his wife Smt. Ruby E Fanibanda were covered under the mediclaim policy for the

last many years. Spread over 3 months beginning January, 2003, Shri Fanibanda and his wife had undergone cataract operations on both their eyes. When a claim was preferred in the month of March for the said cataract operations for both Shri & Smt Fanibanda for total amount of Rs. 1,94,720/- the Company, based on the panel doctor's opinion settled the claim for Rs. 1,38,712/- only. Aggrieved with the decision of the Company Shri Eruch Fanibanda represented to the Company and not receiving any reply he approached the Insurance Ombudsman for intervention to get his full claim for Rs. 1,94,721 plus interest for the delay. Parties to the dispute were heard and the records have been perused. An analysis of the complaint would reveal that the dispute is regarding the deductions made from the Hospital bills. However, there is only one issue namely the charges of the Surgeon for atleast two major complications like glaucoma and retinal damage which he had to be contend with cataract operation in respect of Smt. Fanibanda. Moreover, both Shri & Smt. Fanibanda are of advanced age with other complications of their health problems. If all these are taken care of, a view emerge that at least surgery for Smt. Fanibanda could call for different treatment than uniform charges made for all four cases. Shri and Smt. Fanibanda are insured with the company since long and they have demonstrated their faith in the mechanism and functioning of insurance. Considering their age and other health problems and reckoning the criticality of the surgery, the National Insurance Company Limited is directed to make a payment for additional amount of Rs. 28,000 towards the claim of Shri Fanibanda for the hospitalisation of Shri Fanibanda and Smt Fanibanda for the cataract operations done in both the eyes.

Mumbai Ombudsman Centre
Case No. Case No. GI - 409 of 2003 - 2004
Shri Mahendra T. Romani
Vs.
United India Insurance Co. Ltd.

Award Dated 06.10.2004

Shri Mahendra T. Romani, resident of 504, Ashra Building, Hanuman Co - op Housing Society, 5th floor, Sitaram Jadhav Marg, Lower Parel (W), Mumabi – 13 was insured under mediclaim policy No. 020300 / 48 / 02 / 04056 issued by United India Insurance Company, D.O. 3. Smt. Bhamasa M. Romani wife of Shri Mahendra Romani was admitted to Bombay Hospital on 27.12.2002 to 02.01.2003 for Hysterectomy operation, When a claim was preferred for Rs. 30,227/- by Shri Mahendra Romani, the company settled the claim for Rs. 11,501/- Aggrieved by the decision. Shri Romani represented to the Company and not received any favorable decision approached the Office of the Insurance Ombudsman, seeking intervention of the Ombudsman in the matter of settlement of his claim. The records have been perused and the Parties to the dispute were called. At the hearing it was noticed that the insured / claimant, submitted necessary documents before the TPA representative and there was substantial agreement in respect of accepting these documents as proof of having incurred the expenditure and there were some expenses, which were disallowed either as per pre - hospitalisation or post hospitalisation expenses. These were all justified by production of valid proof. Accordingly, at the behest of Ombudsman, they agreed to consider the areas of dispute by mutually exchanging the documents and resolving appropriately the balance amount which would be due to the claimant. It was agreed that they would do so and this Award is being passed with a direction to the effect.

United India Insurance Company Limited is directed to settle the balance amount of the claim after their TPA has tallied their records / documents with the Claimant / Insured to the extent of admissible amount from the date of payment of claim of Rs. 11,510 till the date of final settlement now being arrived alongwith simple interest @ 6%.

Mumbai Ombudsman Centre
Case No. GI - 159 of 2003 - 2004
Shri Pirani Abdul Kanji
Vs.
United India Insurance Co. Ltd.

Award Dated 06.10.2004

Shri Pirani Abdul Kanjii who was covered under the mediclaim Policy issued by the United India Insured Co, Divisional Office 121000 through Life Line EMS India Ltd had approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim which was rejected by United India Insurance Company Limited under policy No. M - 1 - 02102 - 1. Shri Pirani Abdul was hospitalised at Bombay Hospital form 23.08.2002 to 26.8.2002 for varicose veins. When a claim preferred by Shri Abdul Kanji to the Company for the said hosptialisation, the Company, based on their panel doctor's opinion, repudiated the claim stating that the ailment was pre - existing and the history of varicose veins was not disclosed in the proposal form which tantamount to non - disclosure of material fact. Not satisfied with the decision of the Company, Shri Kanji represented and not receiving any reply approached the Office of the Insurance Ombudsman seeking intervention in the matter of settlement of this claim.

Report of the case have been perused and the parties to the dispute were heard. The case papers have been studied and critically analysed. As the insured had taken the policy only from 24.04.2001 from New India and then renewed with United India and the claim is in the second year of operation, the claim is unsustainable as a pre - existing disease which was not disclosed by him at the time of making the proposal for insurance. The Company's decision to reject the claims cannot therefore be questioned.

Mumbai Ombudsman Centre
Case No. GI - 144 of 2003 - 2004
Mr. Hasmukh Shah
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 07.10.2004

Mrs. Jyoti Hasmukh Shah was Hospitalised at Lilavati Hospital for Craniospinal Tumour. The claim for the same was preferred on 31.10.2002 to the Company since the claim was in the second year of the policy period the Company obtained Indoor Case papers from the hospital though Investigator Triple 'S'. After going through the Indoor Case Papers, the Company concluded that the various diseases mentioned in the same were not disclosed in the proposal form and repudiated the claim under Exclusion Clause 4.1 of the mediclaim policy as also for non - disclosure of material facts. Mr. Hasmukh Shah approached the Ombudsman stating that his case is genuine and it should be settled by the Company.

The Insured had preferred the claim against hospitalisation for Craniospinal Tumour which was being processed by the company for settlement. It had revealed from the hospital case papers that the Insured had two Knee Replacements, was treated for Angina and Hypertension for 5 - 7 years and was also a known case of hypothyrodism for 5 - 7 years which were not disclosed to the insurance Company while proposing for insurance. Hence, although the Craniospinal Tumour could not be related to the existing ailments as mentioned above, they rejected the claim on the ground of suppression of material facts and non - disclosure of these ailments which were pre - existing at the time of proposal. Considering the facts, circumstances and evidence on record it is established that the Insured Smt. Jyoti H. Shah had a history of Knee Replacement, Hypothyroidism, Angina and Hypertension. If appropriate disclosure would have been made while proposing the insurance, the Company would have taken proper underwriting decisions. However,

considering the fact that such non - disclosure had taken place for one knee replacements during the policy period and the ailment of Angina and Hypertension does not have any direct nexus with Meningioma which is a slow growing tumour in the Craniospinal region which needed excision and Craniospinal surgery.

The Oriental insurance Company Ltd, is directed to settle the claim of Mrs. Jyoti Hasmukh Shah for her hospitalisation at Lilavati Hospital from 17.09.2002 to 26.09.2002 fro Craniospinal Tumour on ex - gratia basis @ 30% only of admissible hospitalisation expenses.

Mumbai Ombudsman Centre
Case No. GI - 211 of 2003 - 2004
Mr. Ramniklal M. Thakkar
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 07.10.2004

Shri Ramniklal Thakker was hospitalised at Jaslok Hospital for Bile Duct Calculus under care of Dr. Pankaj Dhawan. When the claim was referred by Shri Ramniklal Thakker in respect of the said hospitalisation, the Company referred the matter for a medical opinion and as per the opinion of their panel doctor, Dr. M. S. Kamath, the claim was repudiated on grounds of pre - existence of the disease. The Company stated that as per records it was observed that Shri Thakkar had undergone Gall Bladder surgery in 1987 and the history of removal of Gall Bladder had not been disclosed in the proposal form neither at the time of inception of the policy nor at the time of increasing the sum insured. Thus, the Company treated it as pre - existing and invoking clause 4.1 of the mediclaim policy repudiated the claim.

It is revealed that the insured had choleocysectomy i.e. removal of Gall bladder stones in 1987. This is apparent from the hospital case as also from the ultrasonography of the abdomen done in January, 2003. The Insured's own admission during the hearing dated 01.09.2003 confirmed that he had the surgery and he did not consider it necessary to disclose the removal of gall bladder which was done more than 2 years back at the time of making the proposal. The statement of Dr. Pankaj Dhawn in his certificate had mentioned that Shri Thakker was suffering from repeated attacks of Jaundice due to large common bile duct calculus. The same doctor clarified his statement in his certificate dated 08.04.2003 to mention that the disease was not pre - existing as there was no stone in the common bile duct Unfortunately, this is totally unacceptable since it is the common bile duct which was removed as per the ERCP Report of Jaslok Hospital. The point at issue will be that calculus of such a size would not form in a few months but over a long period which would any way point out that it was pre - existing at least for a few years. It is also highly probable that while removing the gall bladder with stones in 1987, one or two small stones may have escaped into Common bile duct and later created complications. This would be medically and technically a probability which cannot be ruled out with certainty and therefore, would become a possible pre - existing condition. However, this is unfounded and therefore, not being pressed further. The Insured's statement that he did not consider it as an important disclosure cannot be accepted as any surgery is an important intervention in the health condition which must be intimated. Even beyond this, any important health status in the form of various questions in the proposal form has to be replied comprehensively. Choleocysectomy is certainly an important information to the Insurance Company and if it would have been declared there would have been appropriate decisions as regards exclusions under the policy. In the facts and circumstances, it is not material to look for the actual formation of Calculus in the Common Bile Duct and go by pre - existence of this condition specifically restricted to the common Bile Duct. On the strength of the non - disclosure which occurred twice both at the time of making proposal and also at the time of the increase in Sum Insured, coupled with a pre - disposing

condition, the contention of the Company that the claim is not entertainable cannot be faulted and there is no reason to interfere with this decision.

Mumbai Ombudsman Centre
Case No. GI - 202 of 2003 - 2004
Mrs. Arnavaz Hoshang Mohta
Vs.
United India Insurance Co. Ltd.

Award Dated 08.10.2004

Mrs. Arnavaz H. Mohta had visited USA and had been covered under the above policy. She suddenly developed eye problem over there and had to be operated at Turner Eye Institute at USA. She had submitted her claim to the Mercury International Assistance and Claims Ltd., England. Mercury International had informed Mrs. Mohta that they are unable to deal with her claim because the policy contains a specific exclusion relating to pre - existing medical conditions and which preclude the Insured person from claiming reimbursement under the above numbered policy.

The Insured approached the Ombudsman and prayed to settle her genuine claim. The company had written to the Insured that as the Mercury International is not setting the claims they were processing the claim and asked to furnish her with Discharge Card of the hospital alongwith bills and receipts and also the treatment received from Dr. Qureshi Maskati in the year May, 2002. In reply, Mrs. Mohta informed the company that the treatment taken from Dr. Qureshi was from May 2000 and not from May 2002 as claimed by the Company.

Videsh Yatra Mitra Policy is an overseas medical policy and admission of this is being done by the Companies through a foreign servicing Agnecy M/s Mercury International. This Agency had a claims settlement guide in terms of which they go through the processing and settlement of the claim ultimately vetted by the respective insurance Companies as Insurers. There is in existence a Memorandum of Understanding between the parties to this arrangement. In line with the same the advice given at the hearing was in order and tune with the provision of Rule 15 of RPG Rules i.e. Ombudsman's role as a mediator and counsellor. It appears the device was given on the basis of United India's self contained note submitted to this Forum. In the light of the submission it is clear that the claim was alive and under processing and there were certain requirements. The Company's statement that they were not aware that the claim had been rejected by Mercury International is unacceptable and as per Memorandum of Understanding they have to take the responsibility of sorting out to the satisfaction of the complainant. At the same of time, the complainant Smt.Mohta is also required to submit and provide all documents and information regarding the treatment received not only in USA but also in the India, to enable the company to come to an appropriate decision.

The United India Insurance Company, D.O. 3 is hereby directed to obtain all necessary docuents / records and liaise with M/s Mercury Internationa and take expeditious steps to settle the issue on facts and merits of the case as appropiate. The case is hereby disposed of from this Fourm.

Mumbai Ombudsman Centre
Case No. GI - 382 of 2003 - 2004
Shri Gunvant S. Mehta
Vs.
National Insurance Co. Ltd.

Award Dated 12.10.2004

In the matter of above complaint, the issue was non - settlement of claim for reimbursement of Cataract operation charges at Nidhi Eye Hospital, Ahmedabad. The

ground of repudiation by National Insurance was that the Cataract operation was excluded during the first year of policy and since there was a gap of nearly a month between the earlier policy and the subsequent policy, the Company rejected the claim as per Exclusion Clauses 4.3.

The matter was represented by the Insured, which was rejected and, therefore, he preferred an appeal before the Ombudsman.

In their letter dated 23.09.2004, National Insurance regretted their mistake and wrote directly to Shri Gunvant S. Mehta and sent a discharge voucher for Rs. 15,853/- in full and final settlement of the claim. During the hearing Shri Mehta was informed that National Insurance Company has settled the claim for Rs. 15,823/- and sent a discharge voucher to Shri Mehta on 23.9.2004 and a letter to that effect has been received at this forum on 29.9.2004. Shri Mehta mentioned that he has not yet received the discharge voucher and he also raised the issue of interest for delayed settlement of claim after he lodged the claim with National Insurance Co.

It is seen from records that the policy was first taken from 25.9.1998 to 24.09.1999 and, at the next renewal as there was a gap of one month a fresh policy was given from 30.10.1999 to 29.10.2000 which was renewed from 30.10.2000 to 29.10.2001 and the claim was lodged on 22.10.2001 which was clearly at the end of the 2nd year even reckoning from the renewal in 1999. The claim was, therefore, held up unnecessarily and should have been settled long back.

It is noted from the letter of national Insurance Company dated 23.09.2004 addressed to Shri Gunvant S. Mehta with a copy to the office of Insurance Ombudsman that the claim is being settled for Rs. 15,853/- subject to discharge voucher being duly executed by Shri Mehta. As there has been delay in settling the same, which was totally uncalled for, it warrants payment of interest over and above the admissible amount of claim of Rs. 15,853/- offered by National Insurance Company.

National Insurance Company Ltd., D.O. XIV, is directed to settle the claim of Shri Gunvant Mehta, for the admissible amount of Rs. 15,853/- together with interest at 6% from the date of repudiation of the claim till 23rd September, 2004 towards full and final settlement of the claim as per complaint lodged by Shri Mehta with this Forum.

Mumbai Ombudsman Centre
Case No. GI - 458 of 2003 - 2004
Ms. Binal A. Gandhi
Vs.
United India Insurance Co. Ltd.

Award Dated 15.10.2004

Ms. Binal A. Gndhi took first time the policy with United India Insurance Co. Ltd. She was admitted in Shruti Clinic under Dr. R. M. Shah for treatment of hoarseness in voice. After Examination, the doctor performed Tonsillectomy for Septic Tonsils and also Microlaryngoscopy i.e. for removal of Vocal Cord Mass. The company rejected the claim through their TPA – M/s Family Health Plan Ltd. For Rs. 8,490/- on the ground that the disease was pre - existing. She approached the insurance ombudsman mentioning that as per the advice of her family doctor, Dr. Shamak Hora, She got admitted under the care of ENT Consultant, Dr. R.M. Shah who advised operation. After examination, it was detected that she was having both septic tonsils and tiny vocal nodules which were operated. It was mentioned that these ailments were not existing previously and the diagnosis was made only after hospitalisation. The analysis of the claim reveals one aspect prominently viz. the only after hosptialisation. The TPA who has sent the letter of repudiation twice refers to the reason as pre - existing ailment. Secondly, they have stated in their letters the diagnosis and operation as Tonsillectomy, while actually both Tonsillectomy and Microlaryngoscopy i.e. operation of Septic Tonsils as also removal of Vocal Cord mass was done which was

not mentioned in the letter sent to Insured. A critical analysis reveals that the chief complaint for which the Insured Ms. Binal Gandhi was admitted was hoarseness of voice and Dr. R.M. Shah has written this in all documents and clinic records while the discharge summary has mentioned D.M.S. and Tonsillectomy under treatment given.

In the facts and circumstance, it is felt that hair - splitting between the two procedures is not possible after the surgery is over. It is possible that some kind of trouble in throat and vocal cords being so closely inter - related may have been there which is not clearly established. In view of this, the best course would be to settle the claim for 75% of the admissible expenses incurred at the Nursing Home to strike propriety.

Mumbai Ombudsman Centre
Case No. GI - 365 of 2003 - 2004
Shri Hasmukh Patel
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 18.10.2004

Shri Hasmukh Patel was covered under Mediclaim Policy issued by The Oriental Insurance Company Limited, Dadar D.O. since 28.8.2000. Shri Patel was hospitalised at P.D. Hinduja Hospital from 28.11.2001. to 2.12.2001 for treatment of Chronic liver disease and (R) renal calculus & HT and when he preferred a claim for the said hospitalisation under Policy No. 48 / 2002 / 2361 for the period 28.8.2001 to 27.8.2002, the Insurance Company repudiated the claim vide its letter dated 23.9.2002 on the ground of 'pre - existence' and also by invoking exclusion clause 4.8 excluding the disease / condition on the ground of intake of alcohol which was reiterated under their Grievance department letter of 4.9.03. Shri Patel represented to the Insurance Company and being dissatisfied with and aggrieved by the decision of the insurance Company approached this Forum for redressal of his grievances. Parties to the dispute were heard and the records have been perused. In view of the statement recorded by the hospital authorities about the duration of symptoms of the disease and diagnosis of Hepatomegaly, Portal adenopathy, Alcoholic Cirrhosis of liver, non functional kidney, loss of appetite for last 18 - 20 months and regular alcohol intake, it would be evident these diseases were pre - exiting at the time of taking his first policy in August, 2000.

In the facts and circumstances the decision of the Company to repudiate the claim on the grounds of pre - existence of disease (clause 4.1) and consumption of alcohol (clauses 4.8) together with non disclosure of ailments prior to taking the policy cannot be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 156 of 2003 - 2004
Shri Rajaram Srinivasan
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.10.2004

Shri R. Srinivasan who was insured under mediclaim Policy No. 111300 / 01 / 05836 issued by the New India Assurance Company Limited, had approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim which was rejected by New India. Shri Srinivasan was hospitalised at P.D. Hinduja Hospital from 18.11.2002 to 28.11.2002 for Incisional Hernoplasty c Abdominoplasty and when the claim was preferred by Shri Srinivasan, the company repudiated the claim invoking exclusion 4.1 of the policy. Not satisfied with the decision of the Company, Shri Srinivasan represented to the Insurance Company and aggrieved by the decision of the Company, Shri Srinivasan

approached the Insurance Ombudsman seeking intervention in the matter of settlement of his claim.

Parties to the disputes were heard and the records were perused. The analysis of the case reveal that the Insurer / Claimant Shri Srinivasan was operated for Incisional hernia and hernioplasty with abdominoplasty was done in late November, 2002. He was operated in 1973, i.e., 30 years back for hernia which was repaired and so long was well managed and remained under control to enable to him to lead a normal life. He had declared this in his proposal for Insurance with the Company, while taking the policy some 15 years ago. He had a claim free operation for all these years to earn maximum cumulative Bonus 50% as admissible under the policy.

In the facts and circumstances, the decision of The New India Assurance Company Limited To repudiated the claim on the grounds of pre - existence of the disease is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 154 of 2003 - 2004
Shri Dilip H. Broker
Vs.
The New India Assurance Co. Ltd.

Award Dated 21.10.2004

Smt. Jyoti D. Broker was suffering from severe weakness for some days prior to her hospitalisation so she consulted Dr. M. B. Agarwal who is a welknown Haematologist and Haemato - oncologist. It was later diagnosed as Myelodysplastic Syndrome (Refractory anaemia) and doctor advised injection EPREX - 10,000/- to bring improvement in her blood deficiencies. Because of her weak condition and high dose of the injection, the doctor advised her to get admitted to a hospital. The Company referred the matter to Dr. Bakul P. Dhruva who opined that the insured was hospitalised for investigation purposes and also for less than 24 hours so the claim falls under Exclusion Clause 4.10 of the mediclaim policy. Accordingly, the Company repudiated the claim.

Shri Broker approached the Ombudsman with, a plea that claim should be settled by the Company. Shri Dilip Broker, contention was that his wife was suffering from MDS which according to him was another type of blood cancer. He said his wife had under gone bone marrow biopsy and the reports stated that her hemoglobin was very low and the platelets were also very low. The treating doctor, Dr. Agarwal had stated that his wife had to be given Eprex injection of maximum 10,000 units at the hospital and hence she was admitted to the hospital as it was felt that this injection could create some reaction. He said that as his wife did not have any reaction she was discharged after the injections were given. The analysis reveals there was no emergency for hospitalisation, no criticality in health status for which no advice as such for hospitalisation was given. In fact it also appears that some diagnosis was done before the hospitalisation and the investigation and the investigation done at the hospital were more extensive and wide ranging to evaluate all possible causes particularly malignancy. Dr. Agarwal, Haematologist and Haemato - onclologist Conducted various tests of blood which revealed normal bone marrow, low platelets on smear certain other complications of blood chemistry with out any malignancy.

However, one issue has got to be kept in mind. The diagnosis is Myelodysplastic syndrome and refractory anaemia. Refractory anemia indicates a condition in which patients get resistant to ordinary treatment. Myelodysplasia refers to defective formation of the Spinal Cord. This refers to a long drawn treatment relating to blood formation, bone marrow function and total blood chemistry. It also reveals that the diagnosis was well before the admission to the hospital and therefore, falls within 4.10 exclusion.

Mumbai Ombudsman Centre
Case No. GI - 470 of 2003 - 2004
Shri Madan Mohan Agarwal

Vs.
The Oriental Insurance Co. Ltd.

Award Dated 27.10.2004

Shri Madan Mohan was insured under the Mediclaim Policy No. 121502 / 48 / 2002 / 330 with Oriental Insurance Co. Ltd., Direct Agent Branch, Mumbai. When he preferred a claim with the insurance Company for his hospitalisation and operation expenses for his left leg Varicose at Kamdar Nursing & Polyclinic Pvt. Ltd. During the period 19 - 09 - 2002 to 23 - 09 - 2002, the Company rejected his claim on the ground that his disease was pre - existing.

Dissatisfied and being aggrieved with the decision of the Company the Complainant, Shri Agarwal approached the office of the Ombudsman for intervention in the matter of settlement of his claim.

A joint hearing was held on 11.10.2004 in the office of Insurance Ombudsman where in the Claimant deposed that he felt a sudden sensation in his left leg and after pricking the same, he found that blood was oozing allover the place, for which he was immediately advised to consult a special doctor and as per his advice he was operated on September 2002. He states that he was not aware of the disease and never consulted any doctor for the disease, except for the first time in September, 2002.

Shri Dilip Malekar, Branch Manager, represented for the Company and as per his submission the insured was not treated by Dr. Kamdar of Kamdar Nursing Home hence the actual duration of the disease could not be available from him. The case paper was referred to the Panel Doctor, Dr. K. C. Shah and as per his observation the patients must have contracted much before hospitalisation. Dr. M. S. Kamath, Medico Legal Consultant of the Company also opined that the nature and dimension of the disease at which stage operation had to be conducted, clearly suggest that it would be of longer duration that 2 years.

Based on the above findings and a thorough scrutiny of case papers it is concluded that the complaint of Shri Madan Mohan Agarwal for payments of claim on account of hopitalisation is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 90 of 2003 - 2004
Dr. Pushpakant M. Kedia
Vs.
United India Insurance Co. Ltd.

Award Dated 28.10.2004

Dr. Pushpakant Kedia approached the Office of the Insurance Ombudsman with a complaint dated 24.4.2003 against the partial offer of Rs. 1,10,000/- in connection with his hospitalization expenses of Rs.5,48,493/- in August, 2001 at Breach Candy Hospital for Angiography and By - pass by United India Insurance Company Limited, D.O. XII. When the policy came for renewal in May, 2001 Dr. Kedia proposed to increase the Sum Insured from Rs. 1 lac to Rs. 5 lac after filling the proposal form which was accepted. Dr. Kedia was hospitalized on 16.08.2001 to 17.8.2001 at Breach Candy Hospital for Angiography and again from 21.08.2001 to 30.8.2001 for Coronary Artery By - pass Graft (CABG). When the claim was filed with the Company on 27.8.2001 the Company by letter dated 26.4.202 informed Dr. Kedia that as per their medical opinion blockage of 75% to 90% was not possible within a span of three months and it becomes a pre - existing condition as far as the Sum Insured of Rs. 5 Lacs was concerned and hence they were ready to offer an amount of Rs. 1,10,000/- (including 10% C.B.) as full and final settlement Dr. Kedia

represented to the Company and not receiving any reply approached the Forum Seeking intervention of the Ombudsman to settle his claim of Rs. 5,48,593/- with interest of Rs. 2,50,000/- for delay of about 2 years. Parties to the dispute were heard and records have been perused. The circumstances, coupled with Investigation reports strongly suggest onset of the complications much earlier and thus pre - existence of the disease in invasive manner so as to cause severe atherosclerosis in the arteries over a period of time so much so that five arteries would be blocked. Read in conjunction with all these the decision of the Company to settled the claim on the basis of original sum insured with Cumulative Bonus accrued till that time cannot be faulted and should not be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 395 of 2004 - 2005
Smt. Jyoti Hiralal Mehta
Vs.
The New India Assurance Co. Ltd.

Award Dated 1.11.2004

Smt. Jyoti Hiralal Mehta approached the Office of the Insurance Ombudsman with a complaint dated 4.8.2003 against the New India Assurance Company Limited, D.O. 142000 for restricting the sum insured to Rs. 50,000/- against sum insured of Rs. 1,50,000/- in respect of her late husband Shri Hiralal Mehta's hospitalization at Nanavati Hospital for Cardio Respiratory Arrest in a case of the Acute Coronary Syndrome c Pulmonary Oedema c Cardiogenic Shock c Acute renal insufficiency c Diabetes mellitus c Diabetes Ketoacidosis. When the claim was filed by his wife Smt Jyoti Hiralal Mehta the Company informed Smt. Jyoti H. Mehta that as the sum insured was enhanced by Rs. 1,00,000 from May'99 at the time when Diabetes was diagnosed the original sum insured of Rs. 50,000 + Cumulative Bonus of 15% would be payable. Not satisfied with the decision of the Company, Smt Mehta represented to the Company and also approached the Office of the Insurance Ombudsman seeking intervention in the matter of settlement of her claim for Rs.1,95,000/- Parties to the dispute were heard on 12th August, 2004 and the records have been perused. The case records both regarding policy documents and hospital treatment received by Late Shri Mehta in 1999 and 2003 were studied and it has been decided that the claim of Smt. Jyoti Hiralal Mehta for reimbursement of expenses towards her Late husband Shri Hiralal Mehta's hospitalization at Nanavati Hospital for treatment of heart ailments is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 205 of 2003 - 2004
Shri Prakash Bhatia
Vs.
United India Insurance Co. Ltd.

Award Dated 3.11.2004

Shri Prakash Bhatia alongwith his wife and daughter was covered under mediclaim Policy No. 121200 / 48 / 01 / 03337 for the policy period 8.8.2001 to 7.8.2002 from United India Insurance Company Limited, D.O. Malad, Mumbai for sum insured of Rs. 50,000/- Smt. Juhi Prakash Bhatia wife of Shri Prakash Bhatia was hospitalized at P.D. Hinduja Hospital from 02.01.2002 to 03.01.2002 for Medical Menisci tear posthorn c MCL Sprain c mild effusion (Lt) knee. When the claim was preferred by Shri Prakash Bhatia for Rs. 20,000/- for the said hospitalization to United India Insurance Company Limited, the Company rejected the claim by their latter dated 18.6.2002 invoking clause 4.2 and 4.10 of the mediclaim policy. Aggrieved by the decision of the Company, Shri Bhatia represented to the Company stating that he had policy since 1996 and the rejection of the claim under the exclusion clause 4.2 and 4.10 was not correct. Not receiving any favourable response from the Company, Shri

Bhatia approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. The parties to the dispute were heard and the records of the case have been perused. The question is primarily coming up that the decision not to go for surgery was entirely insured's decision, but the ailment was there and correction was suggested. Strictly on this ground and based on the facts and circumstances, the claim of Shri Prakash Bhatia is held sustainable.

United India Insurance Company Limited is hereby directed to settle the claim of Shri Prakash Bhatia in respect of his wife Smt. Juhi P. Bhatia's hospitalization at P.D. Hinduja Hospital from 2.1.2003 to 3.10.2003 for Medical Menisci tear posthorn c MCL Sprain c mild effusion (Lt) knee. There is no order for further relief.

Mumbai Ombudsman Centre
Case No. GI - 204 of 2003 - 2004
Shri Surendra C. Varma
Vs.
The New India Assurance Co. Ltd.

Award Dated 4.11.2004

Shri Surendera C. Varma approached the Office of the Insurance Ombudsman with a complaint dated 7.7.2003 against the partial settlement of his of Rs. 3,80,194/- at connection with his hospitalization expenses to the tune of Rs. 3,80,194/- at Lilavati Hospital for CAD by the New India Assurance Company Limited D.O. 110902. Shri Varma was covered under Mediclaim Policy issued by the New India Assurance Company Limited since 1997 for Sum Insured of Rs. 2,50,000/-. In the year 2001 - 2002 Shri Varma increased the Sum insured by Rs. 1 lac thus making a total of Sum Insured to Rs. 3,50,000/-. Shri Varma was hospitalized on 17.10.2002 to 01.11.2002 for CAD at Lilavati Hospital and Research Centre and when the claim was filed with the Company for Rs. 3,80,194/- the Company settled the claim of Rs. 3,12,500/-. Not satisfied with the decision of the Company he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman to settle his balance claim of Rs. 64,694/- plus interest taking his basic Sum Insured of Rs. 3,50,000 + Cumulative Bonus.

Parties to the dispute were heard on 15th September, 2003 and the records have been perused. The scrutiny of the claim file with all records reveal that New India appointed M/s G.S. Naik – Aparaj & Co to investigate into the claim lodged by Shri Varma and the Company's representative, on authority received from the Insured / Claimant, met the Doctor's on duty who wrote the history of the patient as also the Surgeons and other hospital staff to get the details of the metter on which the main dispute rests. It is evident form the records submitted by the Investigator together with the written confirmation issued by the concerned Doctors, that Shri Varma had earlier an episode of similar nature 4 years back for which received treatment from a private Nursing Home.

In the facts and circumstances of the case, the claim of Shri S.C. Varma is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 167 of 2003 - 2004
Mrs. Hooda Sakina Ismail
Vs.
The New India Assurance Co. Ltd.

Award Dated 04.11.2004

Mrs. Hooda Sakina Ismail was covered under a mediclaim Policy No. 110900 / 48 / 99 / 07088 of the New India Assurance Company Limted for a period 01.03.1999 to 28.02.2004. When she preferred a claim with the insurance Company for her hospitalisation at Prince Ali Khan Hospital for the period 06.01.2002 to 08.01.2002 "General Weakness", the Company rejected her claim under exclusion 4.10 of the Policy Condition.

Not satisfied with the decision of the Company the Insured approached the office of the Ombudsman for redressal of her claim.

A joint hearing was held on 19.08.2003 in the office of Insurance Ombudsman wherein the Complainant deposed that she was admitted in the Prince Ali Khan Hospital under the advice of doctor Dr. Virani for diagnostic purposes and treatment since she was having fever off and on, pain and General Weakness, etc.

Shri Anil Chitra, represented the Company and as per submission the Insured was admitted in the hospital for General Weakness and the admission was only for investigation purpose and in the Discharge Card it is mentioned that the hospitalisation of the Insured was not required. Hence the Company repudiated her claim under exclusion clause 4.10.

On the basis of the above findings and a careful scrutiny of the case papers is concluded that the complaint of Mrs. Hooda Sakina Ismail for payment of claim for her hospitalisation is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 217 of 2003 - 2004
Shri Madhusudan Kantawala
Vs.
The New India Assurance Co. Ltd.

Award Dated 04.11.2004

Shri Madhusudan Kantawala lodged a complaint to the office of Ombudsman about non - settlement of mediclaim of his wife Smt. Geeta M. Kantawala by the New India Assurance Co. Ltd. through their Third Party Administrator (TPA) M/s. TTK Healthcare Services Pvt. Ltd. on the ground of exclusion clause No 4.1 of the Mediclaim Policy which exclude settlement of claims on account of pre - existing diseases from the scope of the Policy. The insured took out the Mediclaim Policy w.e.f. 17.12.1999 for the first time and was enjoying Cumulative Bonus of 15% and the claim was lodged under the Policy No. 112700 / 48 / 02 / 06535.

Parties of the dispute were heard on 17.09.2003. The company alongwith their TPA appeared and deposed that the Complainant had been insured since 1996 but there was a break in insurance in September 1999 and the Policy had been effective since 17.12.1999. CT Scan report of the Insured dated 24.02.2003 mentions history of irregular bleeding 3 - 4 years and a know case of Endometrial carcinoma and the Insured was aware of the same since February 1999, i.e. prior to taking the fresh policy in December 1999. The Complainant submitted that his wife had irregular bleeding in June 1999 and therefore the CT Scan was taken and the report was normal, if the disease was there before 1999, then the report itself would not have been normal. Therefore the history of irregular bleeding should not be taken as 4 years old but should be taken only as 3 years should does not go beyond December 1999 when the policy was taken.

Evidence together with documents on record have considered. From the record the Insured's contention that the CT Scan was normal is not correct. The clinical finding given in the CT Scan dated 24.02.2003 viz. "irregular bleeding for 3 - 4 years K / C / O endometrial carcinoma" is a finding based on the statement of the patient as such a history can be given by the concerned female patient which corroborates with the earlier investigations and consequent treatment taken.

In the facts and circumstances the complaint of the Insured for reimbursement of expenses on account of hospitalisation is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 253 of 2003 - 2004
Shri Hitesh Purushottambhai Patel
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 04.11.2004

Shri Hitesh P. Patel was hospitalised three times at Lilavati Hospital, Muljibhai hospital in Gujarat and in Parvish Nursing Home in Andheri for various diseases e.g. Chronic Renal Failure, ESRO / Hypertension, Sclerosis HT, Lymphadenopathy, Adenitis, Koch's disease and Fistula etc. The company forwarded the claim papers to the Dr. M. S. Kamath for his opinion, based on Discharge Card of the hospital mentioned that there was a clear remark that the insured was having Hypertension and High Serum Creatinine in 1990. From The present Serum Creatinine of 1.6. to 1.7, he concluded that Shri Patel was in early stage of renal failure and coupled with Hypertension in 1990, the disease could be pre - existing and therefore the claim would not be payable. However, he admitted that if the insured could produce the policy documents before 1990, the claim would be payable as per the Sum Insured at that time + Cumulative Bonus. He approached the Ombudsman stating that the insurance policies are from 1986 and he had not claimed from 1986 to 1991 and Company had paid claim 3 times after 1991 but his claim arising in December, 2002 was withheld by the Company. It appears on the scrutiny of the relevant papers, that the entire dispute relates to the inception of the policy issued by the Oriental Insurance on which processing and admission of the claim is dependent. The papers submitted by Smt. Geeta H. Patel following the unfortunate date of Shri H. P. Patel appears to be at least from 1988 - 89. There are a few thing which can be tied together. The first is that the insured had admitted that the Oriental Insurance have paid him some claims and the first one dates back to 1991 for Hernia. Hernia is a first year exclusion disease and therefore the policy is to be at least running for two years to constitute a claim in 1991. Dr. M. S. Kamath admitted in his report that the policy records of the Oriental Suggest that Shri Patel was insured since 1991. Smt. Patel in her letter of October, 2004 had reasoned out by substantiating from the policy copy produced for 1993 - 1994 that Shri Patel and Smt. Patel respectively earned Cumulative Bonus for 5% and 25%. Her argument was under Shri Patel's Policy of 1991 a claim was made so the bonus became zero in 1992 and since no claim was preferred under policy it enjoyed 25% Cumulative Bonus and by making a back calculation the policy comes to at least 1988 - 1989 period which is an acceptable proposition and can be taken as a solution. In the facts and circumstances, the Oriental Insurance Company Ltd. is direct to settle the claim of Late Shri Hitesh Purushottambhai Patel for his hospitalisation from 02.11.2002 to 17.12.20025 at Lilavati Hospital, Muljibhai hospital and Parvish Nursing Home on the basis of actual Sum Insured available in the year 1990 with Cumulative Bonus if any. This amount may be released with a token simple interest of 6% from the date of hearing till the date of settlement.

Mumbai Ombudsman Centre
Case No. GI - 176 of 2003 - 2004
Shri Tilakraj Jewanmal Gupta
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 05.11.2004

Smt Renukadevi Gupta, wife of the Complainant Shri Tilakraj Jewanmal Gupta, was covered under a mediclaim Policy no. 121300 / 48 / 2002 / 1583 issued by the Oriental Insurance Co. Ltd since 03.09.1990. She preferred a claim for treatment of Incisional Hernia and Umbilical Hernia for which she was admitted to P.D. Hinduja Hospital from 08.08.2002 to 20.8.2002. The claim was rejected for the Company on the ground of suppression of material facts, as she had underwent hysterectomy operation in the year 1986 and the same was withheld in the proposal form.

Aggrieved by the decision of the company a complaint was lodged with the office of the Ombudsman by the Complainant claiming hospitalisation charges for the treatment for Rs. 1,25,000/- plus interest plus damage towards mental harassment.

Parties to the disputes were herd on 10 - 9 - 2003 and the records of the case have been perused. P.D. Hinduja Hospital's narrative summary gives the diagnosis on incisional and

umbilical hernia. It also records history of Hysterectomy (R) Paramedian scar and under pertinent physical findings the remarks is “Hernia – (R) infraumbilical paramedian scar. All these should be read in conjunction with ultra sonography report of the Abdomen date 17.7.2002 under “Impression”, it is written, “Right Paramedian para umbilical focal abdominal wall defect (underneath the previous surgical scar) with herniation of the bowel loops through the wall defect”. The next comment to “please correlate with clinical and other investigation findings”.

The complainant’s contention that the surgery was done in 19865 and therefore it was not mentioned in proposal from submitted in 1990 is not acceptable. In fact this is a non - disclosure of a material fact for which the contract can be avoided. Secondly it is a pre - existing condition regardless of the surgery being successful, wound getting healed and there being no complications subsequently. Dr. Kishore C. Shah, a noted surgeon has stated in his certificate that the Sonography report mentions “Herniation is a previous surgical scar” and therefore the claim cannot be accepted. The Sonography report is an objective corroboration, not based on any opinion or analysis made. The above remarks therefore dispels the certificates issued by both Dr. Devarajan and Dr. Udwadia to suggest there was correlation between the two events of surgery. Both these Doctors have harped on other causes of hernia which is very true, indeed hernia can occur in any place. However the possibility of intra abdominal pressure as one of the factors has been tested by factual finding of the USG to confirm what was the exact cause. Dr. Devarajan was guarded in his comment to say that there are other causes of hernia which is not disputed at all. In view of the above findings the claim is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 225 of 2003 - 2004
Shri Rajesh L Thakker
Vs.
The New India Assurance Co. Ltd.

Award Dated 08.11.2004

Shri Rajesh L Thakker was initially covered under mediclaim policy alongwith his sister, Ms. Smitha Thakkar. As Ms. Smitha Thakker got married, Shri Thakker requesting the Insurance Company in the year 2001 to delete his sister’s name and include his mother Smt. Devikanta L. Thakker’s name in the policy. The Company accepted the proposal based on the normal medical report of Smt. Devikanta Thakkar and a policy was issued covering Shri Rajesh Thakkar and Smt. Devikanta Thakkar. Smt Devikanta Thakkar was admitted in the Sharddha Polyclinic Nursing Home on 12.11.2002 for treatment of headache vomiting and giddiness. As she showed no improvement, she was shifted to Bombay Hospital on 14.11.2002 to 26.11.2002 for Cerebellar & Occipital lobe lymphoproliferative disorder. When the claim was preferred by Shri Rajesh Thakkar for Rs. 89,934/- for the said hospitalisation, the Company rejected the claim invoking clause 4.1 of the mediclaim policy. Not satisfied whit the decision of the Company, Shri Thakkar approached the Office of the insurance Ombudsman seeking intervention of the ombudsman in the matter of settlement of his claim. The parties to the dispute were heard and records perused. Apparently things appear to have revolved around making some rational estimation about this type of complications being there for quite sometime and at least before the proposal was made and the policy was taken in 2001. A deep study of the clinical findings backup by the MRI and scan could detect the ailment after the positive symptoms of giddiness, vertigo, vomiting and fall were manifested since 2 / 3 months. Viewed in this context, it would be difficult to accept that the Insured had any inkling of the policy was taken in 2001 and well before this period to constitute non - disclosure of deliberate suppression.

The other issue of some complications remaining for sometime must have been there but in the absence of actual treatment record, the duration cannot be conclusively stated. As the policy is in operation for 3 years at the time of hospitalization, the chances are the it was operation for 3 years at the time of hospitalization, then chances are that it was a

borderline case of manifestation. Accordingly, it would be appropriate to admit 60% of the cost on ex - gratia basis and settled the claim.

Mumbai Ombudsman Centre
Case No. GI - 203 of 2003 - 2004
Shri Ramchandra Rawte
Vs.
The New India Assurance Co. Ltd.

Award Dated 08.11.2004

Shri Ramchandra Rawte approached the Office of the Insurance Ombudsman with a complaint dated 7.7.2003 against partial settlement of his claim. Shri Ramchandra Rawte was covered under mediclaim policy since 1997 with The New India Assurance Company Limited for a sum insured of Rs. 2,00,000/- with Cumulative Bonus. When Shri Rawte preferred a claim for Rs. 51,353/- to The New India Assurance Company Limited for his two hernia operations which were carried out at Hinduja Hospital. The company settled the claim for Rs. 36,557/-. Not satisfied with the settlement Shri Rawte returned the discharge voucher and asked the Company to settle his full claim amount. Aggrieved by the attitude of the company as well as the TPA, i.e. M/s TTL Health Care Servcie Pvt. Limited, Shri Ramchandra Rawte approached the Office of the Insurance Ombudsman seeking intervention in the matter of settlement of his claim of Rs. 51,353/- alongwith interest and mental agony.

Parties to the dispute were heard and the records have been perused.

A study of the case papers and the critical analysis of the same clearly points out that there has been unfortunate delay. The Company should have handed over the discharge voucher after consolidating both the discharge vouchers amounting to Rs. 36,557 and 14,618 respectively to make the total amount of Rs. 51,157 to resolve the issue then and there. As the claim was not settle till date, order was passed directing the New India Assurance Company Limited to Settle the claim of Rs. 51,175/- together with a simple interest @ 8.5% as mentioned in the body the Awards calculated from 10th April, 2003 to 9th October, 2003 in respect of Shri Ramchandra Rawte for his hospitalisation at P.D. Hinduja Hospital from 26.1.203 to 30.1.2003.

Mumbai Ombudsman Centre
Case No. GI - 197 of 2003 - 2004
Smt. Manjula A. Patel
Vs.
The New India Assurance Co. Ltd.

Award Dated 08.11.2004

Smt. Manjula A. Patel was insured under the mediclaim policy issued by the New India Assurance Company Limited under Policy No. 48 / 140300 / 5510 for sum insured of Rs. 2,00,000 with 35 % Cumulative Bonus for the period 20.9.2001 to 19.9.2002. It is reported that she is having continuous policy since last eight years. Smt. Manjula Patel was hospitalised at Lilavati Hospital and Reserch Centre on 11.9.2002 to 19.9.2002 for left knee replacement. When a claim was preferred for the said hospitalisation to New India, the Company repudiated the claim invoking clause 4.1 of the Mediclaim policy. Not satisfied with the decision of the Company Smt. Patel represented to the Company and not receiving any reply she approached the Office of the Insurance Ombudsman. Records of the case have been perused and the parties to the dispute were heard. The main dispute in this case is pre - existence of the ailment which is taken from hospital records as narrated to the Doctor. It is a fact that ostoartherities leading to surgery takes a long time to develop into a big complication ultimately requiring surgery. However, the exact duration can vary with other health parameters which vary from case to case. The X - ray reports point out gross osteoarthritic changes of both knee joints with more severity on left knee

and distinctly this goes beyond 4 / 5 months as mentioned elsewhere and also in a Certificate which makes it non - aceptable. The type and grade of the disease is marked by progressive cartilage deterioration in synorial joints and vertebrae. The complication must have grown over a period, year by year requiring left knee replacement and that way it can be called pre - existing. However, since there is no proof of treatment and the fact that the Insured had the policy since last 8 years, propriety demands that the claim should not be totally rejected on the grounds of pre - existence of the disease as some element of doubt as regads the exact duration of knee problems remains. Accordingly, it would be just and fair to grant 50 % of reimbursement of cost and expenses on account of hospitalisation for this illness on Ex - gratia basis and settle the claim.

Mumbai Ombudsman Centre
Case No. GI - 191 / 2003 - 2004
Shri Ajay V. Gohil
Vs.
The New India Assurance Co. Ltd.

Award Dated 08.11.2004

Shri Ajay Gohil was insured under Mediclaim Policy 110600 / 48 / 02 / 05094 with The New India Assurance Co. Ltd. for the period 17.10.2002 to 16.10.2003. He has preferred a claim for his wife's hospitalisation at Bombay Hospital from 28.10.2002 to 29.10.2002 for treatment of Cervical Spondylosis. The Company repudiated his claim stating that the hospitalisation was only for the purposes of investigation and the claim falls with Exclusion Clause 4.10.

Aggrieved by the decision of the Company, Shri Ajay Gohil approached the Insurance Ombudsman for intervention in the matter. A hearing was held before the Insurance Ombudsman on 17.9.2003 when the Complainant appeared and deposed that he was having mediclaim policy since 1989 and his wife was hospitalised in October 2002 due to sudden development of neck pain and as per the treating doctor - Dr. Keki Turel - she was hospitalised and after conducting physiotherapy and medications her condition improved and discharged from the hospital. According to Shri Ajay Gohil all the treatment were done as per the doctor's advice and the company's contention that the hospitalisation was only for the purpose of investigation was wrong.

The analysis of the facts and circumstances of the complaint together with case papers reveal that first of all there was no critical emergency which necessitated hospitalisation. Secondly the hospitalisation was utilised for a host of investigations and it was detected to be Crvical Spondylosis. This is a very common ailment which is traeted without hospitalisation and the diagnosis also could have been done as an outpatient only. The treatment package with physiotherapy follow a pattern and therefore, despite having a positive ailment, the need for hospitalisation is not established and therefore attract the terms of 4.10 exclusion clause of the Policy. In the facts and circumstances of the case the decision of the Company to repudiate the claim cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 300 / 2003 - 2004
Smt. Kasturben Keniya
Vs.
National Insurance Company Ltd.

Award Dated 08.11.2004

Smt. Kasturben Keniya lodged a claim with National Insurance Company for Rs. 1,50,000/- for hospitalisation and treatment of Osteoarthritis of both knees and Right total Knee

replacement at Jasraj & Raj Group of Hospital from 09.3.2003 to 23.3.2003. Her claim was repudiated by the Company stating that the ailment was pre - existing.

Aggrieved by the decision of the Company the Complainant approached the office of the Ombudsman for redressal of her complaint. A hearing was held by the Ombudsman on 31.10.2003 when both the parties were heard. The complainant deposed that when the proposal was made she had no problem with the knees and she was attending to her daily chores and there was no deformity earlier. According to her Osteoarthritis existed in every person after the age of 40 years but operation is resorted to only when there that pain and manifestation of the disease which was not much earlier. The company through its representative deposed that the papers relating to total knee Replacement were examined by them and from the X - ray report, it was revealed that the insured had chronic Osteoarthritis and since the patient had developed bow legs and severe defomity it confirmed that the disease would have existed for not less than 10 - 15 years. The Company also sought a second opinion from Dr. L. N. Vora, MS (OR). FCPS, FRCS, M. Ch Orth., who also opined that the disease was of earlier origin not less than 5 years.

It is therefore, established through medical history, clinical records investigation reports and also external manifestation that the onset of the disease was well before the surgery and if one goes by estimation it should be a reasonable guess backed up by facts to put it beyond 5 years at least, if not more. As the policy was taken from the year 1999, it would be called pre - existing at the time of taking out the Policy hence the decision of the Company repudiating the claim on the ground of 4.1 cannot be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 182 of 2003 - 2004
Shri Harkishan Ratanji Shah
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 08.11.2004

Shri Harkishan R. Shah consulted his family Physician Dr. Kisor Shah due to severe chest pain and back pain who in turn referred him to Dr. V. G. Gokhale, Cardiologist of Shrenik Hospital and as per his advice he got admitted in the same hospital and CT scan, Myocardial Perfusion Scintigraphy and Treadmill Test was taken and Dr. Gokhale who also referred him to Dr. Bhaskar Shah for his opinion. After hospitalisation he preferred a claim to the Oriental Insurance Company Ltd. for his hospitalisation at Shrenik Hospital. The Company referred the matter to Dr. M. S. Kamath for his medical opinion who opined that the patient was admitted for investigation at Shrenik Hospital. No Special treatment barring usual medicines were mentioned as having been administered to patient and the Company repudiated the claim under Mediclaim policy Exclusion Clause 4.10. He approached the Ombudsman praying that his claim should be settled by the Compnany.

