GEN INSURANCE- INDIVIDUAL MEDICLAIM
AHMEDABAD

GENERAL=INDIVIDUAL MEDICLAIM

Case No. 11-004-0371-13
Mr. Rasikbhai Ghelani Vs. United India Insurance Co. Ltd.
Award dated 1st October 2013
Repudiation of Mediclaim

The Complainant took treatment for back pain and expense incurred for Rs.42,573/- was repudiated by the Respondent on the basis of non availability of required hospitalization records.

It is proved the treatment could have been on OPD basis which is outside the scope of policy, hence complaint dismissed.

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Case No.11-004-0377-13
Mr. Lalitkumar L. Dave Vs. United India Insurance Co. Ltd.
Award dated 1st October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Cancer Esophagus and expense claimed for Rs.38,072/- was repudiated by the Respondent as per exclusion clause No.4.8 of the policy condition.

Complainant not disclosed his habit of tobacco chewing which was a major cause of cancer.

In view of this complaint dismissed.

****

Case No.11-009-0378-13
Mr. A.M. Vijayan Vs. Reliance General Insurance Co. Ltd.
Award dated 1st October 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment Carcinoma of Thyroid and incurred expense of Rs.1,49,037/- was repudiated by the Respondent under pre-existing disease clause No.1 of Reliance Health wise policy.

Complainant had policy since 2008 but the insured taken treatment in the month of August 2008 which is four months prior to taking policy. Thus, the complaint dismissed.

****

Case No.11-003-0379-13
Mr. Yogesh R. Mehta Vs. National Insurance Co. Ltd.
Award dated 4th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment Vomiting, Gabhraman, HTN etc. and expense incurred for Rs.30,074/- was repudiated by the Respondent under clause No.4.10 of the policy conditions.

Respondent explained the insured was treated on OPD basis which is not payable hence complaint dismissed.

****

Case No.11-004-0380-13
Mr. S.C. Pathak Vs. United India Insurance Co. Ltd.
Award dated 4th October 2013
Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Ureteric stone with chronic renal failure and expense incurred for Rs.72,596/- was partially settled by the Respondent for Rs.68,959 and deducted Rs.3,637/- invoking policy condition No.1.2 (C).

Complainant's argument he is a policy holder since 2000.

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

Therefore complaint dismissed.

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Case No.11-002-0382-13
Mr. Yogesh N. Rawal Vs. The New India Assurance Co. Ltd.
Award dated 7th October 2013
Repudiation of Mediclaim

Complainant lodged a claim of Rs.34,169/- for hospitalization expense of his wife for the treatment of Piles was repudiated by the Respondent under pre-existing disease.

Previously insured was covered with Ifco Tokio for which continuity benefit was granted but no proof is available. Subject treatment was in the second year of the policy and there is a waiting period of two years, so complaint dismissed.

****

Case No.11-004-0381-13
Mr. Kirti J. Kapadia Vs. United India Insurance Co. Ltd.
Award dated 7th October 2013
Partial repudiation of Mediclaim

Complainant underwent Rt. Knee Joint treatment and expense incurred Rs.54,279/- was partially settled by the Respondent for Rs.48,389/-and deducted Rs.5,890 stating that deductions were made as per policy condition No.1.2. (c).

Respondent clearly explained the deductions made by them in their claim settlement sheet which is just and proper.

In view of this Respondent's decision is upheld and complaint dismissed.
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Case No.11-002-0383-13
Mr. Ghanshyambhai S. Patel Vs. The New India Assurance Co. Ltd.
Award dated 7th October 2013
Repudiation of Mediclaim

Complainant lodged a claim of Rs.16,688/- for hospitalization expense of his wife for the treatment of Sinusitis and Hysterical behavior was repudiated by the Respondent under Exclusion clause No.4.4.6.

Complainant fails to produce first consultation paper, indoor case papers etc which makes the claim suspicious and could have been an OPD treatment.

In view of this complaint dismissed.
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Case No.11-009-0385-13
Smt. Sarojben S. Patel Vs. Reliance General Insurance Co. Ltd.
Award dated 8th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Fibroid Uterus and expense incurred for Rs.83,355/- was repudiated by the Respondent under clause No.1 and condition 17 of the policy.

Investigation Report shows the insured was advised for Hysterectomy 6 to 8 years back and the policy was incepted on 06-09-2010 which is considered as pre-existing disease.

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

Case No.11-004-0384-13
Mr. Kartik B. Thaker Vs. United India Insurance Co. Ltd.

Award dated 8th October 2013
Partial repudiation of Mediclaim

Complainant hospitalized for Convulsion and lodged claim for Rs.36,700/- was partially repudiated by the Respondent for Rs.18,460/- stating that Sum Insured increased from Rs.50,000/- to Rs.1.00 Lac since 2011 and also some discrepancies in the treatment papers.

However complaint dismissed.

****

Case No.11-004-0388-13
Mr. Kanubhai C. Panchal Vs. United India Insurance Co. Ltd.
Award dated 11th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Eye cataract and expense incurred for Rs.21,521/- was repudiated by the Respondent on the ground of Exclusion clause No.4.3, there is a waiting period of two years and policy is in the 2nd year.