Shri Harkishan Shah contended that during hospitalisation he had undergone tests and also treatments were given. He informed that at the time of taking the policy he had submitted sugar reports, which were normal, and he had been holding the policy for lasts 5 - 6 years and this was his first claim, and so the claim should be paid. A close study of the papers together with written submission and oral statements at the hearing would reveal that essentially there was no emergency for hospitalisation. It should be borne in mind that the basic concept of insurance in to act and behave “as if uninsured”. In the present case, the pain at back and chest could normally be examined by a qualified doctor and the tests could be carried on. The very fact that virtually whole host of tests have been carried out is indicative of expectation of reimbursement under hospitalisation which was avoidable. The results of all tests are normal except to some extent some problem of mild spondylotic changes in the dorsal spine and atherosclerotic changes in the abdominal aorta. The

Myocardial perfusion scintigraphy, CT scan of chest, Dorsal spine all have been done extensively with good rsults. The liver function was good and the findings categorically ruled out any coronary artery disease which was suspected by the Insured and for which he said he was scared not to have angiography. The hospitalisation was then solely for investigation purpose and to rule out heart disease without any particular ailment requiring specific treatement as a result. In the facts and circumstances, the decision of Oriental Insurance co. Ltd. to repudiate the claim under specific exclusion clause of 4.10 as stated above cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 248 of 2003 - 2004
Shri Vipul Natvarlal Mody
Vs.
The New India Assurance Co. Ltd.

Award Dated 09.11.2004

Shri Vipul Natvarlal Mody had taken mediclaim policy from the New India Assurance Co. Ltd. The claim occurred when his mother Smt. Taramati M. Mody was admitted in Dr. Balabhai Nanavati Hospital for Carcinoma (R) Breast Surgery Radial Mastectomy. He approached the Ombudsman praying that the Insurance Company should settle the claim without further delay. Shri Vipul Mody received a cheque for Rs. 44,412/- which is deducted from the claim amount. Smt. Rekha Mody deposed that the Company should pay interest to her for delay in setting the claim. As regards disallowing some amount form the claim amount, she stated that whatever prescriptions available with them were produced to the Company The company's contention was that the TPA wanted some clarifications from the Company due to that the delay had occurred. The Company was advised to examine payment of interest for delayed settlement of claim as per IRDA Regulations. The complainant's contention was that after submission of the claim papers, he should have got the cheque but actually he has received the payment by a cheque which is a short payment of Rs. 1,148/-. It should be mentioned here that sometimes processing and settlement may require some more time than 30 days if there are some pending requirement and lack of clarification about the nature of expenses. Similar, some expenses may not be payable like administrative charges, telephone calls etc. whilst in the Hospital. Again some expenses may not be substantiated and at the hearing it appeared the complainant mentioned there was no more documents which could be submitted. Accordingly, the deduction of Rs. 1,148/- appears in order. As regards the delay, it should be noted that unless the TPA or the Company is able to prove that there was incomplete documentation by the complainant for which the TPA or the Company had to get back to the Hospital or the complainant, the demand made by the complainant to processing delay to the Hospital or the complainant, the demand made by the complainant to processing delay of 30 days maximum will have to be accepted and accordingly interest for delayed payment from 17.05.2003 to 28.08.2003 as claimed by the complainant, Shri Mody may be admitted. As regards the rate of interest as per IRDA guidelines i.e. 2 % above the market rate of interest ruling at that period may be granted which would be 9 %.

Mumbai Ombudsman Centre
Case No. GI - 289 / 2003 - 2004
Smt. Vimla Premji Mamania
Vs.
United India Insurance Co. Ltd.

Award Dated 09.11.2004

The complainant Smt. Vimla Premji Mamania took a mediclaim policy from United India Insurance Co. Ltd, for herself and her son Shri Mitesh P. Mamana, The renewed Policy No. 120704 / 48 / 01 / 01770 was valid till 22.8.2002.

The issue for which the complaint has been lodged with the office of the Ombudsman is non - renewal by the United Insurance Company Ltd., D. O. 120704. The complaint was registered by this Forum and parties were heard by the former Ombudsman on 24.10.2003 in which both Complainant and the representative of the Insurance Company deposed before the Ombudsman. The Compainant mentioned that despite sending pay order in advance and subsequently making representation, the Company turned down their request for renewal. The represntative of the Insurance Company pointed out that as per terms of Clause 5.9 of the Policy condition renewal may not be done by the Company at their option.

It appears the issue of non - renewal used to be referred to the Ombudsman and accepted by them also for adjudication. However there is no specific provision in the Redressal of Public Grievances Rules, 1998 to register complaints of non - renewal of existing policies. It is understood that members of Insurance Companies who form the Governing Body of Insurance Council (GBIC) decided to put up the matter before the Board of the Governing Body of Insurance Council to get their advice on the particular issue of non - renewals. Based on the unanimous opinion of the members following a discussion at length on the issue at their meeting, GBIC issued a circular dated 18.3.2004 in its advisory capacity that renewal of Mediclaim Policy may not be entertained under RPG Rules, 1998. In line with the advice it is also felt that Mediclaim Policy and for that matter, general Insurance Policies are only annual contracts and if the Insurance Company takes suitable underwriting decision based on their claims experience and certain other aspects of the policy operation, they would be entitled to do so as this in an underwriting decision for which they are answerable to their respective Board of Directors appointed by the Government of India. In the facts and circumstances of the case, the complaint of the Complainant for non - renewal of the Policy by the Insurance Company is dismissed.

Mumbai Ombudsman Centre
Case No. GI - 363 of 2003 - 2004
Shri Sanjay Vinayak Nakhye
Vs.
The New India Assurance Co. Ltd.

Award Dated 09.11.2004

Shri Sanjay V. Nakhye was insured with the New India Assurance Co. Ltd. and policy Issued without any exclusions. He was admitted in Shree Samarth Nursing Home for Degenerative Transverse Tear Medical Meniscus with Osteo Arthritis (L) knee. It was settled by the Company and again when the 2nd claim was lodged for operation within 2 months of the first claim, the Co. referred the matter to its panel doctor Dr. R. R. Nawalkar and he opined that ‘High Tibial Osteotommy’ is an accepted surgical procedure done for a Genu Verus Deformity. It takes a few years to develop Genu Verus Deformity and it can be said that the deformity existed even prior to the arthroscopic first surgical intervention. The company rejected the claim under Exclusion Clause 4.1 of the mediclaim policy. Shri Sanjay Nakhye approached that Ombudsman with a pray that his claim is genuine and it should be settled by the Company. His contention was that the operation was only a follow up of the arthroscopy test which pointed to the exact complication which was removed by the operation and therefore, should pointed to the extract complication which was removed by the operation and, therefore, should be settled. The first diagnosis was Degenerative Transverse Tear Medical Meniscus with medical compartment Osteoarthritis (Lt) Knee for which Arthoscopy Lt. Knee was done on 02.09.2002. Subsequently, he was hopitalised again for the same ailment for knee joint malalignment with Grade II Osteoarthritis changes and Genu Verus Deformity for which Osteotommy was done. The reports clearly show high tibial Osteotommy and Genu Verus Deformity. The findings on the Arthoscopy was Grade II Osteoarthritis changes medical femoral and tibial, mild Synovial Hypertrophy and Synovitis. The first operation cleared the effusion and as recurrent problems remained further surgery on Left knee joint was done. It is also mentioned as a Genu Verus eformity which develops over a period making it a bow leg which show a bending outward of the leg.

In view of the same if may be reasonably held that the disease is old and since the policy was taken from year 2000 if could be called pre - existing in that sense. However, the Insured's first claim was paid by the company now cannot take the defence that the first claim was wrongly paid. The New India Assurance Company Ltd. is directed to settle the claim of Shri Sanjay Vinayak Nakhye for his hospitalisation at Shree Samarth Nursing Home on ex - gratia basis at 50% of the admissible express only.

Mumbai Ombudsman Centre
Case No. GI - 294 / 2003 - 2004
Smt. Padma P. Shah
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 10.11.2004

Smt. Padma P. Shah was covered under a Mediclaim Policy No. 48 / 02 / 1396. She had preferred a mediclaim for Rs. 31,510/- and Rs. 1,35,009.50 for her hosptialisation at Bombay Hospital and Breach Candy Hospital during the period 18.12.2001 to 22.12.2001 and 13.01.2002 to 19.01.2002 respectively for treatment of acute intestinal obstruction due to unknown cause". The Company repudiated her claim stating that the hospitalisation was primarily for diagnostic purpose hence under exclusion clause 4.10, the claim cannot be entertained.

The Insured approached the Insurance Ombudsman for redressed of her complaint. Both the parties were heard 16.10.2003. All the evidence on record, statements and submission has been duly considered.

All the evidence on record, statements and submission have been duly considered and the certificate dated 19.09.2002 issued by Dr. N. H. Banka of Bombay Hospital states that the Complainant was admitted under his care and after investigation she was found to have Sub - acute intestinal obstruction due to Bacterial overgrowth syndrome. A scrutiny from Breach Candy Hospital under the head "findings" it had been observed that "no intrinsic algemic pathology, no adhesion and no other abnormalities and colonoscopy with normal limit". It seems finally the Doctors felt that she was suffering from Sub - acute intestinal obstruction with a question mark on the diagnosis. All these have been based on actual medical report and therefore are acceptable. Primarily the investigations were conducted to find out the cause of the problem and diagnose the disease. However while the exact positive existence of the disease in the from of actual diagnosis was not evident but it cannot be denied also that repeated occurrence of intestine obstruction was suffered by the insured. It is also true that unless the investigations are conducted the diagnosis will not be completed. The question would be whether the investigations could have been conduction as an outpatient and the answer would be in the affirmative. In the sense alone the stay in two hospital could have been avoided. Mediclaim Policy is an insurance scheme and therefore it is covered by the principles of insurance that in the operative clause is mentioned, as "expenses reasonably and necessarily incurred" should be reimbursed. Viewed in that context the hospitalisation stay expenses would have been avoidable, yet the pain and intense suffering should be kept in view and perhaps, no one would allow himself or his relatives to suffer without getting proper treatment. Admittedly some of the investigations could be better managed in an atmosphere like hopsital with better managed in an atmosphere like Hospital with better infrastructure facility. Considering all these aspects the Insurance Company is directed to settle the claim of the complainant to the extent of 40%of admissible expenses.

Mumbai Ombudsman Centre
Case No. GI - 189 / 2003 - 2004
Smt. Pilloo F. Chinoy
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.11.2004

Smt. Pilloo F. Chinoy was covered under Mediclaim Policy No. 11140 / 48 / 01 / 05181 form 14 - 9 - 2001 to 13 - 9 - 2002 and she had the Policy since 1995. She had made a claim for the hospitalisation at Breach Candy Hospital during the period 13 - 6 - 2002 to 20 - 6 - 2002 for treatment of Laryngeal Stridor and Dysponea. The Company repudiated her claim stating it was a pre - existing disease and falls under exclusion clause 4.1 of the mediclaim Policy. Not satisfied with the decision of the Company she approached the Insurance Ombudsman Seeking intervention in the matter. Both the parties were heard.

All the evidence on record, statement etc. furnished by the Complainant and also by the Insurance Company have been considered. The issue is that the Company took the stand that hypertension which was pre - existing before the insurance was taken had given rise to laryngeal Stridor and Dysponea (breathlessness). They have also taken IHD for granted although not proved by test etc. before the Policy was taken. In fact Laryngeal stridor is nothing but a harsh, high pitched sound of respiration as if blowing wind due to some obstruction upper way. In facts, these symptoms can be associated with lung function and related illness. Simple hypertension on strict medication and controlled diet without being associated with Diabetes and advance lipid profile would not led to IHD immediately. There had not been any other adverse health conditions which are strong predisposing factors for Smt. Chinoy noe the Company had proof of treatment of hypertension, before the inception of the policy. Later she was diagnosed to have adeno carcinoma of Lt. Lung and the company's medical consultant got an opportunity to have a relook and finally advise on the admissibility of the claim. He, however, defended his earlier opinion. It would be clear that the presenting symptoms of dysponea and Laryngeal stridor would appear in proper perspective if viewed in the context of the final diagnosis. Dysponea is not a disease by itself it may present in many other illnesses, for which Hypertension may not be the trigger. Even Hypertension is also a symptom that may be caused by many other health factors. Hence to treat the entire episode as outcome of Hypertension which has caused IHD earlier, i.e. before inception of the Policy, would be improper. However, a point has to be considered that by their admission the complainant had said that Hypertension was there which was not disclosed, which is a non - disclosure and suppression on the part of the insured. There should have been declaration as in the advanced age the Company would have taken some underwriting decisions before accepting her insurance. Strictly on this ground and the fact that later diagnosis of adeno carcinoma of Lt. Lung can be linked with all the pre - exising symptoms, it is directed to settle the claim to the extent of 75% of admissiable expenses in respection of hospitalisation of Smt. Pillo F. Chinoy.

Mumbai Ombudsman Centre
Case No. GI - 426 / 2003 - 2004
Shri Gautam Parekh
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.11.2004

Shri Parekh Gautam was insured for mediclaim Policy with New India Assurance Company Ltd under the Policy No. 2001 / 112500 / 48 / 01 / 02833 for Sum Assured of Rs. 1,00,000/- for the period from 25.6.2001 to 24.06.2002.

Shri Gautam Parekh had undergone operation of Carbuncle in the back in Cumballa Hill Hospital and he claimed expenses of Rs. 98,000/- towards hospitalisation. However, the company proposed to settle the claim for Rs. 40,000/- only and sent a voucher for the same. Not satisfied with the decision. Shri Parekh Gautam represented the matter to the Regional Office which agreed with the decision of the DO of New India Assurance that they decided that payment of Rs. 40,000/- is a reasonable amount towards room charges, nursing expenses, charges for Surgeons, Anesthetist etc., in terms of the policy conditions and also as per their expert's opinion. Not

satisfied with this decision Shri Parekh Gautam approached the Ombudsman on 12.11.2003. The case was registered and the documents were called for scrutiny. Details of the claim with complete records of hospitalisation and treatment records, investigation reports, expenses incurred etc called for from both parties. The complainant had also not responded except sending P - II & P - III forms which were unsubstantiated by any treatment records, reports, investigation etc.

From the papers made available to this Forum it appears that the insured admitted with carbuncle over Rt. Side of back and excision was made. According to insured the charges were Rs. 98,000/- while he was offered Rs. 40,000/-. The Insurance Company felt that settlement was as per terms of the Policy being reimbursement as “reasonably and necessarily incurred”. There is record with this Forum giving the basis and details of such settlement. It is also presumed that the Insured has received the payment as full and final settlement and then preferred a complaint with this Forum. It is not intended to drag the matter further asking for confirmation of receipt of payment which the company should ensure and confirm. In the facts and circumstance this Forum would refrain from passing any judgment on this complaint and would revert it back to the company, New India Assurance Company for suitably explaining and clearing the doubts of Insured about the actual reimbursement made. However as the Divisional office was the processing and settling office which failed to provide any information to this Forum despite repeated requests, the matter is now referred back of Mumbai Reg. Office I of the Company for direct handling to conclude the complaint with an advice to this Forum. The concerned Divisional Office is hereby asked to be responsive to the requirements called for by this Forum the lack of which has caused the Complaint to remain unresolved so long.

Mumbai Ombudsman Centre
Case No. GI - 285 / 2003 - 2004
Shri Bhawani Shankar Bajoria
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 10.11.2004

Shri Bhawani Shankar Bajoria took Policy under Mediclaim Insurance for himself and his spouse Smt. Pushpa B. Bajoria for Rs. 1,00,000/- each from the Oriental Insurance Company Ltd., Jalgaon in the year 1999. Later the sum insured was increased to Rs. 3,00,000/- from 5.4.2002 and on renewal, a fresh Policy No. 162500 / 48 / 2003 / 00075 was issued. Shri B.S. Bajoria lodged a claim for Rs. 3,00,000/- with the Insurance Company on 17.7.2002 for the By - pass surgery of his wife Smt. Pusha B. Bajoria who underwent the same at Bombay Hospital. The claim was initially offered for settlement at Rs. 1,00,000/- by the concerned DO of the Insurance Company. The insured did not accept the same and made a representation for which papers were sent to their Controlling Office for examination. The RO of the Company found that the patient had old Ischaemic Heart disease and Grade III angina developed over a longer duration of period and on this ground they regretted their liability to pay the claim.

The entire records have been studied... Smt. Pushpa B. Bajoria, was admitted in Sahyog Critical care centre, Jalgaon on 16.6.02 and she was diagnosed as a “Known case of Hypertension with Diabetes Mellitus with Ischaemic Heart disease with Hypothyroidism with unstable Angina”. As per the Discharge Summary from Bombay hospital the diagnosis was “Tripple Vassel Disease” and the insured underwent CABG on 24.6.2002. In the certificate dated 27.11.2002 that is well after the treatment Dr. Eric Berges, Consulting Cardiologist, Bombay Hospital has mentioned that Smt. Pushpa Bajora was suffering from Diabetes 5 to 6 months prior to 2.6.2002. As per the Indoor case papers of Bombay hospital, the insured was having Choking sensation with uneasiness and perspiration – 2 - 3 days back. Bombay Hospital Discharge card mentions that the patient had Exertional Angina Grade III, ECG showed ‘Q’ waves in lead III, ST changes in VI - V6. Angiography on 19.6.02 showed Tripple Vessel Disease and Dr. Bhattacharyya’s letter dated 24.06.2002 showed Triple

Vessel Disease and Dr. Bhattacharyya's letter dated 24.06.02 mentions that "She received 5 Arterial Grafts and all severe obstructions and moderate blocks have tackled". The Left Ventricular Ejection Function was 37.18% only. This corroborates with the assertion that the ailment was of much earlier and thus pre - existing. In the facts and circumstances of the decision of the Oriental Insurance Company to repudiate the claim under Exclusion clause 4.1 as also for non - disclosure of material information cannot be questioned. Hence, the claim for reimbursement of expenses made by the Complainant Shri Bhawani Shankar Bajoria on account of hospitalisation of his spouse Smt. Pushpa B. Bajoria is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 296 / 2003 - 2004
Smt. Parwana Gustad Vakshoor
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 16.11.2004

Smt. Parwana Gustad Vakshoor was covered under the Mediclaim Policy since 1996 witht the Oriental Insurance Company Limited, Divisional Office – 9. She Was hospitalised from 29.10.2002 to 30.10.2002 at Breach Candy Hospital and Research Centre and was operated for Excision of lesion both armpit and left groin. When Smt. Vakshoor preferred a claim of Rs. 75,366/- for the said hopitalisation, the Company after referring the matter to their panel doctor, Dr. M. S. Kamath offered to settle the claim for Rs. 55,614/- and sent a discharge voucher to Smt. Vakshoor. As Smt. Vakshoor did not agre to the amount settled by the Company, she signed the discharge voucher for payment under protest and sent the same to the company on 14.3.2003. The company informed Smt. Vakshoor that they cannot issue cheque as the Discharge voucher was for part payment and under protest. Hence she was asked to discharge the same in full and final settlement. Dissatisfied by the decision of the Company Smt. Vakshoor represented to the company but the Company, vide their letter dated 2.6.2003 reiterated their earlier decision. Aggrieved by the said decision he approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim. Parties to the dispute were heard on 26.09.2003 and the records were perused. Considering the nature of such surgery and the sensitivity of the parts where it was done Rs. 10,000 each would be a reasonable figure. However, for the duration of surgery and the commensurate effort of anesthetist Rs. 5000 would be reasonable.

In the facts and circumstances of the case the Oriental Insurance Company Limited is directed to settle the claim of Smt Parwana Gustad Vakshoor for her hospitalisation at Breach Candy Hospital and Research Centre for Excision of lesion both armpit and left groin for 65,614 (55,614 {if not paid}+ 10,000) alongwith 6% simple interest on the total amount till the date of settlement to be made. There is no order for any other relief.

Mumbai Ombudsman Centre
Case No. GI - 195 / 2003 - 2004
Shri Custodio Fernandes
Vs.
The New India Assurance Co. Ltd.

Award Dated 17.11.2004

Shri Custodio Fernandes took a Mediclaim Policy 140100 / 48 / 01 / 11415 with New India Assurance from 18.3.2002 covering self and family members including his father Shri Alex Fernandes. The complainant made a claim for Rs. 20,000/- for hospitalisation of his father during the period 15.12.2002 to 22.12.2002 at Sanjeevani Hospital where Dr. Bhavesh Dhanoria, Consulting Physician, Cardiologist & Diabetolist treated Shri Alex Ferbnandes for Diabetes mellitus. The Complainant lodged a claim with New India Assurance. The Company repudiated his claim vide its leter dated 21.03.2003 stating that the claim falls

under exclusion clause 4.1 i.e. being a pre -existing disease beofor taking the mediclaim policy with the Company.

Dissatisfied with the decision of the Company, the Complainant approached the office of the Insurance Ombudsman for redressal of his claim. A hearing was conducted on 09.09.2003 and 12.09.2003 when both the parties were disposed there oral statement.

All the evidence on records, statements and submissions have been duly considered and examined. It is evident that as per the advice of Dr. Renita D'Silva dt. 15.12.2002, the family physician of the insured, Shri Fernandes was admitted for treatment at Sanjeevani Hospital on 15.12.2002 with the remark "Referring Mr Alex Fernandes known case of Diabetes Mellitus – uncontrolled diabetes, COPD, HT – put on Loser H. Kindly admit". The immediate cause of hospitalisation seems to be the pathological test which was conducted on 14.12.2002 when it was found that he was suffering from very high incidence of blood sugar with the reading showing Fastings 469 mg and After meals 669 mg. and the remark was (++++) and therefore the interpretation would be it was strongly positive and uncontrolled for which, in fact, Dr. D'Silva advised him to get admitted straightaway.

The hospital case papers have recorded "uncontrolled passing of urine for 18 days High FBS and PPBS Urine glucose (+) on insulin". The extremely high blood sugar, glucose in urine, only controlled with insulin etc. clearly shows that the development was over a long was period to reach that stage and even by admission of Doctor D'Silva the insured was detected diabetic in March 2002, it would appear that at the time of taking the policy the disease, was there. Moreover, adverse ECG to indicate possible heart problems would also indirectly prove the existence of the causative factors like hypertension and Diabetes Mellitus and it now appears that both were present giving rise to heart problems. By a letter dated 18.03.2003 Dr. Bakul P. Dhruva, M.D. Consulting Physician, also confirmed that the available records clearly suggests that the insured is a known case of diabetes and has been on treatment. The diabetes is as old as to lead to beta - cell Exhaustion leading to insulin admission. Under the circumstances the claim of the Complainant for reimbursement of expenses incurred cannot be sustained.

Mumbai Ombudsman Centre
Case No. GI - 179 / 2003 - 2004
Shri Jinesh k. Shah
Vs.
National Insurance Co. Ltd.

Award Dated 17.11.2004

Shri Jinesh Shah took out a mediclaim Policy no. 250600 / 48 / 2001 / 8505608 for self (Rs. 1,50,000/-) his wife (Rs. 1,00,000/-) and three daughters (Rs. 50,000/- each) and the Policy was not qualified by any express exclusion (s). According to him he first took out the Policy in the year 1990. In his complaint Shri Shah stated that his wife Smt Harshita J. Shah developed Chest Pain and she was admitted in Life Line ICCU & Nursing Home on 16.9.2002 for certain medical examination and test

Shri Shah lodged a claim for Rs. 9407.50 with the Insurance Co. viz. National Insurance Company Limited which was repudiated by the Company under clause 4.10 of the exclusion clause of the Policy.

Being dissatisfied with and aggrieved by the repudiation of the Claim the complainant approached the Office of the Ombudsman for redressal of the claim. A hearing was held on 18.09.2003 and also on 16.10.2003 and both parties were heard.

Dr. M. S. Kamath, Medicolegal Consultant, represented the Company and reiterated the admission was only for one day and it was "Primarily for investigation purposes" as per opinions of two panel doctors. He submitted that the repudiation under clause 4.10 was in order.

All the statements, submission and evidences on record are consulted and considered carefully by this Forum. It is noted that the Company before rejecting the claim, two more specialists Dr. Shantilal Jain and Dr. Ismail Bandookwala and their opinions were exactly similar. Dr. Bandookwala remarked “She did not have any acute Symptoms requiring treatment but the hospitalisation was only for the purpose of investigations including stress test and thyroid function test were normal”. Dr. S.S. jain also observed “Main objective of hospitalisation for one day was for various investigations which could have been performed on outdoor basis”.

Under the circumstances, this forum is of the opinion that the decision of the company to repudiate the claim was in order.

Mumbai Ombudsman Centre
Case No. GI - 206 / 2003 - 2004
Shri Pravin Panchal
Vs.
The New India Assurance Co. Ltd.

Award Dated 17.11.2004

Shri Pravin Panchal was covered under Mediclaim Policy 111200 / 48 / 02 / 02771 of his wife Smt. Aarti Pravin Panchal with the New India Assurance Co. Ltd. The policy was for the period from 14.6.2002 to 13.06.2003. Shri Pravin Panchal preferred a claim for Rs. 52,500/- under the above policy towards his hospitalisation at Nanavati Hospital for the period 25.9.2002 to 29.9.2002 for the treatment of Coronary Artery Disease. The Insurance Company vide their letter dated 17.4.2003 repudiated his claim on the ground of the disease being pre - existing at inception. Not satisfied with the decision of the Company the complainant approached the office of the Insurance Ombudsman vide his letter dated 07.7.2003 for intervention in the matter of settlement of the claim.

Thereafter a joint hearing was fixed before the Insurance Ombudsman on 01.9.2003 and both parties were heard. The insured has admitted that he had hypertension even before he submitted the proposal for insurance. He has also admitted that he did not disclose this in the proposal form when he opten for fresh cover. His point was that hypertension is not related to Ischaemic heart disease as all hypertension people do not get Coronary Artery Disease. Moreover, he felt that clause 4.1 would exclude only the disease itself but not the related disorders as per the earlier exclusion and Company cannot exclude all other disease being related or caused etc. The whole dispute is on the exact meaning and intended meaning of the clause and it would be necessary to analysis the factors which are responsible to cause the ailments. If the hospital case papers are gone through it would be seen Shri Panchal took the Policy first time in 2001 when he was 41 years old within 16 months he had to undergo Angioplasty. His pre - operation ECG report was commented upon by the Hospital as “ECG showed ST - ? changes in anterior leads”. He had hypertension for last 4 years which is recorded and he was on regular medicines, which are also noted in the history sheet. The Insured has also admitted this in his written submission. The point is hypertension is also a symptom which slowly builds the effect of it and known as “Silent killer” if untreated over a period The presence of this at the time of making a proposal of insurance as admitted by him but not mentioning this constitutes non - disclosure and suppression of material fact which goes to the root of the contract and makes it avoidable. Secodly, going by the intensity of the disease leading to PTCA (Angioplasty) and the ECG changes, it could be inferred logically that even Ischaemic heart disease was developing while the proposal was made. If the declaration was there, the Company could have asked for investigation report which normally no Company would call for unless some complications are declared. The Company also could have taken some underwriting safeguards by means of exclusions which could have been more than hypertension alone and therefore the decision of the Company to repudiate the claim on grounds of non - disclosure and existence of the disease as per 4.1 exclusion clause of the

Policy cannot be faulted. Under the circumstances the claim of Shri Pravin Panchal is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 104 / 2003 - 2004
Shri Kundanmal R. Jain
Vs.
United India Insurance Co. Ltd.

Award Dated 17.11.2004

Shri Kundanmal R. Jain took a Mediclaim Policy No. 020700 / 48 / 00 / 56356 which was renewed for a sum insured of Rs. 1 lac the period from 26.2.2001 to 25.2.2002. He preferred a claim for hospitalisation from 7.7.2001 to 10.7.2001 at Lilavati Hospital in connection with the expenses incurred by him for Coronary Angiography. According to the Insured, claim form was submitted on 3.7.02 to the Insurance Company, which was not accepted by them and subsequently he forwarded the papers on 14.10.02 to the Regional Manager of the United India Insurance Co. Ltd., which was acknowledged by them on 22.10.02. The Insured then approached Insurance Ombudsman for an early settlement of the claim.

The records received from the complainant together with hospital case papers have been studied. As per the case records dated 6.7.01 of BMC Hospital, the Insured took treatment as an Outpatient and Coronary Angiography was advised on urgent basis. On going through the case Summary of Lilavati Hospital, it is observed that the Doctor had diagnosed the disease as Tripple Vessal Coronary Artery disease. The Doctor had stated that the patient was a known case of Hypertension since 15 years and on treatment. The Insured was admitted in Lilavati Hospital on 7.7.01 and discharged on 10.7.01. Coronary Angiography was done and the insured was advised CABG operation but on the insistence of the patient, immediate discharge was done. In the ECG dated 14.7.01, Dr. Rajiv D. Karnik has reported Ischaemic Heart Disease - Severe multivessel CAD and hypertension The insured was advised to get Coronary Angiography done on urgent basis by BMC Hospital on 6.7.01, i.e. four months after the renewal of the Policy and the diagnosis of Tripple Vessel disease / hypertension for which recommendation of CABG operation by Lilavati Hospital would indicate the chronic condition of the Coronary Artery disease. The past history of hypertension since 15 years mentioned by the Doctor of Lilavati Hospital also is a contributing factor to heart disease. Thus it is evident that the Insured was suffering from Hypertension well before the date of proposal which was not disclosed by him to the Insurance Company. It is noted that the Insurance company does not maintain proper records of claims and asked for the copies from the claimant. Even this Forum had to provide the records received from claimant to give them for their attention. United India needs to streamline their system of record keeping and customer servicing. The claim of Shri Kundanmal R. Jain for reimbursement of expenses incurred by him for hospitalisation under the above policy is not tenable.

Mumbai Ombudsman Centre
Case No. GI - 378 / 2003 - 2004
Smt. Jyoti Naresh Gurnani
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 18.11.2004

Smt. Jyoti Naresh Gurnani approached the Office of the Insurance Ombudsman by a complaint dated 22.09.2003 against rejection of her Mediclaim by the Oriental Insurance Company Limited, Mumbai CBO 12. It is reported that Shri Naresh Gurnani husband of Smt

Jyoti Gurnani was insured since October, 1991 with the Oriental Insurance Company Limited. Shri Naresh Gurnani was hospitalised due to Cardio Respiratory Arrest and when the claim was preferred by Smt. Jyoti Gurnani for the said hospitalisation the Company based on their panel doctor's opinion repudiated the claim dated 14.7.2003 stating that at the time of taking the policy the insured had not disclosed the fact of having stroke 10 years back. Not satisfied with the decision of the Company, Smt. Gurnani represented to the Company and approached the Insurance Ombudsman. Parties to the dispute were heard and the records produced before this Forum shows 5% Cumulative Bonus in 1997 - 98 and since there was no other information or records produced in support of a claim made under the policy, it would be difficult to ascertain the exact quantum of Cumulative Bonus accrued under the policy. There is no record before this Forum and the Company showed helplessness in retrieving from old records. However, from the documents received by this Forum it appears that Sum Insured was increased to Rs. 2,50,000 from 12.10.99 to 11.10.2000 and prior to that the sum insured was Rs. 1,50,000 and under the policy of 1997 - 98 the bonus element is only 5 % which meant that there could have been some earlier for which Cumulative Bonus earned was minimal.

In the facts and circumstances The Oriental Insurance Company Limited is directed to settle the claim of Smt. Jyoti Gurnani in respect of her husband's hospitalisation at various hospitals taking the sum insured as Rs. 1,50,000/- and pay the admissible amount.

Mumbai Ombudsman Centre
Case No. GI - 359 of 2003 - 2004
Shri Bhau Kashinath Chavan
Vs.
The Oriental Insurance Company Limited

Award Dated 19.11.2004

Shri B. K. Chavan alongwith his wife was covered under mediclaim policy issued by the Oriental Insurance Company Limited, Ghatkopar D. O. when a claim was preferred by Shri B. K. Chavan to the Company for the hospitalisation of his wife for Bilateral femoral Thromboembroectomy, the Company repudiated the claim stating that the ailment was pre - existing and invoked clause 4.1 of the policy. Not satisfied with the decision Shri B. K. Chavan represented to the Company and also approached the Office of the Insurance Ombudsman seeking intervention in the matter of settlement of his claim. Records of the case perused and the parties to the dispute were heard.

A critical study of the records, reports and the statements made by both parties reveal that Smt. Chavan, had Rheumatic heart disease. This is a disease normally happening in chidhood between 5 and 15 years and recur later may be anytime with fever. The accompanying diseases like Multiple Sclerosis (MS) is a chronic auto - immune inflammatory disease of the Central Nervous System which affects the entire body slowly. All these diseases are recorded in the hospital papers. As there was a break in insurance cover in the policy for 1999 - 2000 for 10 days, the Policy was treated as fresh from 29.6.2000 and, therefore, cannot be considered for payment being pre - existing ailment.

In the facts and circumstances, the decision of Oriental Insurance to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 295 / 2003 - 2004
Shri Shashikant G. Damani
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 19.11.2004

Shri Shashikant G. Damani was covered under a Mediclaim Policy No. 124104 / 48 / 2003 / 179 issued by the Oriental Insurance Company Ltd. The Policy was for a period from 26.09.2002 to 25.09.2003. He preferred a claim for Rs. 44,476.20 under the above policy towards his hospitalisation at Bombay Hospital for the period 12.11.2002 to 15.11.2002 for the treatment of Calculous Cholecystitis. The Company vide their letter dated 27.01.2003 repudiated the claim on the ground that the claimant was suffering from this disease even before taking the policy and as per the policy exclusions clauses 4.1 & 4.2 the claim is not payable. Being aggrieved with the decision of the Company the Complainant approached the office of the Insurance Ombudsman for his intervention in the matter of settlement of his claim. A joint hearing of the parties were held on 26.9.2003 wherein both the parties were deposed their views.

On further scrutiny of the records it is observed that the discharge summary submitted by the insured it was mentioned that he had been suffering from this disease for the past 3 weeks, which means from 23.10.2002 (date of admission on 12.11.2002) obviously contracted within one month of the policy being taken and as per Policy condition 4.1 & 4.2 the claim is not admissible. As per the indoor case paper submitted by the insured it is clearly mentioned that there is a history that the patient was hospitalised and treated conservatively. It shows that the insured had taken treatment elsewhere, may be before the policy or after the policy, which is not disclosed to the Company. The insureds deposed before the Ombudsman when he came for hearing that he was not admitted in the hospital before. When the Ombudsman asked the insured repeatedly to let the Forum know the hospital details so that the same can be verified and decided on merits, the insured mentioned that he had been not admitted to any hospital. How could the hospital write such a history then is the question. It shows that the insured was not disclosing certain facts, which were necessary to arrive at whether he had treatment earlier to the policy. To take advantage of the policy the Insured waited for one month after taking the policy and then got admitted for operation. Needless to mention that the Gallblader stones will not be formed in one day or two, and the insured must have been sufffering with the problem even before taking the policy.

Having gone through the entire records duly backed up by investigation reports, clinical findings and actual treatment thorugh surgery, it is evident the disease was there for quite some time and the asurgery was availed later. Hence the Forum is of the opinion that the decision of the Company to repudiate the Claim under exclusion clause 4.1 & 4.2 is in order.

Mumbai Ombudsman Centre
Case No. GI - 453 / 2003 - 2004
Shri Himanshu P. Thakkar
Vs.
The New India Assurance Co. Ltd.

Award Dated 23.11.2004

Shri Himanshu P. Thakkar covered under Mediclaim Policy No. 120700 / 48 / 02 / 1237 for the period 06.12.2002 to 05.12.2003. He lodged a claim with New India for hospitalisation expenses in connection with treatments of Cervical spondylosis and the related investigations. As the business was administered through Third Party Administrator, Medi Assist India Pvt. Ltd., the Papers were sent to the TPA who after processing the same maintained that the claim fell under exclusion clause 4.10 of the policy and therefore not payable. Being aggrieved at the decision he approached the Ombudsman's office for intervention of Ombudsman in the matter and resolution of the same. After perusing the case papers the parties were called for hearing on 4.10.2004 when both parties were heard.

On an analysis of the entire case papers together with the Doctor's Certificate and investigation report etc. it appears that the Company has rejected the claim on the ground that the hospitalisation was not essential in nature. The panel Doctor of New India Assurance Company and the TPA held the view that all the investigations are routinely done on out patient basis and therefore hospitalisation was not necessary. They felt that MRI brain and cervical spine was done from a different place where the patient was not admitted and this was primarily done to explore the possibility of Vertibro Basillary insufficiency. Dr. Dastur's Report has been examined and he has mentioned that the investigations carried out are justified but it did not warrant hospitalisation. A scrutiny of the MRI scanning brain reveals no abnormality except Diffuse cerebral atrophy which could be age related. The scan of Cervical Spine reveals mild cervical spondylosis, otherwise no abnormality was noted. Hence, it could be mentioned that there was no positive existence of illness as such but there was an attempt to find out the cause of ailments to get into a proper diagnosis. It distinctly points to the fact that the treatment advice on discharge was quite routine and non - specific. The advice was given for CBC after sometime as the blood report suggested Macrocytic Anemia.

For all the above mentioned reasons, it could be concluded that the hospitalisation was not essential and it has been done only for diagnosis purpose which is out of the purview as per the exclusion clause mentioned above, hence it is held that the claim is not sustainble.

Mumbai Ombudsman Centre
Case No. GI - 380 / 2003 - 2004
Shri Ramesh Mehta
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 23.11.2004

Shri Ramesh P. Mehta was covered under a Mediclaim Policy No. 2002 / 1242 issued by Oriental Insurance Co. Ltd., Mumbai City Branch Office No. 1 for the period 27.3.2002 to 26.3.2003 for a Sum Insured of Rs. 1,00,000/- Shri Mehta had this Policy from 1991 and had earned 40 % Cumulative Bonus under the Policy. When Shri Mehta preferred a claim with the Oriental Insurancce Company Limited for the hospitalisation at Bhatia General Hospiral for treatment of Thyroid with Multimodular goitre from 10.8.2002 to 17.8.2002., The Company referred the papers to their panel Doctor Dr. M. S. Kamath and as per his report they repudiated the claim under exclusion clause 4.1, i.e. pre - existence of the disease before the proposal was made and policy was taken. Aggrieved at the decision, Shri Ramesh Mehta made an appeal which was also turned down. He later approached the Office of the Insurance Ombudsman seeking intervention of Ombudsman in the matter of settlement of his claim for the surgery of thyroid glands in two hospitalisations at Bhatia General Hospital.

The parties to the dispite were called for the hearing and records perused. On an analysis of the entire case papers together with the comments made by the Company's Medico legal Consultant, Dr. M. S. Kamth it appears that the main point on which the claim was rejected was based on the reference made in the summary made on the discharge record part (1) of a hospital in United States dated 6.5.2002. As these papers do not refer to the duraion of the thyroid problem the benefit must be given to the Insured on the basis of the analysis made herein and rely on the Bhatia Hospital case papers duly supported by the Doctor's remarks and treatment.

In view of the facts and circumstance, the Oriental Insurance Company Limiteds is directed to entertain the claim in question of Shri Ramesh Mehta in connection with his hospitalisation expenses at the Bhatia General Hospital for Thyroidectomy with Multimodular goitre under policy No. 2002 / 1242 and pay the admissible expenses only.

Mumbai Ombudsman Centre
Case No. GI - 344 / 2002 - 2003
Shri Ashok Goyal
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 23.11.2004

Shri Ashok Goyal submitted a claim for Unstable Angina with Diabetes Mellitus for his Hospitalisation from 12.5.2002 to 15.5.2002 at P.D. Hinduja Hospital, Mumbai.

The Company repudiated the claim by letter dated 5.8.2002 notifying it as 'No Claim' as it was observed from the policy file that request for renewal of Mediclaim Policy for the year 2002 / 2003 was received on 22.2.2003 i.e. five days after the expiry of previous policy on 17.2.2002 thus causing a break in insurance and as such a fresh policy was issued for the period 22.2.2002 with exclusions of pre - existing diseases.

Shri Goyal, represented to the company by his letter dated 21.10.2002 and asked for reconsideration by the Company by granting the renewal and treating it as a continuous insurance which the Company did not accept.

The Insured and Complainant, Shri Ashok Goyal, then approached the Ombudsman on 10.12.2002 requesting his intervention. While the Ombudsman held a hearing on 1.10.2002, the issue of renewal and continuity in Insurance appeared the dominate point in contention to be resolved for consideration of his complainant for settlement of claim by Oriental. It is on this point that the Insured latter filed a Writ petition No. 1802 of 2003 in the High Court of Judicature at Bombay against Oriental Insurance Company.

As per Provision 13 (3)(c) of RPG Rules 1998, adjudication of the complaint NO. GI - 344 / 2002 - 2003 if Shri Ashok Goyal, for his claim for payment of hospitalization expenses cannot be considered by the Forum any longer at this stage.

However, as the cause of action for this Forum is not exactly the same on which the Writ Petition has been filed but rather wider to cover both the issue, it would not be possible to dispose of the complaint now and it would be better to adjourn disposal of the proceedings till the Writ petition by the Hon'ble High Court of Bombay.

Mumbai Ombudsman Centre
Case No. GI - 121 of 2003 - 2004
Shri Naval N. Gandhi
Vs.
United India Insurance Co. Ltd.

Award Dated 24.11.2004

Shri Naval N. Gandhi, resident of Umbergaon Building, 1st floor, Opp.
Krishna Nagar, Dr. B.A. Road, Parel, Mumbai approached the Office of the Insurance Ombudsman with a Complaint dated 28.5.2003 against partial settlement of his claim by United India Insurance Company Limited, Divisional Office – 3. Shri Naval N Gandji was7 covered under policy No. 020300 / 48 / 02 / 04102 issued by United India Insurance Company Limited, Divisional Office – 3 for the period 29.11.2002 to 28.11.2003. When Shri Gandhi preferred a claim for Rs. 1,13,600.95 for the treatment of Ureteric Colic the Company settled the claim for Rs. 1,03,656/-. Not satisfied with the decision of the Company, Shri Gandhi represented to the Company and approached the office of the Insurance ombudsman seeking intervention of the Ombudsman in the matter of settlment of his claim of Rs. 10,000/-. The records have been perused and parties to the dispute were heard.

From the records it is observed that against the claim amount of Rs. 1,10,357 the Company has disallowed Rs. 6701/-. At the hearing on August 1, 2003 the Ombudsman had advised

the Company to resolve the matter immediately. It is strongly felt that this is purely an administrative matter and there is no point of law, subtle interpretation of any condition or any application of mind to confirm or reject one or the other position taken by the Company or the claimant. In the facts and circumstances the above case is reverted to United India Insurance Company Limited with a direction to resolve the matter at their end on the basis of policy terms, conditions and exceptions. There is no order for any other relief.

Mumbai Ombudsman Centre
Case No. GI - 596 of 2003 - 2004
Shri Shrikrishna Rajaram Khanolkar
Vs.
The New India Assurance Co. Ltd.

Award Dated 29.11.2004

Shri S. R. Khanolkar, resident of 14, Shreeniketan, Main Road, Pandurangwadi, Goregaon (East), Mumbai - 400 063 was insured under mediclaim policy No. 112900 / 48 / 02 / 01247 issued by the New India Assurance Company Limited, D.O. 112900 for the period 01.01.2003 to 31.12.2003 for sum insured of Rs. 2,00,000. Shri Khanolkar was hospitalised for DM c CVA c Rt front parietal infarct c IHD at Suchak Maternity General Hospital from 8.2.2003 to 17.2.2003 for which he preferred a claim to the New India Assurance Company Limited, D.O. 112900. Aggrieved for not receiving any response or the claim amount Shri Khanolkar approached the Office of the Insurance Ombudsman.

The analysis of hospital indoor papers reveals that Shri S. R. Khanolkar was a proven diabetic and hypertensive for long 15 / 20 years with obviously all the ill effects of these diseases. In another place the indoor case papers mentioned the duration of the diseases as 20 - 25 years. The long sufferance from these diseases caused deleterious effects on other organs and the entire system was affected. The Insured was on continuous treatment and regular insulin dependent. The Insured had a Cardio Vascular Accident (CVA) within one month of taking the policy. From all these, it is quite obvious that the insured took out the policy with the ailments being there as pre - existent. Hence the claim of Shri Shrikrishna R. Khanolkar for his hospitalisation at Suchak Maternity General Hospital from 8.2.2003 to 17.2.2003 for DM c CVA c Rt. Front parietal infarct c IHD is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 495 of 2003 - 2004
Shri Jeewanjee H. Moriswala
Vs.
The New India Assurance Co. Ltd.

Award Dated 30.11.2004

Shri Jeewanjee H. Moriswala was under Overseas Mediclaim Policy, under Policy No. 110900 / 46 / 02 / 804879 of the New India Assurance Company Ltd., Mumbai for the period from 4.6.2002 to 30.11.2002, subject to specific exclusion of all Mediclaim expenses incurred directly due to total Hip Replacement and related illness. The claimant had an accidental fall on 11.11.2002 in USA, and the right femoral neck was fractured. He preferred a claim for Right Hip Hemiarthroplasty for his hospitalisation at Mercy General Hospital, USA. The Company vide letter dated 12th September, 32003 regretted their inability to consider the claim pertaining to the right hip replacement and stated that the decision of repudiating the claim by Mercury International was judicious as the policy excludes Total Hip Replacement which is a very specific exclusion and pertains to expenses incurred for surgical intervention after fracture of upper end of femur and complications arising therefrom. As far as the expenses incurred in respect of treatment of

right shoulder was concerned, it was well within the scope of the policy and competent authority accorded approval to pay US $ 1516.33 towards full and final settlement and asked him to give his consent for acceptance of the said amount. The company vide letter dated 19th November, 2003 informed Shri Moriswala, that the medical opinion is a confidential which is not released to the Insured. However the contents of the said opinions were intimated to him and if the amount of US $ 1516.33 was not acceptable it would be presumed that he was not interested to get the settlement of the claim. Not satisfied with the explanation of the company, Shri Moriswala, approached the ombudsman vide his letter dated 21.1.2004 and 12.3.2004 requesting his intervention. A joint hearing with New India and the party was to be held on 18.10.2004, but New India could not be present at the hearing although a notice was sent to them well in time. The Insured and Complainant was represented by Smt. J. Moriswala, wife of the Insured and she was assisted by Dr. Kapadia.

Since hip surgery (left) was done in 1997, it would be seen that the Company took a decision to exclude any surgery or treatment for hip replacement and allied ailments and in fact they have excluded the entire consequences attributable to such ailments as per the proposal form and the medical history read in conjunction with the reports submitted to the company. Here the total hip replacement would be taken as bilateral replacement which would include right and left both and normally the underwriting restrictions imposed following any ailment / complications / illness mentioned in the proposal form, result into total exclusion with the nature, extent and dimension of the entire complications are removed from the scope of liability to meet the concept of insurance, which is always contingency based and should be accidentally contracted and not incidentally involved. To that extent, New India's argument and the exact import of the exclusion clause appear to have satisfied this Forum and, therefore the complainant's contention that it was hemi - arthoplasty of half joint of right hip (only the femoral head) was replaced and, therefore, should be payable is not sustainable. As regards right shoulder, New India, had confirmed settlement under their letter dated 12.9.2003 and the statement appearing therein have clarified the payment terms under different heads of expenses incurred by Shri Moriswala. A total mount of US $ 1516.33 was payable to him which was not accepted by Shri Moriswala. Since, he did not accept the amount, there was no question of allowing interest to be levied on this amount. In the facts and circumstances, the claim of Shri Moriswala, fors payment of entire medical expenses arising out of the accidental fall in U.S.A. causing injury of right shoulder and right hip is partially entertainable as per New India's letter dated 12.9.2003, which is held sustainable. The New India Assurance Company Limited is directed to settle the claim of Shri Jeewanjee H. Moriswala , for the admissible amount as per their terms of settlement of US$ 1516.33, which was offered to him in accordance with the procedure followed for actual payment in respect of Overseas Mediclaim policies in Rupee Terms. There in no order for any other relief.

Mumbai Ombudsman Centre
Case No. GI - 373 of 2003 - 2004
Shri Deepak Karande
Vs.
The New India Assurance Co. Ltd.

Award Dated 30.11.2004

Shri Deepak Karande was insured under the Mediclaim Policy with New India Assurance Company Ltd. D.O. 111300, Policy No. 111300 / 48 / 02 / 00957 for the period 01.06.2002 to 31.05.2003 for a sum insured for Rs. 1,00,000/-. He preferred a claim with New India for Rs. 2,45,000/- for his hospitalisation at Kikabhai Cardiac Institute from 14.12.2002 to 25.12.2002 for Cardiac ailment. The Company vide its letter dated 03.03.2003 rejected the claim stating that while making enquiry with the hospital it came to know that it was a pre -

existing disease and the patient was on routine check - up since January 1993. Not satisfied by the decision of the Company the complainant with the office of the Ombudsman to intervene in the matter. The parties to the dispute were called for a hearing on 05.8.2004 and both the parties were made their submission on the hearing.

All the evidence on record, statements and submission of the parties have been considered. As per the panel doctor Dr. Bandookwala's report the insured had undergone tests including echo cardiograph for his heart condition. Thus he could not have remained ignorant of the heart disease. Although the treatment was taken later on there is no doubt that the condition was present and insured was aware of the same while taking the cover. Shri Deepak S. Karande underwent various medical tests at Smt. Sushilaben R. Mehta & Sir Kikabhai Premchand as also at Glenmark Cardiac Centre for Echocardiogram and Colour Doppler test. As per the test result he had a severe aortic stenosis with peak / mean pressure Gradient 90 / 68 mm Hg. He was advised to undergo Aortic Valve Replacement surgery in the near future. In the report it is also stated that since his overall health was good and there is no ailment of hypertension, diabetes, kidney malfunction etc. and his heart muscles were good there was no symptoms like chest pain or breathlessness. As per medical records, Aortic Valve condition most likely could be a congenital condition i.e. since birth. It cannot be acquired that way and can remain largely asymptomatic although at times there could have been some signals, here and there which must have given note to some complications. The fact that it got detected ever in routine check - up, points to some indications like murmur sound in Stethoscope etc. In any even this was a pre - existing condition and even if the Insured was not aware of the same the result would be no different although there may not be any question of non - disclosure by the Insured. In the facts and circumstances the repudiation of claim by the New India Assurance Company Ltd. for hospitalisation of Shri Deepak Karande and consequent reimbursement of expenses is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 168 of 2003 - 2004
Shri Rajendra Ramkisan Karwa
Vs.
National Insurance Co. Ltd.

Award Dated 30.11.2004

Shri Rajendra Ramkisan Karwa lodged a claim under Policy No. 270707 / 48 / 85 / 00366 / 2001 for Rs. 2,14,913/- incurred for his wife Smt. Kalawati R. Karwa who was admitted in Jairam Hospital at Nasik Road, for Cardiac treatment. Smt. Kalawati R. Karwa was admitted on 10.12.2002 for Arrhythmia due to actue coronary syndrome and was discharged on 16.12.2002 with advice for 2D Echo and further follow - up. Accordingly she was admitted in Rubu Hall Clinic, Pune, where angiography was done on 11.01.2003 and thereafter she was admitted in N.M. Wadia Hospital , Pune on 13.2.2003 where Coronary Artery By - Pass Graft (CABG) was done on her. The claim was repudiated by the Company on the ground of suppression of material facts and pre - existence of the disease. The National Insurance Company further refused to renew the policy on the grounds of non - disclosure of material facts and adverse claim status. A hearing was held on 26.08.2003 where the Complainant filed a Written Statement in respect of his case. Since the Company could not attend the hearing on 26.8.2003 a further hearing was held on 25.09.2003 in which Shri Chandrakant Lohar, Branch Manager, deposed his views.

All the submission, evidences on record and material Documents were considered and it is observed from the copy of the discharge card dated 16.12.2002 that the patient was a known case of hypertension and IHD for the past 9 years and had been on regular treatment. If further appeared that the patient was earlier admitted for hypertension and was treated accordingly. The policy was taken w.e.f. 30.3.2001 and in the proposal form the insured did not disclose the fact of the ailment she was suffered from and thereby

withheld material information. A further analysis of the hospital case papers and the discharge summary reveals that the she was under regular treatment for Hypertension / Ischaemic heart disease. The Coronary Angiography Report of Grand Medical Foundation, Ruby Hall Clinic, Pune also gives a clear picture about the abnormality noticed. In the facts and circumstances, this Forum holds the veiw that the Repudiation of the claim by the National Insurance Co. is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 230 of 2003 - 2004
Smt. Kamla Ramvallabh Bhangadia
Vs.
The New India Assurance Co. Ltd.

Award Dated 30.11.2004

Shri Ramvallabh C. Bhangadia was covered under a joint Mediclaim Policy No. 150800 / 48 / 00 / 04653 for the period 11.12.2000 to 10.12.2001 issued by the New India Assurance Company Ltd., Unit 150800 for sum insured of Rs. sum insured of Rs. 1,50,000/- with accrued Cumulative Bonus of Rs. 37,450/- which was subsequently renewed for the period 11.12.2001 to 10.12.2002 under Policy No. 150800 / 48 / 01 / 01808.

Shri Ramvallabh C. Bhangadia preferred a claim for his hopitalisation for the period 11.11.2001 to 26.11.2001 for operation for Stomach Cancer and further treatment of Chemotherapy (fist cycle) for the period 11.12.2001 to 15.12.2001, Chemotherapy (Second Cycle) for the period 03.01.2002 to 09.01.2002, Chemotherapy (third cycle) for the period 18.02.2002 to 23.02.2002 and Radiotherapy for the period 11.04.2002 to 26.04.2002. The claim for operation expenses was settled by the Company but the expenses incurred for treatment of Chemotherapy & Radiotherapy totaling Rs. 1,77,689 - 30 was not settled. Shri Ramvallabh C. Bhagadia unfortunately expired on01.05.2002. Since there was no positive response from the Company regarding the settlement of pending claim, Smt. Kamla Ramvallabh Bhangadia, wife of the insured by her letter dated 15.07.2003 approached the Insurance Ombudsman for redressal of her grievances. A joint hearing was held by the Ombudsman on 30.9.2003 when both the parties were deposed their views.

It seems both sides were arguing on an issue different emphasis for which sufficient clarity was not available within the terms of the Policy. Chemotherapy & Radiotherapy done after the surgery for Cancer is part and parcel of the same treatment and must be taken as one illness. When the matter was referred to the controlling office, the Divisional Office got a reply that if is coming under the definition of “one continuous illness” in which case there is no problem of settling the claim.

In the facts and circumstances as mentioned above, the complaint of Smt. Kamla Ramvallabh Bhangadia is therefore held sustainable and the Insured Company is directed to pay the admissible expenses only upto the sum insured available under the renewed policy.

Mumbai Ombudsman Centre
Case No. GI - 264 of 2003 - 2004
Shri Rakesh Kumar Jalan
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 6.12.2004

Shri Rakesh Kumar Jalan along with his wife Smt. Shabnam Jalan was covered under Mediclaim Policy issued by The Oriental insurance Company Limited., Divisional Offcie – 8 since 1997. Smt Shabnam Jalan was hospitalised initially at Breach Candy Hospital from 2.1.2003 to 3.1.2003 for Diagnostic Hysteroscopy and later was hospitalised from

20.1.2003 to 26.01.2003 from Hysterectomy at the same hospital. When Shri Rakesh Kumar Jalan preferred a claim for the said hospitalizarion the Company based on the opinion of their panel doctor settled the claim amount of for Rs. 1,21,385/- Not satisfied with the decision of the Company, Shri Rakesh Jalan Represented to the Company and approached the office of the insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his partial claim of Rs. 21,950/-. The records have been perused and parties to the dispute were heard.

The issue is simple namely, the deduction of Rs. 21,950 in two hospitalisation. The complainant rightly wanted to know the reasons for deduction of the amount. It seems Oriental Insurance Company did not clearly spell out the deductions under each head which did much later alongwith their letter of May 27,2003. The Company's arguments that the Mediclam Policy is based on the principle of reimbursement of reasonable expenses necessarily incurred cannot be faulted as it is enshrined in the operative clause of the policy. Moreover the Insured received the settlement as "full and final" and it is believed some explanation was given to him by the Company.

In the facts and circumstances, the decision of the Oriental Insurance Company Limited is in order.

Mumbai Ombudsman Centre
Case No. GI - 132 of 2003 - 2004
Shri. Sahaj H. Gyanchandani
Vs.
National Insurance Co. Ltd.

Award Dated 6.12.2004

Shri Sahaj H. Gyanchandani who was covered under mediclaim Policy issued by National Insurance Company Limited, D.O. Kalyan under Policy No. 48 / 01 / 8501122 for the period 4.10.2000 to 3.10.2001 for sum insured of Rs. 1,00,000/- was hospitalised at Shri Balaji Health Foundation from 9.7.2001 to 8.8.2001. When Shri Gyanchandani preferred a claim to the Insurance Company, the Company Vide their letter dated 22.04.2003 repudiated the claim as it did not satisfy as per the definition of "Hospital / Nursing Home" under clause 2.1 (a) and (b) and also invoked clause" 4.8 of the Mediclaim policy. Not satisfied with the decision of the Company, Shri Gyanchandani represented to the Company and aggrieved by the decision of the Company Shri Gyanchandani approached the office of the insurance Ombudsman 'seeking intervention of the Ombudsman for settlement of claim of Rs. 39,749/-. The records of the case have perused and the parties to the dispute were heard.

The Investigation conducted revealed that Dr. Balaji Tambe's Health Foundation is not registered either as a Hospital or Nursing Home under the Local authorities. In absence of compliance with policy definition 2.1 (a), at least 2.1 (b) would be complied with in toto. Considering all these aspects and strictly in terms of the policy, the decision of the Company to repudiate the claim cannot be faulted. However, since Ayurvedic treatment is admissible and the insured did take the treatment on the basis of a positive existence of an illness as per the Investigation conducted at Jaslok Hospital, a special consideration in his favour in the form of an ex - garia payment may be made.

In the facts and circumstances, National Insurance Company Limited is directed to make a lump sum ex - gratia Payment of Rs. 15,000/- (approximately 40% of the expenses incurred at Balaji Health Foundation for Heart treatment to Shri Sahaj H. Gyanchandani.

Mumbai Ombudsman Centre
Case No. GI - 557 of 2003 - 2004

Shri. Jal Dhunjishaw Bhathena
Vs.
The New India Assurance Co. Ltd.

Award Dated 6.12.2004

Shri J. D. Bhatena suffered from heart attack on 18.2.2003 and was hospitalized at B. D. Petit Parsee General Hospital and then underwent angioplasty at P. D. Hinduja hospital. When he preferred the claim to the Company, the Company repudiated the claim by letter dated 6.10.2003 stating non - disclosure of pre - existing disease in the proposal form. Not satisfied with the decision of the Company, Shri Bhatena represented to the Company alongwith a certificate dated 12.12.2003 issued by Dr. Z. F. Udwadia to reconsider his case. Not receiving any reply he approached the Office of the Insurance Ombudsman. Parties to the dispute were heard on 20.9.2004 and the records were perused.

The analysis of the file all the records reveal that the hospital Indoor case papers have recorded epileptic fit in 1982 which was thereafter controlled and managed by medicine. The Insured himself has admitted this and mentioned that he did not realize that it would be a point to disclose in the proposal form. The case papers further reveal that the insured had an episode of T.B. in spine in 1996, which is also disclosed and recorded with the Company. Then there is finally a record of Hypertension for 3 years. It is commonly believed that the case history in the hospital is recorded only discussion with the Insured or his relatives. Since both epilepsy and T.B, Spine were not disclosed before taking the policy in 1998 constitutes non - disclosure material to the contract irrespective of the fact whether it was material to the cause of loss / claim.

In the circumstances, the Company's decision to repudiate the claim on the ground of disease not being disclosed need not be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 348 of 2003 - 2004
Shri Sushilkumar Sureka
Vs.
The New India Assurance Co. Ltd.

Award Dated 7.12.2004

Shri Sushilkumar Sureka alongwith his wife Smt. Usha S. Sureka was insured with the New India Assurance Company Limited, Divisional Office 110900. Smt. Ussha S. Sureka was hospitalised at Bala H. anuman Meternity and Surgical Hospital, Mumbai form 17.10.2002 to 18.10.2002 for Anxiety Neurosis when Shri Sushil Kumar Sureka lodged a claim under the policy No. 110900 / 48 / 02873 to the New India Assurance Company Limited, Divisional Office 110900 for his wife's hospitalisation. The Company based on the opinion of their panel doctor repudiated the claim by their letter dated 18.12.2002 invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Sushil Kumar Sureka represented to the Company but the Company reiterated their earlier stand of repudiation. Aggrieved by the decision of the Company, Shri Sushil Kumar Sureka approached the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs. 5229/-. Records of the case have ben perused and the parties to the dispute were heard.

The documents including hospital case papers have been studied. It is evident that the criticality in the health status was not manifested so to get the patient admitted to a hospital. In fact the hospitalisation resulted into some investigation which could have been conducted as an outpatient only The Insured / Claimant obtained a certificate from Dr.

Nandlal K. Jotangia who did home visit to examine the patient but his certificate was dated 1.10.2002 i.e. after the admission and discharge of the patient on 4.9.2002 and therefore, is less significant. In fact there was no positive existence of any ailment requiring control and management only through hospital care. Accordingly the company's contention that the claim is not admissible under the policy as per 4.10 exclusion is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 355 of 2003 - 2004
Shri Bhavesh Shah
Vs.
United India Insurance Co. Ltd.

Award Dated 8.12.2004

Shri Bhavesh Shah was covered under Mediclaim Policy No. 020300 / 48 / 02 / 04636 from 20.12.2002 to 19.12.2003 of United India Insurance Co. Ltd, Divisional Office No. III, Mumbai. He lodged a claim for reimbursement of medical expenses incurred by him due to Idiopathic Gynecomastia for his hopitalisation on 17.05.2003. M/s Medicare TPA Services Pvt. Ltd., the Third Party Administrator (TPA) of the Company rejected the claim stating that "Indiopathic Gynecomastia is usually bilateral and occurs during adolescence. In the absence of any drug intake it is quite evident that gynaecomastia was pre - existing and hence not payable".

He represented to the company by his letter dated 9.9.2003 but not getting any reply, he approached the Ombudsman on 9.9.2003 requesting for his intervention.

The company could not attend the hearing, however, Shri Bhavesh Shah, appeared and deposed before the Ombudsman on 6.12.2004. He submitted that he experienced pain and swelling on the left breast during the last 2 - 3 years and when it was intense, he got it examined by the Doctor. He felt strongly that he had no knowledge about this illness and, therefore cannot be pre - existing. He mentioned that the first policy was taken from 1993 and thereafter continuously renewed.

This is an aliment frequently encountered by some persons for which normally medication is suggested and sometimes, it naturally subsides. However, in extreme case when the swelling becomes intense, surgery is recommended to obviate possible future complications. In the context of the exact ailment and the contention of the doctor, it would have been taken as existing for quite sometime, but for the facts that the Insured was having the policy from 20th December, 1993 without any break and, therefore, the benefit of the doubt is in his favour.

Following the hearing on 6.12.2004, United India Insurance Co. Ltd, D.O. III, vide fax dated 6.12.2004 have informed the Ombudsman Office that the claim of Shri Bhavesh Shah, has been settled vide cheque No. 327448 dated 24.11.2004 amounting to Rs. 34,956/- the case is, therefore, closed at this Forum.

Mumbai Ombudsman Centre
Case No. GI - 503 of 2003 - 2004
Shri L. N. Ghirnikar
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.12.2004

Shri L. N. Ghirnikar was covered under Policy No. 1112000 / 48 / 01 / 10254 from 09.12.2001 to 08.12.2002 issued by the New India Assurance Company Ltd. for an Amount of Rs. 1,00,000/- and he had Mediclaim insurance policy since 1990. Shri L. N. Ghirnikar lodged a Complaint before this Forum on account of repudiation of claim by the new India Assurance Company Ltd. D. O. 111200 for his hospitalisation at P.D. Hinduja National Hospital during the period 17.9.2002 to 23.09.2002. Shri L.N. Ghirnikar then preferred a

complaint against the Company before the insurance Ombudsman for redressal of his grievances. Parties to the dispute were called for hearing on 01.11.2004 when the Complainant and the representative of the Insurance Company were heard.

An analysis of records it can be observed that the Policy was renewed after a gap of 25 days with date of commencement 9.12.1993 under a new Policy No. 48 / 733337 for which the same was treated as fresh Policy. However, there was no mention by the Insured about “TURP” performed in 1990, this fact was informed by the insured in his letter dated 20.11.2003 addressed to the Forum. As per the Discharge Card of P. D. Hinduja National Hospital that Shri L. N. Ghirnikar was admitted in the hospital on 17.09.2002 and the diagnosis was Recurrent Adenoma Prostrastis for which operation of Cystic Via TURP was done on 18.9.2002. It has also been mentioned that the Insured was a known case of ‘BEP’ and was having past history of TURP in 1990.

A further deeper analysis would reveal that the insured claimed to have made a disclosure in the Policy taken in 1990 that he had an ailment of Prostrate Gland which was later operated. It appears further that after a gap of 25 days when new Policy was taken in 1993 the Insured did not mention the operation TURP as he had no problem at that time. In fact if New India had settled this claim it was necessary for New India to take on record this ailment to excluded the same on the ground that the policy in 1993 was a fresh one following the gap of 25 days. As this was not done the issue was open. The Insured continued thereafter with year to year renewal and then the complication came in 2002. Usually like CABG operation TURP also give a trouble free life of 10 to 12 years and after that there may be problems which could recur. Therefore, although technically it could be taken as a pre - existing ailment, since according to the Insured New India had settled the claim in 1990 which has not been contested by them which documentary evidence, the subsequent claim should fall under their policy as a covered disease. However there is non - disclosure of TURP done in 1990 this has deprived New India to assess the risk properly and take underwriting safeguard. As a consequence of the same and in view of the analysis made based on circumstantial evidences, New India is directed to settle the claim of the complainant for 50% of admissible expenses on ex - gratia basis.

Mumbai Ombudsman Centre
Case No. GI - 311 of 2003 - 2004
Shri Umesh Mehta
Vs.
United India Insurance Co. Ltd.

Award Dated 10.12.2004

Shri Umesh Mehta who was covered under the Mediclaim Policy Issued by the United India Insurance Company Limited, Malad D. O. was hospitalised from 24.3.2003 to 9.4.2003 for Acute Tracheo Bronchitis at Shah Surgical Hospital and Meternity Home, Mumbai. When the claim for Rs. 1,10,572/- was preferred by Shri Mehta in respect of the said hospitalisation, the Company entrusted the same to their Third Party Administrator i.e. M/sFamily Health Plan Limited for settlement of the claim. Not receiving any reply the Company Shri Mehta approached the Office of the I nsurance Ombudsman.

Pursuant to the Complaint lodged before the Insurance Ombudsman, the TPA informed the Company that as per the Investigations carried out it was found that the bills were inflated. Hence the Company advised the TPA to repudiate the claim. Accordingly Shri Umesh Mehta was informed vide letter dated 10.12.2003 by the TPA that the claim has been repudiated under clause 5.7 of the Mediclaim policy. The Company also informed Shri Mehta that his policy would not be renewed. Records have been perused and the parties to the dispute were called for hearing. The United India insurance Company or the invertigator has not been able to prove fraudulence on the part of the Nursing Home or the insured. In absence of conclusive and clinching proof of either the direct nexus or fraudulence on

either side, it should be appropriate to allow the claim only upto the maximum limit of Rs. 40,000 - stated by the TPA in their letter dated 30.7.2003 addressed to United India as a lump sum payment and resolve the dispute in a bid arrive at a partial Solution.

As regards non - renewal of the policy it should be mentioned that this Forum is not empowered to go into the underwriting aspects, renewals etc as per Rule 12 of the RPG Rules, 1998 and therefore, would refrain from commenting on the property or otherwise.

Mumbai Ombudsman Centre
Case No. GI - 165 of 2003 - 2004
Shri Ganesh Madhukarrao Bagul
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 10.12.2004

Shri Gansh Madhukarrao Bagul was covered under a Mediclaim Policy No. 161500 / 008 / 48 / 02 / 2074 issued by the Oriental Insurance Company from 27.12.2001 to 26.12.2002. He preferred a claim against Oriental insurance for Rs. 61,370/- for his hospitalisation and treatment of Growth hormone realising Pituitary Tumour or Adenoma at Jaslok Hospital form 13.02.2002 to 20.02.2002. The company repudiated his claim stating that the diseases falls in the category of pre - existing disease and excluded as per policy condition 4.1. Agggrieved by the decision of the Company the complainant approached the Insurance Ombudsman seeking intervention of the ombudsman in settlement of his claim. A joint hearing of the parties were held on 25.8.2003 wherein both the Complainant and the representative of the Insurance Company were heard. All the evidence on record, statements and admission of the parties have been considered. As per the report dated 14.2.2002 of CT Scan of Head / Pituitary done at Hospital it is found that there is a mild fullness of pituitary gland along its right side. There is marked thickening of Clavarium and all these findings show the disease ‘Pituitary micro adenoma’.

While the Discharge Card of Jaslok Hospital clearly disclose that growth hormone releasing Pituitary Adenoma, Dr. R. D. Nagpal of Samarat Endocrine & Diabetes Clinic in his certificate dated 7.02.2002 has diagnosed it as a clear case of acromegaly. He has also identified the medical needs of the patient and with this clear indication referred him to Dr. Hemant Phatale M. D. D.M. (Endocrine). It will be noted from the diagnosis “Acromegaly” that it will leave certain visible signs of identifying the problems even outwardly. As per Taber’s Cyclopedia Medical Dictionary. ‘Acromegaly’ indicates a Chronic disease marked by elongation of bones of the extremities and certain head bones Especially the frontal bones and jaws with enlargement of the nose ;lips and thickness of the soft tissues of the face. It is in this context that there has been numberous references in the hospital case papers that it is a classic case of Pituitary malfunctioning for which appropriate treatment was given. The patient was also asked to have regular follow - up and sustained steroid treatment.

In the facts and circumstances it is establish that the disease was of longer duration then the first Policy and therefore could be taken as pre - existing and thereby excluded from the scope of the policy under 4.1 exclusion clause. Hence the claim of Shri Ganesh Madhukarrao Bagul for reimbursement of his hospitalistion expenses is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 384 of 2003 - 2004
Shri Naina S. Kamdar
Vs.
The New India Assurance Co. Ltd.

Award Dated 10.12.2004

Smt. Naina alongwith her husband Shri Satish Kamadar was covered under the mediclaim policy issued by The New India Assurance Company Limited since 1996 for Sum Insured of Rs. 1,00,000/- In the year 1999 Smt. Kamdar increased the Sum Insured by Rs. 2 lacs thus making a total of Sum Insured to Rs. 3,00,000/- Smt. Kamdar was hospitalised in the month of December, 2002 for Post PTCA & LAD stented for IHD (CAD) at Lilavati Hospital and Research Centre, Mumbai and when the claim was filed with the Company for Rs. 2,73,331/- the Company offered settlement of and he returned the voucher for Rs. 1.,03,500 duly signed under protest. The Company took their earlier stand and conveyed to the Insured vide their letter dated 27.5.2003. aggrieved by the decision of the Company the Insured approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman to settle his balance claim of Rs. 1,70,051/- + Interest. The records have been perused and the parties to the dispute were heard The entire records produced to this Forum have been analyzed On analysis of the hospital records of Lilavati Hospital. Mumabi, it is revealed form the Discharge card dated 30.12.2002 that the Insured was having past history of anterior wall myocardial Infarction 4 years ago, which means the illness was existing well before the increase in sum insured in the year 1999. It is therefore reasonably concluded that ailment being prior to 1999, the Isnured would be eligible to have Rs. 1 Lac as sum insured for heart disease only while for any other disease Rs. 3 lacs sum insured would be available.

Based on the above facts and circumstances the Company's decision to settle Rs. 1,03,500 on the basis of original sum insured of Rs. 1 lac with Cumulative Bonus accrued on it, is in order.

Mumbai Ombudsman Centre
Case No. GI - 412 of 2003 - 2004
Shri Navinchandra Lallubhai Patel
Vs.
The New India Assurance Co. Ltd.

Award Dated 13.12.2004

When Shri Navinchandra Patel Preferred a claim to the New India Assurance Company Limited for his wife Smt Devindraben Patel's hopitalisation at Gujrat Endocrine Centre for treatment of Hypertension, COPD and Pulmonary Tuberculosis, the Company repudiated the claim by their letter darted 8.7.2003. On further representation by Shri Patel to the Company, the Company again reiterated their stand of repudiation vide their letter dated 10.9.2003 invoking clause 4.1 of the policy. Aggrieved by the decision of the Company, Shri Patel approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman on 14.10.2003. Notices were sent to the parties of the dispute and Shri Navinchandra Patel had complied with the completion and submission of P - II and P - III forms. The Company did not respond and these Forum had to send reminders to the Company to comply with the requirements which delayed the case further. It is a matter of pity that the Insurance Company, 'New India' took inordinately long time to respond to the requirements of this Forum. In the meantime Shri Navinchandra Patel challenged the issue of non - settlment of his claim in the Consumer Disputes Redressal Forum. As per Provision 13 (3) (C) of the Redressal of Public Grievances (RPG) Rules, 1998, adjudication of the Complaint No. GI - 412 / 2003 - 2004 of Shri Navinchandra Patel, for his claim for payment of hopitalistion expenses cannot be considered by this Forum any longer at this stage.

In the facts and circumstances, the Complaint No. GI - 412 of 2003 - 2004 of Shri Navchandra Lallubhai Patel in the matter of his claim for hosptialisation of his wife under Mediclaim policy against the New India Assurance Company Limited is hereby dismissed without going into its merits as per Rule 13(3) (C) of RPG Rules, 1998.

Mumbai Ombudsman Centre

Case No. GI - 385of 2003 - 2004
Shri Dinesh M. Shah
Vs.
The New India Assurance Co. Ltd.

Award Dated 13.12.2004

Shri Dinesh M. Shah, alongwith his family was covered under Mediclaim policy No. 111100 / 48 / 02 / 03482 from 20.08.2002 to 19.08.2003 of The New Assurance Company Ltd., Divisional Office No. 111100, Mumbai He lodged a claim for reimbursement of medical expenses incurred by his wife Smt. Raksha D. Shah, due to Unstable Angina, Teiz's Syndrome, Segmental Lumbar Spondylosis for her hopitalisation on 17.6.2003 at Sterling Hospital.

The Complainant vide letter dated 27.8.2003 informed the insured that the file was referred to their Panel Doctor who had opined that the documents submitted do not mention any symptoms / emergency,. which would require admission in the hospital and the investigation and treatment could have been done on the OPD basis. Hence the Company regretted their inability to entertain the claim under Exclusion Clause 4.10 of the Mediclaim Policy. Not satisfied with the reply, he approached the Ombudsman on 21.09.2003 requesting for his intervention.

On analysis of the claim file together with the expert opinion of he Panel Doctor, it would reveal that the insured was covered under the policy since 9.8.2003 with Exclusion of Appendicitis and Diabetes. She was admitted in Sterling Hospital, Ahmedabad for Unstable Angina and Segmental Lumbar Spondylosis for which she was investigated and treated. The documents submitted do not mention any emergency situation for which the patient would require admission in the hospital. The discharge summary of the patient / insured clearly reveals that some investigations were done on 17th January, 2003 whereby no history of any major illness was detected. The Insured had general complaint of Left side Back pain and Chest Pain associated with perspiration, vomiting and breathlessness. For all these ailments, she was moved from one Department to another for various investigation like echo cardiology, X - Ray L.S. Spine etc. She was Discharged in good condition and advised to have X - ray of both Knee AP Lateral and Physiotherapy after X - ray report. There was no other existence of any illness.

In the light of the above, as the hospitalisation was utilised mainly for investigation purposes with proper advises from the concerned doctors, it is felt that the same could have been done as an out - patient and, therefore, the rejection of New India Assurance Company under the terms of the policy need not be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 290 of 2003 - 2004
Shre Deenyar S. Jehani
Vs.
The New India Assurance Co. Ltd.

Award Dated 13.12.2004

Shri Deenyar S. Jehani who was covered under the Mediclaim Policy issued by The New India Assurance Company Limited, DO 110800 had preferred a claim for his hospitalisation from 27.4.03 to 21.5.03 at Breach Candy Hospital for laparotomy with ileostomy for pelvic abscess with diverticulities. The said claim was settled for Rs. 3,15,000/- by the Company. In the Discharge Card of the Breach Candy Hospital it was mentioned that Shri Deenyar Jehani had to undergo 2nd operation within 2 - 3 weeks. Accordingly, Shri Jahani got hospitalised at Breach Candy Hospital on 27.7.2001 and underwent Cyst DJ left colon operation. When he preferred the claim for the second hospitalisation expenses, the New India Assurance Company limited rejected the claim on the ground that Shri Deenyar Jehani had purposely postponed the operation in order to get the claim under the renewed

policy as no balance of sum insured was available under the previous policy. Not satisfied with the decision of the Company, Shri Jahani represented to the insurance Company, but the company reiterated their earlier stand of repudiation. Aggrieved by the decision of the company. Shri Deenyar Jahani approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. Records of the case have been perused and the parties of the dispute were called for hearing.

A critical analysis of dispute would reveal that the issue really is the handling of continuous treatment arising out of same ailment. Even if the Insured has delayed the second operation, no specific charge can be held against him since no direct adverse impact of the delay has been advised by the Surgeon nor it caused a critical medical emergency to get it done exactly on conclusion of the 3rd week. As an arguments, it can be said that if the policy was not taken and one had to finance the cost, one would seek Doctor's permission to delay it by a couple of weeks to arrange funds. Viewed in this context New India's repudiation is set aside on ground of taking a narrow view of the whole claim.

Mumbai Ombudsman Centre
Case No. GI - 166 of 2003 - 2004
Shri Madhukar Anant Mestry
Vs.
United India Insurance Co. Ltd.

Award Dated 13.12.2004

Shri Madhuakar Anant Mestry was covered under a Mediclaim Policy for the period from 16.05.2002 to 15.5.2003 vide Policy No. 0221200 / 48 / 02 / 00750 with the United India Insurance Company Ltd., D.O. 12 for a sum insured of Rs. 50,000/-. He preferred a claim of Rs. 56,844.50 for his hospitalisaion and treatment at Lokmanya Tilak municipal Medical College & Hospital (Sion Hospital) from 20.11.2002 to 23.11.2002 where he underwent Coronary Angioplasty on 22.11.2002. The Company repudiated his claim on the ground that the disease was existing disease. Not satisfied with the company the complainant approached the Ombudsman's office for redressal of his claim against United India Insurance Company. A hearing was held on 25.09.2003 and 26.08.2003 when both the parties were deposed their statements.

An analysis of the claim filed with all the records available would reveal that the Company rejected the claim on the ground that Diabetes and Hypertension were pre existing and as per exclusion clause of the Policy 4.1 the claim was repudiated. In the proposal from Shri Madhukar Anant Mestry had written that he does not have any ailment nor was he on any treatment and that he enjoying good health. He submitted also a special questionnaire form for diabetic where he submitted that he didi not have any problems arising out of diabetes or hypertension. Both these forms were signed dated 16.5.2002 and the Policy was issued to him and his wife for Rs. 50,000/- from 16.5.2002 to 15.5.2003 under Policy No. 0201200 / 48 / 00750. This being the first policy he took from the United India with the declaration of good health and no ailment as mentioned above the policy was given without any exclusions. The Insured's contention that the Company did not raise any issue about the pre - existing disease viz. Diabetes And Hypertension would, therefore, appear irrelevant as there was no cause for the company to ask the same in view of the clear statements.

As regards the impact of Diabetes and Hypertension to Cause cardiac problems it would be relevant to record here that the nexus between the two is well established medically. Diabetes along or hypertension alone causing the Cardiac problem vis - a –vis. Both the diseases taken together i.e. Diabetes Mellitus and Hypertension causing heart problems would be far greater. Diabetes mellitus is a chronic disorder of Carbohydrate metabolism marked by Hyperglycemia resulting from inadequate production or use of insulin. The Insured had type II diabetes which occur frequently in individual over 40 years and after remain undetected. Over a sustained period it gradually causes stenosis and occlusion of

the Arteries causing obstruction in the flow of blood. If associated with Hypertension it would form a formidable pre - disposing factor to cause Coronary Artery disease. However, as human body mechanism is quite strange and varies from person to person there are numerous instances were diabetic patients may not have heart problems even after long periods. The issue would be as the Diseases were pre - existing, these contributed to Coronary Artery disease (CAD) and the linkage and nexus was established. If this was declared and disclosed before the proposal was made the Company would have got an opportunity to underwrite the proposal in a special manner and not with normal risk assessment.

To substantiate his claim the Insured had produced a certificate of Dr. Nilesh Gautam, Cardiologist of Sion Hospital and he opined that not all patient of Diabetes develop Coronary Artery disease, which is not disputed but the certificate never say that with these two diseases being there, CAD would be independent totally. In the particular case these two diseases were the risk factors. As per the observations of the panel doctor, Dr. D.M. Dayal the Insured was admitted with a sudden attack of myocardial infarction on 20.11.2002 and the angiography revealed 2 vessels blocked. This cannot occur all of a sudden must have been existing over a period of time. It was also mentioned that the patient was having unstable angina and even a plain resting ECG gave evidence of significant changes. In the facts and circumstances, the decision of the Company to reject the claim be the ground of pre - existence of the diseases Diabetes and Hypertension which were not disclosed and at the time of proposal, cannot on questioned. Hence, in facts circumstances of the case the claim of Shri Madhukar A. Mestry hospitalisation expenses is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 476 of 2003 - 2004
Shri Parshotamdas N. Advani
Vs.
The New India Assurance Co. Ltd.

Award Dated 13.12.2004

Shri Parshotamdas N. Advani was covered under a Mediclaim Insurance Policy No. 140100 / 48 / 02 / 04990 from a sum insured for Rs. 50,000/- 20% Cumulative Bonus issued by the New India Assurance Company Ltd. He had the policy since 1998 with exclusion of Heart and Circulatory diseases. Shri P. N. Advani was admitted to Nanavati Hospital on 11.11.2002 with the symptoms of crime incontinence drowsiness and altered level of consciousness which was later diagnosed to the effectes of Hyponatraemia in a case of Syndrome of Inappropriate secretion of Anti –diuretic Hormone(SIADH). Shri Advani lodged a claim with New India Assurance Co. for his hospitalisation from 11.11.2002 to 18.11.2002 for the treatment received by him which was rejected by the company on the ground of exclusion under the Policy with appropriate endorsement. Being aggrieved at the decision Shri Parshotamdas N. Advani lodged a Complain with Insurance Ombudsman seeking his intervention.

All the submissions, contentions, Medical opinions and evidence on record have been duly considered by Forum. As per the Discharge Card of Nanavati hospital, the patient was suffering from Syndrome of inappropriate secretion of antidiuretic Hormone (SIADH), having weakness in the left of his body since 10.11.2002. It was also mentioned in the Discharge Card that the patient was a known case of Hypertension and also taking medicines for Ischaemic Heart Disease for last 4 to 5 years having undergone CABG 2 years back. The discharge card and history sheets of Nanavati Hospital shows that the patient had suffered from Septicemia also. However, in view of the explanation tendered by the treating doctor, it is made to understand that the insured suffered from “metabolic encephalopathy due to SIADH”. This implies that the insured suffered Primarily from SIAD and secondarily form cerebral symptoms arising out of effects of SIADH, which is

electrolyte imbalance. Also the insured's ailments is described as cerebral atrophy, multiple lacunar infarcts and various other, which are all consequent to impairment of the vascular supply to the brain. As such it can be seen that the origin of the insured's ailment is traced to vascular problem, which has been excluded from the scope of the Policy. The insured was admitted in Nanavati Hospital accompanied by his son who is also a Doctor. The history and clinical notes written at the time did mention "altered leave of consciousness" "incontinence in urine" and "weakness of the left half of the body" which had neurological focus. However as mentioned by the company's medical consultant, SIADH is a symptom, but the cause may be a combination of many factors and certainly the Circulatory disorders and inadequate blood supply to the brain should be a dominant factor. Hyponatraemia is know as decreased condensation of sodium in the blood. Hyponatraemia of SIADH is due to inability to dilute urine which can occur as a result of inappropriate functioning of Pituitary gland caused by Central Nervous System disorder. The hospital could not get at the cause of SIADH and it would said that while SIADH has many causes with vascular infarct being a dominant one, the other ones not being conclusively, proved, teh contributory roles of criss - cross effects of combination of circulatory, vascular, neurological, function at and organic disorders which include COPD, Sleep apnea could be plying their part to cause the complex problems. In absence of any conclusion by the Hospital authorities who actually examined and treated the patient, subsequent opinions would be in the domain of theory and since the patient was admitted under Dr. K. C. Shah, the neuro physician, we cannot also ignore his view. Moreover New India has later paid a claim of hyponatraemia for treatment at Lilavati Hospital which although is not for consideration of this Forum, yet acts at the back of the mind. For all these reasons some benefits of the doubt, may be given to the Insured and in absence of conclusive proof, I feel only 50% of the cost incurred for this hospitalistion become payable, subject to working out exact admissible amount. In the facts and circumstances, New India Assurance Co. is directed to settled the claim of the complainant only 50% of the expenses incurred subject to working out exact net admissible amount.

Mumbai Ombudsman Centre
Case No. GI - 434 of 2004 - 2005
Shri Hasmukh T. Chudasma Joshi
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 15.12.2004

Shri Hasmukh T. Chudasma was covered under the mediclaim since 1997 with the Oriental Insurance Company Limited, Divisional Office - 4. When Shri Chudasma preferred a claim of Rs. 41,213/- for his hopitalisation for left eye cataract operation from 3.3.2003 to 4.3.2003 at Bacha 's Nursing home, the Company after referring the matter to their panel doctor, Dr. M. S. Kamath offered to settle the claim for Rs. 31,402/- and sent a discharge voucher to Shri Chudasma. As Shri Chudasma did not agree to the amount settled by the company , he signed the discharge voucher for part payment under protest and sent the same to the company on 28.7.2003. Dissatisfied by the decision of the Company, Shri Chudsma represented to the Company but the company also reiterated the decision taken by the Divisional Office. Aggrieved by the said decision he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim. The records of the case have been perused and the parties to the dispute were heard.

A close look at the case reveals that whole dispute is about the surgeon Dr. Keki Mehta's fees of Rs. 29,000 which was reduced to Rs. 20,000 as per Oriental's letter dated 5.9.2003 to this Forum. As regards the other charges disallowed, all appear to be relevant as per the grounds mentioned against each.

The matter has been delayed for quite long and the Complainant has been denied even the partial settlement as he had not submitted the discharge voucher. Having regard to the submission to the insured and the expenditure actually incurred by him as also company's contention in terms of mediclaim policy the best via media solution would be to grant Rs. 25,000 as the cost of surgery and settle the claim for Rs. 36,402/-. However, if some of the medicines which were disallowed earlier are now substantiated by the insured the Company can consider those and suitably raise the amount of the payment. It would be necessary to send a letter showing items disallowed with appropriate reasoning.

Mumbai Ombudsman Centre
Case No. GI - 478/ 2003-2004
Smt. Prabha K. Lamba
Vs.
National Insurance Co. Ltd.

Award Dated 30.11.2004

Smt. Prabha K. Lamba lodged a complaint to the office of Ombudsman about non-settlement of mediclaim for the hopitalisation and treatment of her husband Shri Kuldeep Lamba at Desai Hospital Pvt. Ltd from 27.12.2002. to 03.01.2003 for treatement of Cirrhosis of liver with portal hypertension and hepatitis. Shri Lamba was covered under Mediclaim Policy No.250700/48/02/8506392 for the period from 28.11.2002 to 27.11.2003 for sum insured of Rs. 1,00,000/-. The Insurance Company repudiated the claim under Policy exclusion clause 4.1 on the ground that the insured was suffering from this illness much earlier than taking the policy. Being aggrieved by the decision of the Company the Complainant approached the Insurance Ombudsman for redressal for her grievances. The records were perused and a hearing was held in the office of the Ombudsman on 15.10.2004 when both parties were deposed their submissions.

On analysis of the records submitted to this Forum it is observed that the insured had taken a Mediclaim Policy on 25.08.2000 to 24.08.2001 for sum assured Rs. 1 lac and renewed the policy on 28.11.2001 after a gap of 3 months and the company treated the policy as a fresh policy effective from 28.11.2001 for a period of one year and subsequently policy was renewed for a period of one year from. 28.11.2002 tom 27.11.2003, with Policy No. 250700/48/02/8506392. Scrutiny of the medical reports could reveal that the insured was admitted in Sarla Nursing Home during the period from 29.12.2003 to 03.01.2003 and was diagnosed to have Cirrhosis of liver c portal Hypertension c Hepatis. Gastroscopy was done on 29.12.2002 by Dr. Sandeep Shah. As per the findings of the Endoscopy Report dated 17.01.2003 from Dr. N.K. Banka, Bombay Hospital, there was evidence of severe Congestive Portal, H/o. Gastropathy. He was again admitted at Sarla Nursing Home for treatment on 30.01.2003 as per the advice of Dr. C.C. Nair and was discharged on 06.02.2003 for the same ailment with varical bleed. Since his condition started deteriorating he was admitted in Dr. Balabhai Nanavati Hospital on 06.02.2003 for further management. He was operated on 07.02.2003 but he passed away at Nanavati Hospital on the same day. Cirrhosis of liver cannot develop suddenly, it is a sustained malfunction of the liver over a long period of time, which gives rise to Portal Hypertension and finally bleeding esophageal varices. As regards portal hypertension it can be conclusively said that there remained an obstruction of the flow of blood through the liver which cause increase pressure in the Portal vein to cause this hypertension. This most certainly proves that this disease was long standing. In the facts and circumstances of the case, the decision of the Company to repudiate the claim is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 263/ 2003-2004
Shri Fanil Navin Shah

Vs.
The New India Assurance Co. Ltd.

Award Dated 30.11.2004

Shri Fanil Navin Shah alongwith his family was covered under a Mediclaim Policy No. 111900/48/02/02846 for the period 03.08.2002 to 02.08.2003 with the New India Assurance Co.Ltd., for a sum insured Rs. 1,00,000/- with varying cumulative bonus. The complainant preferred a claim for hopitlisation form 13.11.2002 to 14.11.2002 of his wife Smt. Swati Fanil Shah for severe head-ache. The Company repudiated the claim on the ground that the hopitalisation was primarily for the purpose for various diagnostic test. His representation to the Company was turned down on the ground of hopitalisation for less than 24 hours as per Policy exclusion clause 2.3 Not satisfied with the decision of the Company the Complainant approached the Ombudsman's office for redressal of his claim against New India. After perusing the records a joint hearing of the parties were held on 10.10.2003 when both the parties were submitted their views.

All submissions, contentions and evidences on records have been duly considered by this Forum. It is observed form the Discharge Summary Card of Smt. Swati Shah that, she was admitted at Nivaran Hospital at 8.30 p.m. on 13.11.2002 and discharged at 8.00 p.m. on 14.11.2002. She was under medical treatment of Dr. Kesar S. Shah for treatment of Migraine. Also the patient had undergone various medical tests such as CT Scan, X-ray of Chest and PA, abdominal sonography, blood chemistry test etc. as per the advice of Dr. Kesar Shah and all the reports were normal. Further Scrutiny of the discharge card and indoor case papers it is observed that there are no remarks of treating Physician as regards discharge. The complainant has mentioned in his complaint that his wife took early discharge from the hospital in view of domestic urgency. As a general practice if the patient requires hopitalisation as per the treating physician and at the same time the patient does not want to be hospitalised in such case the treatment physician puts a remarks "Patient discharged against medical advises of his/her own responsibility". This also prove that hopitalisation was not necessary. The type of illness Smt. Shah had is quite commonly treated through medication after carrying out the necessary investigations as an outpatient. There was no emergency, no criticality for hospitaliation. All the tests the could be done without hopitalisation as it did not require any medical management of concern and CT Scan or MRI Could be done as an outpatient in a hospital or diagnostic centre. It therefore comes under exclusion clause 4.10 of the Policy. The claim does not also fulfil policy condition of hospitaliation for minimum 24 hours and comes under clause 2.3 of the Policy. Under the facts and circumstances of the claim of Shri Fanil Navin Shah for reimbursement of hospitalization expenses incurred by his spouse Smt. Swati F. Shah is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 601/ 2003-2004
Shri Yogesh Shantilal Vyas
Vs.
The New India Assurane Co. Ltd.

Award Dated 14.12.2004

Shri Yogesh Shatantilal Vyas was covered under medicliam policy alongwith his wife Smt. Uma Vyas since 2000. He preferred a claim for hopitalisation of his wife for eye treatment in Aditya Jyot Eye Hospital from 10.06.2003 to 11.06.2003. She was treated for Myopic Choroidal Neovascularisation (CNV) in the right eye. When the claim was lodged with the New India Assurance Co.Ltd., they rejected the same on the ground that the disease was pre-existing. Smt Uma Vyas was started having complications in early 2002 for which after consultation with few doctors, he consulted Dr. Natarajan and was adavised Choroidal Neovascularisation (CNV) in the right eye. It was a laser surgery and he vouched to mention that at the time of proposal the complications were not there. Smt. Shailaja Desai, represented the New India Assurance Co. Ltd., and deposed that this being a technical

issue the file was referred to an eye specialist who opined that Myopia is a complications which occurs in the childhood and grows with the age and the particular problems refers to long Myopia for which it was considered as pre-existing which was not disclosed when the policy was taken.

On a through examination of the case papers coupled with case summary ann concerned doctors opinion is was appeared that Smt. Uma was having Myopia and Fundus Examination with binocular indirect ophthalmoscope revealed evidence for peripapillary chorioretinal atrophy, posterior staphyloma in both eyes. She was diagnosed to have myopic macular degeneration in both eyes. She was referred to a famous eye surgeon Dr. S. Natarajan and after through examination it was decided that she should have Choroidal Neovascularisation in the right eye. The entire surgical procedure with various steps followed by the specialist/ consultant Dr. Nazimul Hussain and Dr. S. Natarajan, having been examined. The Company also referred the case papers to Dr. Gul J. Nankani, Consulting Eye Surgeon who has clearly opined that “Myopia usually sets in childhood and grows in adolescence till the age of 18-20 years.” As per medical Dictionary Neovascularisation is a development of new blood vessels in the structure and Choroidal is a portion of dark blue vascular layer of the eye. In a effect therefore the long Myopia would be predisposing factor to cause this and this was not disclosed while the policy was taken. The insured was using contact lenses and this was possible that these complications was developed later but the fact that she was Myopic was an important information for the Insurance Company.

In the facts and circumstances, the decision of the Company to repudiate the claim on the ground of pre-existence of disease of disease as also of non-disclosure of the material facts cannot be intervened.

Mumbai Ombudsman Centre
Case No. GI - 594/ 2003-2004
Shri Rajendra K. Shah
Vs.
United India Insurance Co. Ltd.

Award Dated 14.12.2004

Shri Rajendra K. Shah, was covered under mediclaim Policy of United India Insurance Company Ltd., Jalagaon B.O., since 1996 and he had included his two sons from 1998.

He lodged a complaint with United India Insurance Co. Ltd., that while going through the policy No. 230501/48/0300755 for the period 31.7.2003 to 30.7.2004, it was observed by him that the premium charged for his son is exactly 100% more than the premium chargeable as per the chart for Mediclaim Policy. He further stated that he had submitted a claim for his son for the year 2002-2003. As per condition 9.1, of the Policy, “In case a claim under the policy in a respect of insured person who has earned the Cumulative Bonus the increased percentage would be reduced by 10% of Sum Insured at the next renewal”. Accordingly, the amount of cumulative bonus decreases by 10% but no where it is mentioned that there will be loading in the premium if claim is made.

The company vide letter dated 23.1.2004 informed Shri Rajendra K. Shah, that the loading of premium of 100% is correct, since the claim ration was more than 250%. Not Satisfied with the decision of the Company, Shri Rajendra K. Shah, approached the Ombudsman by his latter darted 23.12.2003 seeking intervention in the matter.

It appears from the papers forwarded to this.Forum as also the complaint lodged by Shr. Rajendra K. Shah dated 23.10.2003 that the issue relates to Underwriting of Mediclaim Policy and fixing of appropriate premium by the company. Based on the Underwriting principles, the company has charged loading over the existing premium which has been challenged by the complainant.

As per RPG Rules 1998, Rule 12, the Underwriting issues together with fixing of premium in relation of the claims renewals of previous policy etc. would not be an area on which the Ombudsman must adjudicate. It would, therefore be necessary for the Company to satisfy the Insured with facts and figures to convince that no discrimination had been made in charging a particular rate of premium which is warranted by claims experience or by any other internal guidelines. In the facts and circumstances, the above complaint is dismissed from this Forum with a direction to the company that they should explain in detail the mechanism of charging a loading on the policy to the satisfaction of the Insured.

Mumbai Ombudsman Centre
Case No. GI - 280/ 2004-2005
Shri Albino Gomes
Vs.
United India Insurance Co. Ltd.

Award Dated 14.12.2004

Shri Albino Gomes took a mediclaim policy from United India Insurance Co.Ltd. for a Sum Insured of Rs. 30,000/- for a period of twelve months till 02.02.2004. He was having severe ear pain and consulted Dr. A. D. Noorani, ENT Surgeon and on whose advice the Myringo Plasty Surgery of right ear was conducted on 28.10.2003. After hospitalisation, he preferred claim to the Company for his hospitalization at Dr. Gracias Nursing Home, Margao for Myringo Plasty Surgery of right ear. All necessary Documents submitted by the Insured was sent to the TPA, i.e. MedSave Health Care Limited Mumbai by the Company for their decision. They had intimated their decision of repudiating the claim to the Company stating that as per their panel doctors opinion, the present ailment is pre-existing which was not disclosed whilst opting for cover and it falls under Exclusion Clause 4.1 of the mediclaim policy.

Shri Albino Gomes represented to the Ombudsman seeking intervention in the matter. An analysis of case papers indicate that the Insured would have had recurring problems in his right ear for which he consulted Dr. Noorani and after audiogram Myringo Plasty was suggested. This is a plastic Surgery of the tympanic membrane. Usually inflammation of the tympanic membrane (eardrum) takes place in the childhood and very often the parents ignore the signs of Otitis media. More often this do not get proper treatment and cause problems in adolescence. The Myringo Plasty is a correction which is required for the long term treatment of the ear which was done in the instant case.

In view of the intensity of the illness and complications it appears the disease was in existence for sometime. As this is a first year policy, the Company's decision to reject the claim on the ground of pre-existence of the disease cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 404 / 2004 - 05
Shri Vijay Shantilal Shah
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 17.12.2004

Shri Vijay Shahntilal Shah was insured with family under the mediclaim policy issued by the Oriental Insurance Company Limited, Ghatkopar D. O. When Shri Shah preferred a claim for CAG and PTCA, the CAG claim was settled by the Company for Rs. 1,37,527 and the claim for PTCA (Angioplasty) for Rs. 2,14,000 was offered to be settled for Rs. 1,39,073 which he did not accept. Shri Shah represented to the Company for payment of full claim of Rs. 2,14,000 which was again rejected. Being aggrieved by the decision of the Company against partial settlement of the claim, Shri Vijay Shantilal Shah approached the Insurance

Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim.

Records have been perused and the parties to the dispute were called for hearing.

The submissions of the Insured have been examined in conjunction with the documents which have been produced before this Forum. It seems that it was purely a case of administrative lapse on the part of the Company. The most striking feature is the whole deal i.e. reduction of Sum Insured, was not intimated to the insured immediately and neither IPD was called for nor refund was made. Shri Shah came to know about the action after the claim was lodged and the corresponding refund cheque was also not sent to the Insured only recently. On the contrary the next policy for the period 2003-2004 was issued with Sum Insured of Rs. 3 lacs. Considering the entire facts and circumstances, the action of the Company after issue of the policy for Rs. 3 lacs without specifying reasons for either withdrawl or reduction by issue of a fresh endorsement would be construed as irregular and therefore, non-acceptable. The Insurd's contention therefore, that the claim should be payable in full is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 82 of 2004 - 2005
Shri Salarine Lawrence D'Souza
Vs.
The New India Assurance Co. Ltd.