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

****

Case No.11-002-0386-13
Mr. Dhaval Jha Vs. The New India Assurance Co. Ltd.
Award dated 11th October 2013
Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Fistula Ano and expense incurred for Rs.74,108/- was partially settled for Rs.51,775/- by deducting an amount of Rs.22,333/- by the Respondent as per clause 2.1 of Individual Mediclaim policy.

Respondent clearly explained the deductions made by them which are right and proper hence complaint dismissed.

****

Case No.11-018-0387-13
Mr. Mansukhbhai B. Ginoya Vs. Future Generali India Insurance Co. Ltd.
Award dated 11th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Falciparum Malaria and incurred expense of Rs.8,527/- was repudiated by the Respondent on the grounds that the hospital did not fulfill "Hospital Parameters" under clause No.1.1. Hospital is not registered with local authority nor equipped with adequate inpatient beds/facilities. In view of this complaint dismissed.

****

Case No.11-004-0390-13

Mr. Viral D. Nayak Vs. United India Insurance Co. Ltd.
Award dated 11th October 2013
Partial repudiation of Mediclaim

A hospitalization expense of the complainant for Rs.17,272/- lodged by the complainant was partially settled by the Respondent for Rs.9,182/-thereafter in addition paid Rs.6,330/- subsequent to his grievance with R.O., by deducting an amount of Rs.1,760/- on the basis of eligible room rent under Sum Insured of the policy.

Therefore complaint dismissed.

****

Case No.11-005-0391-13

Mr. Kuman G. Khunt Vs. Oriental Insurance Co. Ltd.
Award dated 14th October 2013
Repudiation of Mediclaim

Complainant's 3 years old son treated for Ureteric stone and expense incurred for Rs.58,613/-Hospitalization + Rs.6,465/- Post hospitalization were repudiated by the Respondent under Exclusion clause 4.3.

Complainant's argument the policy was in 3rd year but previous policy with United India and granted continuity with the Respondent.

As per IRDA guidelines, the insured had not completed the norms of the continuity benefit so Respondent issued fresh policy and surgery performed in the first year of the policy.

Hence complaint dismissed.

****

Case No.11-004-0393-13

Mrs. Kavita S. Pandya Vs. United India Insurance Co. Ltd.
Award dated 14th October 2013
Partial repudiation of Mediclaim

A claim of Fibroid and Hysterectomy expense for Rs.69,419/- to the complainant was partially settled by the Respondent for Rs.42,727/- and remaining amount deducted invoking policy condition No.1.2.1.

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

****

Case No.11-003-0397-13
Mr. Pravinbhai P. Patel Vs. National Insurance Co. Ltd.
Award dated 15th October 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of piles and expense incurred for Rs.17,887/- was repudiated by the Respondent as per exclusion clause 3.3 of the policy condition.

The insured patient taken treatment in ayurvedic hospital, Ayurvedic treatment is not covered in the policy hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-002-0398-13
Mr. N.C. Raval Vs. The New India Assurance Co. Ltd.
Award dated 17th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Ischemic brain disease, epilepsy etc and expense incurred for Rs.30,885/- was repudiated by the Respondent giving reason that non payment of additional premium for pre-existing disease.

Policy covered since 1997 but pre-existing disease since 20 years however Respondent's decision is upheld and complaint dismissed.

****

Case No.11-004-0399-13
Mr. Shailesh G. Mehta Vs. United India Insurance Co. Ltd.
Award dated 18th October 2013
Partial repudiation of Mediclaim

Complainant's wife treated for Laparoscopic Hysterectomy and claimed for Rs.61,074/- was partially settled an amount of Rs.20,450/- by the Respondent under condition No.1.2 C & D.

Representative of the Respondent clarified all deductions in details to this Forum during the Hearing which is right and proper thus complaint dismissed.

****

Case No.11-003-0400-13
Mr. Prafulbhai L. Wadhwana Vs. National Insurance Co. Ltd.
Award dated 22nd October 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Aortic Aneurysm at Apollo Hospital and expense incurred for Rs.5,18,921/- was repudiated by the Respondent on the ground of pre-existing disease under clause No.4.1 of the policy conditions.

There is a waiting period of 3 years to cover pre-existing disease and the claim lodged in the 1st year of the policy i.e. within 3 months from commencement of policy.

Thus, Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0404-13
Mr. Hemal J. Patel Vs. National Insurance Co. Ltd.
Award dated 22nd October 2013
Repudiation of Mediclaim

Complainant's 2 year old son hospitalized for treatment of Idiopathic Nephrotic Syndrome and expense incurred for Rs.26,562/- was repudiated by the Respondent on the ground of pre-existing disease under clause No.4.1 of the policy conditions.

There is a waiting period of 3 years to cover pre-existing disease and the claim lodged in the 1st year of the policy.

Thus, Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0405-13
Mr. S. Palani Vs. National Insurance Co. Ltd.
Award dated 24th October 2013
Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of her Rt. Ear at Chennai and expense incurred for Rs.21,927/- was repudiated by the Respondent on the ground of pre-existing disease under clause No.4.1 of the policy conditions.