Award Dated 20.12.2004

Shri Salarine L. D'Souza was covered under a mediclaim policy issued by the New India Assurance Co. Ltd. Shri D'Souza lodged two claims for chronic renal failure and Nephrectomy (left) on 11.04.2002 and later for kidney transplant (left) on 10.06.2002 at Devaki Hospital, Chennai. The claim was rejected by the New India Assurance under Exclusion Clause 4.3 of the Mediclaim policy mentioning the disease to be congenital and pre-existing. He then approached Insurance Ombudsman seeking his intervention.

An analysis of the case with all the documents submitted before this Forum reveals that the Insured had a history of polycystic kidney, he had serious renal problems, was a known hypertensive and left kidney was totally non-functional. He was admitted to Devaki Hospital Ltd., Chennai for Nephrectomy and left kidney transplant which was done on 11.04.2002 and 10.06.2002 respectively. He was advised maintenance haemodialysis twice a week with other instructions on diet and habits. The various Investigation Reports which have been produced before this Forum coupled with the Discharge Summary of Devaki Hospital and the relevant comments of Dr. C. M. Thiagarajan himself makes it evident that the Insured was having renal problems for quite sometime and long before the policy was taken. The Ultrasonography Report of the kidney gives a picture of the cysts and their size and shape goes to show that the cysts were congenital. It is remarked by the specialist "a Classic case of Adult Polycystic Kidney Disease (APKD)." The medical records clearly mentioned this as "an inherited renal disorder transmitted as an autosomal dominant trait in adults. It is one of the most common hereditary disorders. Treatment includes medical therepy for renal failure with eventual renal diaysis and renal transplantation."

Viewed in the context of the above clause it is apparent that polycystic kidney is a congenital internal disease which is not covered under the policy. It, therefore, becomes pre-existing as well apart from being lodged in the first year itself. On all these counts therefore the rejection of the claim by the New India assurance is in order.

Mumbai Ombudsman Centre
Case No. GI - 428 of 2004 - 2005
Smt. Chandralekha Shrimal
Vs.
The New India Assurance Co. Ltd.

Award Dated 21.12.2004

Smt. Chandralekha Shrimal approached Office of the Insurance Ombudsman seeking intervention for settlement of her claim under Policy No. 111400 / 48 / 02 / 13319 (12.2.2003 to 11.2.2004) for full amount which was rejected by New India Assurance Co. Ltd. / TTK Healthcare Services Private Limited in respect of hospitalisation of her husband. Shri Dilip Shrimal took a Mediclaim Insurance Policy for sum insured of Rs. 1 lac in February 1990 from New India Assurance Co. Ltd. and continued renewal of the policy every year. He submitted his claim for the Hospitalisation for the period 15.7.03 to 25.7.03 for a claim amount of Rs. 1,19,789/- under Policy No. 111400/48/02/13319 to TTK Healthcare Sercives Pvt. Ltd. who considered his claim and sent the Claim Voucher dated 13.1.2004 for Rs. 1,15,993/- for execution by the Insured. After the Discharge Voucher was sent to the company by the insured on 28.1.04, the insured expired on 19.3.04. Smt. Shrimal represented to the company and at the intervention of Grievance Cell, New India Assurance Co., she received a letter dated 21.9.04 from TTK Healthcare Services Pvt. Ltd. offering a payment of Rs. 15,993/- only. The claimant refused to accept the amount.

On analysis of the entire records, it is observed that the increase in sum insured from Rs. 1 lac to Rs. 2 lacs was made with effect from 17.7.01 under Policy No. 111400/48/00/10685 for which necessary endorsement was placed on the Policy after collecting the extra premium of Rs. 514/-. The Policy No. 111400/48/62/13146 was issued on renewal of previous Policy, for sum assured of Rs. 2 lacs for Shri Dilip Shrimal without any cumulative Bonus thereon for the period from 12.2.2002 to 11.2.2003 and thereafter renewed on each expiry. He maintained stable function till May 2000 and then started having edema on evaluation and increased Serum Creatinine. Renal biopsy (graft) was done in 2002, and it was clearly a case of diabetic nephropathy with chronic renal failure (CRF) with uncontrolled diabetes and hypertension. In 1992 the Kidney graft had taken place and thereafter time to time treatment has been taken and claims paid. New India despite full knowledge of not only diabetes, but also serious renal problems including CRF, did not either restrict the sum insured available for the related disease. In the facts and circumstances of the claim of Smt. Chandralekha Shrimal for full settlement of hospitalisation expenses incurred by her husband late Shri Dilip Shrimal is sutainable The New India Assurance Co. Ltd. is directed to settle the claim for the admissible full amount keeping in view the total sum insured available, i. e. on the basis of Rs. 2,00,000/- after deducting the claims already paid in the same policy year.

Mumbai Ombudsman Centre
Case No. GI - 418 of 2003 - 2004
Shri Jayantilal R. Parikh
Vs.
The New India Assurance Co. Ltd.

Award Dated 21.12.2004

Shri Jayantial R. Parikh was hospitalised from 13.12.2002 to 24.12.2002 at Breach Candy Hospital for By - Pass Surgery (CABG) and L. V. Aneurism surgery. When Shri Parikh preferred a claim for the expenses incurred for the said hospitalisation the Company handed over the papers to M/s Paramount Healthcare Services P. Ltd. their Third Party Aministrators to look into the case. The TPA after going through the papers submitted by Shri Parikh offered to settle the claim for Rs. 1,72,500/- (1,50,000 being previous sum insured and 15 % C. B.) which was not accepted by Shri Parikh. Not satisfied with the decision of the Company, Shri Parikh represented to the Company but not receiving any favourable decision approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman to settle his claim for full sum insured which was available to him.

The records have been perused and the parties to the dispute were heard. The case has been analysed based on the documents produced and the hospital case papers received at

this Forum. Although it suggest that symptoms may have not been very revealing yet the fact cannot be denied that the Insured had an old Myocardial Infarction associated with exertional fatigue, occasional breathlessness coupled with Hypertension. Considering all these and based on the circumstantial evidence and the preponderance of probability it is felt that the Company's rejection of the claim for enhanced Sum Insured is an attempt to correlate the episode to positive existence of some disease which could not be proved. It is therefore, felt that the case would merit a different consideration. In the context of what had come up during the analysis and there not being any conclusive proof of the medicines Shri Parikh was taking before the increase of Sum Insured, the solution would lie in granting some more relief than partial claim for Rs. 1.5 lacs with appropriate Cumulative Bonus i. e. 1,72,500 as granted by the Company.

In the facts and circumstances, I feel that settlement of claim on the available Sum Insured, of Rs. 3 lakhs plus Cumulative Bonus earned would be appropriate and therefore, decide to hold the complaint and claim of Shri Jayantilal R. Parikh sustainable.

Mumbai Ombudsman Centre
Case No. GI - 335 of 2003 - 2004
Shri Kirit D. Doshi
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 22.12.2004

Shri Kirit D. Doshi and his wife was covered under mediclaim policy of the Oriental Insurance Company Ltd. He was admitted in Sunflower Nursing Home for Lumbo discogenic under the care of Dr. P. S. Mamtora, M. S. (Orth.). After hospitalisation, Shri Doshi preferred a claim for a sum of Rs. 24,272/- to the Company. The Company had sent claim file to their panel doctor, Dr. M. S. Kamath for his expert opinion. He opined that in the Discharge Card of the Hospital it is mentioned that Insured was having severe backache prior to admission so the disease is pre-existing. The Company intimated to the Insured on 04.03.2003 that the claim is excluded under 4.1 of the mediclaim policy. Again Company referred the case to Dr. M. S. Kamath and he confirmed non-admissibility of the claim.

The claim has been analysed at this Forum. It appears from the case history that the Insured had a recurring problem of back pain and that it was for quite sometime. He had the policy from September, 1999 and got hospitalised in Septembe, 2002 i. e. after 3 years of the policy came into force. The severity and intensity was not too great and unbearable earlier else he would have been forced to get himself admitted to the Hospital. The Hospital papers suggested he had a bout 3 years ago which coincides with around the date of taking the policy. Low back pain is a symptom which is experienced by many in the hard city - life for which sometimes there is a tendency to ignore the ailment also. In this case, the Insured must have stated the facts before the doctor to trace the ailment and get the best treatment. However, it is true that the intervertebral disc or discogenic pain started before hospitalisation and the MRI had shown early onset of the disease with "mild protrusion". This ailment, particularly discogenic pain, was of recent origin and going by the tenure of the policy for 3 years it makes a case for consideration. However, as there was back pain episodes before, it should be considered as a predisposing factor without being strongly symptomatic. Based on this argument, I consider the claim to be acceptable but on ex-gratia basis at 50 % only.

Mumbai Ombudsman Centre
Case No. GI - 520 of 2003 - 2004
Shri Neville K. Mistry
Vs.
United India Insurance Co. Ltd.

Award Dated 23.12.2004

The complainant, Shri Neville Mistry lodged a claim with United India for his wife's hospitalisation with a complaint of severe pain in chest and restlessness. The claim was settled by United India for Rs. 13,330/- as full and final settlement while Shri Mistry felt that the claim has been paid short by Rs. 5,223/- which has been deducted by the Company. As he did not get any favorable reply from the Company, he approached Insurance Ombudsman Office seeking intervention of the Ombudsman.

The dispute is totally objective and does not require any application of mind speficially to adjudicate on any critical or complicated issue. It is simply whether an expenditure has been made and if, so where is the authority to incur that cost and what is the proof of that cost e.g. prescriptions reports etc. If no advice is there or the reports are not available, the cost is not reimbursed. As per the Insured's statement signied by his Agent Shri H. Nekoo prescriptions were attached to chemists' Bill purchased outside Hospital Bills. This is an indication this Forum has got and it can be cheaked by the TPA only. The other costs can also be vouched and accepted or rejected. The complaint of Shri Neville K. Nistry is sutainable, it is reverted to United India Insurance Company. The Company is hereby directed to intervene themselves and check with TPA to justify all disallowed items and make further payment of only admissible amount, if any. The check should be on the documents already submitted and no records like prescription, doctor's advice, clarification on pathological reports etc. should be entertained now by the Company and after fully determining any additional amount duly sustantiated they are authorised to settle without further reference to this Forum.

Mumbai Ombudsman Centre
Case No. GI - 434 of 2004 - 2005
Smt. Illa Yogesh Joshi
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 23.12.2004

Master Nishidh Joshi son of Shri Yogesh Joshi and Smt. Illa Joshi was hospitalised for Right Inguinal Hernia at Ambulatory Surgery Clinic and Hernia Centre from 18.8.2003 to 19.8.2003 and when the claim was preferred by Smt. Illa Joshi, the Company referred the matter to their panel doctor, Dr. M. S. Kamath and based on his opinion settled the claim for Rs. 28,368/-. Not satisfied with the decision of the Company even after representation, Shri Yogesh Someshwar Joshi on behsalf of Smt. Illa Joshi approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim of Rs. 23,000/- which was disallowed by The Oriental Insurance Company Limited against his claim of Rs. 65,000/-. Records have been perused and the parties to the dispute were heard.

The issue of dispute is not admission of liability and payment of claim but short payment or partial payment of a claim which has been admitted by the Company. The reason for short payment, as per the Company, is due to certain charges have been made far above the market standard.

The analysis reveals that all costs have been reduced by 50 %. The issue is such on which there cannot be any specific ruling as such or adjudication by this Forum; there is hardly any scope for application of mind in that sense of the term. Yet I am satisfied that 'Oriental' has applied their mind to analyse market rates and analysed charges advertised by some top hospitals in the city to arrive at bench mark rates. Going by the nature of surgery and the "time and trouble" method, I feel cost of surgery may be increased to Rs. 20,000/- and the 'Anesthetist charges to Rs. 4,000/-, but the hospital charges appear to be in order for such an operation.

Mumbai Ombudsman Centre
Case No. GI - 590 of 2003 - 2004
Shri Murlidhar K. Koundinya
Vs.
The New India Assurance Co. Ltd.

Award Dated 24.12.2004

Shri Murlidhar K. Koundinya, alongwith his wife Smt. Nirmala Koundinya were covered under the mediclaim policy from September, 2000. Smt. Nirmala Koundinya was hospitalised for Post Menopausal P / V Bleeding at Poona Hospital from 2.12.2002 to 9.12.2002 and when claim was preferred the Company repudiated the claim by letter dated 28.2.2003 invoking clause 4.1. Aggrieved with the decision of the Company Shri Koundinya represented and not receiving any reply approached this Forum. Records have been perused and the parties to the dispute were heard.

The analysis of the case reveals that Smt. Nirmala Kundinya was diagnosed at KEM hospital to have Endometrial Polyp which was operated in 1998. This had to be done because of an episode of post menopausal bleeding and this was confirmed in Dr. Leela Desai's letter. This fact was not disclosed when the policy was taken in September, 2000 with The New India Assurance Company Limited. Based on the past history it is evident that the operation must have been delayed to get the advantage under the terms of the policy exclusion i.e. first year diseases such as Cataract, Benign prostatic Hypertrophy, Hystrectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal diseases, Fistula in anus, piles, Sinusitis and realted disorders as these are not covered under the policy. In that process the disease becomes pre-existing when it was lodged in the 2nd year of the operation of the policy.

In the facts and circumstances, the contention of the Company that the disease was pre-existing which was based on the opinion of Dr. (Brig) A. S. Narayanswamy is in order and cannot be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 267 of 2003-2004
Shri Hiten Himatlal Thakkar
Vs.
The New India Assurance Co. Ltd.

Award Dated 24.12.2004

Shri Hiten Himatlal Thakkar with his spouse Smt. Mallika H. Thakkar was covered under a Mediclaim Policy No. 130700/48/01/01354 for the period 13.7.2001 to 12.7.2002. He preferred a mediclain for his wife's hospitalisation at Gupte's Hospital from 24.6.2002 to 29.6.2002 and operation expenses for Pelvic Endometriosis. The Company repudiated his claim on the ground that the claim falls under exclusion clause 4.8 and 4.12 i.e. the case is related to pregnancy or period to pregnancy.

On a Scrutiny of records, if appears from the report dtd. 08.10.2002 of Dr. Sudhir V. Gupte, Consulting Obstetrician, Gynecologist & Laparoscopist of Dr. Gupte hospital that Smt. Mallika Thakkar was operated for Endometriosis & chocolate cyst. This was a treatment related to Endomertiosis and in no way related to pregnancy or conditions related to pregnancy. Therefore clauses 4.8 and 4.12 are not applicable in this case. According to Dr. Bandookwala, the panel doctor of the Company, as per the discharge card and the first consultation report of Dr. Gupte, she had been married for 1 ½ year and without any issue. She was found to have pelvic endometriosis and operated for the same. Endometriosis is the presence of endometrium (normally confined within the internal lining of the uterus) at abnormal sites outside the uterus. This endometrium bleeds during period leading to

adhesion and fibrosis of the pelvis. Endometriosis constitutes a major cause of infertility and thus requires treatment to enable further child bearing. Further during the operation, the right ovary which was found to be bulky was cauterized – procedure aimed at promoting ovulation (egg. Formation). As per his opinion the treatment was not for any pregnancy related condition or complication as such, but was essential for the insured to achieve a wanted pregnancy in future; hence this attracts the provision of exclusion clauses 4.8.

The issue was referred to Dr. (Mrs.) Sudha Sheth an eminent Consulting Obstetrician & Gynecologist for her considered expert medical opinion. Dr. Sheth in her detailed and considered opinion specifically mentioned that "Endometriosis" is a "Disease" and the treatment for Endometriosis was not for sterility but for Dysmenorrhoea and the ovarian cyst. Further to a specific term of reference as to whether the treatment taken can be considered to be related to pregnancy – Dr. Sheth replied in the negative. She further confirmed that Endometriosis is "not related to pregnancy". Endometriosis may cause infertility in some women. However, the disease of Endometriosis his to be treated irrespective of the fertility status of the women.

Dr. Sheth opined that in the instant case the patient could have been operated upon even if she had children, in order to get rid of the disease of Endometriosis as a primary concern. On examination of all the evidence on record, the depositions, the expert medical opinions I am inclined to hold that the patient had Endometriosis which is an ailment necessitating treatment by surgery and the same should not be so stretched to relate to pregnancy or treatment for sterility and then repudiate the claim invoking clause 4.8 of the Mediclaim policy. Hear the presence of the disease is most crucial to the insured and if the cure from the ailment facilitates the process of conception later, it would be incidental and not intentional. I, therefore, set aside the repudiation of the claim vide the Company's letter 24.10.2002 and ordered to settled the claim.

Mumbai Ombudsman Centre
Case No. GI - 726 / 2003-2004
Smt. Rajeshwari V. Iyer
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 24.12.2004

Smt. Rajeshwari Vishwanathan Iyer was covered under the Mediclaim Policy issued by The Oriental Insurance Company limited, Thane D.O. She was hospitalised from 11.8.2003 to 20.8.2003 for obstructed ventral hernia at Sahayog Hospital, Thane. When the claim was preferred by Smt. Rajeshwari Iyer in respect of the said hospitalisation, the Company repudiated the claim under clause 4.1 of the Mediclaim policy. Not satisfied with the decision, Smt. Iyer represented to the Grievance Cell of the insurance Company and since she did not receive any reply, she approached the Office of the Insurance Ombudsman.

The claim has been scrutinized at this Forum and all the available records have been duly perused. The Insured made a declaration in the proposal form for the policy she took from 15.2.2002 that she had Spondylosis and Umbilical Hernia operation in 1993. It was clearly disclosed and the Company had enough information to apply their mind for properly underwriting the risk. The policy taken from February, 2000 and on 30th April, 2001, The Oriental Insurance Company settled the claim for intra – peritoneal obstruction – exploratory laparectomy. The second claim under the Policy is present one for consideration for hospitalistion for Obstructed Ventral Hernia Surgery on 11th August, 2003. The remark on the hospital case papers as also the Discharge Summary is very clear to confirm the case of Obstructed Ventral Hernia.

The above analysis clearly leads us to some conclusion which should be spontaneously coming to anybody's mind. Apart form the facts that the 1993 Umbilical Hernia which was

mentioned in the proposal form could have acted only as a remote cause, the later problems arising out of weakening of abdominal wall due to incision/surgery necessitated by the Obstructed Ventral Hernia acted as a direct proximate cause. The fact remains that the Insured had Umbilical Hernia for which surgery was done in 1933. The Subsequent complications could well be part of this ailment at the entire abdominal region become vulnerable being a pre-disposing factor to cause herniation cannot be overlooked.

However, in the chain the 1993 episode would appear well controlled and managed until intervened by a different cause of resort to another surgery for intraperitoneal obstruction in 2001 which thus acted as sole and independent cause to break the chain and dominate as the immediate cause. Based on this argument, I decide the claim should be settled in full.

Mumbai Ombudsman Centre
Case No. GI - 282 / 2003-2004
Shri Vinodkumar P. Vohera
Vs.
The United India Insurance Co. Ltd.

Award Dated 31.12.2004

Shri Vinod Kumar P. Vohera was covered under the Mediclaim Policy No. 121200/48/01/07942 for the period 5.3.2002 to 04.03.2003. He preferred a claim for his hospitalisation at Shri Hurkisondas Nurroutumdas Hospital during the period 1.8.2002 to 5.8.2002 for treatment of Giddiness, sweating and chest pain. The company repudiated the claim invoking Exclusion Clause Nos. 4.1 and 5.7 of the Policy. Being dissatisfied with the decision of the Company Shri Vohera approached the office of the ombudsman for redresseae of his grievance against United India Insurance Company.

The records and the documents produced before this Forum have been Evaluated. It seems the Company has gone by the declaration made by the Insured that he did not suffer from Hypertension, although he did consult Dr. A. R. Mashru who certified that the he was the family doctor of Shri Vohera and that Shri Voher was suffering from Hypertension since January 2002 for which he was on regular medicine Ampress A. T. Dr. Mashru has also confirmed that his ECG & X-ray was taken & X-ray Shared cervical spondylosis All these information tally with the hospital case papers which made the following comments. “C.O. Giddiness on lying down, C.O. sweating which Lt. Sided pinching chest pain, H. O. of similar episode in the past,, H.O. neck stiffness, No. H.O. of unconsciousness”. They have described patient “known D.M. and known HT (??)”. In some other place the history mentions “past history of High B.P.” and agin “Not on any anti Hypertension drug”.
All these are noting by the doctor dated 01.80.2002 on the history sheet which must have been narrated by the patient himself. The diagnosis provisionally arrived was C.V.A. (cardio Vescular Accident) with Cervical spondylosis. The other diagnosis of IHD was not confirmed as it was considered that although ECG showed ST.T. changes, the other factors were good and perhaps the patient was to be kept under observation with appropriate medication. The various other investigation made at the hospital appear normal excepting that the patient reported B. P. 70/110.
From all the above it appears that the Insured suppress that truth and made a guarded statement before the hospital authorities for the claim to pass through. From all the above finding the Company’s contention that the claim was repudiated under Exclusion Clauses 4.1, 5.5 and 5.7 cannot be questioned. Accordingly, the claim of Shri Vinodkumar P. Vohera for his hopitalisation is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 89 / 2004-2005
Shri Bhuvnesh Chandra
Vs.

The New India Assurance Co. Ltd.

Award Dated 31.12.2004

Shri Bhuvnesh Chandra was covered under a Mediclaim Policy No. 111300/48/03/02960 for the period 28.8.2003 to 27.08.2004 and he was having this policy since 28.8.2001. He preferred a claim for the expenses incurred for his hospitalisation at Breach Candy hospital for Angiography on 14.8.2003 and subsequent operation for Angioplasty on 22.8.2003. The company repudiated his claim invoking exclause 4.1 of Mediclaim Policy. Being Aggrieved by the Decision of the Company, he approached the office of the Insurance Ombudsman for redressal of his claim. A hearing was held on 23.11.2004 when both the parties made their statements.

All Submissions, contentions and evidence on record had been duly considered by the Forum. A scrutiny of the certificate dated 01.10.2003 issued by Dr. Shantilal S. Jain, Consultant Cardiologist and Critical Care Physician shows that Shri Bhuvnesh Chandra was detected to suffer from mild hypertension due to stressful conditions in 1995. The insured was admitted to Breach Candy for Angiography on 14.8.2003 and for Angioplasty on 22.8.2003 and was operated by Dr. Ashwin Mehta. On submission of his claim paper the Company appointed M/s The Escorts to investigate the whole issue It seems the most authentic record would be the Breach Candy "patients' narration of history" received by "The Escorts" which clearly narrates and records the following data which are risk factors as per hospital records.

The case papers containing Doctor's orders had noted noriginally "H/OP HTN since 4/5 yrs on Tab Amlodac, Borderline diabetic on diet control" "H/O smoking +" Interestingly the hypertension was first cut from 4/5 yrs to weeks and even that was cut out. These writings were later cut with a remark "patient denies".

It is Evident from these developments that there has been a conscious attempt to suppress the truth of Insured's suffering from hypertension thinking that it would affect the settlement of claim. A number of attempts were made to convince the Insurance Company about the duration of hypertension and Dr. Shantilal Jain's certificate is an attempt to the effect. However, the narration sheets with Insured's signature is a proof of the correct statements and everyone would speak the truth about one's health condition to get best of treatment. The Insured appeared to be on medication "Amlodac" and was a borderline diabetic to be on controlled diet. In the facts and circumstance, the claim lodged by Bhuvnesh Chandra for his hospitalisation expenses is not sustainable

Mumbai Ombudsman Centre
Case No. GI - 356 of 2003 - 2004
Shri Tapan K. Tarania
Vs.
National Insurance Co. Ltd.

Award Dated 31.12.2004

Shri Tapan Kumar Tarania approached the Ombudsman with a grievance that National Insurance Company Ltd. had not reimbursed the expenses incurred for his father's cataract eye operation by stating that there is a gap of 5 months in insurance policy and therefore the policy was treated as a fresh policy.

The issue is resting on National's treating the policy issued to Bank of India as a non-continuous policy broken by 5 months after the date of expiry that is 31.12.2001. The analysis further reveals that the confusion has been created by the competition amongst four Public Sector Companies to get the business of Bank of India USP to their books and lack of prompt information to the consumers about the transitional arrangement and name of the insurer. Bank's role in availing the service of the Insurance Company cannot be ruled out. The resultant effect is the unfortunate denial of claim, the consequence of which is faced by the consumers i.e. the insured. However, going by the spirit of the contract

between the two contracting parties and the facts that effectively the policy was in operation since a few years, the transitional arrangement and consequent aberration should have been taken care of by National who got the business from Oriental. As the original policy dated back a few years and the fact that actually the Insured sent his premium and proposal form to Oriental which had to be diverted plus the premium amount got changed twice because of change in the cost structure, a more rational and practical approach was expected of National Insurance Company. The company had stick the technical point of 1st year exclusion but in such type of Group to Policies the approache should have been Practical to reckon the fact that the first cataract operation was paid by New India in the year 2000. Secondly, 'National' have taken the policy notionally effective from 1st January, 2002 to fall in line with the single date of operation although premium was received in late May 2002 and cover was granted from 1st June , 2002. The Company had denied the claim being 1st year policy, at the same time, they received the premium late, hence granted technically from 01.6.2002 although the policy dates back to 1st January, 2002 for all practical purposes. If it is so, then as per clause 4.2 the spirit of an enabling provision would be to grant continuity as per previous insurance with any other Company. The strength of the analogy would be the relevant portion of clause 4.2 which states "in case of the insured person having been covered under this scheme or group insurance scheme with any of the Indian Insurance companies for a continuous period of preceding 12 months without any break." This enable "National" to treat the claim as not under 1st year policy as the gap has been though caused an administrative rigmarole where the person actually remained insured throughout.

On balance, taking all facts and circumstances, the Insured's claim can only be considered for 50% expenses incurred on ex-gratia basis to meet the ends of justices subject to realization of full annual premium from the Insured.

Mumbai Ombudsman Centre
Case No. GI - 673 of 2003 - 2004
Smt. Maria Isabela Pereira
Vs.
National Insurance Co. Ltd.

Award Dated 31.12.2004

Smt. Maria Isabela Pereira, was covered under Mediclaim Policy No. 270907/48/02/8501635 from 15.11.2002 to 14.11.2003 of National Insurance Company Ltd., Panaji, Goa. She lodged a claim for reimbursement of medical expenses incurred by her due to Bilateral Ulceration of Axillary Lipomas for her hospitalisation from 22.4.2003 to 26.4.2003 at J. M. J. Hospital, Goa.

The TPA, Paramount Health Service Pvt. Ltd. Vide letter dated 15.12.2003 informed the Insured that as per policy copy, Diabetes is excluded from the policy and currently the patient has complaints of Lipoma in right armpit for a year which requires excision to prevent ulceration which occurs due to Diabetes. Hence the Company regretted their inability to entertain the claim under Exclusion Clause 4.1 of the mediclaim Policy. She represented to the TPA of the company by her letter dated 28.1.2004 stating that the Consultant Surgeon nowhere mentions Diabetes as the cause of the Ulceration of the Lipomas of both arms which was also rejected by the TPA/Company. Not satisfied with the approach, she approached the Ombudsmanon 29.1.2004 requesting for his intervention. The parties were called for hearing on 7.12.2004, but neither party appeared before the Ombudsman.

On a close analysis of the case papers, is appears that the treating consultant, stated that the patient had complaints of Lipoma in right armpit since a year, which required excision of prevent ulceration. It has been noted by the Specialist, that Diabetes causes Lipomas

which is Small tumour like abscess at various places, in the body. In it quite a common knowledge about “diabetic abscess” or “diabetic foot”, the terms used by the Doctor and the aggravation of those caused by diabetes. It is also noted form the policy documents that Diabetes was excluded from the scope of the Policy offered to Smt. Maria Isabela Pereira and as a result, the company took shelter under the Clause 4.1 of the policy. According, the decision of National Insurance to repudiated the claim under Exclusion Clause of Diabetes cannot be interfered with.

In the facts and circumstances, the claim of Smt Maria Isbela Pereira, in respect of her hopitalisation due to Bilateralm Ulceration of Axillary Lipomas cannot be entertained.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 751 of 2003 - 04
Shri Ashok Talakshi Chheda
Vs.
The Oriental Insurance Company Limited

Award Dated 04.01.2005

The complaint addressed to the Office of the Insurance Ombudsman by Shri Ashok Chheda seeking intervention of the Ombudsman in settlement of the claim which was repudiated by The Oriental Insurance Company Limited for his father’s hospitalisation for fistula surgery have been perused and the parties to the dispute were called for hearing. On a close analysis of the case papers and the relevant documents produced before this Forum it is evident that although Ayurvedic treatment was taken initially for treatment of fistula-in-ano it was treated in Bala Hanuman Maternity and Surgical hospital by Dr. Kothai and surgical excision was done for fistula by him. The insured was later admitted to Lilavati Hospital and had to undergo further surgery for swelling and pain in abdomen. It is evident that there were complications and this was aggravated by the earlier surgery. Although complete record was not available to this Forum, it appears that the Insured had treatment and surgery for wall abscess drainage and laparotomy colostomy was done. It is true that lot of complications developed following Fistulectomy done in Bala Hanuman and Oriental’s Contention that these are not covered because of Ayurvedic doctor treating with modern medicine (Allopathy) is precluded by medical science as also by law cannot be contested. Shri Talakshi Cheeda was insured with Oriental continuously from 1994 thereby proving his faith in insurance. He took Ayurvedic treatment in good faith without knowing the legal implications of the doctor administrating Allopathic medicine. In fact the concerned doctor is more responsible than the patient although the effect on the admissibility of the claim does not change by this analysis.

Taking, therefore, a moderate view and having noted the role of fistulectomy in the emergency evacuation of the Insured to Lilavati Hospital leading to a prolonged treament and in view of other specific complications, I decide to allow only 25% of the expensed incurred at Lilavati Hospital only from January 4, 2003 to January 29, 2003 and resolve the dispute.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 277 of 2003 - 04
Shri Arun V. Bavdekar
Vs.
United India Insurance Company Limited

Award Dated 05.01.2005

Shri Arun V. Bavedkar, took out a Mediclaim Policy 120801 / 48 / 02 / 00526 from United India for self and his family for the period w.e.f. 29.7.2002 to 28.7.2003. His wife, Smt.

Anagha A. Bavdekar, fell ill in the month of April 2003 and was treated at Vishwas Hospital, Das Hospital and Bombay Hospital during the period 16.4.2003 to 17.4.2003, 19.4.2003 to 25.04.2003 and 28.4.2003 to 29.4.2003 respectively and Shri Bavdekar preferred a claim for Rs. 58,315/- on the Company for the expenses incurred towards the hospitalisation of his wife.

The Company repudiated the claim invoking exclusion clause 4.1 which deals with pre-existence of disease. Being aggrieved by the decision of the Company, Shri Bavdekar approached this Forum for redressal of his grievances.

All the evidence, depositions and records have been perused and duly considered. It appears from all these records that Smt. Anagha used to have bouts of headache occasionally since her childhood. From the case papers of Bombay Hospital it appears that Smt. Anagha was suffering from headache since childhood. She was diagnosed to be a case of Lt. PCA - Fusiform Aneurysm Sub-Arachnoid Haemorrhage on discharge from Bombay Hospital on 29.4.2003. The hospital case papers clearly state that the patient used to have mild headache since childhood (left side of head frontal region). The episodes around 2 / 3 per month used to take place and used to subside after analgesics. However on 16.4.2003 when she was brought to hospital she was unconscious with severe pain. As per medical science Aneurysm is a localised abnormal dilatation of a blood vessel, usually an artery due to congenital defect or weakness in the valve of the vesel. Fusiform Aneurysm refers to tapering at both ends. The presence of the symptoms in Smt. Anagha Bavdekar perfectly matches the behaviour pattern and etiology of this disease and conveniently points to a case of congenial disease. The past episodes starting from childhood is a case in point. The Insured Shri Arun Bavdekar alongwith his wife Smt. Anagha Bavedkar took the policy from United India for first time w.e.f. 29.7.2002 and Smt. Anagha Bavdekar fell ill on the same first year itself. There could be an issue that so long the policy was not taken and when it was taken, the claim was lodged in the first year itself which may be concidental but strongly suggestive of positive existence of an ailment of which the Insured was aware. Based on the detailed history and medical corroboration through Bombay Hospital case papers it is evident that the symptoms of the ailments were there before the policy was taken and therefore both the charges of non-disclosure of material facts and pre-existence of the disease for which the repudiation has been made by United India. In the facts and circumstances of the case, it is held that the claim of Shri Arun Bavdekar towards his wife's hospitalisation expenses is not tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI 74 of 2004 - 05
Shri Ram Prasad Mukherjee
Vs.
United India Insurance Company Limited

Award Dated 05.01.2005

Shri Ram Prasad Mukherjee who was insured with United India Insurance Company, Divisional Office Vashi had preferred two claims for his hospitalizations at Mahatma Gandhi Mission's Hospital and Appollo Hospital for treatment of Myocardial Infarction and Coronary By-Pass Surgery which was done for the period from 18.1.2003 to 25.01.2003and 12.03.2003 to 21.03.2003 respectively. The Company based on the opinion of their panel doctor repudiated the claim invoking clause 4.1 and non disclosure of the material fact. Shri Mukherjee represented to the Company and not receiving any favourable reply from the Company, Shri Mukherjee approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim of Rs. 1,05,000/- The records have been perused and the parties to the dispute were heard. All records available with this Forum, which includes documents received and written submissions made have been gone through in detail. The critical analysis of all the issues and the subsequent follow up by both the Company and the Insured of their respective stand points reveal the fact that

the record has been corrected on Shri Mukherjee's protest and request and after the discharge which is important to note.

It will appear that from whatever has been produced before this Forum and not contradicted by actual treatment records of Insured's hypertension being of exactly 5 / 6 months from the date of hospitalisation, it is difficult to accept the contention as such and circumstantially, 9 years duration will prevail. Secondly, the other point being of non-cooperation or non-production of treatment particulars which is proved circumstantially, the Company's viewpoint becomes acceptable. Based on the circumstantial evidence and pre-ponderance of probability, the Company's contention that the claim is not payable is tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI 494 of 2003 - 04
Shri Rasiklal Padia
Vs.
The New India Assurance Company Limited

Award Dated 06.01.2005

Shri Rasiklal Padia was insured under Mediclaim Policy 140501 / 48 / 02 / 00389 with the New India Assurance Co. Ltd. The Policy was for the period from 30.7.2002 to 29.7.2003 and he was having this Policy since 30.7.2001. Shri Rasiklal Padia preferred a claim for his hospitalisation at Bharatiya Arogya Nidhi Sheth Kantilal C. Parikh General Hospital from 07.3.2003 to 17.3.2003 for treatment of Prostatic hypertrophy and micro-surgery TURP. The Company repudiated his claim under clause 5.5 of Mediclaim Policy.

Not satisfied with the decision of the Company he approached the Insurance Ombudsman for redressal of his grievances. A Joint hearing of the parties were held on 18.10.2004 wherein both the Complainant and the representative of the Insurance Company were heard.

All the evidence on record, statements and submission of the parties have been considered and the following analysis would reveal the facts. Dr. Subhash M. Mulimani in his certificate dated 13.5.2003 stated that he was the family doctor for Shri Rasiklal Padia for last two years and that Shri Padia suffered from UTI for which he was treated by him in July 2002 for a week. 'New India' followed up this point with Insured and wanted to have complete record of treatment from the Insured and Complainant Shri Padia which was not submitted despite several attempts made by the Company. Later the Insured was admitted in Bharatiya Arogya Nidhi Sheth Kantilal C. Parikh General Hospital for treatment and he was diagnosed to have Benign Prostatic Hypertrophy (BPH+) Grade II and Cystoscopy c TURP was done on 10.3.2003. The hospital case papers have recorded the presenting symptoms clearly as "increased frequency of urination since 8.9 months" which is a positive sign of Prostatic hypertrophy and easily detected through Ultra Sonography.

In the facts and circumstances as stated above it is held that the claim made by Shri Rasiklal Padia for his hospitalisation expenses under the above Policy is not tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 248 of 2004 - 05
Shri Shantilal Bansilal Chordiya
Vs.
United India Insurance Company Limited

Award Dated 10.01.2005

Shri Shantilal Bansilal Chordiya was covered under a Mediclaim Insurance Policy No.161900 / 48 / 04 / 00260 issued by United India Insurance Co. Ltd., Pune D.O.4. He preferred a claim for Inferior Wall Myocardial Infarction for which he was hospitalised between 16.5.2004 and 25.5.2004 at Grant Medical Foundation Ruby Hall Clinic, Pune. The

complaint for which he approached Insurance Ombudsman's Office was delay in settlement and finally partial settlement of claim which he initially rejected and later wanted to accept "under protest" with a suitable discharge voucher so qualified which the Insurance Company did not accept. As it amounted to repudiation of the claim, representation of the complaint was registered at this Forum under Rule 12 of R.P.G. Rule 1998.

While examining the written submissions of both the Complainant and the Respondent i.e. the Insured and the Insurer it appears that because of positive noting inthe hospital records and discharge summary dated 25.5.2004 of Grant Medical Foundation, Ruby Hall Clinic, that Shri Shantilal Chordiya had a past record of Diabetes and Hypertension for 10 years and was on active treatment the Company wanted to investigate the matter further. The Company, United India, examined the file thoroughly in consultation with their Medical Advisor and taking a comprehensive view decided to settle the claim for an amount of Rs. 1,24,500/- in accordance with the original sum insured of Rs. 83,000/- plus 50% Cumulative Bonus. In other words, they did not consider the increase of sum insured to Rs. 3 lakhs in 1997 and Rs. 5 lakhs in 2000 on the ground of the disease being pre-existing. While this Forum was considering to hear both the parties and adjudicate suitably on the complaint made by Shri Chordiya, it appears that the Complainant Shri Chordiya approached the Additional Consumer Redressal Forum, Pune District, Pune, for redressal of his grievances. This information has now been authenticated before this Forum by producing a xerox copy of the notice issued to United India and the relevant Complaint No.ADDT-151 / 04 dated 01.12.2004 before the Additional Consumer Redressal Forum, Pune District, Pune. In view of this latest development, this Forum is guided by Rule 12 (3) (c) which is quoted below :-

"13 (3) No complaint to the Ombudsman shall lie unless
(c) the complaint is not on the same subject matter, for which any proceedings before any court, or Consumer Forum, or arbitration is pending or were so earlier".

In the facts and circumstances, the complaint of Shri Shantilal Bansilal Chordiya cannot be entertained and accordingly dismissed by this Forum.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 271 of 2004 - 05
Shri Rajiv Shamrao Sangrolikar
Vs.
United India Insurance Company Limited

Award Dated 12.01.2005

Shri Rajiv S. Sangrolikar took a mediclaim policy from United India Insurance Company, Divisional Office, Margao, Goa covering himself, his wife and children for the period 31.8.2000 to 30.8.2001 under Policy No.120602 / 48 / 037 / 000077 / 2000. Smt. Seema R. Sangrolikar, wife of Shri Rajiv S. Sangrolikar complained of chest pain and some discomfort in the month of February, 2001 for which she was taken to Goa Medical College and was treated there. For further investigations on advice of her treating doctor Smt. Sangrolikar was admitted to Wockhardt Hospital, Bangalore in May, 2001 where she had undergone CAG, EP Study and then Radio frequency Ablation. When Shri Sangrolikar preferred a claim to the Company for the said hospitalisation, the Company rejected the claim invoking exclusion clause 4.1 of the policy. Aggrieved by the decision of the Company, Shri Sangrolikar approached the Office of the Insurance Ombudsman. The records of the case have been perused and the parties to the dispute were heard.

It appears that there was serious irregularities in Smt. Sangrolikar for definitely much longer period for failure to generate appropriate electrical impulse in the heart's chamber which caused fatigue, palpitation, shortness of breath, breathlessness, chest pain and fainting spell. It was exactly this irregularity namely ventricular tachycardias, a life threatening heart rhythm which was identified and treated at Wockhardt Hospital. Together

with this the Insured was a known case of having Diabetes Mellitus and was on medicines and insulin dependent.

In view of the above exclusions and strictly based on the facts and circumstances, coupled with investigations which have clearly indicated the ailments and also in line with medical opinion received from Dr. S.S.Morais dated 20th May, 2002, the decision of United India Insurance Company Limited to repudiate the claim on the basis of above exclusion cannot be questioned.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 244 of 2003 - 04
Dr. V. Srinivas
Vs.
The Oriental Insurance Company Limited

Award Dated 13.01.2005

Dr. Srinivas was covered under mediclaim policy issued by The Oriental Insurance Company Ltd. in the year 1999 and in June, 2001 he covered his wife Smt. Vidya Srinivas for a sum of Rs. 3 lakh. The claim arose due to hospitalisation of Smt. Vidya at Hinduja Hospital in November, 2002 for lump in the left breast. When the claim was preferred to the Company, it was repudiated stating that the insured person was suffering from cancer since 1998 which was not disclosed in the proposal form submitted and that the claim was made for the disease which was pre-existing i.e. before the time of taking the insurance. The analysis of the records reveals that this dispute was centering around the issue of non-disclosure of surgical removal of Benign Lump from the right breast of Smt. Vidya Srinivas which the complainant felt was immaterial as it was mere Benign and not malignant and therefore it was not pre-existing as cancer in left breast. Any surgery on the body of a person as also any complications for which treatment has been received in the past is necessary to be declared as an important health condition. Viewed in the context of the findings together with the facts and circumstances, it is not really material to consider whether the cancerous stage existed for which the Insured must declare the status, but all interventions in health condition need to be mentioned. Strictly going by the fact that the insured had a surgery in 1998 i.e. before the policy was taken which was vitally linked with acceptances of the risk, it was necessary to disclose the same for commencement and continutation of the contract and strictly on that ground the repudiation of claim by the Company cannot be questioned.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 434 (A) / 2003 - 04
Shri Vinod Sumatilal Shah
Vs.
The New India Assurance Company Limited

Award Dated 13.01.2005

Shri Vinod S. Shah had been holding a mediclaim policy of The New India Assurance Co. Ltd. and renewing the same without any break. He submitted a claim to the Company for his hospitalisation in Bombay Hospital for acute onset of loss of memory. The Company after referring the matter to its panel doctor informed the Insured that from the Indoor case papers of Bombay Hospital it is clear that he was having Hypertension since 12 years and he was suffering from Transient Ischeamic Attack which is related to Hypertension and no special indoor therapy requiring hospitalisation given and only investigation was done and therefore the claim falls under Exclusion Clause 4.1 & 410 of the mediclaim policy. This Forum has studied the records made available in respect of this claim. The hospital discharge card has summarised the entire episode as Transient Ischeamic Attack (?) or Transient Global Amnesia with treatment given for controlling Hypertension which read 190

/ 110. The hospital papers initially recorded hypertension 12 years which was later altered to 7 years without proper authorisation or any authentication by the hospital authorities which is patently noticeable. Various other investigations were done some of which were unrelated. However, MR Cerebral Angio revealed an infarct in the right MCA territory alongwith mild diffuse cerebral atrophy. The panel doctor of the Company, Dr. Punrandare has mentioned that Shri Shah has suffered Transient Ischaemic Attack which is related to hypertension which was pre-existing. Incidentally, the policy of Insured was in the 10th year and hypertension for 12 years would date back to pre-policy period which was not disclosed and also pre-existing. The correction of the discharge card from Hypertension 12 years to 7 years is palpable as the Indoor case papers were not corrected. In such a situation, it could be reasonably held that this change was made to get the claim established under the policy. The alteration unsupported by any notations or authentication is illegal and unethical. In the facts and circumstances, the contention of the Company that hypertension was pre-existing and some of the tests were done just for the purpose of investigation cannot be questioned.

Mumbai Ombudsman Centre
Case No. IO / MUM / A / 397 / 2004.05
Shri Mukul Chandra Dhar
Vs.
The New India Assurance Company Limited

Award Dated 13.01.2005

Shri Mukul Chandra Dhar and his family was covered under a Mediclaim Policy 140100 / 48 / 02 / 05219 with the New India Assurance Company Ltd. He preferred a claim for Rs. 5,00,000/- being reimbursement of expenses for hospitalisation and treatment of his son Shri Sanjeet Dhar for his Head Injury and drowsiness at Holy Family Hospital from 24.3.2003 to 26.3.2003 and thereafter at Bombay Hospital from 27.3.2003 to 31.3.2003. The Company repudiated the claim invoking exclusion clause 4.8 of the Mediclaim Policy.

Dissatisfied with the decision of the Company the Complainant approached this Forum for redressal of his grievances. After perusal of all documents a joint hearing was held on 07.12.2004 when both the parties were heard. A scrutiny of the Discharge Summary of the Holy Family Hospital where Shri Sanjeet Dhar was admitted it is observed that the patient was under the influence of alochol. In Bombay Hospital case papers it was recorded that the patient was under the influence of alcohol and had a fall. He had history of vomiting with head injury and was kept under observations. The Company gave this claim file for proper analysis by their Consultant Physician Dr. Bakul P. Dhruva M.D. He felt “the alcoholic stupor causes obtundation that leads to imbalance and error of judgement. This finally leads to the fall and consequent head injury”. Dr. M.S.Kamath, Medico-legal Consultant of the Company mentioned that the Insured was under the influence of alcohol and it was mentioned in the hospital case paper that he was a chronic alcoholic. His point was without going into further details, the Company would not be liable to pay for the loss i.e. the expenses incurred in connection with the treatment as per exclusion clause 4.8 of the policy condition. It further appears from the various investigations conducted that the blood chemistry of Shri Sanjeet Dhar was quite adverse in registering high ranges in respect of Bilirubin, Alkaline Phosphatase, Lactate Dehydrogenase, S.G.P.T. (ALT), S.G.O.T. (AST).

In the facts and circumstances as stated above the claim lodged by Shri Mukul Chandra Dhar (since deceased) and the claimant Shri Sanjeet Dhar for his hospitalisation expenses is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 686 of 2003 - 04
Shri Arvind M. Shah

Vs.

The United India Insurance Company Limited

Award Dated 17.01.2005

Shri Arvind M. Shah alongwith his wife Smt. Amrat A. Shah and son were insured with the United India Insurance Company Limited, Malad D.O. since 1999. Smt. Amrat A. Shah was admitted to Bombay hospital from 18.10.2002 to 28.10.2002 for ILD Pul. HTN, RVH, Micro Vascular angina. When the claim was preferred by her for the said hospitalisation the Company referred the matter to their panel doctor, Dr. M.S.Kamath and based on his opinion repudiated the claim by letter dated 5.2.2003. On Shri Shah's representation also the Company reiterated their earlier stand of repudiation. Agrieved by the decision of the Company, Shri Arvind Shah approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the settlement of his wife's claim.

Records have been perused and the parties to the dispute were heard. The analysis reveals that the Insured Smt. Shah had Interstitial Lung disorder (ILD) with Pulmonary Hypertension and Micro Vascular angina for which she had received treatment following proper investigation in Jaslok Hospital in 1995. The Company obtained hospital records from Jaslok from which it appears that she had lung biopsy and CT Scan of Lung and the disease was diagnosed as ILD (Interstitial Lung Disorder). Further analysis of Indoor case papers reveals that Insured Smt. Amrat A. Shah had Asthma since 6 yeaRs.

In the facts and circumstances as there is clear evidence of the Insured suffering from Asthma, breathlessness, Lung and Pulmonary disease which was not declared while taking the policy in 1999, the decision of the Company to repudiate the claim is in order.

Mumbai Ombudsman Centre

Case No. IO / MUM / GI - 512 of 2003 - 04

Smt. Brijesh Dharamchand Jain

Vs.

The United India Insurance Company Limited

Award Dated 17.01.2005

Smt. Brijesh Dharmachand Jain who was insured with United India Insurance Company Limited, D.O.13 got a chest pain and was admitted to Jaslok Hospital from 16.12.2002 to 18.12.2002 where she had to undergo Angiography and she was advised Coronary Artery Bypass graft surgery. Smt. Jain was then admitted to Breach Candy Hospital and Research Centre from 18.12.2002 to 27.12.2002 where Coronary Artery Bypass Graft was done. When Smt. Jain preferred the claim to the Company for the said hospitalisations, the Company repudiated the claim on the ground of pre-existing disease and non-disclosure of material facts. Not satisfied with the decision of the Company, Smt. Jain represented to the Company and aggrieved for not receiving any response from the Company, Smt. Jain approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement for her claim.

The records were perused and the parties to the dispute were heard. The records made available to this Forum have been carefully analysed and the records indicated very strongly pre-disposing factors throwing up sufficient symptoms for the Insured, Smt. Brijesh D. Jain to disclose her health condition at the time of taking the policy only a year back i.e. December, 2001. Going by the records and the statements made before the doctor coupled with the records of treatment received by Smt. Jain, it is abundantly clear that first of all the diseases were pre-existing as per hospital records which must have been written on the basis of Insured's statement, and secondly there was non-disclosure of material fact quite vital for underwriting the risk. Hypertension for long years coupled with adverse lipid profile as is evident from High cholesterol for which she was under medication, would prove a potential high risk factor for IHD which ultimately she contracted as there is clear nexus between the two ailments and the fact that the disclosure was not made at the time of

proposal without allowing the Insurers, United India Insurance Company Limited to take appropriate underwriting mesures, repudiation of claim by the Company is in order.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 553 of 2003 - 04
Shri Ashok B. Jejani
Vs.
The National Insurance Company Limited

Award Dated 18.01.2005

Shri Ashok Jejani alongwith his wife Smt. Usha Jejani and children were insured with National Insurance Company Limited since 25.2.1999. Smt. Usha jejani was taken to Hyderabad and was admitted to Mediciti Hospital from 07.02.01 to 22.2.2001 for post renal transplant-Benign Mesothelioma. When the claim was preferred to National Insurance Company Limited by Shri Ashok Jejani for the said hospitalisation, the Company repudiated the claim on the ground of non-disclosure of material fact.

Shri Jejani represented to the Company and not receiving any favourable reply he approached this Forum seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs. 3,20,000.

The complaint, alongwith other papers received by this Forum, have been perused and the parties to the dispute were called for hearing.
This Forum has been provided with the case papers of Shat-Ayu Hospital and Research Centre, Nagpur, Grant Medical Foundation, Ruby Hall Clinic, Pune and later of Mediciti Hospital, Hyderabad from where Smt. Jejani had taken treatment.

Further scrutiny reveals that the Insurance was taken first time on 25th February, 1999 for Rs. 1 lac. On next renewal thereafter it was increased by 3 times to Rs. 3 lacs from 25th February, 2000 and per Dr. Mukesh Mishra's remark and confirmation dated 2.5.2000 that patient was hypertensive over last 5.6 yeaRs. It is a proven fact that Hypertension over a long period will damage kidney and therefore, doctors give protection to kidney by means of some good combination drugs for Hypertension. The nexus between Hypertension and Renal Failure is also established together with adverse blood report. However, going by the classical symptoms and recurrent problems as also the advanced stage of Chronic Renal problems, it is established by circumstances and preponderance of probability that the disease was pre-existing alongwith HTN which was not disclosed.

In the facts and circumstances the decision of the Company to repudiate the claim cannot be interfered with.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 403 of 2003 - 04
Shri Yogesh Trivedi
Vs.
The Oriental Insurance Company Limited

Award Dated 19.01.2005

Shri Yogesh Trivedi was covered under a Mediclaim Policy No.2002 / 1111 issued by the Oriental Insurance Company from 03.12.2001 to 02.12.2002. He preferred a claim against Oriental Insurance for medical expenses incurred on Retina detachment operation performed at Aditya Jyot Eye Hospital at Dadar, Mumbai. The Company rejected his claim stating that his claim comes under the purview of Exclusion caluse 4.1. Being aggrieved by the decision of the Company the Complainant approached the Insurance Ombudsman for intervention in settlement of his claim.

A joint hearing of the parties were held on 06.09.2004 when both the parties appeared and deposed their statement. An analysis of the case would reveal that the important issue was

disclosure of Cataract Surgery for Rt. Eye in November 2000. This operation was done prior taking the Mediclaim Policy. The other point is that the Insured was a high Myopic which is also an important fact for disclosure. The contract of insurance is based on the principle of good faith and therefore full disclosure of health status and particularly surgical intervention in the health condition would be a very important declaration, as it would be vital for underwriting of the risk. Non-disclosure of this would be taken as a deliberate suppression of material fact and consequently it would lead to having pre-existing ailment which is excluded from the scope of the Policy. In terms of medical theory high myopic persons could develop many complications after a few years and always become vulnerable for Retina detachment for which this was a material fact for disclosure which was not done.

In the facts and circumstances the decision of the Oriental Insurance Company Ltd. to repudiate the claim on the ground of non-disclosure and pre-existence of ailment under clause 4.1 need not be interfered with. Accordingly, it is held that the claim of Shri Yogesh Trivedi for reimbursement of expenses incurred in connection with his Retina detachment and consequent correction by surgery is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 398 / 2003 - 04
Shri Sandeep Jumale
Vs.
The New India Assurance Company Limited

Award Dated 20.01.2005

Shri Sandeep Jumale along with his parents, wife and daughter Kum. Samruddhi had taken insurance policy for the first time on 28.3.2000 for the period 28.3.2000 to 27.3.2001 for a sum insured of Rs. 25,000/-. Kum Samruddhi was hospitalized at Rajabahadur hospital from 13.12.2000 to 18.12.2000 for Patent Ductus Artenosus. When the claim was filed by Shri Sandeep Jumale for the said hospitalisation the Company referred the file to their panel doctor and based on their opinion repudiated the claim invoking clause 4.3 of the Mediclaim Policy. Not satisfied with the decision of the Company Shri Sandeep Jumale represented to the Company but the Company reiterated their earlier stand of repudiation.

Aggrieved by their decision Shri Sandeep Jumale approached the Insurance Onbudsman seeking intervention of the Ombudsman in settlement of his claim for Rs. 25,000/-. His contention was that he was not aware of this disease and came to know about this disease only after the 2d Echo test done. Records have been perused and the parties to the dispute were heard.

The analysis of the hospital case papers together with investigation reports reveals that Kum. Samruddhi Jumale was suffering from a disease called Patent Ductus Artenosus (PDA) for which she was operated upon. The disease is marked by persistence of communication between the main pulmonary artery and aorta, after birth. It inhibits prostaglandin synthesis which is treated successfully by using drugs. This points out the fact that as a child she lived with it and therefore strongly indicated a congenital status.

As congenital internal disease is excluded from the scope of the policy the decision of the Company to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI 178 / 2004 - 05
Smt. Vasumati S. Bhankharia
Vs.
The Oriental Insurance Company Limited

Award Dated 20.01.2005

Smt. Vasumati Shashikant Bhankharia was covered under the Mediclaim Policy issued by The Oriental Insurance Company Limited, Mumbai D.O.-17. She was hospitalised at Smt. Shushilaben R. Mehta & Sir Kikabhai Premchand Cardiac Institute Mumbai from 18.7.2002 to 27.7.2002 for Triple Vessel Disease (TVD) c HT c DM c CABG x 3 grafts. When Smt. Bhankharia preferred the claim in respect of the said hospitalisation, the Company repudiated the claim invoking clause 4.1 of the Mediclaim policy. Not satisfied with the decision, Smt. Bhankharia represented to the Company but the Company reiterated their earlier decision of repudiation. Aggrieved by the decision of the Company Smt. Bhankharia approached the Office of the Insurance Ombudsman. The records have been perused and the parties to the dispute were heard. On analysis of the entire records submitted to this Forum, it is noticed that Smt. Bhankharia, the insured was admitted in Lilavati Hospital on 5.6.2002 and there was mention of "known case of Hypertension on medicine-irregular (18.20) years and known case of Diabetes Mellitus 18-20 years on medicine". It is true that Smt. Bhankharia has mediclaim Insurance with Oriental Insurance Company since 1988 and policy had earned maximum Cumulative Bonus of Rs. 40,000/-. It has been reported by her that she had received the claim amount from the Insurance Company in 1991 for the treatment received by her for Angina pain (IHD) in 1991. However, there is no record available in this regard either from the Company or from the Insured. Going by the fact that the Insured accumulated Rs. 40,000 Cumulative Bonus and has continuity in Insurance cover, he has demonstrated his abiding faith in the mechanism of insurance. The other point would be that in absence of actual record of treatment for HT and DM received by Smt. Bhankharia and also that an earlier claim was settled by 'Oriental' for Angina pain in 1991 which has not been contradicted or confirmed by the Company because of absence of records, we could take the issue forward and consider the settlement of this claim from a different angle.

The facts of hospital case history cannot be overlooked which is a recorded evidence and keeping this in mind and on the basis of the analysis made in this Award, some consideration to settle the claim atleast on 50% ex-gratia basis would be the best option for the sake of natural justice.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 613 / 2003 - 04
Shri Santosh Kumar Kejriwal
Vs.
The National Insurance Company Limited

Award Dated 25.01.2005

Shri Santosh Kumar Kejriwal was covered under a Mediclaim policy with National Insurance Company Limited, D.O.3, Mumbai since 2002. He was hospitalised at Cumballa Hill Hospital and Heart Institute on 28.11.2002 to 1.12.2002 for IHD c HTN and PTCA c stent to LAD and OM was done on 29.11.2002. When Shri Santosh Kumar Kejriwal put up a claim to National Insurance Company for reimbursement, the same was repudiated by the Company on the ground that as the claim was approximately related to the pre-existing blood pressure, his claim fell under exclusion clause 4.1 of the Mediclaim Policy and as blood pressure was excluded from the policy, the claim was not payable. Not satisfied with the decision of the Company, Shri Kejriwal represented to the Company for reconsideration, but the Company reiterated their earlier decision of repudiation. Shri Kejriwal then approached Ombudsman's Ofice requesting intervention of the Ombudsman, on going through the papers, parties to the dispute were called for hearing.

The scrutiny of the file reveals that the dispute is centering around the exclusions incorporated in the policy viz. Hypertension (Blood Pressure) as per Insured's declaration in the proposal form. The Company National Insurance Company rejected the claim on the

ground that Hypertension was pre-existing as per Insured's declaration as also the recording by the hospital record of HTN being there since 10 yeaRs. The Insured strongly felt that the claim was wrongy repudiated as Cardiac ailment was independent of Hypertension.

The hospital records were perused. The diagnosis was Hypertension with IHD. Further examination revealed that Shri Kejriwal had an adverse lipid profile and was diagnosed to have hyperlipidemia. Hyperlipidemia is characterized by an excessive quantity of fat and increase of lipids in the blood which cause severe occlusion. Adverse lipid profile with Hypertension and obesity of the Insured would act as a strong risk factor for IHD and in Shri Kejriwal's case exactly that has happened. The occlusion of the arteries suggested long standing HTN with adverse blood profile. The Insured has contested that HTN has not caused the IHD but the medical theory proves that HTN strongly associated with adverse lipid profile has the nexus with heart diseases.

In the facts and circumstances the decision of the Company to repudiate the claim on the basis of Hypertension which was excluded in the policy causing Coronary Artery Disease for which Angioplasty was done, cannot be questioned.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 456 / 2003 - 04
Shri Kantilal Gulabchand Kothari
Vs.
The New India Assurance Company Limited

Award Dated 27.01.2005

Shri Kantilal G. Kothari alongwith his wife Smt. Manjula K. Kothari was covered continuously under the Mediclaim Policy issued by The New India Assurance Company Limited, Mumbai D.O.-111800 since 1993. Smt. Manjula Kothari was hospitalised at Colony Nursing Home, Mumbai from 7.1.2003 to 8.1.2003for excision of swelling on scalp. When Shri Kothari preferred the claim in respect of his wife's hospitalisation, the Company repudiated the claim vide letter dated 9.4.2003 invoking clause 4.1 of the Mediclaim policy. Not satisfied with the decision, Smt. Manjula Kothari represented to the Company and aggrieved by the decision of the Company Shri Kantilal G. Kothari approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim. The records have been perused and the parties to the dispute were heard. The examination of the claim papers in line with the hospital case papers reveal that the swelling was growing in size over a period and started paining only sometime before it became fully symptomatic and painful to get it examined by a Doctor and finally operated at the hospital. Evidently therefore, some 9 years back i.e. while the policy was taken in 1993, Smt. Kothari was not aware of any pain, swelling or abnormally growth to mention in the proposal form as a pre-existing ailment which is also corroborated by her attending physican. In the light of this the noting of Dr.Markand V. Bhatt about swelling for 10 years should be seen more as a statement to show that the patient lived with it without any problems. He has precisely mentioned that if increased in size in 5 years and became painful only recently i.e., before hospitalisation. Dr. A.V.Patil of EMC on the basis of which New India declined the claim, has stated on his opinion dated 31.3.2003 that "The swelling was silent for 5 years and then gradually became symptomatic. Though it is true that at the time of inception of the policy in 1993, the claimant would not have thought that she will have to incur expenses for the swelling, it was her duty to disclose the fact about the swelling in the proposal form".

As New India has admitted that she had a continuous policy since 1993 and the claim took place on 7th Jaunary, 2003 i.e. on full completion of 9 years effectively the Complainant's claim for reimbursement is tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 407 / 2003 - 04
Smt. K.L.Manjani
Vs.
The New India Assurance Company Limited

Award Dated 27.01.2005

Shri Lalraj D. Manjani and his wife Smt. K.L.Manjani was covered under a Mediclaim policy No.111200 / 48 / 01 / 15823 issued by the New India Assurance Company Ltd. from 22.3.2002 to 21.3.2003. Smt. K.L.Manjani preferred a claim against the Insurance Company for the hospitalisation of her husband at Jaslok Hospital during the period 01.05.2002 to 12.9.2002 due to a fall and suffering fracture and later on developing Flaccid Quadriplegia. The Company repudiated her claim stating that Shri Manjani fell down due to alochol consumption and the same falls under Exclusion Clause 4.8 Not satisfied with the decision of the Company the Smt. K.L.Manjani approached the Ombudsman's office for redressal of her claim against New India.

A scrutiny of Medical Report and history sheet of Jaslok Hospital reveals that Shri Manjani attended a party where he took 3 / 4 pegs of alcohol. Next day early morning he went to the bath-room for vomiting. While coming back from the bath-room he lost his balance and fell on hisface, after which he was not able to move his hands / legs. There was no history of headache, seizures or loss of consciousness. As per the recorded history, he was suffering from Hypertension since last 30 years and also suffering from Psoriasis since last 35 years but was not on any treatment when he was hospitalised. He had fixed flexion deformity of neck since 30 years but was not diabetic or had any heart disease. He used to take two pillows while sleeping.

As a result of the fall, he had both external and internal injuries. He was diagnosed having Traumatic dislocation of cervical vertebra C3 / C4, Flaccid Quadriplegia secondary to cervical myalgia, Posterior Cervical decompression and anterior cervical fusion. On neurological examination, it was observed that he had flacid quadriplegia with absent deep tendon jerks and mute plantaRs. He had total sensori-motor autonomic disconnection below C4. He had an abnormal respiration. His CT scan of cervical spine showed extension subluxation of C3 over C4 without any fracture, causing severe compromise of spinal canal. Dr.A.V.Patil of Expert Medicolegal Consultancy, appointed by the Company, has observed that as per the documents submitted it is clear that Shri L.D.Manjani was under the influences of alcohol (hangover) when he fell down in the bathroom and thereby sustained injury causing further complications. Therefore the claim becomes non-payable as per clause 4.8 of Mediclaim Policy.

The analysis reveals that the Insured had a number of complications which were not disclosed. Long standing hypertension would cause cardio-vascular disorder and coupled with some deformity existing, he was quite vulnerable for circulatory disorder related diseases. All these diseases were influenced by the existing disorders which were not disclosed coupled with use of alcohol for which the repudiation of the Company is in order in terms of the Policy. In the facts and circumstances, the claim of Smt. K.L.Manjani for reimbursement of expense incurred on account of her husband's hospitalisation is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 452 / 2003 - 04
Shri Sandeep S. Bagalkar
Vs.
The New India Assurance Company Limited

Award Dated 27.01.2005

Shri Sandeep S. Bagalkar was covered under mediclaim policy of the New India Assurance Company Ltd. since 2000. In the year 2002, he was hospitalised in Lilavati Hospital. He was diagnosed as Mild Duodenitis, Grade II Internal Piles. The Branch Office repudiated the claim under Exclusion Clause 4.1 of the mediclaim policy. The Company referred the matter to panel doctor who opined that insured was admitted for Colonoscopy alone, which is an investigative test. The treatment followed by Colonoscopy did not require hospitalisation and can be given on OPD basis, so the claim is not admissible under Exclusion Clause 4.10 of the mediclaim policy.

From the analysis of the case papers particularly the opinions given by the doctors who treated Shri Sandeep S. Bagalkar it appears that Shri Bagalkar had positive existence of some ailments for which he was referred by his attending Physician to Consultant Gastroenterologist Dr. Samir S. Parikh who also attends Lilavati Hospital. On his advice he was hospitalised for thorough scan of the problems in the abdomen and passing stool etc. A close scrutiny revealed that occult blood was there in stool and this came in two consecutive tests. Clinically, it suggested some deeper complications in the gastric system for which investigations were necessary. Endoscopy and Colonoscopy could be done as an outpatient but usually small sedation is given and often patients develop nausea, giddiness and vomiting associated with similar other complications for which effective management and close monitoring becomes necessary. The Company did not consider this letter and instead Dr. Milind C. Padhye advised the Company ro repudiate the claim as hospitalisation was not required as only investigation was done which could have been done as an outpatient. The interesting point is that the Company felt comfortable in getting a specific rejection from their panel doctor instead of getting his views in the form of recommendation on which the Company would apply their mind.

The examination of the above case reveals that the Dr. Parikh, a specialist in the field did the investigation only to diagnose the disease which is the best way to arrive at. The Histopathological report (Biopsy) cleared Shri Bagalkar of any malignancy but the positive existence of the illness was sustained as a result of the study. Viewed in this context, the opinion of the Company's stand that hospitalisation was done only for the purpose of investigation is not sustainable as there was a positive illness for which necessary treatment was given with further advice for appropriate follow-up and therefore the Complainant's claim is tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 727 / 2003 - 04
Shri Girish P. Gowalani
Vs.
The New India Assurance Company Limited

Award Dated 31.01.2005

Shri Girish Gowalani approached the Ombudsman with a grievance that the Insurance Company i.e. The New India Assurance Company Ltd. rejected the claim of his father's hospitalisation by stating that the Insured was suffering from HIV infection and person who are HIV positive are prone for all infections like TB etc. due to immuno compromised state. Shri Pahalajrai B. Gowalani was hospitalised in Raheja Hospital from 02.06.2003 to 07.06.2003 for lung cancer. He was again admitted in Vaze Hospital on 11.06.2003 and Dev Nursing Home from 13.06.2003 to 23.06.2003 for acute hepatitis with pulmonary koch's with hypertension. Shri Girish Gowalani, son of the Insured preferred a claim to the Company for his father's hospitalisation in various hospitals. The Company referred the matter to Medicolegal Consultant for their opinion and they opined that the Insured was

known seropositive i.e. suffering from HIV positive so the claim falls under Exclusion Clause 4.9 of the mediclaim policy.

An examination of the claim papers reveal that the Insured submitted the proposal duly completed and signed dated 06.08.2001 without any record of illnesses and complaints he was having. The Insurance was taken in his 65th year, which was accepted with usual general reports without incisive examination of blood etc. However, the claim has revealed that he was sero-positive and one after the other all complications started when he was a semi-full grown HIV infected. The accepted medical theories and the classical recorded history has documented that immuno suppression and deficiency syndrome will have a series of complications viz. diarrhea, pneumonia, tuberculosis, lung diseases, hepatic disorders and a multiple other diseases. All these are due to dismantle of the immunity which invades the body and gets infested with all kinds of attacks. In view of the conclusive proof through investigations of the Insured's being HIV infected and this being clearly an exclusion under the policy as noted above, the decision of New India to reject the claim is held sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 457 / 2003 - 04
Smt. Hazel D'Mello
Vs.
The New India Assurance Company Limited

Award Dated 31.01.2005

Smt. Hazel D'Mello had taken the insurance policy with The New India Assurance Company Limited for the period 15.3.2002 to 14.3.2003 under Policy No.150104 / 48 / 01 / 04323. Smt. Hazel D'Mello contracted breast cancer in November, 2002 and was hospitalized for the cancer treatment. The claims preferred by her for the said hospitalisation was settled by New India with short payment of Rs. 8,000/-. Further, the said policy was renewed for the period from 21.3.2003 to 20.3.2004 under policy No.150104 / 48 / 02 / 00640 with exclusion of cancer and other related diseases. Smt. Hazel D'Mello was hospitalized on 14.4.2003 for low blood count, platelet count and also for radiation. When the claim was preferred by Smt. Hazel D'Mello the TPA repudiated the claim stating that as cancer and related diseases were excluded claim was not payable. Not satisfied with the decision of the Company Smt. Hazel D'Mello represented to the Company and aggrieved for not receiving any favourable decision she approached the Office of the Insurance Ombudsman seeking intervention of Ombudsman. Her contention was that at the time of renewal of the policy she was forced by the Company that she would be issued policy only with exclusion of cancer and related diseases and if she did not agree the policy would not be renewed. She pleaded to this Forum for settlement of her claim, to remove the exclusion clause as she did not have cancer when she took the policy for the first time, policy be dated 15.3.2003 and the Insurance cover be increased to Rs. 2,00,000. The records have been perused and the parties to the dispute were called for hearing. The examination of the file with related papers reveal that the whole dispute is in respect of initial refusal by New India to renew the existing Policy No.150104 / 48 / 01 / 04323 expiring on 14.3.2003on the ground of high claims ratio, refusal to increase the Sum Insured to Rs. 2,00,000 from 1,50,000 on the expiring policy and New India's willingness to issue the renewal only on their terms to exclude cancer and related ailments under the renewed policy. The fourth issue emerging out of this is New India's inaction and to delay to accept the renewal cheque beyond 7 days and then to issue the renewal to treat the renewal inoperative and the policy a fresh one. Having issued the policy, they cannot back out because of claims lodged under the policy and their action to refuse renewal is squarely on the basis of continued and recurring nature of claim and potentially being claim intensive is clearly an act of opportunism and highly discriminatory underwriting policy which cannot be accepted

from any angle and certainly confronting the principle of 'natural justice'. However, the whole episode pointedly focuses New India's desperate attempt to refuse the renewal and further recurrent claims on their policy. The Forum does not have any intention to meddle into the underwriting policy of a Company while adjudicating on the complaints but this is of a blatant nature not relating to any basic underwriting issue but simply stonewalling the Insured to get renewal and thereby resort to all unhealthy practices only to deny future claims which have already been admitted and settled by them. Accordingly, New India's decision to reject the claim under the renewed policy treated by them as a fresh policy is hereby set aside and the Insured's complaint is upheld.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 648 / 2003 - 04
Shri Shirish M. Bhosale
Vs.
The National Insurance Company Limited

Award Dated 31.01.2005

Shri Shirish M. Bhosale alongwith his family members was covered under a Mediclaim Family Care Flower Policy No.260600 / 48 / 01 / 125 / 740 issued by National Insurance Company Limited through Winner Capital & Credit Ltd. and Safal Concept Marketing Pvt. Ltd., Mumbai for a sum insured of Rs. 1,00,000/- for a period of 5 years from 19.11.1999 to 18.11.2004 by paying a premium of Rs. 21,000/-. Shri Shirish M. Bhosale was hospitalized at Ruby Hall Clinic and Rao Nursing Home from 10.4.2002 to 15.4.2002 for Heart attack. When a claim was preferred by him to Winner Capital & Credit Ltd., the Winner Capital forwarded the file to the National Insurance Company Limited. Not receiving any reply inspite of several reminders Shri Shirish Bhosale approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. It seems from records that various personal lines insurance coves like Mediclaim, PA, JPA orgainzed through the efforts of Winner Capital and further marketed by Safal concept Marketing have run into some administrative problems with some of the public sector Companies including National Insurance Company and The New India Assurance Company for which Winner Capital has been seeking some remedies as also the Insurance companies are taking their defences. This Forum is not in any way concerned with this type of administrative issues or purely underwriting matters as per RPG Rules 1998 and therefore, would neither comment nor adjudicate on the merits of the matter. From the various letters of Shri Bhosale it appears that he received this policy. No details of treatment etc. have been received by this Forum. As the hospitalisation took place in April, 2002 under the Policy issued through Winner Capital by National Insurance Company, the following order is passed to resolve the matter.

(a) Considering all aspects of the matter and having regard to the terms set out regarding processing of claims being through Winner Capital as per the certificate it would be necessary for both these Agencies i.e. Winner Capital and National Insurance Company and also the Marketing Agency Safal Concept Marketing to resolve the matter subject to the terms and conditions of the policy, if not done in the meanwhile.

(b) Consequently the issue of documents etc. should be in the domain of the Insurance Company and Winner Capital without effecting this Forum.

(c) As regards additional expenses like phone calls, follow up expenses etc. this Forum does not pass any order.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 463 / 2003 - 04
Smt. Bharti Jayantilal Vyas
Vs.
The New India Assurance Company Limited

Award Dated 31.01.2005

Smt. Bharti Jayantilal Vyas alongwith her husband Shri Jayantilal Prabhashankar Vyas was insured with The New India Assurance Company Limited, Divisional Office - 110800 since 1998. Smt. Vyas was hospitalized at Sir Hurkisondas Nurrotumdas Hospital and Research Centre from 12.9.2002 to 14.9.2002 for Anginal Pain. When Smt. Vyas lodged a claim under the policy No.110800 / 48 / 08688 to The New India Assurance Company Limited, Divisional Office 110800 for the said hospitalisation, the Company based on the opinion of their panel doctor, repudiated the claim invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision of the Company, Smt. Bharti Jayantilal Vyas represented to the Company and aggrieved by the decision of the Company, Smt. Vyas approached the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of her claim.

Records of the case have been perused and the parties to the dispute were called for hearing on 7.10.2004. The hospital papers reveal that there was a clear diagnosis of the Insured's ailments and at the time of discharge on 3.5.2002 she was advised that CABG will have to be done. The records suggest that the decision to go in for surgery was delayed and in between there was some problem which she has narrated herself that the condition was akin to heart attack. There was chest pain and associated discomfort but no other symptoms to suggest an attack. The diagnosis was Anginal pain which is the result of the neglect of the Insured going by the advice she received in May, 2002. Subsequent claim intimation and hospitalisation did not give any new diagnosis for which hospitalisation was required to have some more tests. In fact the Insured apparently decided to go for a different line of treatment at Saaol Heart Institute and paid a lump sum fee for 1 year treatment. In view of this there was casual approach of the Insured towards the whole episode and the mediclaim policy was utilised only to pay for further set of investigations which could have been avoided and since it was their own choice could have been done as an outpatient.

In the facts and circumstances, the complaint of Smt. Bharti Jayantilal Vyas for hospitalisation at Sir Hurkisondas Nurrotumdas Hospital and Research Centre from 12.9.2002 to 14.9.2002 for Anginal Pain is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 467 / 2003 - 04
Shri V. D. Paranjpe
Vs.
The United India Insurance Company Limited

Award Dated 31.01.2005

Shri Vasant D. Paranjpe with his spouse Smt. Kavita Paranjpe and daughter was covered under a Mediclaim Policy No.120800 / 48 / 01 / 01680 for the period 10.9.2001 to 09.9.2002. He preferred a claim for hospitalisation at National Chest Hospital from 19.3.2002 to 28.3.2002 of his wife Smt. Kavita Paranjpe for breast cancer treatment. His representation to the United India Insurance was turned down on the ground of exclusion clause 4.1 i.e. pre-existing disese. Not satisfied with the decision of the Company the Complainant approached the Ombudsman's office for redressal of his claim.

Dr.M.S.Kamath, Medicolegal Consultant of the Company, in his report states that in the Discharge Card of the Hospital and other papers on file, it is mentioned that the patient was having lump in the left breast for a few weeks prior to admission. It is further mentioned that the patient was a known case of cancer to the right breast and was operated for the same in July 2000.

The analysis of this claim reveals that the Insured was indeed covered under the Group Policy for SBI Card holders with Delhi office of United India. United India, Thane office,

proceeded with the usual formalities and procedures of handling new proposals and they were not expected at that time to go through the details of claims received under the earlier Policy. As a result, on the strength of the application form which recorded the disease and treatment, United India, Thane, D.O.excluded this disease from the Policy which was accepted by the Insured and Complainant without raising any issue of earlier Policy being issued by United India, Delhi Office on which claim was admitted by them. Strictly speaking that was a different contract with SBI Card and United India and as a member, Shri Paranjpe was covered with his wife. he voluntarily wanted to get himself separately covered under a separate policy and only after claim raised the issue with the Company. There is merit in this stand of the Company, United India.

However the case as revealed now would give enough evidence that the family was covered earlier by the same Company and the underwriting instruction of the Company is clear in this regard that such cases would not constitute pre-existing condition. Admittedly Shri Paranjpe has raised the issue only after the claim was rejected and tried to take shelter under the administrative instruction of the Company in regard to treatment of pre-existing cases. Strictly viewed in this context the claim can only merit some “out of Policy Contract” consideration, i.e. on ex-gratia basis at 50% of the admissible expenses incurred by him. Accordingly United India is directed to settle the claim for admissible expenses only @ 50% being settlement on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 465 / 2003 - 04
Shri Mohan S. Pawar
Vs.
National Insurance Company Limited

Award Dated 31.01.2005

Shri Mohan S. Pawar was covered under a Mediclaim Policy No.253501 / 48 / 8500 / 22 for the period from 31.01.2001 to 30.01.2002. He preferred a claim of Rs. 42,809.79 for his hospitalisation and treatment in connection with his heart ailment. The Insurance Company vide their letter dated 01.3.2002 repudiated the claim stating that the disease was pre-existing. Being aggrieved with the decision of the Company the Complainant approached this Forum for intervention of Ombudsman in the matter and resolution of the same.

The analysis of this case along with the hospital records and investigation reports reveal that the patient Shri Mohan Pawar was admitted with chest pain and palpitation. The history recorded states that he had diabetes for 15 years and was hypertensive also for which no duration is noted separately. It was further remarked that he was on insulin which meant that his diabetes was controlled by medicine and he was insulin dependent as well. KEM Hospital recording was IHD with DM and HTN. The certificate issued by Dr. Prakash Kher says Shri Pawar had first IHD on 03.09.2001 and in the same certificate be confirms his diabetes to be since 14 / 15 years and being regularly followed up by him since 3 yeaRs. Rane Hospital recording also corroborates the period of diabetes and also a case of hypertension without specifying the period. They graded him as class III-IV Angina patient as well leading to 2 vessels blockage.

All these objective findings suggest clear evidence of the ailments existing particularly diabetes existing since longtime before the proposal was made. 80% occlusion as was observed cannot occur over a period of a year or so and diabetes for long duration is bound to cause blockages in the arteries leading to IHD. The medical theory about diabetes and the prognosis is indeed quite favourable to having Ischaemic Heart Disease over a period and coupled with hypertension it will hasten the process. The Insured, took the Policy in year 2001 and got admitted in September 2001 which evidently shows that with the type of severity in the disease, it should have been there for quite sometime and as

admitted by all Doctors the long duration of diabetes and being insulin dependent, it only confirmed the pre-existence of the ailment and aggravation of the same by associated hypertension later. Accordingly the decision of the Company to repudiate the claim need not be interfered with. In the facts and circumstances, the claim of Shri Mohan Pawar for reimbursement of hospitalisation expenses in connection with his treatment is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 709 / 2003 - 04
Shri Bharat C. Jain
Vs.
United India Insurance Company Limited

Award Dated 01.02.2005

Shri Bharat C. Jain who alongwith his wife and children were covered under mediclaim policy issued by United India Insurance Company Limited, Divisional Office-1 had approached the Office of the Insurance Ombudsman by seeking intervention of the Ombudsman in settlement of his daughter's claim which was rejected by United India Insurance Company Limited under policy No.0200100 / 48 / 02 / 08201. Kum Dipti Bharat Jain, daughter of Shri Bharat C. Jain was hospitalized at Bombay Hospital on 4.8.2003 to 15.8.2003 for Malignant Hypertension. When a claim was preferred by Shri Bharat Jain to the Company for the said hospitalisation, the Company did not send any reply nor the claim amount, hence he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. Records of the case have been perused and the parties to the dispute were heard From the examination of the records of the hospital together with investigation reports and the comments made by the concerned doctors it appears that Kum. Dipti Jain was admitted with emergency situation when she started feeling discomfort, giddiness and vomiting at house. She was taken to ICCU and the initial recording was severe uncontrolled Hypertension, Azotemia of unknown cause. Malignant Hypertension refers to a form of Hypertension that progresses rapidly accompanied by severe vascular damage which was therefore, quite a sudden and quick development for which the charge of pre-existing disease cannot be levelled for the claim preferred by Shri Bharat C. Jain, the Complainant. Moreover the policy was effective from 31st December, 2001 and hospitalisation took place on 4th August, 2003 i.e. nearly after 2 years of operation for which the point is further established.

In the facts and circumstances the repudiation of United India Insurance Company Limited on the ground that the disease was pre-existing is not sustainable with the hospital records pointedly mentioning the detection of Hypertension only three months back.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 460 / 2003 - 04
Shri Jasbir Singh Narula
Vs.
Oriental Insurance Company Limited

Award Dated 02.02.2005

The Insured, Smt. Gurjit Kaur Narula approached Insurance Ombudsman with a grievances that the claim for her husband's hospitalisation for Angiography in Institute of Cardio Vascular Disease at Chennai and at Wockhardt Hospital, Mumbai, for C.A.B.G. was not settled by the Company which was a genuine claim and that it should be settled by the Company. Smt. Gurjit Kaur Narula and her family members were covered under mediclaim policy of the Oriental Insurance Company Ltd. since 05.06.2002 and on 22.8.2002 she preferred a claim for her son's hospitalisation at Madras Medical Mission for coarctation of aorta. After scrutiny of the discharge card, the Company came to know that the Insured

was suffering from congenital heart ailment and the ailment being congenital and the insured being fully aware of the said disease, the claim fell under Exclusion Clauses 4.1 and 4.2 of the mediclaim policy for which it was repudiated by the Company.

The disease was of such nature that the non-disclosure looked deliberate to constitute a malafide intention. On Shri Narula's request the Company agreed to issue a policy to him and his wife that is clearly after the first policy was declared void and cancelled mid-term well before the expiry date. The earlier policy issued as a group and Family Cover ceased to operate and became in operative and therefore, Shri Narula's belief and insistence that the policy was continuous is not correct and of no consequence. In the context of the claim lodged by Shri Narula for CAG and CABG in hospital, Chennai and Wockhardt hospital, Mumbai, would be considered in the light of the policy issued from 29.04.2003 and the claim lodged by Shri Narula within one month would evidently lie outside the scope of considertion being under the exclusion clause of falling within a minimum waiting period.

As per medical history and established theory the type of heart ailment Shri Narula had and the invasive nature of complications which resulted in three arteries blockage would be a long-standing complication. Moreover, going by the fact that since the beginning there was patently a non-disclosure about the health condition of his son and his earnestness to get him covered at least by the Company after the policy was cancelled pointed to some unfavourable intention as per clause 5.7 as also coming under 30 days waiting period exclusion clause to be ineligible to the claim. In the facts and circumstances, the decision of the Oriental Insurance Company to repudiate the claim of Shri Narula cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 581 / 2003 - 04
Shri Mukul M. Mehta
Vs.
National Insurance Company Limited

Award Dated 03.02.2005

Shri Mukul Mehta had taken insurance cover for the first time for himself, his wife, children and his mother for the period 31.12.2001 to 30.12.2002 which was renewed further for 31.12.2002 to 30.12.2003. Smt. Rekha M. Mehta mother of Shri Mukul Mehta developed eye problem and she was admitted to Aggarwal Eye hospital from 8.5.2003 to 9.5.2003 and was operated for LE Phacoemulsification c Antiglaucoma under Local anesthesia on 8.5.2003. When Shri Mukul M. Mehta preferred a claim to the National Insurance Company Limited for the said cataract surgery, the Company repudiated the claim stating the Cataract + Glaucoma cannot develop in a short span of 1 year and 6 months. Hence they invoked clause 4.1 of the mediclaim policy being the disease pre-existing. Not satisfied with the decision of the Company, Shri Mehta represented to the Company and approached the Insurance Ombudsman seeking intervention of the Omubdsman to settle his claim.

The records have been perused and the parties to the dispute were called for hearing. The case papers together with investigation reports and findings clearly reveal that Smt. Mehta had developed Cataract for quite some time and as per the certificate of Doctor Aggarwal it was overgrown and "hyper mature". As Cataract was evidently pre-existing and became the proximate cause for Glaucoma, rejection of the claim by National Insurance Company is sustainable since the policy was effective only for 18 months.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 324 of 2003 - 04
Shri Atul Amratlal Kamdar
Vs.
The Oriental Insurance Company Limited

Award Dated 08.02.2005

Shri Amratlal Keshavlal Kamdar was covered under the mediclaim policy of the Oriental Insurance Company Ltd. He was hospitalised in Lilavati Hospital for Isheamic Heart Disease and Coronary Artery Disease. After hospitalisation, he submitted his claim to the Company for reimbursement of the expenses. The Company referred the matter to its panel doctor and after receiving his views the Company informed the Insured that in the indoor case papers of Lilavati Hospital it has been mentioned that the patient had diabetes since 6 yrs and diabetes is the proximate cause for IHD and therefore, it is pre-existing and falls under Exclusion Clause 4.1 of the mediclaim policy. The analysis of the claim file together with the hospital case papers of Suchak Hospital and Lilavati Hospital for the claims lodged by Shri Atul Amratlal Kamdar reveals that arising out of a clear noting of the history by the hospital authorities in respect of previous ailments of Shri Kamdar i.e. diabetes for 6 yrs, the claim has been repudiated by The Oriental Insurance Company Ltd. The Oriental has given a subsequent statement under their letter of wherein they have defended their action to settle the claim on the ground that diabetes was stated to be 2½ yrs duration under the first claim for which he was hospitalisated in Suchak Hospital. The issue therefore is the exact duration of diabetes in respect of the policy and whether diabetes could be the sole cause for Coronary Artery disease (CAD) and Ishaemic heart disease (IHD). It gives us a further lead for analysis and the first thing which strikes is that the policy was taken in October, 1999 and there was enough disclosure by Shri Kamdar that he had high blood sugar with PP reading 150mg. The Company did notice this but did not take any action and decided to put exclusion for cataract and also note ‘right hand operated with steel rod’ under Smt. Kamdar’s policy only but no exclusion for “diabetes” was put on the policy in respect of Shri Kamdar’s policy. It would therefore, be safely concluded that even after getting an important information on Insured’s health status if the cue is not taken nor probed further, it would be taken to mean that the company has either ignored it or abetted it as of no consequence. Later when the claim is lodged, the Company says they have gone by the duration of 2½ yrs of diabetes and therefore passed the first claim without any problem.

There is small remark in hospital case papers of Lilavati Hospital that he was on T.Aten which indicates Tablet Atenolol which is a drug for Hypertension. A view also could emerge that in one place there is a remark by Doctor that he was on medication for three yeaRs. Normally, the patient is aware of some complications when he was on a daily thereapy and taking this, the Suchak Hospital records of 2½ yrs duration of Diabetes Mellitus comes closer to a correct statement although admittedly there was contradictory noting in Lilavati papeRs. Notwithstanding the analysis made out of the available documents backed up by medical records, it is apparent that the insured was taking some medicines and was having some problems which he did not fully disclose except giving his blood sugar reading which was of course, not further picked up by the Company. Since the recording of the disease and its sole contributory role in causing IHD is debatable, I decide that the claim may be admitted to the extent of 50% only of admissible expenses.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 483 / 2003 - 04
Shri Chandrakant Pannalal Munoth
Vs.
The United India Insurance Company Limited

Award Dated 08.02.2005

Shri Chandrakant P. Munoth who was insured with United India Insurance Company, Branch Office, Panvel had preferred claim for his hospitalization at Smt. Sushilaben R. Mehta & Sir. Kikabhai Premchand Cardiac Institute, Mumbai for the period from 23.11.2002 to 10.12.2002for Coronary Artery Disease. He had undergone PTCA of LAD of 23.11.2002 and CABG x 2 Grafts on 1.12.2002. It is reported that Shri C.P.Munoth was insured with the United India for the last 12 years and in his 11th year of the policy there was a break in

the policy for 12 days. The Company refered the file to their panel doctor, Dr. M.S.Kamath for his opinion and based on his opinion repudiated the claim vide their letter dated 22.10.2003 invoking clause 5.5 and 5.7 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Munoth represented to the Company and aggrieved for not getting any favourable response from the Company, Shri Munoth approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim of Rs. 4,63,863.50 + Interest + Mental Harassment. The records have been perused and the parties to the dispute were heard. As regards, pre-existence of the disease, he submitted that he was not taking any medicines for Hypertension as also for Diabetes regularly. On scrutiny of the file it is established that he was taking some medicines for Diabetes and Hypertension but exact duration was not known. His policy was taken for Rs. 42,000 from 1991 and earned Cumulative Bonus without any claim and later was increased from Rs. 42,000 to Rs. 3,00,000 in 1997. This is an important information and it can be attributed that he became conscious of some positive ailment before this increase which should then be seen with suspicion that he may have done it with an interest to get maximum benefit. Even going by maximum 11 years duration of the illness the policy qualifies for the original Sum Insured unaffected by the increase or further complications of Diabetes or Hypertension which would always be held as non-existing before 1991. He earned 50% Cumulative Bonus on this and therefore, Rs. 63,000 Sum Insured was available for the Insured to get his claim reimbursed. Since the conclusive proof of the charge of having Diabetes or Hypertension before the policy was taken is not established nor the gross fraudulent intention has been proved beyond doubt, I decide that the Company's total rejection may be set aside to temper with a partial settlement only.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 487 of 2003 - 04
Dr. Sharad Sakharam Deshpande
Vs.
The New India Assurance Company Limited

Award Dated 08.02.2005

Dr. Sharad S. Deshpande was covered under mediclaim policy since 1994. On 26.12.2001 there was a seminar at Pratap Center of Philosophy, Amalner where he was called as chief guest and while walking he stumbled against a hidden stone under the red carpet and his left knee hit against cement parapet. He was immediately shifted to Manushree Surgical Hospital under care of Dr. Sonawane, Orthopaedic Surgeon who gave the necessary treatment and advised for knee operation. Dr. Deshpande returned to Pune on 27.12.2001. After hospitalisation, the claim for reimbursement of hospitalisation expenses was submitted to the Company. The Company investigated the matter through Shri Vinod Inamdar from M/s. Insight Intelligence as Investigator who submitted his detailed Investigation reports. After getting his reports the Company informed the Insured that the date of accident is not covered under the policy and the claim fell under Exclusion Clause 4.1 of the mediclaim policy.

The dispute for which the claim has not been considered is only relating to actual effective date of renewal or insurance cover effected after the gap of almost one month and the date of claim occurring under the policy. The Insured Dr. Deshpande has admitted that he delivered the Key note address in the Inaugural day i.e. 26th December and he had no intention to stay on. Shri Vinod Inamdar of Insight Intelligence has vividly explained how he did not receive any co-operation from the autoirities who conducted the Seminar at Amalner and all were trying to maintain silence initially and on being pressed asserted that the accident took place on 27.12.2001 and Dr. Deshpande was shifted the same day. On persistent request and interrogation by the Investigator Shri Inamdar, Dr. Kulkarni has admitted the fact of Dr. Deshpande's admission and treatment on 26.12.2001 and the railway authorities have confirmed that Dr. Deshpande had a confirmed reservation in

Maharashtra Express on 27.12.2001 which left Jalgaon in the evening. This has been confirmed by Dr. Deshpande himself. Based on this it is evident that he took his insurance cover post-haste on 27.12.2001 by mid-day and therefore, the decision of the company to repudiate the claim lodged by the Insured Dr. Deshpande is in order. As regards exclusion of diabetes and hypertension from the new policy this Forum will not pass any order except to observe that it is noticed that after the break in Insurance the company has taken it as fully a new Insurance and has gone by their underwriting consideration which may be taken up separately with them on which this Forum will not adjudicate.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 477 of 2003 - 04
Shri Anand Elia Maben
Vs.
National Insurance Company Limited

Award Dated 10.02.2005

Shri Anand Eila Maben was covered under mediclaim policy issued by the National Insurance Company Limited under Policy No.260301 / 48 / 02 / 8505612. Shri Maben was hospitalized for Coronary Angiography and ECHO 2D at Lilavati Hospital on 21.3.2003. When he preferred a claim for the reimbursement of expenses incurred in connection with the investigations the claim was rejected by National Insurance Company on the ground that hospitalisation was for less than 24 hours and also that it was done solely for investigation purpose and therefore, repudiated the claim under clause 4.10. The claimant made representation to the Company which was also not considered. He then preferred an appeal to the Office of the Insurance Ombudsman. The entire records were perused and parties to the dispute were called for hearing.

It appears, on critical analysis of the claim papers, that Shri Anand Maben was covered under the Insurance Mediclaim Policy since 1994 and there was no break in insurance coveRs. The policy was initially for Rs. 60,000/- which was increased to Rs. 1 lac in January, 1997 and further increased to Rs. 3 lacs in January, 2001. Shri Maben has not preferred any claim in the last 10 years and he preferred only the claim for CAG and Echo 2d which was rejected. The issue is whether CAG was done under medical advice and was necessary to be done because of positive existence of illness and if so whether hospitalisation was also done. It seems Shri Maben had chest pain which was examined and he was referred to a Consultant to rule out any cardiac problem. It was obviously an evaluation of his health status when the invasive investigation like angiography was advised apart from Echo cardiogram.

Considering the entire facts of the case and the apparent genuineness as manifested from the submissions made by the Insured and going by the fact that CAG should always be conducted through proper medical management and controllable environment, I decide that the complaint of Shri Anand Maben is sustainable and claim should be settled in full.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 716 / 2003 - 04
Shri Vasant Narayan Gadre
Vs.
National Insurance Company Limited

Award Dated 10.02.2005

Shri V.N.Gadre was insured under the policy issued by National Insurance Company Ltd., Mumbai Policy No.250800 / 48 / 01 / 8501657 and he preferred a claim against the National Insurance Co. Ltd. for the treatment received in connection with Prostrate Hypertrophy, which included certain diagnostic tests for a sum of Rs. 5160/- only. However the Insurance

Company rejected the claim on the ground that there was no hospitalization for more than 24 hours and that the tests were conducted only for diagnostic purpose which were not payable under clause 4.10 of the Policy. He felt aggrieved with the decision and since his representation was also not considered, he approached the Office of the Insurance Ombudsman for redressal of his grievances. On appropriate examination of the case, it appears that the dispute is quite clear in so far as it relates to the fundamental issues as to whether the diagnostic tests carried out for genuine complaints and ailments claim would be payable under the terms of the Policy. The company has taken shelter under clause 4.10. The clause confirms that there should be a compulsion for hospitalization as it is evident from the expression “for which confinement is required at a Hospital / Nursing Home”. As it would be seen the necessary element of the clause is the fundamental issue viz, whether the confinement or hospitalization was necessary or not, as otherwise, the diagnostic tests because of presence of an ailment would not be justified and therefore no reimbursement would be possible.

The mediclaim insurance policy is designed to cover strictly the claim arising out of hospitalization and the relevant expenditure incurred as a result of treatment received in the hospital in respect of ailments, which is covered under the terms of the policy. The Insured made a strong point that although he was insured since last 4 years from the date of hospitalization, he did not lodge any claim except the one for his prostrate problem. The Company rejected the claim on the ground of Exclusion Clause 4.10. The company on their part confirmed that since there were only tests carried out and the Insured had a claim free 4 years policy, they decided to pay 1% of the Sum Insured i.e. Rs. 750/- as per medical check up facility available under the policy. Considering all these factors, the decision of the company to reject the claim on the ground of Exclusion Clause 4.10 cannot be questioned and the payment made by them for health check up expenses is considered appropriate. The complaint of Shri V.N.Gadre for payment of his claim for Prostrate Hypertrophy and related investigations and treatment under his Policy against National Insurance Company Ltd. is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 479 / 2003 - 04
Shri Sushil Kumar Thapliyal
Vs.
The Oriental Insurance Company Limited

Award Dated 11.02.2005

Shri Sushil Kumar Thapliyal and his wife Smt. Vimla Thapliyal was insured with The Oriental Insurance Company Limited, D.O.3. Smt. Vimla Thapliyal was hospitalized for chest pain at Dr. Balabhai Nanavati Hospital from 20.6.2003 to 21.6.2003 and had undergone CAG on 20.6.2003. When Shri Sushil Kumar Thapliyal lodged a claim for the said hospitalisation under the policy No.121200 / 48 / 04 / 831 to The Oriental Insurance Company Limited, the Company repudiated the claim on the ground that it fell under exclusion clause 4.10 Aggrieved by the decision, Shri Sushil Kumar Thapliyal represented and not receiving any reply Shri Sushil Kumar Thapliyal approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim. Records were perused and the parties to the dispute were called for hearing. The dispute is regarding the Company treating the admission to hospital specifically for CAG is solely for investigation purposes.

The analysis of the claim file reveals that the Insured Smt. Thapliyal was getting breathlessness, chest pain off and on with occasional vertigo for which the attending Doctor suspected unstable angina. In order to rule out Cardiac problems she was advised to get herself admitted to Nanavati Hospital specifically for Coronary Angiography. The point to note would be that the Investigation was pre-determined and the fact that claims

were being lodged earlier to evaluate her health status proved that the treatment methodology was apparent. It is true that CAG is the only device to evaluate heart problems and in that context only through investigation proper diagnosis can be done. The fact of monitoring and medical management of CAG cannot be ruled out and the Insured did have some ailments for which she got referred by her Doctor. In fact hospital record says she was hypertensive. However, as it was solely and specifically for CAG which was determined and directed to be done without the findings of actual complications, it fell within the provisions of 4.10 as applied by the Company. Nevertheless since the Investigation was done, the patient passed through all tests including invasive insertion of catheterization and fulfilled other parameters of the provisions coupled with need for management and she did have Hypertension as a positive ailment, I decide that 50% of the admissible expenses should be granted to her.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 500 / 2003 - 04
Shri Rajendra Yashwant Damle
Vs.
The Oriental Insurance Company Limited

Award Dated 11.02.2005

Shri Rajendra Yashwant Damle who alongwith his wife and son was insured with The Oriental Insurance Compnay Limited, M.C.D.O. 8 had preferred a claim to The Oriental Insurance Company Limited for his hospitalisations at Dhanwantari Hospital and Cumballa Hill hospital for IHD and DM for the period 18.7.2003 to 22.7.2003. The Company based on the opinion of their panel doctor repudiated the claim invoking clause 4.10 of the mediclaim policy. Shri Damle's representation to the Company was also turned down. Aggrieved by the decision, Shri Rajendra Damle approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim. Records were perused and the parties to the dispute were called for hearing. The scrutiny of the claim file with all the records available with this Forum and the analysis in the particular case reveals that he had ECG changes and the CAG report gave Ramus-60% Stenosis and left Circum 70% lesion and 60% tubular lesion distally. Other aspects were normal and diagnosis was double vessel disease. There was evidently some complications which needed to be corrected and though the Insured took the route of medical management through therapy it was his individual judgement which must have been approved by the concerned cardiologist. The Company cannot question as to why he did not necessarily have Angioplasty or CABG following CAG investigation and under no circumstances it would be pressed upon a person to undergo surgery only to qualify to get the claim. It is to be noted that CAG is an invasive investigation and some patients show signs of adverse reactions which require monitoring of health status for sometime. The procedure was done and it was found that Shri Damle had some existence of heart problem. It is true that CAG is the only device to evaluate heart problems and in that context only through investigation proper diagnosis can be done. The Insured has met the conditions of the policy by getting admitted in the hospital. The fact of monitoring and medical management of CAG cannot be ruled out and the Insured did have some ailments for which he was referred by his Doctor. Nevertheless since the Investigation was done, the patient passed through all tests including invasive insertion of catheterization and fulfilled other parameters of the provisions coupled with need for management, the above claim of Shri Rajendra Yashwant Damle is tenable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 542 / 2003 - 04
Shri Rohinton Badha
Vs.

The Oriental Insurance Company Limited

Award Dated 14.02.2005

Smt. Kety Badha mother of Shri Rohinton Badha was hospitalized at Sanjeevani Hospital and at B.D.Petit Parsee General Hospital during the period 3.3.2003 to 13.3.2003 for Heart attack and she expired on 13.3.2003 at B.D.Petit Parsee General Hospital. When a claim was preferred by Shri Rohinton Badha to the Company for the said hospitalisations, the Company referred the matter to their panel doctor and based on the opinion of their panel doctor repudiated the claim invoking clause 4.1 of the mediclaim policy. His representation to the Company was also turned down and hence he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman. Records of the case have been perused and the parties to the dispute were called for hearing on 14.12.2004.

On examination of the relevant records it appears that 'Oriental' took the Insurance proposal from Smt. Badha for the first time when she was 72 years old and therefore decided to get her medically examined through usual investigations including ECG. The procedure was done through Sehat India Health Care and the reports were normal. In fact the comments which were made by Sehat India may be regarded as specialist's comments who are being consulted by 'Oriental' before acceptance of the proposals. The ECG report was remarked "normal" although there was some adverse comment about her'Obesity'. Oriental issued the policy without any exclusions despite the age factor of the Insured. It would appear therefore that Oriental did underwrite the risk consciously with full application of mind. 'Oriental' later questioned the ECG findings and got the tracings examined by a Specialist Cardiologist after the death of the insured and rejection of the claim by them. All investigations like Lipid profile, ECG report etc. were done by their nominated Pathological outfit and it was upto them to throughly scrutinize those. If they have not done so, it would be taken that they had no reason to doubt the scrutiny done by Sehat. As no exclusions were also put on the policy it is felt that Oriental believed her to be a normal risk. Yet as per medical opinion later obtained there was problem and since those appeared even in ECG, the CAG would have revealed some more problems. Under the circumstances, the Company's decision to repudiate the claim should be tempered with partial settlement of the claim to the extent of 50% of admissible expenses incurred by Complainant Shri Rohinton Badha for treatment of his mother.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 459 / 2003 - 04
Shri Prakash K. Parmar
Vs.
The Oriental Insurance Company Limited

Award Dated 15.02.2005

Shri Prakash Parmar was insured with The Oriental Insurance Company Limited, Panvel Divisional Office since 1998. Smt. Pramila Prakash Parmar wife of Shri Prakash Parmar was hospitalized at Bombay Hospital from 14.12.2002 to 19.12.2002 for HCV (Hepatitis C). When the claim was preferred by Shri Prakash Parmar for the said hospitalisation the Company based on their panel doctor's opinion repudiated the claim invoking clause 4.1. Not satisfied with the decision of the Company, Shri Parmar represented to the Company alongwith a certificate given by the treating doctor, Dr. J. S. Sorabjee, but the Company reiterated their stand of repudiation. Aggrieved by the decision Shri Parmar approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim.

The records of the case have been perused and the parties to the dispute were called. Based on the analysis it is felt that both the Insured and the Company must share the consequences of the claim in equal proportion and I decide that in absence of conclusive proof of the Company's charge of infected blood transfusion and the Insured's being

singularly affected by this cause without any other cause, the equity would demand at least 50% settlement of claim on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 469 of 2003 - 04
Shri Kishore N. Shah
Vs.
National Insurance Company Limited

Award Dated 17.02.2005

Smt. Zilpa K. Shah was first admitted at Rushabh Nursing Home for conservative management of acute Appendicitis with Renal Calculus. Repeat Sonography of whole abdomen revealed Renal Calculus with pregnancy of six weeks. She was readmitted to Rushabh Nursing Home for appendectomy and medical termination of pregnancy (MTP) as reportedly the foetus may have suffered damaged due to investigations particularly BaMeal etc. After completion of MTP and laparoscopic sterilisation i.e., Tubeligation (TL) appendectomy was to be done but it was abandoned as she developed Pulmonary Oedema and serious complications, she was shifted to Suvarna Hospital for ventillatory support and intensive care. Finally, she was transferred to Hinduja Hospital for treatment of Acute Respiratory Distress. The Insured preferred a claim to the Company after her hospitalisation for a sum of Rs. 1,94,826/-. The Company referred the file to Dr.Ismail B. Bandookwala for his medical opinion and he opined that the voluntary termination of pregnancy falls under the exclusion clause 4.12 / 4.12.1 of the policy and the sterilisation falls outside the purview of the mediclaim policy as it is the treatment neither of any disease nor injury. Accordingly, the Company settled the claim for Rs. 29,874/-. Again Company referred the matter to Dr. Fardun Dastur, for his opinion and he upheld the decision of Dr. Bandookwala.

Smt. Zilpa K. Shah was primarily to be treated for Appendicitis and Appendectomy was suggested. The diagnosis were made through Ultra Sonography (USG) which also revealed renal calculus in the Pelvic Ureterine junction. It is somewhat unintelligible as to how six weeks pregnancy could not be detected earlier even through investigations, granting that the Insured was unaware of the same. However, it has been mentioned later that six weeks gestational pregnancy was detected whilst in the Rushabh hospital for Appendectomy. As per the narration it appears that the MTP with Sterility Surgery i.e. Tubeligation (TL) was taken up and completed but as the patient developed serious complications leading to Pulmonary Oedema the rest of the operation procedure i.e. Appendectomy was abandoned. The patient was shifted to Suvarna Hospital for ventillatory support and intensive care for a couple of days but as the condition worsened she was shifted to P.D.Hinduja Hospital for further management for treatment of Acute Respiratory Distress. The Company has rejected the claim for MTP and also the subsequent treatment following complications of respiratory distress arising out of Pulmonary Oedema. However, the exclusion clauses are quite clear in their scope as not to cover any expenses incurred relating to treatment of pregnancy through the expression “arising from or traceable to pregnancy” and therefore the exact cause would not be material for consideration of the claim. Accordingly, the decision of the Company to pay Rs. 29,874/- being the relevant amount admissible as per policy is in order. In any case, the exact contribution of pregnancy related ailment cannot be evaluated easily and therefore, a rational view would be to grant at least 50% of the expenses incurred at Hinduja Hospital to the Insured.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 609 / 2003 - 04
Shri Brijendra Sunderlal Mehta
Vs.
The New India Assurance Company Limited

Award Dated 18.02.2005

Shri Brijendra Mehta took an insurance cover alongwith his wife Smt. Charulata Mehta for the first time in 2000 and at the time of proposing for insurance he had disclosed that his wife had undergone hysterectomy, hernia and appendicitis and the Company had excluded these diseases from the policy. Smt. Charulata Mehta had pain and swelling for which she was hospitalized at Kamala Polyclinic and Nursing Home 10.4.2003 to 16.4.2003 for Laparatomy-Adhesionolysis + Repair of abdominal wall with prolene mesh. When Shri Mehta preferred a claim of Rs. 54,786.13 for the said hospitalisation, to the Third Party Administrator i.e. M/s.Paramound Health Services Pvt. Ltd., they repudiated the claim vide their letter dated 14.8.2003 stating that the present complications were due to previous surgery and hence the claim was not payable. Aggrieved by the decision of the Company, Shri Mehta represented to the Grievance Cell of the Company and not receiving any reply from the Company he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim.

The records of the case have been perused and the parties to the dispute were heard on 10.2.2005.

In the face of the specialist's observations and critical comments received by New India duly corroborated by actual surgical procedure it is apparent that past surgery had certain deficiency which also caused abdominal wall weakness and therefore, it can reasonably be argued that the present claims were all due to past incision / surgery and therefore, pre-existing. The policy exclusions are also apparent under Smt. Mehta's policy to exclude these types of ailments.

In the facts and circumstances the decision of the Company to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 755 of 2003 - 04
Shri Mahesh C. Ajmera
Vs.
The Oriental Insurance Company Limited

Award Dated 21.02.2005

Shri Mahesh C. Ajmera was covered under mediclaim policy since 06.10.1999. He experienced uneasiness and restlessness and consulted Dr. J. Parekh, Cardiologist who advised Stress Test and also Coronary Angiography. He underwent hospitalisation for evaluation of heart ailment at S.R.Mehta Cardiac Institute. Shri Mahesh C. Ajmera preferred the claim and when the claim arose the Company referred the file to its panel doctor, Dr. M.S.Kamath and he opined that in the indoor case papers it is mentioned that the insured was admitted for CAG which is basically a diagnostic test. The final diagnosis in the discharge summary is Stress Test Positive for Ischaemia. Therefore, he opined that the claim fell under Exclusion Clause 4.10 of the Mediclaim policy. It is nodoubt a fact that Shri Ajmera, the Insured under the policy, was specifically admitted to the hospital for Coronary Angiography (CAG) to evaluate the exact nature of heart ailment with assessment of stenosis of arteries. Strictly speaking therefore there was no critical emergency necessitating immediate hospitalisation and emergency treatment. In fact the doctors suspected some complications and wanted to evaluate the same through Stress Test and if necessary CAG. The Stress Test was positive for Ischeamia and the CAG showed normal results and small blockage of 40% LAD which going by the age of Shri Ajmera was quite normal. He had no Hypertension, no diabetes and had no history of chest pain, palpitation and sweating. There was no knowledge about any adverse family history and the lipid profile was also not available for examination by this Forum. Doctor's and Nurse's notes clearly indicated that the patient was admitted only for CAG.

In view of the above conclusive evidences it was clear that Shri Ajmera wanted to evaluate his health status particularly whether he was suffering from any heart ailments or not. It was therefore clearly for diagnostic purpose that he decided to get admitted to the hospital and the entire hospitalisation was utilised only for Stress Test and CAG. There was no criticality, no emergency for getting admitted in hospital also. Accordingly, in terms of Exclusion Clause 4.10, the Company's repudiation is in order.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 424 of 2003 - 04
Shri Suhas G. Kulkarni
Vs.
The New India Assurance Company Limited

Award Dated 21.02.2005

Shri Suhas G. Kulkarni alongwith his parents was covered under the Mediclaim policy since 1993 with The New India Assurance Company Limited, Divisional Office-112500. When Shri Suhas Kulkarni preferred a claim of Rs. 3,43,710 for his father Shri Ghanshyam Kulkarni's hospitalisation at Breach Candy Hospital from 28.8.2000 to 06.09.2000 for Coronary By-Pass Graft, the Company settled the claim on 05.03.2001 for Rs. 17,996. The Company also excluded Hypertension and Diabetes under policy No.112500 / 48 / 99 / 06248. Aggrieved by the decision of the Company, Shri Kulkarni represented to the Grievance Cell of the Company but the Company reiterated the decision taken by the Divisional Office. Hence he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim. The records of the case have been perused and the parties to the dispute were heard. The analysis of the complaint together with relevant records made available to this Forum reveals that the Complainant held the view that when hospitalisation takes place the post hospitalisation amount would be already to his credit for spending maximum amount available which is not correct. The interpretation would be that any time the hospitalisation takes place which is an important interpretation earlier hospitalisation would cease with second hospitalisation and treatment cost incurred till that time would constitute for payment under post hospitalisation head of account.

Based on the facts and circumstances of the case the decision of the Company to settle the claim for Rs. 17,996 appears to be in order.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 350 / 2003 - 04
Shri Noshir B. Umrigar
Vs.
The Oriental Insurance Company Limited

Award Dated 22.02.2005

Shri Noshir B. Umrigar took mediclaim policy from 1.9.2001 to 31.8.2002 from The Oriental Insurance Company Limited, D.O.8. It is reported that earlier to this he was covered under the mediclaim policy issued from the Divisional Office-IV of the Oriental Insurance Company. Shri Umrigar was hospitalized at Breach Candy Hospital on 29.5.2002 to 30.5.2002 for Coronary Artery Disease. When Shri Umrigar preferred a claim for the said hospitalisation, the Company based on the opinion of their panel doctor, rejected the claim vide their letter dated 13.1.2003 on the ground that the hospitalisation was primarily for diagnostic purpose and invoked clause 4.10 of the policy. Not satisfied with the decision of the company Shri Noshir B. Umrigar represented to the Grievance department of the Company and aggrieved by the decision Shri Noshir B. Umrigar approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his

claim. The records have been perused and the parties to the dispute were called for hearing.

The analysis of the claim file reveals that the Insured Shri Noshir B. Umrigar was suffering from chest discomfort, jaw pain off and on and was getting tired by walking short distance at home, climbing stairs etc, hence his doctor advised him to undergo stress test at Kambala Hill Hospital and then on receiving positive report he was advised by the doctor to go for angiography for which he got admitted to Breach Candy Hospital for Coronary Angiography which was done on 29.5.2002. The procedure was done and it was found that Shri Noshir B. Umrigar had some heart problem. Initially angioplasty was advised but later Shri Noshir B. Umrigar wanted to have the By-pass in U.S. which was later done. No issue can be raised as to why he got it done in U.S., but the fact that he got it corrected by a surgery satisfies the provisions of the clause. The fact of monitoring and medical management of CAG cannot be ruled out and the Insured did have some ailments for which he was referred by his Doctor. Nevertheless since the Investigation was done and the patient passed through all tests including invasive catheterization and fulfilled other parameters of the provisions coupled with need for management, the above claim of Shri Noshir B. Umrigar is sustainable.

As regards non-renewal of the policy it should be mentioned that this Forum is not empowered to go into the underwriting aspects, renewals etc. as per provisions of Rule 12 of the RPG Rules, 1998 and therefore, would refrain from commenting on the propriety or otherwise.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 425 / 2003 - 04
Smt. Aziza Begum
Vs.
United India Insurance Company Limited

Award Dated 22.02.2005

Smt. Aziza Begum who was insured with United India Insurance Company, Divisional Office-13 had preferred a claim for her hospitalization at Keraleeya Ayurveda Samajam Hospital and Nursing Home, Shornur for the period from 25.1.2001 to 23.2.2001 and had undergone treatment for Vatha Vikaram. When Smt. Begam preferred a claim to the Company for the said hospitalisation, the Company repudiated the claim invoking clause of 4.8 (General Debility), 4.1 (Pre-existing) and 4.13 (Naturopathy). Not satisfied with the decision of the Company, Smt. Aziza Begum made representation to the Grievance Cell of the Company and aggrieved by the decision Smt. Began preferred an appeal to the Office of the Insurance Ombudsman. Records have been perused and the parties to the dispute were heard. On examination of the file with the documents provided to this Forum, that it gives enough indication that Smt. Begum received treatment which was a combination of natural treatment which included rest, recreation and certain physical exercises and discipline which are followed in health clubs in particular. Such clubs are now in operation in and around big cities with holiday resorts etc. which are typically not yet brought under the common form of Mediclaim policy. In that context the Company's approach that it covered a lot of areas which are not within the purview of mediclaim policy as per clauses above, cannot be faulted. Yet there was some treatment and definitely some ailments for which though no surgery was required, yet investigations were made, medicines were given and hence the positive existence of an ailment could not be ignored. Viewed in this context, some consideration can be made particularly in absence of Company's inability to put forward strong reasonings for branding the treatment as naturopathy and non-payable.
In the facts and circumstances, United India Insurance Company Limited is directed to entertain the claim of Smt. Aziza Begam for her hospitalisation at Keraleeya Ayurveda Samajam Hospital and Nursing Home, Shornur for the period from 25.1.2001 to 23.2.2001

for treatment of Vatha Vikaram and pay only 25% of the admissible amount of expenses on Ex-gratia basis.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 510 of 2003 - 04
Shri Hiroo Mirchandani
Vs.
The Oriental Insurance Company Limited

Award Dated 24.02.2005

Shri Hiroo Mirchandani covered his family under a Mediclaim Policy issued by The Oriental Insurance Company Ltd., Policy No.48 / 2002 / 3081 since 1998. Master Aashis Mirchandani his son, aged 5 years and 9 months was admitted in the Mata Lachmi Hospital on 3.1.2003 and was discharged on the same day after a surgery, i.e. “Circumcision”. When the claim bill was preferred by Shri Hiroo Mirchandani, Oriental Insurance Company rejected the claim on the ground that Circumcision was not covered under the clear policy Exclusion Clause 4.5 and therefore they regretted their inability to consider the claim. The Complainant, Shri Hiroo Mirchandani was dissatisfied with this decision and preferred a complaint against Oriental Insurance Co. in the Forum of Insurance Ombudsman by his letter dated 28.11.03.

The company has rejected the claim on the ground of specific exclusion clause 4.5 which says that the Policy will not pay for treatment expenses in connection with circumcision. In this case the boy had phimosis and balanopesthitis which is a serious infection causing inflammation of the skin covering the glans penis. This is absolutely an emergency situation where surgery is indicated. It was, therefore, rightly diagnosed and treated and therefore, payable. The company has alleged that the hospitalization was less than 24 hours and that Mata Lachmi Hospital has not given them their Registration Number. It is felt that 24 hours hospitalization need not be stressed in this case at all because of the very nature of the surgery and should be classified alongwith the same category of some other surgery for which the company does not insist on full 24 hours hospitalization. As regards the Registratin number of the Hospital, the company is advised to satisfy themselves that the other conditions as per the definition for Hospital / Nursing home given inthe Policy is satisfied and should be sufficient to proceed with the action in this regard. In the facts and circumstances, the decision of the Oriental Insurance Company Ltd. to repudiate the claim of Shri Hiroo Mirchandani is not tenable. The complaint of Shri Hiroo Mirchandani in respect of hospitalization of his son, Mast. Aashish H. Mirchandani is sustainable and the repudiation of the company is set aside. The company is directed to pay the admissible expenses in this regard.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 636 / 2003 - 04
Shri Jitendra J. Doshi
Vs.
The Oriental Insurance Company Limited

Award Dated 28.02.2005

Shri Jitendra J. Doshi was covered under the Overseas Mediclaim Policy issued by The Oriental Insurance Company Limited, D.O.122300 for 35 days from 20.3.2002 to 23.4.2002 for his visit to Kenya, Nigeria and Dar-es-salaam. Shri Doshi met with a car accident at Dar-es-Salaam on 5.4.2002 and had multiple fractures. He was initially hospitalized at Hindu Mandal Hospital, Dar-es-Salaam and reported the claim to M/s.Mercury International Assistance and Claims (UK), the claim settling agent and also Tower Assistance Ltd. Mumbai. As proper treatment was not possible in Dar-es-Salaam he was permitteed to return to India and as decided by the family he returned to India. He was hospitalized at Sir

Hurkisondas Nurrotumdas Hospital and Research Centre from 9.4.2002 to 27.4.2002 and was operated on 12.4.2002. When Shri Doshi submitted claim to The Oriental Insurance Company Limited through M/s. Mercury International Assistance and claims (UK) & M/s. Tower Assistance Ltd. Mumbai, he did not receive any reply or his claim inspite of several follow up with the claim settling agents and the Company. Aggrieved by the attitude of the Company and the Claim settling agents Shri Doshi approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim.

The records have been perused and the parties to the dispute were heard on 17.8.2004. On analysis of the records it is observed that the policy has been issued by The Oriental Insurance Company Limited and for operational flexibility it was to be administered through Mercury International while 'Oriental' would be fully responsible to ensure complete customer service. Although strictly speaking medical costs incurred abroad out of an emergency situation is only covered by the policy, an extended view of the emergency may be taken in the sense that Dar-es-Salaam is not the best place to get proper medical attention and in a critical case like the one faced by Shri Doshi a deviation necessitated by circumstances can be made. Amongst other things there was a communication from Mercury to Shri Doshi that their team would visit in 5-6 days time. The criticality in the health condition would not have permitted such a stay and more so, possibly better treatment would not have been assured to the satisfaction of the family membeRs. Since accident occurred in Dar-es-Salaam and was covered under the policy, the contract should be completed and therefore, whatever costs have been incurred in Mumbai (Hurkisandas Hospital) for the treatment directly related to the acident occuring in Dar-es-Salaam should be reimbursed by The Oriental Insurance Company as a special case.

As mentioned above as regards the repatriation cost there is a direct correspondence between Mercury and Shri Doshi and it would be in order for Shri Doshi to move the matter further with them through 'Oriental' and Tower Insurance. This Forum indeed cannot adjudicate on this issue and pass an Award against a foreign unit to proceed in the matter which could be infructuous.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 522 / 2003 - 04
M/s. The Metal Printers Company -
A / c- Shri Vishwas Laxman Shetye
Vs.
United India Insurance Company Limited

Award Dated 28.02.2005

Shri Vishwas Shetye is an employee of M/s. The Metal Printers Company. The Insured, Shri Vishwas Laxman Shetye was hospitalized at Abhinav Sushrut Hospital for treatment of Typhoid and he preferred a claim to the Company for reimbursement of the expenses incurred at hospitalisation. The Company appointed an Investigator viz. M/s.V.B.Associates due to some confusion about the date of discharge in the Discharge Card of the nursing home. M/s.V.B.Associates submitted its report to the Company stating that in the indoor case papers the date of stay at the hospital is from 18 / 09 / 02 to 24.09.2002 and charged Rs. 1400/- for 7 days at the rate of Rs. 200/- per day which has been altered to Rs. 2,200/- for increasing another 4 days stay. After getting this report, the Company intimated to M/s. Metal Printers Co. that the claim is repudiated under Exclusion Clause 5.7 of the mediclaim policy.

It appears the entire dispute is resting on the Insured's actual hospital stay which as per discharge card is from 18.09.2002 to 28.09.2002 while the Company claims that there has been an alteration in the date of discharge and he wanted to claim more amount for stay charges possibly with the support of hospital. The hospital authorities have strongly denied the allegation stating that the Insured was actually kept till 27.09.2002 and the correction

was duly authenticated by a signature of the hospital doctor. First of all the daily diary of the nurse from Indoor case papers should have been tallied with the objective of getting the record of treatment for all these dates and to check whether stay was extended which was not done. Secondly, the analysis that the patient gave the sample for pathological investigations is not a critical point as in an enteric fever suspected to be typhoid the patient can go by a transport himself for examination in nearby places. The Investigation reports are also dated beyond 24.09.2002 which could even be considered as post-hospitalisation expenses, if asked for by the doctor. Thirdly, when the hospital doctor offered for thorough investigation the Company could have accepted the same instead of holding on to M/s.V.B.Associates point alone and reject the claim on grounds of fraud. Fourthly, it was necessary to hold the further enquiry as the hospital authority counter-charged that no one from United India or the Investigating Unit visited his hospital. Finally, if the alteration is at the hospital level with initials the change cannot immediately come against the Insured or even the hospital people if the alteration is validly done. This Forum feels that enough grounds have not been put forth to deny the claim on charges of fraudulent intention or wrong substantiation of the claim and also that the charges are not squarely proved beyond doubt to justify rejection of the claim. At the same time, there is some noting which has prompted the Investigator to mention in his report the so - called alteration etc. for which the claim cannot be recommended in full. Hence I decide that claim may be settled for 50% only.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 729 of 2003 - 04
Shri Dhanjibhai L. Shah
Vs.
National Insurance Company Limited

Award Dated 28.02.2005

Shri Dhanjibhai L. Shah took a Mediclaim Policy from National Insurance Company Ltd., D.O.IV, Mumbai, No.250400 / 48 / 02 / 85 / 01119 from 11.7.2001 to 10.7.2002. He was hospitalized for Inguinal Hernia and benign prostrate Hypertrophy at Dr.Sadiwala's Clinic from 11.7.02 to 19.7.02 for surgery (Bilateral Hernia repair and TURP). When he put up his claim for reimbursement of expenses, National Insurance Co. Ltd. rejected the same on the ground that it fell under the exclusion clause 4.3 of the Mediclaim Policy as the diagnosis was done and treatment taken during the first year of the Policy. The Insured Shri Shah contested this opinion and represented which was not considered by the Company on the basis of their consultant's view. He therefore approached the Office of Ombudsman under his letter dated 20.2.04 to lodge his complaint and get the justice. The analysis of the claim file reveals that the dispute is regarding non-settlement of the claim being under first year exclusion clause while the Insured claims it to be payable as it was lodged on the 2nd year i.e, after renewal of the 1st year policy.

The Insured was hospitalized for surgery of Prostrate Hypertrophy and Inguinal Hernia (bilateral). The prostrate showed a small calcification apart from growing in size. The inguinal hernia showed a small hypoechoic mass. The Insured went for consultation on 26.6.02 with Dr. Jariwala who advised him surgery and the next day he got him examined by Dr. Sadiwala who concurred with the views expressed by Dr. Jariwala. His prostrate hypertrophy was evaluated as Grade III. The word hypertrophy indeed by itself says it all, it is 'hyper' which connotes big and not small. The Insured took the policy from 11.7.2001 to 10.7.2002. It is evidently clear from the documents submitted to this Forum that the Insured had a clear diagnosis about his two ailments, i.e. hernia and enlarged prostrate during the policy period and well before the expiry of 1st year insurance. Hence the consultation, investigation and initial treatment were all done in the 1st year only, with only the surgery was delayed to get the benefit on a technical ground and that is why the hospitalization was delayed to coincide with the 1st day of the renewed policy. In the facts and

circumstances, the decision of the Company to reject the claim as being under clause 4.3 having in-built pre-existence of the disease as per the terms of the clause cannot be questioned. In consequence, the complainant, Shri Dhanjibhai L. Shah's claim for reimbursement of medical expenses arising out of his hospitalization under Policy No.250400 / 48 / 02 / 85 / 01119 is not sustainable.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 603 of 2003 - 04
Smt. Bharati J. Raval
Vs.
The New India Assurance Company Limited

Award Dated 28.02.2005

Shri Jayendra C. Raval was a mediclaim policyholder of The New India Assurance Co. Ltd. since 1998. He was hospitalised in Jyotiba General Hospital for Cirrhosis of Liver and portal hypertension and was diagnosed as either due to alcoholic cirrhosis or idiopathic cirrhosis. After hospitalisation, the claim was preferred for both these hospitalisation for Rs. 13,258/-. The Company referred the matter to its panel doctor, Dr. Bakul P. Dhruva for his medical opinion and he opined that the insured had preferred a claim for the treatment of cirrhosis of liver and this was acquired by over-indulgence in alcohol intake as it has been mentioned in the hospital record and therefore it fell under exclusion clause 4.8 of the mediclaim policy. Shri Jayendra Raval was again admitted to Sardar Patel General Hospital. He was diagnosed as having liver Cirrhosis, Portal Ht, Hemetemesis, Hepatic encephalopathy. He claimed Rs. 32,722.85 for his hospitalisation expenses. The claim was processed by M/s. Paramount Health Services Pvt. Ltd. (TPA). Again a claim of Rs. 10,576.50 was preferred to the Company for his treatment at Jyotiba General Hospital and he expired on 10.11.2003. The cause of death was Cardio Respiratory Arrest due to (Lt) leg cellutitis with septicomia and Acute renal failure. Smt. Bharati Raval, wife of the Insured approached the Insurance Ombudsman seeking his intervention to settle the claim for Rs. 56,557.35.

The Insured was in a critical stage even at the time of first hospitalisation in September, 2002 and in fact he passed away in six months time which speaks for the enormity and gravity of the disease which affected multi-organ functioning. The final diagnosis was left leg cellulitis with septicemia with cirrhosis of liver, portal hypertension and hepatic encephalopathy associated with Renal failure which determined the end of Shri Raval. All these indicate criticality and chronicity beyond the range of only months, in fact it takes some year to develop into these stages. The important fact to note is that these stages have been reached after medical attention was given and sufficient curative care must have been taken through therapy. The past history says he was alcoholic and the very expression indicates regular intake of alcohol over a period of time. Dr. Nitin J. Patel in his certificate has tried to explain that by clearly confessing that as alcohol has been stopped for 20 years, he is feeling that the disease could be idiopathic which means due to unknown reasons. Liver will continue to function for quite sometime but ultimately it will give rise all sorts of complications which Shri Raval had. However, malnutrition, obesity, auto immunity, diabetes etc. can also cause cirrohosis as it can be drug induced as well. The issue of idiopathic would not gain much ground as the history of alcoholism is already there and most chances will be that the degeneration was provoked and aggravated by this habit even if it was later withdrawn or reduced. In that sense it would be both pre-existing and also an abuse of alcohol. In the facts and circumstance, the decision of the Company to repudiate the claim under clauses 4.1 & 4.8 of the mediclaim policy cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 722 of 2003 - 04
Smt. Asha Kiran Gupta

Vs.

The Oriental Insurance Company Limited

Award Dated 28.02.2005

Smt. Asha Kiran Gupta lodged a complaint as per her letter of December 24, 2003 before the Insurance Ombudsman's Office on the ground that The Oriental Insurance Company Ltd., Mumbai City Divisional Office No.4, did not settle the claim on account of hospitalization expenses incurred for Squint Repair Surgery for her daugher Ms. Sonal Gupta who was admitted in Shroff Eye Hospital, Mumbai on 2.6.2003. The Company rejected the claim on the ground that Squint Repair falls under Clause 4.1 (pre-existing) of the Mediclaim Policy vide Company's letter dated 5.8.03. Smt. Asha K. Gupta made a further representation which was also not considered by the Company and based on the opinion of their Medico-Legal Consultant Dr.M.S.Kamath, they rejected the claim both on the ground of pre-existing illness (4.1) and congenital external disease or defects (4.8) as per their letter dated 11.2.2004. Smt. Asha K. Gupta then preferred a complaint against the Company before Insurance Ombudsman.

Ms. Sonal Gupta was insured with Oriental since 1996. The surgery performed on her was squint correction in both eyes at Shroff Eye Clinic from 2.6.03 to 3.6.03. In the Discharge Card of the Hospital and indoor case papers on file it is mentioned that the insured Ms. Sonal was having squint eyes since age 9 years and using glasses since the age of 9 years and contact lens since last 2 yeaRs. The operative procedure was "squint repair in both eyes". Actually on a reference from Dr. Shroff, Taparia Institute of Opthalmology under Bombay Hospital, the diagnosis was done on 6.5.03 itself and she was posted for surgery in June 2003. It is evident therefore that the defect was there for several years and well before she was covered under Mediclaim Policy at her age 21. It was externally visible no doubt and that way she was having this condition even before the Policy was taken and therefore it was pre-existing as per clause 4.1 of the policy. In the facts and circumstances the complaint of Smt. Asha Kiran Gupta for payment of claim under Policy No.121300 / 48 / 2003 / 748 and reimbursement of expenses incurred in connection with the hospitalization of her daughter Ms. Sonal Gupta is not sustainable.

Mumbai Ombudsman Centre

Case No. IO / MUM / GI - 397 / 2003 - 04

Shri Prafull O. Sheth

Vs.

United India Insurance Company Limited

Award Dated 28.02.2005

Shri Prafull O. Sheth alongwith his wife was covered under the Mediclaim policy since 1986 with United India Insurance company Limited, Divisional Office - 5, When Shri Prafull Sheth preferred a claim of Rs. 10,60,336.35 for his hospitalization at Cumball Hill Hospital & Heart Institute from 12.7.2002 to 27.7.2002, the Company offered to settle the claim for Rs. 3,33,200/- (being 3 lac original Sum Insured + Cumulative Bonus) and sent the discharge voucher vide their letter dated 22.7.2003 to be duly signed by Shri Prafull Sheth. Shri Sheth discharged the voucher under protest and hence the Company did not release the cheque. Not satisfied with the decision of the Comany, Shri Sheth represented to the Company. Not receiving any favourable response from the Company, Shri Sheth approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his full claim. The records of the case have been perused and the parties to the dispute were called for hearing. The analysis of the entire records of this claim would no doubt reveal that it is quite a complicated case with various interventions in the health status of the Insured leading to receipt of treatment from a number of doctors although pre-dominantly two specialist doctors were mostly in command of his needs. To get the record straight, one has to go back to the first claim which was lodged by the Insured for a day's hospitalisation at Cumballa Hill Hospital on 27th December, 1998 for retrosternal discomfort as till then the Insured enjoyed claim free many

years of the policy since inception in 1986. The Company has questioned the subsequent increase of Rs. 5 lacs as it was with the knowledge of claim having occurred for chest discomfort but they have merrily given two policies without even putting exclusion on the policies. Most of the physicians have converged in giving their views that some complications like off and on chest discomfort, occasional chest pain, uneasiness etc. were there and therefore, increase to Rs. 5 lacs could always be with some rideRs. The second policy of Rs. 5 lacs made high concerntration on a single life, going by the trend and some restrictions imposed on the Sum Insured as per the approved structure of the policy. However, admittedly the Company did not raise a point at that time. This Forum feels that based on the assertions and analysis made out of various statements received from the specialists / consultants it would be very reasonable to conclude that the Insured started having some problems after 1998 i.e. beginning 1999.

In the facts and circumstances, this claim should be settled taking the Sum Insured of Rs. 3 lacs available under both the policies plus the cumulative bonus amount appropriately added to resolve the dispute at the earliest.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 733 / 2003 - 04
Smt. Urvashi S. Parikh
Vs.
The Oriental Insurance Company Limited

Award Dated 10.03.2005

Smt. Urvashi Surendra Parikh was covered under and Overseas Mediclaim Policy (B &H) for various sums insured under treatment for illness, Accident benefits, Personal Accident & liability checked baggages etc. unde the Policy issued to her for 365 days beginning 26.7.99. She met with an accident at Washington in USA and was admitted to NRH Suburban Regional Rehab Centre. Her claim for treatment was directly settled by the Hospital and Mercury International, the claim settling Agents, in USA. However she was advised to have a wheel chair, on her discharge from the hospital and she purchased the same from her own resources at a cost of US$ 900. She claimed the amount from Mercury International Insurance Services Pvt. Ltd. as per the Policy but they did not respond. She approached The Oriental Insurance Co. Ltd. on return and the Company rejected the claim as not payable under the Policy for which she preferred an appeal against the Company before Insurance Ombudsman. The company responded as advised under their letter on January 25, 2005 and they mentioned that after getting the views of their Controlling Officer once again, they have reiterated their stand that cost of wheel chair was not payable. A scrutiny of the terms of the Policy together with the convention and practice followed in respect of handling of such claims, a decision can be taken to resolve the dispute. The analysis of the claim reveals that Smt. Parikh was treated well and she was on ambulatory services. It was mentioned that her rehabilitation would be faster and smoother, if she had a wheel chair and which would also enable her to withstand the ordeal of the journey back to India and even thereafter. Wheel chair is an external implement, an aid or a device to rehabilitate faster but not a medical expense, a physician's service which should be bought at a cost. There are many such external implements or apparatus like hearing aid, spectacles, dentures, sleep disorder correction machines, walker, wheel chairs etc. which are not payable under the terms of the policy and the decision of the company to repudiate this claim, therefore, cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 533 / 2003 - 04
Shri Menon Mavelil Unnikrishnan
Vs.
The New India Assurance Company Limited

Award Dated 02.03.2005

Shri Menon Mavelil Unnikrishan alongwith his wife was covered under the mediclaim policy since 1.6.95. The policy was initially for Rs. 1,00,000/- which was later increased to Rs. 3 lacs for both from 31.5.2000. Shri Menon was hospitalized at Narayana Hrudayalaya from 31.3.2003 to 21.4.2003 for CABG (Coronary Artery Bypass Grafting). When Shri Menon preferred a claim to The New India Assurance Company Limited for the said hospitalisation the Company based on the records submitted, settled the claim for Rs. 1,40,000/-. Not satisfied with the decision of the Company, Shri Menon represented to the Grievance Cell of the Company and aggrieved by the decision of the Company, Shri Menon approached this Forum for redressal of his grievances. The records have been perused and the parties to the dispute were heard.

On a scrutiny of the discharge summary of Narayana Hrudalaya it appears that the Insured had an attack of Myocardial Infarction in 1997. The diagnosis was clearly but as “Triple Vessel disease with moderate LV dysfunction”.

The issue is quite focused on existing ailment of Coronary Artery disease and Ischaemic Heart disease with already one episode of Inferior Wall Myocardial Infarction detected in 1997. Hence the increase from Rs. 1,00,000 to Rs. 3,00,000 would be restricted to Rs. 1,00,000/- only for then existing disease i.e. IHD but would be available for other illnesses provided they were non-existent earlier. Hence the Company’s decision to pay the claim on the basis of Rs. 1,00,000 plus applicable Cumulative Bonus is justified and does not require any intervention by this Forum.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 552 / 2003 - 04
Shri Birbal R. Chauhan
Vs.
The Oriental Insurance Company Limited

Award Dated 02.03.2005

Shri Birbal R. Chauhan was insured under mediclaim policy of the Oriental Insurance Company Ltd. since 1999. He was having backache and after consultation with 2 / 3 Doctors, he was admitted at Lilavati Hospital and diagnosed as a case of slipped disc and surgery for the same was done under the care of Dr.P.S.Ramani. He preferred a claim to the Company for reimbursement of expenses incurred on hospitalisation. The Company referred the matter to its panel doctor, Dr.M.S.Kamath for his expert medical opinion. He opined that the surgeon’s fees for the surgery of Rs. 55,000/- is much higher than the current rate of Rs. 30,000/- and may be suitably scaled down. Accordingly, the Company settled the claim for Rs. 75,866/- which include the surgeon’s fees and sent a voucher to the Insured. The Company’s contention was that the Insured had earlier preferred a claim for diabetes and diarrhoea for Rs. 15,776/- in the same year and he is entitled for the balance amount of Rs. 99,224/-.

It is apparent that the dispute is regarding the surgeon’s fees on which honestly there cannot be any adjudication as it should go by actual payment made vis-a-vis the reasonable charges of the hospital doctoRs. Here comes the issue of reasonableness and with soaring medical costs, surgeons are charging more than the standard and entering into a separate contract with the patients to give them a separate receipt as not billed by Hospital. However, the documentary evidence produced by the Company’s consultant appears logical and acceptable. Not withstanding this, as the dispute has been levelled for more than two years, it is felt that it should be resolved with an additional payment of Rs. 6,000/- to strike the equilibrium.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 506 / 2003 - 04

Smt. Varsha S. Gunderia
Vs.
The New India Assurance Company Limited

Award Dated 02.03.2005

Smt. Varsha Gunderia was having the policy since last 8 years and when she preferred a claim for her hospitalisation at Dr. Shah's Fracture Care Hospital & X-ray Sonography clinic for Post Traumatic Rt. knee Haemarthrosis the Company's Third Party Administrator, Raksha TPA repudiated the claim vide their letter dated 25.6.2003 on the ground that it did not require hospitalisation and moreover there were no other investigations or treatment done. Smt. Varsha Gunderia's representation to the Company was also turned down by their letter dated 25.9.2003. Aggrieved by the decision of the Company, Smt. Varsha Gunderi a approached this Forum.

Records were perused and the parties to the dispute were called for hearing on 1.11.2004. The dispute is regarding the need for hospitalisation. The Company's contention that such cases are being done as an outpatient cannot be overlooked as the procedure is fairly simple and remain uneventful. However, the Company cannot insist on the same because of the reasonings given by the attending physican and also for some complications involved normally in knee repair. The same Doctor may have given his views verbally but he has listed out some important features which cannot be ignored that the patient was given sedation which of course induces drowsiness. She had earlier cellulitis over knee which required intravenous injections to provide good and effective coverage. However, IV injections can cause some complications including adverse reactions which require immediate management. The site of aspiration and in fact whole knee would be painful and complete bed rest would be suggested for faster recovery and for close monitoring and better management hospitalisation would be the best opinion.

Considering these factors and also that Smt. Gunderia is an elderly lady the clause for need for hospitalisation can be relaxed and the claim can be settled.

Mumbai Ombudsman Centre
Case No. IO / MUM / GI - 600 / 2003 - 04
Shri Pushpakant B. Mehta
Vs.
The New India Assurance Company Limited

Award Dated 07.03.2005

Shri Pushpakant B. Mehta approached the Insurance Ombudsman with a prayer that his claim for reimbursement of expenses incurred for his wife's hospitalisation is genuine and it should be settled by the Company.

Smt. Chandrika P. Mehta was insured under mediclaim policy of the New India Assurance Co. Ltd. since 1997. While proposing for the policy she had declared her diabetes. On May, 2003, Smt. Mehta complained of chest pain and as advised by the local doctor, she was admitted to Suvidha Nursing Home at Goregaon. As per the advice of the doctor of the said nursing home angiography was done on 04.06.2003 at Asian Heart Institute and by - pass surgery was done by Dr. Ramakant Panda on 06.06.2003. She was discharged from Asian Heart Institute on 13.06.2003.

The entire dispute is centering around only about the fact that the company has rejected the claim only on the ground that she had diabetes Mellitus which was excluded from the policy with all its consequences.

Dr. Ramakant Panda has said in his certificate that diabetes mellitus is not the only risk factor for Coronary Artery disease and Ischaemic heart disease which is accepted. But the contention of Dr.Patil of EMC is that in absence of other factors this would be a sole major factor as is evident by process of elimination. Moreover the Insured had an adverse family history of IHD which was recorded in the hospital notes. As the policy clearly excluded all

the factors associated with diabetes and its related disorders, arising therefrom or aggravated by it, the repudiation by New India Assurance Company is in order.

Mumbai Ombudsman Centre
Case No. GI - 518 / 2003 - 2004
Shri Ashok Badriprasad Vyas
Vs.
The National Insurance Company Limited

Award Dated 9.03.2005

Shri Ashok B Vyas had taken the insurance cover for the first time on 10.7.2001 covering himself alongwith his wife and daughter from the National Insurance Company Limited, Divisional Office VII. The policy was renewed frorn 12.7.2002 to 11.7.2003 under policy No. 250700 / 48 / 2 / 8507568. Smt Shakuntalal A. Vyas wife of Shri Ashok B Vyas was hospitalized at Sir Hurkisondas Nurotumdas Hospital and Research Centre from 27.8.2002 to 18.9.2002 for Perforated caecum & Ileum c Meckel's diverticulum c stricture of ileum (treatment for tear in the Intestine). When the claim was preferred by Shri Vyas for the said hospitalisation the Company based on their panel doctor's opinion repudiated the claim invoking clause 4.1 and non disclosure. Not satisfied with the decision of the Company, Shri Vyas represented to the Company alongwith a certificate given by the treating doctor, Dr. Priyadarshi H Doctor and not receiving any reply from the Company, Shri Vyas approached this Forum for redressal of his grievance. The records of the case have been perused and the parties to the dispute were called for hearing The dispute in this case is regarding the ailment for which Smt Vyas was admitted to Hurkisandas hospital on 27.8.2002, and the past ailment of T.B. in ileocecal region 20 years back are not similar but two different diseases. In fact it produces a vital linkage with the past ailment. The operative notes say "closure of caecal perforation and resection of ileum with stricture" The same doctor has recorded the past ailment of T. B in ileum 20 years back and this fact was not disclosed in the proposal form when the policy was taken. TB of abdomen and surgery is an important health intervention which should have been disclosed to enable the Company to take proper underwriting decision.

In the facts and circumstances the decision of the Company to repudiate the claim on the ground of both pre - existence of the disease and non - disclosure of the past illness are held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 611 / 2003 - 2004
Shri Ranchhodlal N Purohit
Vs.
The National Insurance Company Limited

Award Dated 9.03.2005

Shri Ranchhodlal N Purohit took the Mediclaim Insurance policy for the first time on 4.2.2002 covering himself, his wife and children under Policy No.250700 / 48 / 2001 / 8508248 for Sum Insured of Rs. 1,00,000, Rs. 50,000 and Rs.25,000 respectively. The said policy was renewed for the period 4.2.2003 to 3.2.2004 under Policy No.250700 / 48 / 02 / 8508835 but the Sum Insured under the policy for his wife Smt Laxmidevi R Purohit was increased to Rs. 75,000 and for the other family members remained unchanged. Smt Laxmidevi R Purohit was hospitalized for Menorrhagia Dyspareunia at Purohit hospital from 15.2.2003 to 22.2.2003 and was operated for total abdominal hysterectomy on 16.2.2003. When claim was preferred to the Company for the said hospitalisation, the Company repudiated on the grounds of pre - existing disease by invoking clause 4.1. His representation to the Company was also turned down and hence aggrieved with the

decision of the Company Shri Purohit approached this Forum. Records were perused and the parties to the dispute were heard.

The technical and medical details made available to this Forum reveal that the chief complaints were excessive PV bleeding and dyspareunia with last menstrual period being 15 days back. A portion of the opinion is quoted for better understanding. “On that consultation the patient was advised to have ultrasonography of abdomen and pelvis which was done on 15th February, 2003 which showed enlarged, bulky uterus measuring 9×5.7×5.2 cm and with endometrial thickness of 8mm. On opinion of gynecologist these findings are suggestive of adenomyosis which is of longstanding nature”. Moreover as mentioned above there is a protocol of treatment followed by all Gynaecologists before taking up the last line of complete hysterectomy which suggests that the diagnosis was made but the patient waited for l st year policy to be over for which Sum Insured was also increased selectively for Smt Purohit. The policy was taken from 4th February 2002 and completed just one year as the Insured was admitted to hospital on l5th February, 2003. Accordingly based on the facts and circumstances the decision of National Insurance Company Limited to repudiate the claim on the ground of pre - existence of the disease cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 506 / 2004 - 2005
Smt Devashree Satyen Marathe
Vs.
The New India Assurance Company Limited

Award Dated 9.03.2005

The Complainant Smt Devashree S Marathe approached the Office of the Insurance Ombudsman on the ground that The New India Assurance Company Limited has not settled Rs. 496/- out of her claim of total of Rs. 7533/-. On enquiry she came to know that Rs. 50 represented towards admission charges for the hospital and Rs. 446 towards registration charges of the hospital. She challenged the Company’s rejection on this ground mentioning that reimbursement should be complete and nowhere in the policy these charges have been cited as exclusion. After repudiation letter New India clarified the position to Smt Marathe under their letter dated 2nd August,2004 which did not satisfy the Insured Smt Devashree Marathe.

After perusing the records parties were called for personal hearing at Pune Camp of the Ombudsman. On examination of the file together with relevant documents read in conjunction with submissions made at the hearing held at Pune it is found that Branch Office issued policy and got a clarification from the Divisional Office as also from the Regional Office that as per negotiations finalized between LIC and New India some of the charges like registration, admission, ambulance cost etc would not be payable. This was conveyed to Smt Marathe however, she was still not satisfied and was pleading before this Forum for appropriate redressal of her grievance. Mediclaim policy is governed by the basic preamble which makes it operational to cover expenses which are necessarily and reasonably incurred. This policy was designed by GIC in consultation with Ministry of Finance, Government of India. It would appear that the dispute is resting only on the basic hospital charges incurred by the insured as a result of hospitalisation. It was clearly explained in the minutes and recorded in the proceedings that these are essentially hospital costs which are deemed to be kept out of the purview of the medical cost or physicians services or investigations cost which are necessarily incurred in connection with the diagnosis of the diseases etc. Accordingly this amount of Rs. 496 as deducted by New India is appropriate in terms of the Group policy issued to LIC and as there has been no discrimination this Forum does not have any intention to intervene in the matter.

Mumbai Ombudsman Centre
Case No. GI - 676 2003 - 2004
Shri Mahendrakumar S Kotian
Vs.
The New India Assurance Company Limited

Award Dated 10.03.2005

In the matter of the above complaint the facts are as under:
Shri Mahendrakummar S Kotian was covered under the mediclaim policy issued by The New India Assurance Company Limited under policy No. 110900 / 48 / 02 / 02890 for the period 21.6.2002 to 20.6.2003 for Sum Insured of Rs. 1,00,000/-. Shri Kotian was admitted to Varun Cardiac Clinic from 5.9.2002 to 7.9.2002 for control of Nypertension. When he preferred his bills to New India the same was rejected on the ground that as per their panel doctor's opinion he was admitted for B.P. control and the same did not require any hospitalisation. The claim was thus denied under exclusion clause 4.10 of the policy. Shri Kotian was dissatisfied and he appealed to the Company once again which was also rejected by the Campany. Accordingly, Shri Kotian preferred complaint in the Forum of Insurance Ombudsman After perusing the records parties were called for hearing.
The analysis of the claim file reveals that the Insured was admitted to Varuna Cardiac Clinic for Hypertension and control of B.P. The diagnosis was done and steps to be taken were determined, only implementation of the therapy remained. Usually B.P. treatment follows a set pattern. Doctors take average readings aver a period at different hours of the day, examines the nature of work, life style and habits and form an opinion as to the treatment regime. All these are quite normally done without any hassles. There is no criticality no emergency in this situation for a patient to get admitted to a hospital.
In view of this the need for hospitalization for already diagnosed disease is not fully established and therefore rejection of the Company is in order.

Mumbai Ombudsman Centre
Case No. GI - 511 2003 - 2004
Shri Suresh B. Sadani
Vs.
United India Insurance Co. Ltd.

Award Dated 11.03.2005

The Claim of Smt. Meera Sadani arose after her hospitalisation at Hinduja Hospital from 02.04.2003 to 14.04.2003. She died in the hospital on 14.04.2003 due to haemorrhagic shock following repair of rupture of arch & proximal descending thoracic aorta due to artherosclerosis. The Company referred this matter to its panel doctor who opined that the claim may be investigated and accordingly the Company appointed M/s Swastik International to investigate the above claim. After getting the investigation report dated 16.09.2003, the Company referred the matter to panel doctor again alongwith investigation report and Inpatient Progress notes, who opined that as per the inpatient summary of Hinduja Hospital, the insured was a known case of hypertension and also was on medication for the same. This fact was not disclosed in the proposal form while proposing for the mediclaim insurance. The Company informed its decision to repudiate the claim under Exclusion Clause 4.1 on 22.10.2003 to Shri Suresh B.Sadani.

The analysis of the case papers reveal that Smt.Meera Sadani had Haemorrhagic Shock and rupture of arch. As this happened in the first year of the policy, the Company appointed M/s Swastik International, Investigators and after making necessary inquiries with the hospital authorities, they submitted their reports which is taken as an evidence in this Forum. However, independent of findings of M/s Swastik International, the entire case papers have been scrutinised and it is found that the Insured had rupture of arch and proximal descending thoracic aorta due to arteriosclerosis. It has been stated in the

hospital papers that late Smt. Meera had sudden onset of chest pain. She gave a history of Diabetes Mellitus and Hypertension but she was irregular in taking treatment and for Diabetes she was on diet control. There was bleeding of right ear as well and it started oozing thereafter and the doctors were quite at a loss as multiorgan failure disrupted the entire plan of treatment and finally she expired. The patient on admission recorded as stable and high BP and going by the nature of ailment it appeared to be quite invasive and must have been there for sometime. The repeat CT chest showed Aortic dissection c intramural haematoma. Incidentally, she was 70yrs old when the incident took place and this being the first year policy there would be question as to whether the Company had taken underwriting precautions to examine the health and get her insured. However, it is established through medical records that the ailments were existing when policy was taken and therefore, the Company's decision can be defended.

Mumbai Ombudsman Centre
Case No. GI - 758 / 2003 - 2004
Shri Nitin Sidhakumar Dharadhar
Vs.
The Oriental Insurance Company Limited

Award Dated 11.03.2005

Shri Nitin Sidhakumar Dharadhar alongwith his family members was first insured with The Oriental Insurance Company Limited, D.O. 4 since 1995 and later with Divisional Office - 8 from 20.6.1996. Smt Anuja Dharadhar wife of Shri Nitin S Dharadhar was hospitalised from 21.4.2003 to 26.4.2003 for repair of Para umbilical Hernia at Ameeta Nursing Home and when Shri Dharadhar preferred a claim for the said hospitalisation, the Company based on the doctor's opinion repudiated the claim vide letter dated 22.7.2003 invoking clause 4.1 of the. mediclaim policy. Not satisfied with the decision, Shri Dharadhar represented to the Company but the Company reiterated their earlier stand of repudiation. Aggrieved by the decision of the Company, Shri Dharadhar approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsrnan in settlement of his claim.

The records have been perused and the parties to the dispute were heard The dispute is two fold (a) previous surgery i.e. Caesarian Section for delivery was not disclosed and (b) Hernia can be caused by previous surgeries out of the scars. In this case since the past history of surgery in the same area is very vital and quite relevant it would act as pre - existing. About Ventral hernia the classical theory is if stretching and thinning of an abdominal scar occur, pressure from the abdomen may cause protrusion of part of the gut to cause hernia. Para umbilical is also at the naval region only and refers to the past surgeries leaving, a small cavity to be subjected to pressure of abdomen and cause hernia. On both these rounds therefore, i.e. non disclosure of the surgery and the same being the proximate cause the rejection of the claim by the Company is in order.

Mumbai Ombudsman Centre
Case No. GI - 750 / 2003 - 2004
Shri Jayantilal M Shah
Vs.
The New India Assurance Company Limited

Award Dated 14.03.2005

Shri. Jayantilal Shah alongwith his wife and sons were covered under the Mediclaim policy issued by The New India Assurance Company Limited, Divisional Office - 111700 since 1998. Smt Nirmala Shah was hospitalized at Lilavati hospital from 02.01.2003 to 07.01.2003 for uterine fibroids, Hypertension, hypothyrodism and anaemia. When a claim was preferred by Shri Shah for the said hospitalisation, the Third Party Administrator M/s Raksha TPA vide their letter dated 16.5.2003 repudiated the claim invoking clause 4. l0 of

the mediclaim policy. Not satisfied with the decision of the Company, Shri Shah represented to the Grievance Cell of the Company but they reiterated the stand taken by the Raksha TPA. Aggrieved by the decision of the Company, Shri Shah then approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs.30,000 + Interest. After perusal of the records parties to the dispute were called for hearing.

The analysis of the claim reveals that the patient Smt Nirmla Shah is an aged lady of 74 years when she was hospitalized and was taken when she was 69 years in 1998. She was recorded to have Hypertension since 3 year and was admitted with 170 / 110 and she was on Hypertension treatment. With high B.P. of and aged lady and alleged complications of swelling of feet and P. V. bleeding it was not expected to take a chance of keeping her at home. So far as this limited point of need and necessity of getting an aged lady to be hospitalized rather than take her everyday for necessary investigations at the outdoor if concerned, anybody would dismiss the idea even without a Doctor's advice. As regards Investigations done admittedly a number of investigations were conducted which was definitely to take advantage of the hospitalisation. However, the relevance of most of these is established, particularly considering the age. Based on these findings it could be concluded that the hospitalisation was not for only investigation but these were ailments which were treated with medicine on the follow up advice. However, some of the investigations are in excess and in other cases of younger insureds these investigations could have been done as an outpatient also, but the Company has insured first time a lady insured of almost 70 years and therefore, they have admitted a selection against them.

In the facts and circumstances considering the fact that some treatment / investigations are not consistence or in excess 70% of the cost may be approved.

Mumbai Ombudsman Centre
Case No. GI - 551 OF 2003 - 2004
Shri Karunakar S. Shetty
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 15.03.2005

Shri Karunakar Shetty is a mediclaim holder of The Oriental Insurance Company Ltd. since 2000. He was admitted in Dr. Das Surgical Hospital On 14.07.2003 and diagnosed as unstable Angina + HT + DM old CVA c Acute left ventricular failure and was discharged on 15.07.2003 and on same day he was hospitalised at Wockhardt Hospital for Coronary Artery Disease - Triple Vessel Disease after his hospitalisation, he preferred a claim to the Company for Rs. 2,53,553/- The claim was processed by M/s Raksha TPA and they informed the Insured that he is a known case of Hypertension which is a proximate cause of Incheamic Heart Disease (I.H.D.) due to Which the claim fell under Exclusion Clause 4.1 of the mediclaim policy.

The analysis of the case reveals that the Insured had an attack of Cerebral infarction in July, 2002 for which he was admitted to Hinduja Hospital. The history recorded in the July, 2003 hospitalisation in Wockhardt Hospital "k / c / o DM since 3 - 4 years and k / c / o HT since 1 year" and against each the treatment i.e, medicines being taken were written. The provisional diagnosis was unstable angina with Hypertension and Diabetes Mellitus old CVA (Cardio Vascular Accident) and finally acute left Ventricular failure. In July, 2002, he was declared diabetic and hypertensive with double doses of medicines of both Diabetes Mellitus and Hypertension. His BP reading was 200 / 110 which is very high. The clinical notes written at that time reads "Recently Amlodopin & Aten as also Daomil, both the diseases were in existence. The doctor asked the patient to stop "Ecosprin" because of bleeding piles as the patient was obviously on those drugs of HT & DM in particular with which Ecosprin 150mg was being given in tandem. As regards Wockhardt Hospital records

as noted above the history recorded is clear in giving an insight into the gravity and intensity of the disease leading to Tripple Vessel disease with LVEF as low as 25% only. In line with these findings and actual narration given by the Insured himself or his relatives would carry conviction and the attempt made later to correct the records or produce the certificate from attending physician could appear clearly an afterthought after the incident and therefore, non - acceptable. In the facts and circumstances, the decision of the Insurance Company, Oriental Insurance to repudiate the claim cannot be questioned on the ground of non - disclosure of material facts and pre - existence of illness as per Clause 4.1 of the Mediclaim Policy.

Mumbai Ombudsman Centre
Case No. GI - 679 OF 2003 - 2004
Shri Sunil Nandkishor Newatia
Vs.
The New India Assurance Co. Ltd.

Award Dated 16.03.2005

Shri Sunil Nandkishor Newatia consulted his family physician Dr. N.P.Maheshwari for heaviness in the chest. The doctor attributed the pain is due to gas and prescribed medicines for the same. Even after taking the medicines there was no improvement in the condition of Shri Newatia so Dr.Maheshwari referred his case to Dr.N.H.Banka who advised him to conduct endoscopy and found severe gastritis and started treatment accordingly. Dr.Banka also advised him to go for C.T.Scan, Colonoscopy and Stress Thalium test and in the report of the Stress Thalium test it showed a minor obstruction in the arteries and Shri Newatia was asked to consult a cardiologist and accordingly he approached Dr. Anil Sharma who advised him to go for Angiography. The Angiography was performed by Dr. B.K.Goyal alongwith Dr. Anil Sharma at Breach Candy Hospital.

It is evident from the documents and the case papers submitted to this Forum that the dispute is only regarding linkage of cardiovascular ailment with hypertension which the Insured had and he also admitted the same in his P II form. His point was that Hypertension is not the only cause for Ischaemic Heart Disease. However it is most pertinent and important to point out that the existence of Hypertension for 25 long years or even 18 years as per Hospital records is an essential health condition which the Insured should have disclosed while taking the policy. It constitutes non - disclosure when he fails to make the declaration. The second point is Hypertension is a crucial factor in causing cardiovascular ailment. Hypertension is a great risk factor for Ischaemic Heart Disease (IHD). Hypertension is caused by atherosclerosis of the arteries throughout the body. It is very likely that if a person has atherosclerosis in the general circulation, the coronary arteries will also be affected. Hypertension may cause damage to artery walls. The nexus between hypertension and Ischaemic Heart Disease is well settled in Medicine.

In the facts and circumstances, the decision of the Company to reject the claim under Clause 4.1 as being pre - existence and not disclosed cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 556 of 2003 - 2004
Shri Natvarlal Bhagwandas Patel
Vs.
United India Insurance Company Limited

Award Dated 17.03.2005

Shri Natvarlal B Patel alongwith his wife Smt Sudha Patel was insured with the United India Insurance Company Limited, Malad D.O. Smt Sudha Patel was hospitalised at Mother Care Maternity & Surgical Nursing Home from 19.12.2002 to 23.12.2002 for Secondary infertility

with Left Ovarian Endometrioma with S. Pelvic adhesions. When Shri Patel preferred a claim for the said hospitalisation to United India, the Company repudiated the claim by letter dated 26.2.2003 invoking clause 4.8 of the policy. Not satisfied with the decision of the Company represented to the Company but the Company reiterated their stand of repudiation. Aggrieved by the decision of the Company, Shri Natvarlal B Patel approached this Forum for Redressal of his Grievance. Records of the case have been perused and the parties to the dispute were heard.

On an analysis of the entire records submitted to this Forum, it is observed that the insured was diagnosed to have secondary infertility with left ovarian Endometrioma with S. Pelvic adhesions. From the hospital records, it is also revealed that ultra sonography taken by the Insured on 7.11.2002 showed the uterus bulky with adenomyosis bilateral endometrioma. Endometrioma is termed as a tumor containing shreds of ectopic endometrium and is found most frequently in the ovary and the peritoneal surface of the posterior portion of the uterus. She was operated upon for all these complications. Although she had endometrioma, the uterus was not removed. Obviously with the intention to keep provision for future conceptions. Based on the above fmdings it can be concluded that the treatment was related to sterility or infertility only.

In the facts and circumstances, the decision of the Company to repudiate the claim under Exclusion Clause 4.8 cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 532 of 2003 - 2004
Smt Shobha Dhirajlal Mehta
Vs.
The New India Assurance Company Limited

Award Dated 18.03.2005

Shri Dhirajlal Mehta, husband of Smt Shobha D Mehta was covered under the mediclaim policy issued by The New India Assurance Company Limited, D.0.111200 for the first time from 01.09.1990 for Sum Insured of Rs. 1,00,000 which was later enhanced to Rs. 3,00,000 w.e.f. 01.09.1997. Shri D. Mehta was hospitalized at Bombay Hospital Trust on 24.2.2003 for treatment of renal failure with DM, Hypertension and peripheral vascular disease but he unfortunately expired on 15.3.2003. When Smt Shobha D Mehta preferred a claim for the said hospitalisation the Company repudiated the claim invoking clause 4.1 of the policy. Her representation to the Company was also turned down, hence she approached this Forum seeking justice. Records have been perused and the parties to the dispute were called for hearing. The analysis of the Bombay Hospital case papers reveals that the Insured was Diabetic for 10 years and was on Insulin. He was also hypertensive and was on medicines - Tablet Cardace 5mg bd.

In the facts and circumstances the decision of the Company to repudiate the claim on the ground of non - disclosure of ailments and pre - existence of the disease as per clause 4.1 of the Mediclaim Policy cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 631 / 2003 - 2004
Shri Maharudra Dinkar Borkar
Vs.
The New India Assurance Company Limited

Award Dated 17.03.2005

Late Shri Dinkar B Borkar who was insured with The New India Assurance Company Limited, Divisional Office 153100 was hospitalized at Shree Medical Foundation, Prayag

Hospital, Pune on 22.2.2001. and unfortunately expired on 26.2.2001 due to Acute Cardio respiratory Arrest due to Acute (Rt) Thalamic Haematoma with Acute Myocardial Infarction with Aspiration Pneumonities. When a claim was preferred by Shri M.D.Borkar for the said hospitalisation, the Company repudiated the claim by letter dated 11.7.2001 stating that as Diabetes was an exclusion under , the policy and as the disease suffered by Late Shri Borkar was related to Diabetes, the claim was not payable under clause 4.1 of the policy. Not satisfied with the decision of the Company, Shri M.D.Borkar represented to the Company and not receiving any favourable response approached this Forum for redressal of his grievance.

The records of the case have been perused and the parties to the dispute were called for hearing. The issue for which the Company has rejected the claim is the Insured's suffering from Diabetes Mellitus for long. It is medically established that Diabetes causes a number of complications affecting the general health status of the person and the biggest risk factor would be atherosclerosis in the arteries. The hospital case papers where it was recorded as Cerebro Vascular Accident (CVA), it meant a vascular disease which is a major cause of death in Diabetes. In addition, peripheral vascular disease may lead to Ischaemic and gangrene of lower limbs in the similar manner which cause weakening of the artery wall and therefore dilatation of blood vessel cannot be ruled out because of Diabetes. However, as mentioned above there should be contributory factors of some other diseases independently causing complications whose exact impact cannot be evaluated, and to that extent a reasonable view can be taken to grant only 30% admissible expenses on Ex - gratia basis.

Mumbai Ombudsman Centre
Case No. GI - 529 / 2003 - 2004
Smt.Shamim A.Topia
Vs.
National Insurance Co. Ltd.

Award Dated 18.03.2005

Shri Abdul Kader Topia had a mediclaim policy with National Insurance Company Ltd. and for the first year the Sum Insured was Rs.1 lakh and in 1998 it was increased to Rs.1.50 lakhs and again in 2001 it was increased to 2.50 lakhs. Shri Topia preferred a claim to the Company for his hospitalisation at Jaslok Hospital from 18.03.2003 to 28.03.2003. The Company referred the file to Dr.Ashok Chopra of Medicare Foundation Pvt. Ltd. for medical opinion and after getting his observations, the Company intimated the Insured that the claim is repudiated under Exclusion Clause 4.1 of the mediclaim policy.

The analysis of the case reveal the following features of the claim:

- Late Shri Abdul Kader Topia had three myocardial infarctions in the past, the last being in 1999. He had also Aorto - femoral Bypass in 1999. This gives an idea that Shri Topia was having cardiac related problems well before 1999 and may be before the inception of the policy but he did not declare it. He had a history of brain stroke and loss of speech in 2002. It is evident that he had history of high blood pressure and diabetes although duration of illness was not mentioned and could not be ascertained from the file. The present claim was for swelling of feet with distension of abdomen and vomiting which was diagnosed as a case of chronic liver disease with Congestive Cardiac Failure.

The above clinical history and the diagnosis which mentioned Ishaemic Heart Disease with Cerebro Vascular Accident with Diabetes Mellitus with Hypertension it would be patently apparent that the Insured person had been suffering from these conditions for quite sometime which was not disclosed. The record suggests that he took policy in 1997 initially

for Rs.1 lakh and progressively increased it almost every alternative year. Going by the nature of illnesses and the complications, which were clearly deep - rooted, it stands to reason that the Insured suffered from the illnesses mentioned for quite sometime which were not disclosed before the policy was taken. Since all these were cardiac related problem and DM / HTN were in existence for quite sometime which caused stroke, loss of speech and for which bypass surgery was also done, the analysis made by the Company's Medical Consultant appears in order. All these prove circumstantially beyond doubt that the Insured Shri Topia had the complications well before the first policy was taken in 1997 for which the Company's decision to repudiate the claim cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 325 of 2004 - 2005
Shri Hetal R Gandhi
Vs.
The New India Assurance Company Limited

Award Dated 21.03.2005

Shri Hetal R Gandhi alongwith his wife and daughters were covered under the mediclaim policy issued by The New India Assurance Company Limited under policy No. 1 12500 / 48 / 03 / 08399 for the period 30.12.2003 to 29. 12.2004. The Sum Insured for himself and his wife was Rs. 3,00,000 and for his two daughters the Sum Insured was Rs. 1,00,000 each. It is reported that Shri Gandhi was having the mediclaim cover since 1999. Kumari Darshini Gandhi, the eldest daughter of Shri Hetal Gandhi was hospitalized at Dasgupta Nursing Home from 27.2.2004 to 28.2.2004 for right eye surgery. When Shri Gandhi preferred his bills to New India the Third Party Administrator M/s Raksha TPA rejected the claim under clause 4.5 of the policy. Shri Gandhi was dissatisfied and he appealed to the TPA which was also rejected. Accordingly, Shri Gandhi preferred a complaint in the Forum of Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. After perusing the records parties were called for hearing on 15th March, 2005.

Analysis of the case papers would reveal that the Insured was 5 years old at the time of operation for Right Eye Squint. On perusal of the Discharge Summary Card it is noted that the Insured was admitted for Right Eye Squint operation. In the discharge summary there was no mention of Neurological involvement / Trauma and therefore it can be taken as a congenital defect to be treated through a correction surgery which can also be called a cosmetic surgery. Squint is a defect or anomaly which requires correction and therefore it will fall under Exclusion Clause 4.8 as per the above provisions. In the facts and circumstances the decision of repudiation taken by the Insurance Company cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 646 2003 - 2004
Shri Sunil Purshotamdas Bagaria
Vs.
The Oriental Insurance Company Limited

Award Dated 22.03.2005

Shri Sunil P Bagaria had taken a mediclaim insurance policy from The Oriental Insurance Company Limited, MCBO 2 from November, 2000 covering himself, his wife, and his mother. Shri Sunil Bagaria was admitted to Lilavati hospital and Research Centre from 9.11.2003 to 14.11.2003 for Diabetes with Gastritis with Reflux Oesophagitis with Hypertension. When he submitted the claim for the said hospitalisation the claim was repudiated by the company invoking clause 4.1 of the policy. Aggrieved by the decision of the Company, Shri Sunil Bagaria approached this Forum for redressal of his grievances. After perusing the records, the parties to the dispute were called for hearing.

It appears on scrutiny, that Shri Bagaria was diagnosed to have diabetes with gastritis with reflux oesophagitis with hypertension. The discharge card has recorded this alongwith supporting medical records of being diabetic since 5 years and hypertensive since 8 years with further history of having hernia and hydrocele surgery. The Insured was treated for all the existing ailments plus the new complication of reflux oesophagitis which is a condition in which gastric contents reflux into oesophagens.

However, as the complication reflux oesophagitis with gastritis was a new complication and some treatment was done at the hospital and later alongwith some investigation, as a special case some consideration may be made to grant some portion of the expenses.

In the facts and circumstances, Oriental Insurance Company is directed to admit 20% of the admissible amount of total hospital bills being the proportionate cost of treatment of gastritis with reflux oesophagitis for Shri Sunil P.Bagaria under the policy 2003 / 00899 and settle the claim.

Mumbai Ombudsman Centre
Case No. GI - 647 / 2003 - 2004
Smt Shradha Sunil Bagaria
Vs.
The Oriental Insurance Company Limited

Award Dated 22.03.2005

Smt Shradha S. Bagaria who was insured with The Oriental Insurance Company Limited, MCBO 2 from November, 2000 was admitted to Lilavati hospital and Research Centre from 9.11.2003 to 14.11.2003 for Diabetes with depression with uterine prolapse with stress incontinence of urine. When she submitted the claim for the said hospitalisation the claim was repudiated by the company invoking clause 4.1 of the policy. Aggrieved by the decision of the Company, Smt Shradha Bagaria approached this Forum for redressal of her grievance. After perusing the records, the parties to the dispute were called for hearing the company attended but as the Complainant did not appear her written submissions to this Forum and to the Company were taken on record.

An analysis of the hospital case papers reveals that Smt. Shradha Bagaria was diagnosed to have diabetes with depression with uterine prolapse and stress in continence of urine. She was a known case of having depression since 8 years and diabetes ½ years. The Company felt, as these were not disclosed, the claim was rightly rejected. The consultant of the Company felt that the treatment was for general “run down” condition as well which is not covered under the policy. Depression is a rather a mental state which is no doubt psychosomatic. It can have many effects although the effect on urinary tract or incontinence could be the result of diabetes as well. Diabetes is reportedly for 1 ½ years and the policy was in force since December, 2000 for which it cannot be taken as pre - existing. Accordingly, in the interest of equity some consideration can be made to admit part of the claim as a special case.

In the facts and circumstances, Oriental Insurance Company is directed to settle 20% of the admissible expenses of hospital bill being proportionate cost of treatment for diabetes and related problems and settle the claim of Smt. Shradha S.Bagaria.

Mumbai Ombudsman Centre
Case No. GI - 753 of 2003 - 2004
Shri Ramesh Maheshwary
Vs.
The Oriental Insurance Company Limited

Award Dated 23.03.2005

Shri Ramesh Maheshwary took a mediclaim policy from The Oriental Insurance Company for himself and his family under Policy No.124300 / 2003 / 3238 for the period 27.12.2002 to 26.12.2003. His son Master Raghav Maheshwary was insured for Rs. 50,000 Sum

Insured. He fell sick with vomiting and nausea and was admitted to Lilavati Hospital for Pulmonary Koch's disease i.e. T.B., of lungs with adverse reaction of Anti - Koch's Treatment (AKT) giving rise to Hepatitis 'A' positive from 15.8.2003 to 22.8.2003. When Shri Maheshwary claimed the reimbursement of expenses the Insurance Company i.e. The Oriental Insurance Company rejected the claim on the ground of pre - existing illness which was not disclosed. Shri Maheshwary was aggrieved at the rejection and represented but that was not considered as per the Company's Medico - legal Consultant. Shri Ramesh Maheshwari thus appealed to the Ombudsman for Redressal of his Grievances.After perusing the records both parties were called for hearing on January 19,2005.

Strictly speaking on the ground of non - disclosure the claim may not be considered but since the past ailment of pneumonitis happened 7 years back it would be taken as well controlled and it could be contended that the liver complications were unrelated to and independent of the pneumonitis which he suffered 7 years back in absence of any medical history in the immediate past before the policy was taken. Although pneumonitis with pleural effusion was a risk factor for Koch's disease, but directly Koch's treatment was not claimed under the hospitalisation expenses. It would therefore, not be fair to reject the entire claim but allow at least 50% of the hospitalisation expenses as Hepatitis 'A' virus treatment was triggered only by Anti - Koch's treatment as per the hospital records.

Mumbai Ombudsman Centre
Case No.GI - 587 of 2003 - 2004
Shri Jayantilal L. Shah
Vs.
The National Insurance Company Limited

Award Dated 23.03.2005

Shri Jayantilal Shah had taken a mediclaim policy for himself and his wife Smt. Pushpa J. Shah with Divisional office - XVI of National Insurance Co. Ltd under Policy No. 260800 / 46 / 2001 / 8400057 covering the period from 1.1.2002 to 31.12.2002. Smt Pushpa J. Shah was admitted to Bombay Hospital on 28.8.02 with severe chest pain and after necessary investigations coronary angioplasty was done on 31.8.02 and she was discharged on 3.9.02. When the bills were preferred for reimbursement of expenses with National Insurance Co. Ltd., the claim was under Exclusion Clause 4.2. Shri Jayantilal Shah was aggrieved at their decision and made a representation to the Company and not convinced, he approached Insurance Ombudsman's office for redressal of his grievance.

After perusal of the records both the parties to the dispute were called for hearing.

Shri Jayantilal Shah has mentioned that his wife Smt Pushpa J. Shah had been suffering from Diabetes which was disclosed while availing BOI's Unique Security Plan Scheme. Accordingly, the company excluded Diabetes and the related diseases under the policy issued for the year 1998. Shri Jayantilal Shah's point was that National Insurance Co. Ltd. did not exclude these diseases in the subsequent policy and that Smt Pushpa J. Shah had heart disease and consequent Angioplasty, which was unrelated to the illness Diabetes and therefore the claim should have been settled.

On going through all the relevant records it appears that the insured had a long standing Diabetes for 20 years and this fact has been admitted by the Complainant, Shri Jayantilal Shah. Diabetes is a great risk factor in causing cardiovascular diseases.

Indoor hospital records have mentioned Diabetes to be of 20 years and the patient being on certain medicines which were noted. Having established the cause i.e., diabetes and its effects i.e. cardio vascular disease, the issue of technical lapse not to put the specific exclusion under the Policy in the subsequent years would not be material to disallowance of the claim.

In the facts and circumstances the complainant Shri Jayantilal Shah's claim for reimbursement of expenses incurred in connection with hospitalization of his wife Smt. Pushpa J. Shah is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 534 / 2003 - 2004
Shri Himat B Babla
Vs.
United India Insurance Company Limited

Award Dated 24.03.2005

Shri Himat B Babla was insured under the Mediclaim policy No. 020500 / 48 / 02 / 04513 issued by United India Insurance Company Limited, Divisional Office - 5. It is reported that whilst in Dar - es - salaam , Tanzania, he fell sick and was admitted to Shree Hindu Mandal Hospital in July,2002 and had some tests from Ebrahim Haji Charitable Health Center on various dates in 2002. On reaching Mumbai he was advised by his physician to get admitted to Bharatiya Arogya Nidhi Sheth Kantilal Parekh Hospital in April, 2003 for fresh complications of weakness. He was admitted on 16th April, 2003 and was discharged on 18.4.2003 and was diagnosed as having Iron deficiency Anaemia. When he lodged the claim with United lndia, the company, rejected the claim through their TPA, M/s Family Health Plan Ltd as the hospitalisation was not necessary vide TPA's letter dated 21.6.2003. Being aggrieved Shri Babla made a further reference to the Company but they rejected their claim under their letter dated 3.12.2003. Shri Himat Babla then preferred an appeal against United India in the Forum of Insurance Ombudsman to direct United India to pay the claim. Records of the case were perused and parties were called for hearing. 'The analysis of the dispute reveals that it is on the technical issue whether the hospitalisation was necessary in respect of an ailment like anaemia which the TPA and the Company felt not justified. The discharge card of Bharatiya Arogya Nidhi clearly mentions that the patient was admitted with chief complaints of semi solid stools 2 - 3 times daily black coloured. There were repeated tests on all important pathological factors to determine his illness. All these were done from outside without being admitted to hospital and the diagnosis was apparent.

It would thus appear that the hospitalisation in April, 2003 merely repeated some of the investigations done earlier over a period of one year including those done in Dar - es - salaam and the conclusion of the diagnosis was reached earlier by the noted Haematologist and Haemato - oncologist Dr. Mukesh Desai in January, 2003 and accordingly the treatment also started. The hospitalisation was utilized for additional tests including USG, Scan, Abdominal tests etc which could have been conducted even otherwise as outpatient which in fact was done over a period earlier. As the exclusion clause 4.10 is specific and the policy structure is designed as such, the rejection of United India Divisional Office - 5 on this ground is in order.

Mumbai Ombudsman Centre
Case No. GI - 705 2003 - 2004
Shri Vishwas D Jeurkar
Vs.
The New India Assurance Company Limited

Award Dated 24.03.2005

Shri Vishwas D Jeurkar took the mediclaim Insurance for the first on 8.2.1994. At that time Shri Jeurkar had declared that he was suffering from Diabetes and accordingly the Company had excluded treatment for Diabetes from the policy issued to Shri Jeurkar from 1994 to 1998. But from 1999 to 2002 renewals the exclusion was omitted to be mentioned under the policy. Jeurkar was hospitalized at Indo American Cardiovascular Centre 21.9.2001 to 22.9.2001 for Bilateral lower limb angiography. Shri Jeurker preferred a claim

under the policy No.110902 / 48 / 00 / 03570 where Cumulative Bonus under the said policy was 40% and the exclusion column was declared 'None'.On receiving the claim papers from Shri Jeurkar, Branch Office sought the opinion of their panel doctor and based on. opinion repudiated the claim.His representation to the grievance department was also turned down and hence aggrieved by the decision Shri Jeurkar approached the Office of the Insurance Ombudsman.After perusing the records, the parties to the dispute were heard.

On examination of the various records and documents and the medical opinion of the consultants it appeared that the essential dispute on which claim was repudiated rests on a correct appreciation of the terms and conditions of the policy. The conclusion puts reasonably beyond doubt that it was a case of "diabetic microangiopathy". It would appear from the wordings that intention of the circular is to ascertain the cause and extent of the disease both diagnosis and status. Under the present case Diabetes was directly diagnosed and its likely impact on other vital limbs was known but for proper evaluation the test was done. The dominant cause being Diabetes which excluded the guiding phrase "shall be payable within the terms and condition the policy" will rule out any payment on this ground. Hence the rejection of New India Assurance Company Limited is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 724 / 2003 - 2004
Shri Tushar Shah
Vs.
The New India Insurance Company

Award Dated 9.03.2005

Shri Tushar Shah was covered under a Mediclaim Policy No. 140100 / 48 / 02 / 09571 alongwith his family issued by New India Assurance Co Ltd. He took the Policy initially from l4th December 2000. However, while renewing the policy from l4th December 2002 there was a gap of more than one month for which a fresh Policy was given from 16.1.03 to 15.1.04. Mast. Harsh Shah, his son aged 9 years was covered under this policy for a sum insured of Rs 25,000/-. Mast. Harsh Shah had developed some complications in the ear for which he was hospitalized in Gandhi Nursing Home, Santacruz from 9.6.03 to 16.6.03. He was diagnosed having right ear Cholesteatoma. However, when the claim was lodged with New India, it was rejected by their TPA M/s Paramount Health Services Pvt Ltd vide their letter dated 8.8.03 on the ground that the disease was not covered as per the clause 4.1, i.e. it was pre - existing disease. The complainant's representation was also not considered by New India on the same ground and therefore he approached Insurance Ombudsman's Office with his letter The records of the case were gone through and the parties were called for a personal hearing. All these documents have been made available to this Forum and taking into consideration of their submissions, notings in hospital case papers and Doctor's certificate as produced before this Forum, it is observed that Master Harsh Shah had developed Cholesteatoma, Attic Polyp and Adenoid Hypertrophy. The classical theory of Adenoid Hypertrophy is that it occurs as a result of enlargement of the pharyngeal tonsil and it occurs most commonly to children and may often be congenital or through infection. The attending physician has pointed out that this disease was contracted at least one year back before the hospitalization in June 2003. In other words, by a plain calculation Dr. Nilesh Shah treated him around June 2002. The complainant has admitted that there was delay in taking the renewed policy in December 2002 as the renewal notice did not reach him in time and the company confirmed that a fresh policy was given from 16.1.2003 i.e. after a lapse of 32 days. As the Policy for 2003 - 04 was taken as a fresh one it was the duty of the insured to declare any past ailment which was not done. Hence even discarding the classical theory that it would most commonly be congenital defect, the reasonable conclusion would be that the insured failed to declare it at the time of taking the fresh policy in 2003 for which it was pre - existing and not disclosed. Accordingly the decision of

the company to treat it as a pre - existing disease is sustainable as per terms of the Mediclaim Policy.

Mumbai Ombudsman Centre
Case No. GI - 525 of 2003 - 2004
Shri Arjundev Chhabilchandra Chandan
Vs.
United India Insurance Co. Ltd.

Award Dated 28.03.2005

Shri Arjun C.Chandan and his wife Laxmi Chandan was covered under mediclaim policy of United India Insurance Co. Ltd. Smt. Laxmi was hospitalised at Bombay hospital for cancer treatment. The Company informed Shri A.C.Chandan that the claim for his wife's hospitalisation was repudiated under Exclusion Clause 4.1 and also on non - disclosure of the material facts. There was a delay in paying the premium for 6 days and United India issued a fresh policy as per policy terms. United India has also confirmed at the hearing and it was proved by document by the complainant Shri A.C.Chandan that he had continuous insurance from 1989 and even before with United India. He has also confirmed having received the payment of claim in 1989 for treatment of breast cancer of Smt. Chandan. The later complications in 2001 were as a result of the earlier disease of cancer which was already covered under the policy. She also confirmed that radiotherapy was considered for settlement as it was under the previous policy while only the cost of chemotherapy which was lodged against them was held up on grounds of disease being pre - existing. It seems quite awkward and unethical that in respect of a disease giving rise to a claim which was already settled by the Company could be taken as pre - existing on the ground of the technical lapse of delay that too, not beyond 7 days but within 7 days. It is admitted that 7 days relaxation clause is not automatic nor it can be demanded by the Insured and hence the penalty provision is in order. However the stipulation that satisfactory health certificate from medical practitioner should be provided would be redundant at least in this case as the Company had the knowledge of breast cancer since 1989 and radiotherapy treatment in December,2001. The certificate they were calling for would have intimated them relapse of the disease. If the note under Clause 11 of the policy is read carefully it would exclude any disease contracted during the period of 7 days extension, in addition to other diseases excluded under the expiring policy. Her cancer was not excluded under the expiring policy and strictly speaking the Insured did not contract cancer during the intervening 7 days period but it was all along a pre - disposing factor and a fall out of the previous disease for which maintenance drugs are normally given. United India has confirmed further that the policy earned Cumulative Bonus continuously till March,02 meaning thereby that except the cancer treatment in 1989 there was no other claim under the policy which proves the bonafides of the Insured. Taking that into consideration and a long period of association with the Insured since 1989 and also that she contracted a critical illness like cancer for which the entire society is sympathetic, the Company should have taken a more humane approach and considered the claim for settlement. Considering the fact that the gap is less than 7 days and also because the Insurance Company did not contact the Insured to obtain satisfactory health certificate but proceeded routinely through their agent to give the health status of the Insured, I decide that the claim should be considered in full.

Mumbai Ombudsman Centre
Case No. GI - 624 / 2003 - 2004
Shri Pashupatinath Tulsiyan
Vs.
The New India Assurance Co.Ltd.

Award Dated 28.03.2005

Shri Pashupatinath Tulsiyan and his wife Smt.Sushila Tulsiyan was covered under a mediclaim policy issued by New India Assurance Co.Ltd. for Rs.1,00,000/- each. Smt. Sushila Tulsiyan got admitted to Bombay Hospital for chest pain and was diagnosed to have hiatus hernia and was treated for the same. The claim was forwarded to New India they rejected the claim on the ground of pre - existing illness (clause 4.1) as also hospitalisation only for diagnosis (clause 4.10).

On analysis of the claim file it appears that the Company's consultant examined the file in the light of the Hospital Indoor Case papers. The history recorded mentioned that Smt. Tulsiyan had sinusitis for 12 years, Asthma since 6 years and Migraine since 6 years. She was admitted with complaints of chest pain and burning sensation but had upper respiratory tract problems as well. Necessary investigations ultimately revealed Hiatus hernia and Dyspepsia. The Company's rejection based on the consultant's view is because of non - disclosure of existing illness while taking the policy. They also feel that hospitalisation was only for investigation which could have been done as an outpatient. The Company felt that the discharge card wrote "USG report awaited" which means only investigations were done.

The Insured Smt.Sushila Tulsiyan has been having the policy for more than four years. She must have had the abdominal pain and a general discomfort for which she did not get admitted to hospital earlier. However, when the complications developed further and she had chest pain also, she got admitted. Hence prima - facie there was a case of admission which was also confirmed by the attending physician. The next point was about investigations done at hospital. The clause which is quoted above clearly spells out the need for investigations to arrive at a diagnosis. Unless investigations are done how the conclusion or diagnosis could be made. The other point is that there must be positive existence of an illness which was very much there. The problems identified as hiatus hernia which is quite different in its symptoms and etiology. Hiatus Hernia is the protrusion of the stomach upward into the mediastinal cavity through the esophageal hiatus of the diaphragm. This could be detected only after ruling out there was no cardiac problems, as the symptoms closely resembled those associated with cardiac conditions. The vital test was endoscopy which is normally done under light sedation and controlled condition. It is not a point that it cannot be done as outpatient but the issue is if one has to rule out the possibility of other allied diseases, it has to go through some tests for which the hospital is the ideal place. For arguments sake, if there was any heart problem, would the Company change its views about the necessity for hospitalisation and the need for various tests? As the diagnosis is hiatus hernia there is a better case for consideration. Considering all these, the Company's decision to reject the claim outright is unacceptable. Nevertheless, the point of non - disclosure and that some investigations were conducted relating to these ailments, I decide that 50% of the claim should be paid.

Mumbai Ombudsman Centre
Case No. GI - 231 / 2003 - 2004
Shri Manhar Sheth
Vs.
The National Insurance Company Limited

Award Dated 29.03.2005

Shri Manhar Sheth alongwith his wife and son was initially covered under United India Insurance Company Limited, Divisional Office from 1997. He had taken another Mediclaim Family Floater policy for an additional coverage from National Insurance Company Limited through Winner Capital & Credit Company Limited covering himself, his wife and other family members in the year 1999. The said policy was further renewed for the period 27.9.2000 to 26.9.2001 under policy No. 260600 / 48 / 00 / 125 / 400 for Insured Value of Rs. 2,00,000/-. Smt Ila Sheth wife of Shri Manhar Sheth was hospitalized at Kamdar Nursing Home and Polyclinic Pvt. Ltd, Mumbai from 20.4.2001 to 24.4.2001 for

cholelithiasis with cholecystitis and cholecystecomy for Gall Bladder stone was done on 21.4.2001. When Shri Sheth preferred claim for the said hospitalisation the Company repudiated the claim. Aggrieved by the decision of the Company Shri Sheth represented to the Grievance Cell and not receiving any reply he approached the Insurance Ombudsman Records were perused and the parties to the dispute were called for hearing On close analysis of the entire records submitted to this Forum it is observed that the insured was suffering from cholelithiasis for pretty long time, thereby causing multiple gall stones, and plenty of abdomen adhesions. Thus it is quite possible that the disease was pre - existing and had he disclosed in the proposal form at the time of renewal with National Insurance Co Ltd the policy must have been issued with necessary exclusion clause and the Company would have restricted the Sum Insured to the existing Sum Insured without any increase. In the meanwhile the company although repudiated the claim on the ground of pre - existing disease, has considered for payment of full sum insured Rs 15,000/- with accrued bonus Rs 1500/- Under the facts and circumstances of the case the company's decision to pay only Rs 16,500/- as detailed above appears to be fully justified.

Mumbai Ombudsman Centre
Case No. GI - 650 / 2003 - 2004
Shri JayantKumar T Parekh
Vs.
National Insurance Company Limited

Award Dated 29.03.2005

Shri Jayantilal Parekh alongwith his wife was covered under a Mediclaim Policy issued by National Insurance Company Limited, D.O. 7, Mumbai since July, 2000. He lodged a claim for Acute renal failure following hospitalisation in Lilavati Hospital from 5.2.2002 to 25.2.2002 and again from 17.4.2002 to 20.4.2002 under the renewed policy 250700 / 48 / 2001 / 8501928 from 10.7.2001 to 9.7.2002. However, the claim was repudiated by the Company on the ground of non - disclosure of past ailments and the disease being pre - existing as per clause 4.1 of the Mediclaim policy issued by the Company. Shri Jayantilal Parekh has approached the Ombudsman's Forum finding no resolution coming from the Company despite making a representation. After perusing the records, the Insurance Company and the Complainant were called for hearing on 21.2.2005. The analysis of the claim file with all documents reveals that the Complainant and the Insured Shri Parekh has contended that the disease was detected for the first time on 25.1.2002 and therefore, the claim was payable. The hospital records made available to this Forum have been thoroughly gone through and it appears the contention is not correct in the face of the past illnesses and treatment received by Shri Parekh. In this context therefore, there has been clearly non disclosure of material facts which goes into establishing the contract between the two parties and in this case it has also acted as a pre - existing ailment which the Insured failed to disclose. In the facts and circumstances, the decision of the Company to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 745 / 2003 - 2004
Dr. Sanju R. Patel
Vs.
The National Insurance Company Limited

Award Dated 29.03.2005

Dr. Sanju R. Patel had taken a mediclaim policy from National Insurance Company, Andheri Branch Office for himself and his family through a Group Scheme of Mls Varishield, Mumbai. Some time in February 2003, Mrs. Fatima Patel, wife of Dr. Sanju R Patel was admitted to Nanavati Hospital with backache and abdominal pain. When the claim was lodged with National Insurance Company, they repudiated the same on the ground that

hospitalization was not for 24 hours and that investigations could have been done without hospitalization. The complainant, Dr. Sanju R. Patel then approached Insurance Ombudsman for his intervention in the matter after perusal of the records both the parties to the dispute were called for hearing The issue here was two - fold (a) hospitalization was not for full 24 hours as required and (b) the hospitalization was only for investigation, which could have been done as outpatient. The company took the stand that minimum 24 hours confinement is a Policy condition under clause 2.3 and it has been violated. The Discharge Card says the diagnosis was Lt. Lumber pain with colitis which is virtually the same. It seems hospitalization was utilized only for a number of investigations which very patently suggest that the Mediclaim Policy was taken advantage of. It was not such a complicated state of health that the entire Medical history of the patient was required to be taken to come to a diagnosis. All the reports were normal and the complaints with which she came stood out to be diagnosed with only a medical term given as “Lumber pain with colitis”. The indoor case papers revealed that two USGs done earlier showed Polycystic ovaries and non - obstructing renal calculus (small). Evidently all these investigations were done as outpatient and without any claim on the Insurance Company. In view of this, the contention of the Company that the provisions of both 2.3 and 4.10 clause are applicable cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 358 / 2003 - 2004
Shri Jivram K Taunk
Vs.
United India Insurance Company Limited

Award Dated 29.03.2005

Shri Jivram K Taunk had taken insurance cover for the first time for the period 3.3.1999 to 2.3.2000 for himself which was renewed further for the year 3.3.2000 to 2.3.2001 and 3.3.2001 to 2.3.2002. When the said policy came for renewal in the year 2002, Shri Taunk could not renew and based on the fresh proposal from the Company issued Mediclaim under policy No. 230103 / 48 / 0l / 01968 for the period 15.3.2002 to 14.3.2003 for Rs. 50,000. The said policy was with a gap of 13 days. Shri Taunk was hospitalized at Balaghat hospital, Madhyapradesh on 6.2.2003 to 7.2.2003 for right eye cataract operation with IOL. When Shri Taunk preferred a claim to United India Insurance Company Limited for the cataract surgery which was carried out in his right eye the Company repudiated the claim, as the claim being in the first year of the policy. His representation to the Company was also not considered. Aggrieved by the decision of the Company, Shri Taunk approached the Insurance Ombudsman for redressal of his grievance. After perusal of the records parties to the dispute were called for hearing.

The analysis of the claim file reveals policy was not continuous but was interrupted with a break of 13 days for which it was treated as a fresh policy. On a deeper analysis it appears that the Insured Shri Jivram K Taunk had actually taken the policy since 3rd March, 1999 and got it renewed till 2nd March,2002 i.e. , for 3 years without any break. There was delay in renewing the policy from 3rd March, 2002 and instead it was renewed from l5th March, 2002 to 14th March,2003. After studying the case, I feel, it is an extremely technical view that the Company has taken which is devoid of any logic, equity and justice. Can anybody deny that Shri Taunk had actually the policy running for three years in succession and that he earned Cumulative Bonus as well. The delay if incidental, deserves consideration and that is why the provision has been inserted within the policy. However, the delay was beyond seven days but the basic reason for which the first year exclusion clause has been imposed is to discourage cases of planned surgery. If the Insured had any intention he could have lodged it in the second or third year. The very fact he has not done so, goes to show that he came to know of serious complication only after 3 years and in fact the policy was in operation for 3 years before the cataract surgery. On this ground it merits

consideration and I decide that the decision of repudiation by the Company is strictly not in order from medical and ethical point of view.

Mumbai Ombudsman Centre
Case No. GI - 607 / 2003 - 2004
Shri Jignesh P Shethia
Vs.
United India Insurance Company Ltd,

Award Dated 30.03.2005

Shri Jignesh P Shethia was covered under a Mediclaim Policy No. 121200 / 48 / 00 / 12601 issued by United India Assurance Co Ltd, Malad Divisional Office. He was initially covered as a member of the family with New India in 1996 and later on took the policy from United India in his own name from 1999. He noticed some swellings in his forearm since 3 months before hospitalization on 29.10.2001. These were examined by the physician and he was advised surgery for which he was admitted in Bombay Hospital & Research Centre on 29.11.2001 and discharged on 30.10.2001 after the surgery. However, when he put up the claim for reimbursement of expenses incurred, United India rejected the claim on the ground that it was a cosmetic / plastic surgery, which was not covered under Exclusion Clause 4.5 as per Mediclaim Policy. He contested this decision of the company and represented to them which was not accepted and finally he approached Ombudsman's office for his intervention and resolution of the dispute. The records were perused and both the company and the complainant were called at a hearing The claim papers have been examined at this Forum in consultation with the medical opinion and the relevant documents produced before this Forum. The ailment was diagnosed as "Lipoma" and on going through the hospital notings as per the Discharge Summary of Bombay Hospital and Medical Research Centre it has been mentioned that there were swellings of different dimensions in Right forearm and therefore diagnosed as "Multiple lipoma and excision of multiple lipoma". As the issue is resting on the point as to whether excision was needed or not and the most accepted view would be that if any swelling is allowed to remain in the body for long, it would be appropriate to find out the cause of such swelling to eradicate the possibility of malignancy. In doing so some investigations would be necessary and the physician being the best Judge of the situation if he feels that these swellings should be removed both for diagnostic and therapeutic purposes, it should be acceptable. The issue of cosmetic or aesthetic surgery is also relevant as the external swellings were benign and did not cause any emergency situation. Taking a balanced view on both sides, I decide that while the Complainant's contention can be accepted yet full settlement cannot be granted. In the facts and circumstances United India Insurance Co Ltd is hereby directed to settle 50% of the admissible expenses incurred at Bombay Hospital by the insured Shri Jignesh P Shethia for excision of lipomas

Mumbai Ombudsman Centre
Case No. GI - 741 / 2003 - 2004
Smt Farhin I. Zaveri
Vs.
The National Insurance Company Limited

Award Dated 30.03.2005

Shri Meherally Abdul Rahim G, father of Smt Farhin I Zaveri was covered under a Family Floater Mediclaim Policy No.250501 / 46 / 03 / 8500013 issued by National Insurance Company Limited, D.A.B. V, Mumbai through Winner Capital for the period 10.4.2003 to 9.4.2004 for a Sum Insured of Rs. 2,00,000. Shri Rahim was holding this policy from 1998. Shri Meherally Abdul Rahim was hospitalized at Jaslok hospital on 24.6.2003 for hepatic Encephalopathy but unfortunately expired on 26.6.2003. The cause of 7the death as per the certificate issued by Jaslok hospital is "due to Cardiorespiratory arrest in a known case

of Diabetes Mellitus with Cirrhosis of liver with GI bleed with bilateral bronchopneumonia". When Smt Zaveri preferred a claim with the National Insurance Company Limited for her father's hospitalisation at Jaslok, the Company repudiated the claim under exclusion clause 4.9 being "general debility" not payable under mediclaim policy. Aggrieved at the decision, Smt Zaveri represented to the Company and not receiving any response from the Company, Smt Zaveri approached the Office of the Insurance Ombudsman seeking intervention of Ombudsman in the matter of settlement of her father's claim. The parties to the dispute were called for the hearing on 28.2.2005.

The file has been examined with all documents particularly hospital case papers. Jaslok Hospital case papers recorded the ailment and noted the past history. The patient had history of Diabetes Mellitus for 10 to 14 years controlled on medicine and diet. He was alcoholic, had hemiparesis, GI bleeding for which endoscopy was done in 1997 also. The Insured Late Shri Meherally took the policy from 1998 and obviously all these were not declared. In view of clear recording of Diabetes Mellitus since at least 10 years and abdominal and other ailments from 1997, there has been non - disclosure and consequently the ailments are pre - existing also. Accordingly, the decision of the Company to reject the claim cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 610 / 2003 - 2004
Shri M.I.I.Khan
Vs.
The National Insurance Company Limited

Award Dated 31.03.2005

Shri M.I.I.Khan alongwith his wife Smt Kaniz Begam Khan took a mediclaim insurance policy from National Insurance Company Limited, DAB XVII for the first time in the year 1998. Shri Khan approached the Office of the Insurance Ombudsman with a grievance against National Insurance for non settlement of his wife's claim under Policy No.253501 / 02148 / 8501042 for the period 20.9.2002 to 19.9.2003. Smt Kaniz Begam Khan was admitted at J.P.Hospital, Mumbai from 9.12.2002 to 13.12.2002 for Anterior Wall Infarction and when Shri Khan preferred the claim the Company repudiated the claim by letter dated 19.9.2003 invoking clause 4.1 being pre - existence of the disease, non - disclosure and clause 5.5. being non - co - operation.His representation to the Company was also turned down and hence approached this Forum for redressal of his grievances. After perusing the records, the parties to the dispute were called for hearing on 10.2.2005. The issue on which National Insurance denied the claim is the remark of the Doctor in the hospital papers "k / c / o DM" that is a known case of Diabetes Mellitus. This Forum does not have any detailed case history papers of the hospital nor the Company has been able to get those for which a critical analysis is not possible. The Medico - legal Consultant of National wrote to the Complainant Shri Khan to provide them with whatever records of treatment was available on this score which was not responded for which the Company held the charge of non - cooperation under 5.5. clause of the policy. In effect the Company has not been able to prove the duration of the disease diabetes. During hearing Shri Khan claimed that he had the policy since 1995 but due to financial problems renewals were not in time and with gaps in insurance cover finally had the cover from 1998. The records produced by him subsequently shows that he only had the policy from 1995 and not Smt Khan. Hence it could be held that the policy for Smt Khan was considered only when some health complications developed. Diabetes Mellitus is an incurable disease, it can be controlled no doubt through therapy, diet and by leading a regulated life. It has various adverse effects and the most likely effects would be cardiac ailments. The Company has not been able to produce any corroborative evidences to derive some conclusion. The other point of non - cooperation cannot be held too strongly as in host of other cases, the Company is not getting the entire medical records to analyse claims from the point of admissibility or

otherwise. In view of this inconclusive proof and unrecorded duration of the illness the charge of pre - existing illness is not held sustainable entirely and some benefit of the doubt should go to the Insured. Accordingly, the best course would be to grant 50% of the expenses incurred by the Complainant.

Mumbai Ombudsman Centre
Case No. GI - 675 / 2003 - 2004
Shri Rumi G.Engineer
Vs.
The National Insurance Company Limited

Award Dated 31.03.2005

Shri Rumi G.Engineer alongwith his family was covered under mediclaim policy of the National Insurance Company Ltd. He preferred a claim to the company, after cataract operation of right and left eye of his wife, Smt Freny Engineer. She was under the care of Dr.Burjor P.Banaji. The Company referred the matter to Dr. Ismail B. Bandookwala for his opinion. The Company settled the claim for Rs.64,241/-. The complainant mentioned that all the reports and the chemists bills have been submitted to the company in original and therefore their comments that bills worth Rs. 1115/- have not been paid cannot be accepted.

The claim papers have been examined in line with the records made available to this Forum. It appears that the issue is about short reimbursement of the claim by Rs.29,150/- as per the Insured, while the Company feels that the payment made by them is more than adequate by market standard. This Forum has been noticing a clear trend in Cataract surgery where the charges are varying between various hospitals and the Nursing Homes where specialists attend. The other feature coming to notice is that generally Nursing Homes / Eye Hospitals are preferred for such surgeries and some specialist Eye Surgeons are running the clinics themselves charging certain rates. The Company obtained through their consultant charges for cataract and other eye surgeries as per rate charts of top six hospitals in Mumbai and accordingly reduced the charges made at Dr. Banaji hospital. It is indeed quite a high charge going by the standard charges presented before this Forum and accordingly the deductions made by the Company prima facie becomes reasonable. While the Insured can go to any hospital with best of facilities for which very high charges are made, the reimbursement may not be to the full extent as the policy will be acting by the operative clause as it is primarily an insurance policy where reasonableness in the cost structure will have direct relationship with premium rates. This Forum does not have any special knowledge or authority about the charges for various surgeries and therefore cannot dictate this or that cost being just and unreasonable. However, this Forum can certainly go by the market convention and actual practice vis - a vis the charges for similar surgeries made at other hospitals with comparable infrastructure facilities. The TPA has submitted the comparable charges and it appears the charges made at Banaji's hospital are no doubt higher and therefore it appears National's stand was proper. The Operation Theatre charges of Rs.10,000/- for a simple cataract operation is very steep as also dressing and follow - up charges of Rs.5,000/-. Similarly, pathology reports and ECG report not received by the TPA / Company cannot be reimbursed as also payment of lens which amounts to Rs.1,115/- , However, considering that Dr.Banaji is an eminent surgeon although the Company has granted Rs.12,000/- surgeon's fees plus Rs.5000/- as follow - up / dressing charges , it is felt that another Rs.3000/- for each eye may be sanctioned and accordingly the dispute should be resolved by paying another Rs.6,000/- by National Insurance Company.

Mumbai Ombudsman Centre
Case No. GI - 749 / 2003 - 2004
Shri Kanhaiyalal Ruia

Vs.
United India Insurance Co. Ltd.

Award Dated 31.03.2005

Shri Kanhaiylal Ruia was insured under mediclaim policy of United India Insurance Co. Ltd. Shri Ruia preferred a claim for reimbursement of the medical expenses incurred towards his hospitalisation at Breach Candy Hospital and also at Jaslok Hospital for a period for Diabetic Foot. Company referred the matter to its panel doctor, Dr. M.S.Kamath for his medical opinion and after getting his opinion, the Company informed the Insured about the repudiation of the claim under Exclusion Clause 4.1 of the mediclaim policy. The Investigation report together with some other relevant papers have been submitted to this Forum. The Company's view point was based on primarily Dr. Ramachandra Naik's notings about the Insured being a diabetic since 15 years and secondly the fact that the Insured's diagnosis was 'diabetic foot'. Their medico - legal consultant has given his views that the very expression 'diabetic foot' will determine the duration of diabetes as Shri Ruia's foot was amputated because of gangrene in toe. Similarly, he felt that initial noting by Dr. Naik that diabetes for 15 years and on Insulin and OHA would prove that the Insured was having this problem for quite sometime and well before taking the policy. The United India Insurance Company also gave the file for investigation as different notings were made each time a new hospitalisation took place like in Breach Candy hospital it was mentioned 'known case of Diabetes Mellitus since last 2 years', in Jaslok Hospital it was 'Diabetes Mellitus since one month' and in Dr. Ramachandra Naik's prescription it was noted 'Diabetes Mellitus for 15 years and is on Insulin +OHA' while the Insured claimed that he had undergone pathology tests at Dr. Amin's Pathological Laboratory for first time in his life only on 15.12.2001 when he was diagnosed as having Diabetes Mellitus.

In Breach Candy, Shri Ruia was diagnosed as Diabetic Foot (Lt) and Diabetic gangrene of Left foot which had to be amputated. Against these detailed advice, affidavit of Dr. Naik sound inconsistent. Yet a total reading would make it clear that he made a careful statement as also the Insured, Shri Ruia that when he asked him since when he was suffering from diabetes, he told him that he learnt of it on 15.12.2001. Normally, if the question is since when, it should be always replied in terms of months and years and not that one learnt it on a particular day which could suggest anything about the actual duration of the disease without the Insured knowing about it. Secondly, the varying declaration made at different hospitals ranging between one month to two years and 15 years and even in one case for two days would appear ridiculous when the analysis of the disease is made. In view of the invasive approach of the disease and the damage it caused to the lower limbs forcing the surgeons to amputate the foot clearly suggests the disease is age old and most likely the statement of 15 years with insulin and OHA is the correct version. Accordingly, the Company's decision to repudiate the claims on grounds of pre - existing illness (4.1) cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 614 / 2003 - 2004
Shri Rasiklal Sheth
Vs.
United India Insurance Co. Ltd.

Award Dated 31.03.2005

Shri Rasiklal Sheth was covered under a Mediclaim Policy alongwith his wife Smt. Damyanti Sheth since 30th August, 2001 with United India Insurance Co Ltd, Borivali Divisional Office. He was admitted at Suvarna General Hospital from 11.9.2002 to 14.9.2002, S. R. Mehta Heart Institute on 6.12.2002, at Karuna Hospital from 21.6.2003 to 22.6.2003 and at Lilavati Hospital from 22.6.2003 to 4.7.2003 with a complaint; initially of Ischaemic Heart Disease and subsequently Upper GI bleed and haematemesis (vomiting of blood). However, when the claim was reported and claimed from United India, the Company

took the opinion of Medicolegal Consultant and based his opinion the claim was repudiated vide their letter dated 28.11.2003 on the ground that his previous ailments were not disclosed and this constituted pre - existing ailment of Ischaemic Heart Disease coming under clause 4.1 of the Mediclaim Policy.

The company also took the stand that the insured did not cooperate with them in giving his past history and therefore it came under exclusion clause 5.7 of the Medicalim Policy. The Insured admitted that he had originally a policy since April 1994 which was not renewed on time and hence a fresh policy was taken from 13.8.2001 after a gap of 4 months. He had an episode of Myocardial Infarction (ASMI) in 1999 as per record of Suvarna Hospital which is also evident from the ECG showing old MI which was recorded in the hospital paper. The Insured was also having HTN and was on medicine by the time he got his policy with United India. To a specific question as to whether he had any heart disease, he replied that he had done which proved a wrong statement as his “unstable angina” was detected earlier. His CAG report in December 2002 revealed 100% occlusion of LAD & RCA produced long lesion with 70% for which CABG was advised. This status required time to develop and points to earlier complications as per history noted in Suvarna Hospital. His next contention was that he suffered from GI bleed which is unrelated to the heart ailments but the point would be first of all there was non - disclosure about past ailments material and vital to the contract and secondly there was a wrong statement after lodging the claim. On both these counts, the claim can be repudiated.

Mumbai Ombudsman Centre
Case No. GI - 714 / 2003 - 2004
Smt.Hemlata Khandelwal
Vs.
The Oriental Insurance Co. Ltd.

Award Dated 31.03.2005

Smt. Hemalata Khandelwal alongwith her son was insured under mediclaim policy of the Oriental Insurance Co.Ltd. She preferred a claim to the Company after her hospitalisation at Wockhardt Hospital for Incisional Hernia right side. On 24.09.2003 they informed Smt. Hemalata about their inability to settle the claim. Not satisfied with the decision of TPA, she represented to the Company. The Company in turn referred the matter to its panel doctor, Dr. M.S.Kamath for his opinion and accordingly, the Company repudiated the claim on the basis that the disease was pre - existing and also mentioned that the proposal form does not reveal the history of the past LSCS (Caesarean) surgery undergone 14 years ago.

The dispute here is quite technical and requires an understanding of the disease hernia which as the name suggests, is any protrusion of an organ through the wall of the cavity that normally contains it. The expression incisional hernia is one amongst many forms of hernia. The meaning of ‘incisional’ is clearly understood which refers to any incision made and giving rise to a herniation through the scar of incision. Usually any incision in the abdomen region would make abdominal wall rather weak and vulnerable. The Caesarian section though done 14 years back could act as a predisposing factor. Here by diagnosing it to be incisional it has been clearly meant to be arising out of incision and therefore, caesarian section earlier would act as a pre - existing condition. It occurs from the scar of previous surgery and the hospital record has put the operative note as “repair of incisional hernia”. Hence irrespective of the age of surgery done earlier it would act as a pre - existing status as also the fact that such an important surgery was not disclosed. Accordingly, the decision of the Company to repudiate the claim on ground of 4.1 i.e., pre - existing ailment cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 742 / 2003 - 2004
Smt Nita S Agarwal

Vs.

The New India Assurance Company Limited

Award Dated 31.03.2005

Smt Nita S Agarwal was covered under the Mediclaim policy issued by The New India Assurance Company Limited, Divisional Office - 141700 from August, 2000. Smt Agarwal was hospitalized at Mahavir Medical Research Centre from 28.7.2003 to 7.8.2003 for P.V.Bleeding, DM, HT, Hyperlipidimia / Hypothyroidism and she had undergone Abdominal Hysterectomy. When a claim was preferred by Smt Agarwal for the said hospitalisation under Policy No.141700 / 48 / 02 / 01308 the Company based on their panel doctor's opinion repudiated the claim invoking clause 4.1 of the mediclaim policy. Aggrieved by the decision of the Company Smt Agarwal represented to the Company and not hearing anything from them approached the Office of the Insurance Ombudsman.

After perusal of the records parties to the dispute were called for hearing on 11.2.2005. On an analysis of the entire records it can be concluded that the Hypertension associated with Diabetes Mellitus for which Smt Agarwal was on medication proves rather continuity although exact duration is not known. However, the case history papers of Mahavir Medical Centre have recorded under 'medicines advised' column "Oral anti - diabetic medicines as previously" which clearly indicates that the hospital did not interfere with or withdraw the oral medicines of diabetes which is known as OHA. Oral hypoglycemic agents means that he was on medicines which is clearly explained in Taber's medical dictionary as "Sulfonylurea compounds that cause a decrease in blood sugar". As per proposal form submitted in August, 2000 the insured did not disclose either earlier cataract operation or any of the ailments viz. hypertension, diabetes and hypothyroidism. In that sense if cataract surgery would have been disclosed and necessary medical records would have been submitted, the Company would have gone into details and examined whether other diseases were also pre - existing at that time. This opportunity was not given to the Company because of non disclosure of cataract.

As per analysis made it is evident there was non - disclosure of cataract surgery and it was highly probable that Hypertension / Diabetes Mellitus pre - existed the inception of the policy taken in 2000 for which the decision of the Company to repudiate the claim under Exclusion clause 4.1 need not be interfered with.

Mumbai Ombudsman Centre

Case No. GI - 685 / 2003 - 2004

Shri Jagdish Kumar Mehra

Vs.

The New India Assurance Company Limited

Award Dated 31.03.2005

Shri Jagdish Kumar Mehra was covered under Mediclaim Policy issued by The New India Assurance Company Limited, D.O. 142000 for a sum insured of Rs. 1,20,000 under Policy No.142000 / 48 / 01 / 02028 for the period 06.07.2001 to 05.07.2002. Shri Jagdish Kumar Mehra was admitted to Vaidyaratnam P. S. Varier's Kottakkal Arya Vaidya Sala, Kerala from 3.2.2002 to 4.3.2002 for the treatment of Cervical Spondylosis. When the claim was preferred by Shri Mehra to the Company, the Company referred the matter to their panel doctor and based on their opinion rejected the claim vide letter dated 22.5.2002 stating hospitalisation for the said ailment was not required.

Not satisfied with the decision of the Company, Shri Mehra represented to the Insurance Company but the Company reiterated their stand of repudiation and hence aggrieved by the same, Shri Mehra approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim.

After perusal of the records parties to the dispute were called for hearing on 12.1.2005. The file has been critically examined and it is evident that Shri Mehra was having Osteo

Arthrities of finger joints for 25 years (approx) and was carrying on with Spondylolysis for 3 years as per his admission. Apart from the issue of continuous illness for a long time which will be a quite a relevant pre - existing illness, the very fact that such a treatment was chosen would go to show that it was a planned one. A long stay of one month to treat this illness may be usual for Ayurvedic line of treatment but inconsistent with the mediclaim policy terms and conditions. From the above analysis it would appear that Shri Mehra had preferred Ayurvedic treatment more for toning up his general state of health. All these suggest stay in a hospital would not be necessary. In the facts and circumstances, the decision of the company to repudiate the claim cannot be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 579 / 2003 - 2004
Smt Jayshree D Parvatkar
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

Smt Jayshree D Parvatkar alongwith her husband and children were covered under mediclaim policy issued by The New India Assurance Company Limited under policy No. 111900 / 48 / 01 / 08858 for the period 22.3.2003 to 21.3.2003 for a Sum Insured of Rs. 1,00,000 with 25% Cumulative Bonus. It is reported that they were insured with the Company since 1998. Shri Deepak Parvatkar, husband of Smt Jayshree Parvatkar was hospitalized at Sanjeevani Hospital on 27.2.2003 to 28.2.2003 for Hypertensive Heart Disease. When Smt Parvatkar preferred a claim for the said hospitalisation, the Company based on the opinion of their panel doctor, rejected the claim vide their letter dated 31.7.2003 under exclusion clause 4.10. and clause 2.3 being hospitalisation was for less than 24 hours. Not satisfied with the decision of the company Smt Parvatkar represented to the Company alongwith from Dr. Dhruman Desai which was also turned down. Hence aggrieved by their decision Smt Parvaatkar approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of her claim. The records have been perused and the parties to the dispute were called for hearing.

As regards hospitalisation being not necessary, the relevant records produced before this Forum would be vital for consideration. The hospital papers have recorded the diagnosis as “Hypertensive Heart disease”. The patient was noted to be hypertensive for 3 / 4 years and also had an old Myocardial Infarction which was revealed in the ECG and Echo D. With such a history when a person gets profuse sweating accompanied by chest pain, nobody would take the risk of keeping him at house and endanger his survival. The issue now important should be whether he was having hypertension before the policy was taken. It is distinctly proved to be not so as he claimed to have the policy for many years and it was for New India to challenge the same. Even going by 10% Cumulative Bonus on 1999 policy No.111900 / 48 / 99 / 01 / 139 it would prove that the policy was from 1997 at least without any claim. Hence the uninterrupted, unclaimed policy was free from 1997 and HTN being of 3 / 4 years easily cause to fall after the policy was taken and hence not pre - existing.

In the facts and circumstances the decision of the Company to repudiate the claim is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 703 / 2003 - 2004
Shri Prafullchandra N Kataria
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

Smt Usha P Kataria took a mediclaim cover for the first time on 18.1.2000 for a Sum Insured of Rs. 1.5 lacs which was later increased to Rs. 5 lacs from 18.1.2002. Smt Kataria was hospitalized at Hurkisandas Nurrotumdas Hospital on 29.12.2002 for treatment of interstitial lung disease and for breast cancer. She unfortunately expired on 6.1.2003. When Shri Kataria preferred a claim for the said hospitalisation the Company based on their panel doctor's opinion repudiated the claim. His representation to the Company was also turned down. Hence aggrieved by the decision, Shri Kataria approached this Forum for redressal of his grievances.

After perusing the records, the parties to the dispute were called for hearing on 4.2.2005..

The relevant records submitted to this Forum have been scrutinized and it is revealed that the Insured had suffered from breast cancer and underwent surgery in 1997 followed by Radiotherapy in 1998 and she was undergoing chemotherapy treatment. During the admission in Hurkisandas hospital on 29.12.2002 she was detected to develop left sided pneumothorax for which fluid had to be drained out. The insured expired on 6.1.2003 due to Cardiorespiratory arrest with interstitial lung disease.

In the proposal form dated 18.11.2000 the insured did not disclose about the treatment taken by her for carcinoma of breast and the treatment of chemotherapy that she was undergoing, as a result of which policy was issued without any restriction. This is a serious lapse and non - disclosure vital to the contract of insurance and the policy which was issued could be avoided by the Insurer as per law. Accordingly the Company's rejection of the claim by invoking policy condition 4.1 of the policy which makes it both non - disclosure and therefore, pre - existing is in order.

Mumbai Ombudsman Centre
Case No. GI - 757 / 2003 - 2004
Shri Champalal R.Jain
Vs.
The New India Assurance Co.Ltd.

Award Dated 31.03.2005

Shri Champalal R.Jain was insured under mediclaim policy of National Insurance Co. Ltd. since 1996 and in the year 2002, he transferred it to The New India Assurance Co.Ltd. Shri Jain preferred a claim to the Company, after his hospitalisation at Bombay Hospital for operation of TURP for (Prostrate microsurgery) Benign Prostrate Hypertrophy (BPH). The Company repudiated the claim under Exclusion Clause 4.1 of the mediclaim policy.

The analysis of the claims together with relevant records made available to this Forum makes it clear that the Insured was admitted to Bombay Hospital with serious problems of Urine incontinence, frequency of micturition and urgency to relieve which are classical symptoms of prostrate hypertrophy. Normally people with such complaints are not immediately operated and they are treated with medicines as far as possible and surgery becomes the last resort. It will be logical to hold such a thing happened here also. The reason to hold this view is the fact that the department of Urology noting dated 11.11.2002 specifically writes "Shri Champalal Jain was suffering from burning sensation in passing urine off and on since 10 years signed by Dr. Raju Joshi under whose care he was admitted. Dr. Joshi also gives a certificate dated 30.8.2002 where he writes "Mr. Champalal Jain was suffering from minor urinary symptoms since about 10 years not requiring any surgical treatment". Precisely that is the point raised by the company as he became quite critical during last 6 months leading to his hospitalisation. However, the condition remained for quite sometime which acted as pre - disposing factor and therefore, the illness existed for some time with common complaints earlier. Both lateral lobes were enlarged and it was adenomatous hyperplania Prostrate which explains the duration and status of the hypertrophy. Over and above, Shri Jain had hypertension and he was on medicine Atenolol 50 mg.

Considering the notings and confirmation by Doctors as per their certificates about duration of urinary complications, the defence taken by the Doctor to suggest that the patient was asymptomatic cannot be accepted as a valid ground for ignoring the past complaints not being linked to later prostrate hypertrophy.

Mumbai Ombudsman Centre
Case No. GI - 637 / 2003 - 2004
Smt Aruna J Shah
Vs.
United India Insurance Company Limited

Award Dated 31.03.2005

Smt Aruna J Shah took the mediclaim policy for the first time on 28.3.2001 from United India Insurance Company Limited, D.O. I. Smt Shah was hospitalized at Sir Hurkisondas Nurrotumdas Hospital and Research Centre from 3.12.2002 to 19.12.2002 for Decompressive laminectomy D7 - D9 removal of intradural extramedullary tumour. When the claim was preferred by her to the Company for the said hospitalisation, the Company appointed an investigator to look into the case and based on his report the Company rejected her claim vide their letter dated 11.7.2003. Aggrieved for not receiving any written communication from the Company about the claim following her representation, she approached the Office of the Insurance Ombudsman for justice vide her letter dated 21.1.04.

After the perusal of the records parties to the dispute were called for deposition on 16.2.2005. After considering the submission of the Complainant and perusal of the papers on record it is noticed that Smt Aruna J Shah took mediclaim policy in the month of march, 2001 which was renewed under Policy No. 020100 / 48 / 01 / 09235 for Sum Insured of Rs. 50,000/- from 27.3.2002 to 26.3.2003. She was hospitalized on 3.12.2002 in Sir Hurkisondas Nurrotumdas Hospital, Mumbai as she was having tingling sensation on sole of foot with backache since one month and she was losing balance while walking. On 10.12.2002 intradural extramedullar tumour was removed. Decompressive laminectomy D7 - D9 also was done. The Company's rejection has come on grounds of non - disclosure and pre - existing ailment which, in light of the conclusive findings of the MRI report is in order and hence does not require any interference.

Mumbai Ombudsman Centre
Case No. GI - 508 / 2003 - 2004
Shri Vamaya B Shetty
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

In the matter of the above complaint the dispute is only for non - payment of Rs. 15,000/- as charged by Dr. Ramakanta Panda, Cardiac Surgeon, reportedly assisting Dr. Jamshed J Dalal, Consultant Cardiologist who performed Angioplasty on Shri V.B. Shetty at Breach Candy Hospital on 2.10.2002. Shri Shetty was insured with The New India Assurance Company Limited under the policy No.130700 / 48 / 01 / 03346 and his claim has been fully settled by New India as per the discharge Voucher received by the Company for Rs. 4,64,535/-. However, as there was a deduction of Rs. 15,000 being the fees of Dr. Ramakanta Panda he lodged a complaint with Ombudsman's Office having failed to convince New India about the merit of his claim for this amount. Having gone through the records, both New India and the Complainant were called for a personal hearing. The case has been examined at this Forum and after analyzing the entire records it is found that the entire money was paid in cash. Payment by cheque is a valid recorded document and therefore, the exact authenticity is not established. For angioplasty which is done by

different set of Surgeons, nothing extremely critical or serious nature is envisaged in a hospital like Breach Candy and particularly being handled by Dr. J Dalal a noted Surgeon. Moreover, even if Dr. Panda was there as an associate surgeon to be paid, it should have been immediately logged in the operative notes and registers and then there was no need for Dr. Dalal to certify, he should have directed Shri Shetty to ask for an official confirmation from the hospital authorities, O.T. Supervisor straight away. Finally mediclaim policy is guided by the basic principle of "reasonably and necessarily incurred" expenses to get reimbursement and therefore, if there is any payment not fully substantiated the same may be rejected. Accordingly the Company's decision not to admit the claim for Rs. 15,000 is upheld.

Mumbai Ombudsman Centre
Case No. GI - 623 / 2003 - 2004
Shri Kishore R Jagasia
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

Shri Kishore Jagasia took a mediclaim policy from The New India Assurance Company Limited, D.O. 110600 and he lodged a claim under Policy No.110600 / 48 / 02 / 02553 for excision of mass on vocal chord for which he was hospitalized at Breach Candy Hospital on 24th May,2003. The Company rejected the claim vide their letter dated 27.8.2003 on the ground that a similar episode was diagnosed as vocal nodule as per notings of the discharge card for which he was operated 20 years back. The Company contended that it fell under exclusion clause 4.1 as also non disclosure of material fact. Shri Jagasia represented the case however, the Company rejected the claim on further representation.Aggrieved at this decision Shri Jagasia approached the Insurance Ombudsman's Office. The case has been duly examined and the parties to the dispute were called to depose before the Ombudsman. After analyzing the file with available records together with the hospital discharge summary and indoor case papers, it appears that the Insured had problem of hoarseness in voice which was diagnosed as vocal nodule for which he was operated 20 years back. It is evident from the history that Shri Jagasia was vulnerable and susceptible to vocal chord problems once having operated for nodules and later excision of the mass was a further device to restore his voice to normal calibre. It is admitted that this part of the body i.e.larynx is very sensitive and is given to recurring problems with mildest provocation more so with a past history of this nature. Considering that the New India was not provided with an opportunity to underwrite or accept the business at the time of taking the policy in 1999 with full knowledge, it would constitute non disclosure as also pre - existence of the ailment for which their rejection is in order.

Mumbai Ombudsman Centre
Case No. GI - 559 / 2003 - 2004
Shri Manoj C.Bolur
Vs.
United India Insurance Co. Ltd.

Award Dated 31.03.2005

Shri Manoj C.Bolur was insured under a policy issued by United India Insurance Co. Ltd. The policy was serviced by M/s Family Health Plan Ltd. Shri Bolur was hospitalised at P.D.Hinduja National Hospital for fever. When he preferred the bills against United India Insurance Co. Ltd., the Company rejected the claim on the ground that investigations could have been done on outpatient basis. The case has been examined at this Forum and after analysing the relevant records it appears that Shri Bolur was admitted only for evaluation of fever and the diagnosis as per the discharge card is "fever for evaluation".

Consequently, in the hospital various tests were done including CT scan, Abdomen sonography, X - ray chest and routine blood report were all normal except the sonography which suggested mild hepatomegaly and mild splenomegaly. This was followed up with blood report and hepatitis B check specially which were positive and accordingly treatment was suggested. Clearly the Insured had fever for 15 days which was not coming down and therefore all these tests were done. It should be seen that none of these tests require hospitalisation and in fact the ultrasonography and blood report together with chest x - ray are the usual suggestions which any doctor would give. The entire treatment could have been conducted as an outpatient only and such cases were being treated in that manner only. The mediclaim policy is having an important provision mentioned in the preamble of the policy itself. It mentions that reimbursement will be allowed only when such expenses are “reasonably and necessarily” incurred. This is obviously to exclude only such cases where only investigations would be made to come to the conclusion. The hospital notings following admission and investigation would support the above clause. On admission it was written ‘fever’ and on discharge the diagnosis was ‘fever for evaluation’. As regards treatment he was given only Crocin on admission and later it was remarked “follow up with Hb Ag”. The discharge summary noted “N.AD (No abnormality detected) and advice given “contact OPD after 7 days” with pending reports of CT chest which was also a clear report. In the facts and circumstances, the decision of the Company to reject the claim on grounds of clause 4.10. is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 632 / 2003 - 2004
Shri P. N. A. Narayanan
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

Shri P.N.Anantha Narayanan alongwith his wife Smt Mangalam Narayanan took a mediclaim policy from The New India Assurance Company Limited, D.O. 111200 for the first time on 17.8.2001. When Shri Narayanan lodged a claim under Policy No. 111200 / 48 / 02 / 04303 for his wife’s hospitalisation at Kumar’s Maternity and Surgical Nursing Home from 24.9.2002 to 30.9.2002 for total abdominal hysterectomy, the Company rejected the claim vide their letter dated 25.2.2003 invoking exclusion clause 4.1 on the ground of pre - existing disease and non - disclosure of material fact. Shri Narayanan represented his case to the Company which was also turned down and hence aggrieved by this decision, Shri Narayanan approached the Insurance Ombudsman’s Office. The case has been duly examined and the parties to the dispute were called to depose before the Ombudsman. On analysis of the claim as dealt with by The New India Assurance Company Limited read in conjunction with the records submitted to this Forum, it is noticed that the Insured had history of Menorrhagia since 2 years i.e. prior to the inception of the policy on 17.8.2001. Before admission in the said hospital the insured was attended by Dr.(Mrs.) Medha A Oak, Cardiologist and Diabetologist and as per her certificate dated 16.9.2002 the insured was known case of Hypertension on medicine Aten (50) and Amlong (5) and she had strong family history of Hypertension. Consequently the decision of the Company to repudiate the claim on this ground is tenable and does not warrant any interference.

Mumbai Ombudsman Centre
Case No. GI - 558 / 2003 - 2004
Smt. Vidyadevi J.Sharma
Vs.
United India Insurance Co. Ltd.

Award Dated 31.03.2005

Shri Jagdish Prakash Sharma was insured alongwith his family with United India Insurance Company Ltd., for a Sum Insured of Rs.
50,000/-. On the renewal of the policy his wife Smt. Vidhyadevi J.Sharma was hospitalised for breathlessness and severe palpitation at Purnima Hospital. She was diagnosed to have Supra Ventricular Tachycardia (SVT) and when the claim bill was put up to TPA M/s Family Health Plan Ltd. as nominated by United India, they repudiate the claim under their letter dated 14.10.2003 on the ground that she had hypertension which was not disclosed and it became a pre - existing condition. Shri Sharma approached United India with his request for reconsideration which was also accepted by the Company. He then prepared his claim to Ombudsman Office through his Technical Advisor Shri M.C.Shah dated 16.12.2003. Subsequently, the correspondences were made by Shri Vidhyadevi Sharma with Ombudsman's Office.

United India rejected the claim on the ground that hypertension was not disclosed and because of pre - existing condition. It seems there was no analysis and critical examination by the Company as to what was the diagnosis and what is the causative connection between the disease detected and hypertension. The repudiation letter of the TPA was not explicit about the cause and linkage if at all hypertension was there. First of all let us examine the diagnosis which was Supra Ventricular Tachycardia (SVT) which means "a fast heart beat stemming from an abnormal area in the atria of the heart. It is often benign and relatively easily treated". It is possible that because of fast heart rate, hypertension was marked as a symptom and the medical theory says with faster rates it could result into fall in blood pressure over a period of time with reduced capacity of heart's pumping ability and may result into failure of heart as well. While 2D Echo gave a clean chit clearing all doubts about apparent heart problems, the blood report was positive for anemia with low haemoglobin and the impression was hypochromia (+) Microcytosis (+) Anisocytosis (+). The cryptic noting of "k / c / o Hypertension" as made by the hospital has been taken by the TPA as hypertension which normally it is, but whether with this anemic condition it was hypotension (low B.P.) was not checked by them with hospital indoor case papers. In that context, the repudiation has been unfounded and more so, with the actual above mentioned diagnosis made. Hospital is a place where the investigations under a well - managed environment can lead to some conclusion and that way it was essential. Having made the analysis both ways and the company not being able to establish the duration of Hypertension and its direct nexus with SVT, the best course would be set aside total rejection of the claim made by the Company but to grant only 50% to meet the ends of justice.

Mumbai Ombudsman Centre
Case No. GI - 595 / 2003 - 2004
Smt.Neela N.Vaidya
Vs.
The New India Assurance Co.Ltd.

Award Dated 31.03.2005

Smt.Neela N.Vaidya was covered under a policy issued by The New India Assurance Co.Ltd. Smt.Neela N.Vaidya fell sick and was hospitalised in Bombay Hospital for pain in right Iliac Fossa for which detailed investigations were done which was diagnosed as thickening of IC Junction. The Company rejected the claim on the ground that hospitalisation was not necessary (Exclusion 4.10). The claimant, Smt. Neela Vaidya approached the Company for reconsideration which was not met, for which she approached Insurance Ombudsman.

The Company has submitted the hospital discharge card summary from which it appears that Smt. Neela Vaidya was admitted on 22.01.2003 and was discharged on 24.01.2003 for pain in right Iliac Fossa. Certain investigations were done at the hospital like ultra sonography and colonoscopy. The sonography gave a lead that some complications in the

Iliac region for which colonoscopy was done and diagnosed as thickening of IC junction. The entire issue is resting on whether hospitalisation was necessary for the purpose of such investigations. The Insured's contention is that because of acute pain, she was admitted in the hospital and the hospital is the place where a comprehensive treatment is available to find out what exactly were the complications. Iliac Fossa refers to one of the concavities of the iliac bones of the pelvis. The analysis would reveal that since there was pain in the abdomen it had to be diagnosed and for which investigation was a must. The provision of 4.10 need not be taken too rigidly in this case, as without investigation the diagnosis is not possible. The next issue raised is whether it could be done as an outpatient, the answer would be 'yes' but this point could be raised only after the diagnosis was made that pain was due to thickening of Ilioncecal (IC) junction. The Company's Consultant's argument that the investigations could be done as an outpatient and hospitalisation was not necessary was based on this knowledge, after the investigations were done. The New India Assurance Co.Ltd. is directed to entertain the claim of Smt. Neela N.Vaidya for her admission at Bombay Hospital for pain in right Iliac Fossa and thickening of IC junction from 22.01.2003 to 24.01.2003.

Mumbai Ombudsman Centre
Case No. GI - 641 / 2003 - 2004
Smt Raksha Jasani
Vs.
National Insurance Company Limited

Award Dated 31.03.2005

Smt Raksha Jasani who was covered under the mediclaim policy issued by National Insurance Company Limited, D.O. IV had lodged a claim under Policy No.250400 / 48 / 02 / 85 / 02095 for total abdominal hysterectomy for which she was hospitalized at Dr.Balabhai Nanavati Hospital from 18.5.2003 to 26.5.2003. The Company based on their panel doctor's opinion rejected the claim vide their letter dated 14.7.2003 on the ground of pre - existing disease by invoking clause 4. 1 of the mediclaim policy. Smt Jasani represented her case and the Company took a second opinion from their panel doctor and based on the report reiterated their decision of repudiation on 14.11.2003. Aggrieved at this decision Smt Jasani approached the insurance Ombudsman's Office. The case has been duly examined and the parties to the dispute were called to depose before the Ombudsman. The review of the claim file at this Forum reveals certain features which are vital for admission or otherwise of the claim. First of all the policy was taken only in September, 2000 for the first time by Smt Jasani. Thereafter it had a gap of more than a month of the next renewal making the Company treating the policy as a fresh one as per the terms of Contract and as per Standard Mediclaim Policy. Second point would be the nature of illness. The discharge card and the Indoor case papers noted that the patient was having lower abdomen pain since few years. It is also mentioned that Smt Raksha Jasani had undergone treatment for gynac disorder under the Doctor in 1997 - 98. She had D & C done in 1997, had medical termination of pregnancy 15 years back and the notings are replete with all gynac problems. In her case it was abdominal hysterectomy with bilateral salpingo oopherectomy. Considering the past history which are all related to the present complications, and the progressive growth of fibroids, the decision of the Company to reject the claim on the ground of pre - existing illness which was also not disclosed cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 748 / 2003 - 2004
Smt Archana B Joshi
Vs.

The New India Assurance Company Limited

Award Dated 31.03.2005

Shri Bhaskar V Joshi alongwith his wife Smt Archana B Joshi had taken the mediclaim' cover for the first time in the year 1999 for the period from 30.6. 1999 to 29.6.2000. This policy was renewed for the period 2000 to 2001 and 2001 to 2002. In the meantime as Shri Joshi had taken Videsh Yatra Mitra Policy and the Company had extended the policy for the period 30.6.2001 to 29.06.2002 to 23.11.2002. On Shri Joshi's return to India he filled in fresh proposal form for mediclaim cover and The New India Assurance Company Limited, D.O.130600 issued him the policy bearing No. 140702 / 48 / 02 / 04315 for the period 10.12.2002 to 9.12.2003. This was with a gap of 16 days. All the polices issued by New India to Shri Joshi was with exclusion of heart ailments. Shri Bhaskar Joshi was hospitalized on 27.1.2003 at Icon hospital but unfortunately expired on 31.1.2003. The cause of death was Cardiogenic with acute Hepatic failure with Diabetes Mellitus with dilated cardiomyopathy. When the claim was submitted by his wife Smt Archana Joshi the Company rejected the claim as heart ailment itself was excluded under the policy. Smt Joshi represented to the Company stating that her husband at the time of hospitalisation was suffering from acute hepatitis which later on resulted into complications leading to Cardiogenic acute hepatic failure which was also turned down. Aggrieved by the decision of the Company Smt Archana approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of her claim.After perusal of the records parties to the dispute were called for hearing The reason for non - settlement of the claim is due to the exclusion of heart ailments for Shri Joshi in the policy issued to him. The Complainant raised the issue of hepatitis (Jaundice) being the main reason for the death of Shri Joshi. The hospital paper clearly says "Acute hepatic with encephalopathy underlying IHD". (Ischaemic Heart Disease). This has proved that the heart disease was the pervading illness on which liver complications came later and could be incidental for the very close linkage with the two diseases. The cause of death was Cardiogenic with acute hepatic failure with Diabetes Mellitus with dilated Cardiomyopathy. It would be safely presumed that there were multiple causes affecting vital organs and dilated Cardiomyopathy resulted into Left Ventricular Failure (LVF) and Congestive Cardiac arrest which were usual fallouts of Cardiomyopathy. In the facts and circumstances, since all heart ailments were excluded from the policy the New India's decision to repudiate the claim is in order as per the terms of exclusion.

Mumbai Ombudsman Centre
Case No. GI - 627 / 2003 - 04
Shri Shiv Kumar Saraf
Vs.
United India Insurance Company Ltd.

Award Dated 31.03.2005

The Complainant Shri Shiv Kumar Saraf was covered under a Mediclaim Policy for the period from 13.10.2002 to 12.10.2003 vide Policy No. 020500 / 48 / 02 / 04021 with the United India Insurance Company Ltd., D.O.5 for a sum insured of Rs. 1,00,000/-. The Complainant preferred a claim of Rs. 72,701.15 for his hospitalistion and treatment at Bombay Hospital & Medical Research Centre for the period 06.05.2003 to 16.05.2003 and 24.07.2003 to 05.08.2003 for Left Ventricular failure and congestive cardiac failure. The Insurance Company repudiated his claim on the ground that the disease was a pre - existing disease Not satisfied with the decision of the Company, the Complainant approached the Ombudsman's Office for redressal of his claim against United India Insurance Company. All submissions, contentions and evidence on record have been duly considered by this Forum. After perusing the relevant records a hearing of the parties were held on 10.3.2005.

The Company got this file duly examined by their Consultant, Dr. Bandookwala. As per the indoor case papers obtained from Bombay Hospital it is revealed that Shri Saraf was being treated for Diabetes Mellitus and dilated cardiomyopathy leading to repeated attacks of acute left ventricular failure and congestive cardiac failure. Also a coronary angiography done on 12.05.2003 had showed an advanced dysfunction of the left ventricle and the duration of Diabetes Mellitus has been recorded as four years old and hence it falls under exclusion clause 4.1 i.e. pre - existing condition / disease. He had been in and out of the hospital and has been treated by several Doctors for his chronic complaints and it is difficult to believe that Shri Saraf reached that advanced stage of Heart condition in a short time as the disease is chronic and not acute, as we have seen. The status of the reports submitted to this Forum clearly indicate their likely duration which also corroborates with the fact that Shri Saraf first took the Policy on 13.10.2000 at his age 56years and not before which is positively a selection against the Insurer with the propensity of falling sick being more, even as a normal person with age against us. Hence his claim for hospitalization expenses is not acceptable in view of the documents and submissions as mentioned above, which constitutes suppression / non - disclosure of material facts and also as pre - existing illnesses falling under clause 4.1 of the Mediclaim Policy.

Mumbai Ombudsman Centre
Case No. GI - 640 / 2003 - 2004
Dr. (Smt) Khorshed Pavri
Vs.
United India Insurance Company Limited

Award Dated 31.03.2005

Dr.(Smt) Korshed Pavri took a Mediclaim policy for the first time in 1990 with United India Insurance Company Limited, Divisional Office - III for Sum Insured of Rs. 1 lac which was increased to Rs. 3 lacs in 1999. When she preferred a claim for her hospitalisation at Breach Candy Hospital from 25.6.2003 to 14.7.2003 for Left Hip joint replacement under Policy No. 020300 / 48 / 02 / 02304, the Company after scrutiny of the hospital records offered to settle Rs. 1 lac being the original Sum Insured which Dr. (Smt) Pavri did not accept. Her representations to the Company was also turned down and hence being aggrieved she approached the Office of the insurance Ombudsman seeking intervention for settlement of her full claim amount. After perusal of the records parties to the dispute were called for hearing The analysis of records submitted to this Forum reveals that the Insured was operated for left patellectomy 20 years back, underwent right hip replacement (not left hip) 10 years ago and also a revision surgery 3 years ago (although hospital record says 4 years ago). All these are having a background of pain in right hip since last 10 years. Unfortunately we do not have any investigation reports from the material time i.e. 1993 or before it. In that context the Company's rejection of claim amount for entire expenses i.e. above Rs. 1 lakh is in order as Sum Insured was increased to Rs. 3 lacs only in 1999. However, on a close look at the discharge summary as also hospital records it reveals that she had concurrently received treatment for suspected Crohn's disease which is the other name of regional ileitis - which means inflammatory bowel for which endoscopy and colonoscopy was done. Obviously, there would have been some treatment for this disease and some expenditure incurred. It is also medically established that patients of arthritis on long treatment of pain killers are susceptible to develop gastric problems particularly due to ulcers and this has happened in her case with duodenal ulcer being diagnosed. In this context although it could be the proximately caused by arthritis, since policy is in force from 1990, the Company should calculate the exact amount of treatment incurred on account of this disease and pay the admissible expenses to Dr (Smt) Korshed Pavri.

Mumbai Ombudsman Centre
Case No. GI - 490 / 2004 - 05

Dr. S.S. Bhandari
Vs.
United India Insurance Company Ltd.

Award Dated 31.03.2005

The Complainant Dr. S.S. Bhandari with his spouse Smt. Vijaya Bhandari was covered under a Mediclaim Policy No.160700 / 48 / 03 / 01473 for the period 13.08.2003 to 12.08.2004 with United India Insurance Company Ltd., Pimpri D.O.I for a sum insured of Rs. 1,00,000/- each. The Complainant vide his letter dated 15.07.2004 preferred a mediclaim for hospitalization at Bhandari Hospital, Pune, from 30.10.2003 to 03.11.2003 of his wife for Chest Pain and breathlessness. Since Dr. Bhandari did not receive any response from the Company, he had represented the matter to The Regional Manager, United India Insurance, vide his letter dated 19.08.2004. The Company repudiated the claim on the ground that the hospitalization was primarily for the purpose of investigations and the same did not require hospitalization. Not satisfied with the decision of the Company, he approached the Ombudsman's office for redressal of his claim.After perusing the entire records a joint hearing of the parties were held The analysis of the hospital case paper reveal that Smt. Bhandari was having chest pain for which Angina was suspected. Dr. D.P. Bhoge wanted to get a confirmation on this and accordingly advised her to get admitted for all investigations. In the facts and circumstances the decision of the Company to repudiate the claim on the above ground is in order.

Mumbai Ombudsman Centre
Case No. GI - 704 / 2003 - 2004
Shri Ved Prakash Pawha
Vs.
The New India Assurance Company Limited

Award Dated 31.03.2005

Shri Ved Prakash Pawha was insured under Apat Bandhav Group Mediclaim Insurance Policy issued by The New India Assurance Company Limited, D.O. 112900 to Saraswat Bank since 1993. Shri Pawha was initially covered from 1987 under individual mediclaim policy issued by United India Insurance Company Limited under category I for Sum Insured of Rs. 96,500/-. When Shri Pawha opted for Group Mediclaim Policy from 1993 with New India, the Sum Insured was Rs. 96,500/-. Shri Pawha went on increasing the Sum Insured at intervals during renewals from 1996. His current policy No.112900 / 48 / 03 / 01247 for the period 01.01.2003 to 31.12.2003 was for Rs. 5,00,000/- Shri Pawha was hospitalized for Angiography at Hinduja Hospital on 17.7.2003 and for Angioplasty at Breach Candy Hospital on 7.8.2003. Shri Pawha was granted a cashless amount of Rs. 1 lac from the TTK Health Service for the treatment of heart diseases at Breach Candy hospital. After his discharge from the hospital when Shri Pawha lodged a claim TTK Health Services (P) Ltd after perusal of the file papers final liability of New India would be upto Rs. 1 lac only being the original Sum Insured and as the same was already paid as cashless access no further claim amount would be payable to him for this treatment. Aggrieved by the decision Shri Ved Prakash Pawha represented to the Company and not receiving any favorable response approached the insurance Ombudsman's Office seeking justice for settlement of his claim of Rs.2,02,303.20/- which was not settled by the Company. The case has been duly examined and the parties to the dispute were called to depose before the Ombudsman. The analysis of the case reveals that the Insured himself declared the surgery and heart ailment and therefore, full disclosure has taken place and the subsequent increases were effected without any condition from New India. Alongside this position, we have examined the above underwriting provision in line with the basic principles of insurance, which although not mentioned on the policy will not lose the force or significance. It is imperative, therefore, that there should be a balanced view on the treatment of this claim as per the order given below. In the facts and circumstances, The New India Assurance Co.Ltd. is

directed to settle a further 50% of the balance amount of admissible claims not settled by them and dispose of the complaint.

Mumbai Ombudsman Centre
Case No. GI - 036 / 2004 - 05
Smt. Chandrika S. Kothari
Vs.
New India Assurance Company Ltd

Award Dated 31.03.2005

Smt. Chandrika S. Kothari along with her husband Suryasinh A. Kothari was covered under a Mediclaim Policy No. 112000 / 48 / 03 / 00822 for the period 24.04.2003 to 23.04.2004 with The New India Assurance Company Ltd., D.0.112000 for a sum insured of Rs. 3,00,000/- each with 15% Cumulative Bonus. Smt. Kothari vide her letter dated 27.01.2004 lodged a claim Rs.1,52,259.97 with The New India Assurance Company for hospitalization expenses at Breach Candy Hospital from 07.07.2003 to 13.07.2003 in connection with treatment of Common Bile duct stone and ESWL extraction, when he passed away at the Hospital. As the business was serviced through Third Party Administrator M/s. TTK Healthcare Services Pvt. Ltd., the papers were sent to the TPA who after processing the same intimated Smt. Kothari that the claim falls under Exclusion clause 4.1 hence the claim has been repudiated. Being aggrieved by the decision Smt. Kothari approached the Ombudsman's office for intervention of Ombudsman in the matter and resolution of the same. After perusing the case papers the parties were called for hearing. On scrutiny of the documents it is seen that Dr. Nilima Kadambi in the Mediclaim Checklist of TTK Healthcare Services Pvt. Ltd., has observed that the patient had a post - cholecystectomy status with "Gall Bladder" shown as an exclusion on the policy. He was hospitalized in Breach Candy Hospital for treatment of stone in the Common Bile Duct (CBD), Cholangitis and biliary obstruction. It appears the treatment received by Shri Suryasinh A. Kothari from Doshi Nursing Home during the period 02.06.2003 to 10.06.2003 for management of Acute Cholangitis for Rs. 54,784/- was settled by TTK Healthcare but the Company did not mention this at the hearing. However the subsequent treatment was not passed as "Gall Bladder" was excluded from the policy. It is quite surprising as to how the earlier claim was paid by New India for management of Acute Cholangitis for the treatment received at Doshi Nursing Home in June 2003, while the next claim was rejected. Ethically, the Company cannot reject the claim in July 2003 for CBD stone and other allied treatment taken at Breach Candy Hospital where Shri Kothari passed away. The dispute is in respect of this claim which was rejected and having settled the earlier claim New India had no reason to repudiate the claim on the same ground as the exclusion was not specific to cover all related problems arising out of hepatic functions, and therefore, the complaint made by Smt. Chandrika S. Kothari for payment of the claim is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 604 / 2003 - 2004
Shri Nagindas M. Shah
Vs.
The New India Assurance Co.Ltd.

Award Dated 31.03.2005

The Complainant Shri Nagindas M. Shah was covered under a Mediclaim Policy No 111400 / 48 / 02 / 04305 with The New India Assurance Co.Ltd. D.O. 111400. He lodged a claim for Rs. 45,000/- with New India Assurance Co.Ltd. for hospitalisation at P.D. Hinduja National Hospital & Medical Research Centre during the period
14.01.2003 to 28.01.2003 for treatment of Pyogenic Meningitis, Pneumonia with COPD. It appears from records tha he was shifted from Harshil Heart Hospital on 14.O1.2003 to P.D. Hinduja Hospital. The Company repudiated the claim under exclusion clause 4.1 of the policy i.e. it was a pre existing disease and not disclosed while taking the policy. Being aggrieved at the decision of the Company, the Complainant approached the Ombudsman's office for intervention of Ombudsman in the matter and resolution of the same. After

perusing the case papers the parties were called for hearing From the records produced to this Forum, it is observed that the Insured was admitted to Harshil Heart Hospital on 12.01.2004 and the diagnosis arrived was Pneumonia with Drowsiness. He was discharged on request and was transferred to P.D. Hinduja National Hospital & Medical Research Centre for further management Applying my mind independently and going by the final discharge summary in which the diagnosis has been mentioned as Pyogenic Meningitis with pneumonia and COPD, I feel there would be some scope for segregating Meningitis from pulmonary problems like COPD and pneumonia. However, whatever decision is taken is on the basis of the Insured's begins 78 years of age and having taken the Insurance Policy from 1991 which comes almost within the period of his hospitalisation from inception of the policy. Considering the fact that the policy is in operation for almost 12 years and Shri Nagindas M. Shah's confidence in the system of insurance I, as a special case, grant 50% of the admissible expenses incurred solely for the hospitalisation at P.D. Hinduja Hospital to get treated for the above mentioned disease, to resolve the dispute.