There is a waiting period of 3 years to cover pre-existing disease and the claim lodged in the 2nd year of the policy.

Thus, Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0406-13
Mr. Ramesh K. Teli Vs. National Insurance Co. Ltd.
Award dated 24th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Prolapse Disc L4-L5 and expense incurred for Rs.14,272/- was repudiated by the Respondent on the ground of pre-existing disease under clause No.4.1 of the policy conditions.

From the available treatment papers proved that there is no active treatment given only injection and medicines prescribed which could have been done on OPD basis.

Thus, Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0407-13
Mr. Harshadpuri L. Goswami Vs. National Insurance Co. Ltd.
Award dated 25th October 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Coronary Artery Disease and expense incurred for Rs.5,04,482/- was repudiated by the Respondent on the ground of pre-existing disease under clause No.4.1 of the policy conditions.

There is a waiting period of 3 years to cover pre-existing disease instead the claim lodged after two years and 7 months after commencement of the policy.

Thus, Respondent's decision is upheld and complaint dismissed.

****

Case No.11-004-0414-13
Smt.. Nalini B. Patel V/s. United India Insurance Co. Ltd.
Award dated 8th November 2013
Repudiation of Mediclaim

Complainant's hospitalization and treatment expense for Rs.24,600/- was repudiated by the Respondent on the ground of investigation report shown that the insured patient was not in the hospital when they visited to hospital and staff members reported that she went to home for personal reason which is beyond the scope of the rules.

Thus complaint dismissed.

****

Case No. 11-009-0417-13
Mr.Mukesh A. Patel Vs. Reliance General Insurance Co. Ltd.
Award dated 12th November 2013
Repudiation of Mediclaim

Complainant hospitalized three times for treatment of IHD and Triple Vessel Disease for which total expense incurred for Rs.2,07,000/- was repudiated by the Respondent on the ground of pre-existing diseases.

On scrutiny of previous medical papers of family physician, it is proved the insured was having DM since 5 to 6 years which was not disclosed in the proposal hence Respondent rightly repudiated the claim and complaint dismissed.

****

Case No.11-004-0416-13
Mr. Sachin S. Shah Vs. United India Insurance Co. Ltd.
Award dated 13th November 2013
Repudiation of Mediclaim

A hospitalization expense claim lodged by the Complainant for Rs.92,268/- for the treatment of his son was repudiated by the Respondent as per condition No.4.1 & 4.6.

On the basis of specialist opinion, it is proved the treatment taken for congenital disease which is under exclusion clause.

In the result complaint fails to succeed.

****

Case No.11-002-0422-13
Shri Jayesh Shah Vs. The New India Assurance Co.Ltd.
Award dated 13th November 2013
Partial repudiation of Mediclaim.

Complainant's wife hospitalized for Cardio failure with Acute Renal failure and expired during hospitalization for which expense incurred Rs.75,343/- was partially settled by the Respondent showing the reason that the insured treated at Mumbai, falls under Zone -I and policy taken from Gujarat, falls under Zone-III. Further stated S.A. increased from 50,000/- to 1.00 Lac in 2008-09, there is a cap of 4 years for such treatment so considered old S.A. However Respondent rightly deducted the claim as per T & C of the policy.

In view of the above, complaint dismissed.

****

Case No.11-017-0427-13
Shri Mahesh K. Chainani Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 18th November 2013
Repudiation of Mediclaim

A hospitalization expense of Rs.42,008/- lodged by the Complainant for his mothers heart treatment was repudiated by the Respondent under exclusion clause No.1 of the Terms and Conditions of Senior Citizens Red Carpet Insurance Policy.

On scrutiny of all medical reports, proved the insured treated for long standing ailment before inception of the insurance which is pre-existing disease. Therefore Respondent's decision upheld and complaint dismissed.

****

Case No.11-003-0426-13
Mr. Pratapsingh J. Rao Vs. National Insurance Co. Ltd.
Award dated 19th November 2013
Partial repudiation of Mediclaim

Complainant lodged a claim amount of Rs.26,713/- for his hospitalization and treatment for Liver disease was partially settled by deducting an amount of Rs.7,860/- on the ground of policy terms and condition No.3.12 .

Respondent produced sufficient evidences to prove the deductions made by them hence the Forum also denied the claim so complaint dismissed.

****

Case No.11-005-0431-13
Mr. Sureshbhai R. Sheth Vs. Orientile Insurance Co. Ltd.
Award dated 19th November 2013
Repudiation of Mediclaim

A Claim amount of Rs.2,09,609/- lodged by the Complainant for his treatment expense of CAG followed by PTCA with Stenting to RCA was repudiated by the Respondent under exclusion clause No. 4 of the mediclaim policy.

The treatment taken in the second year of the policy, there was a cap of two years for such disease.

Therefore complaint dismissed.

****

Case No.11-004-0424-13
Mr. Manilal K. Vs. United India Insurance Co. Ltd.
Award dated 20th November 2013
Repudiation of Mediclaim

A hospitalization expense claim lodged by the Complainant for Rs.47,165/- for the treatment of his son was repudiated by the Respondent as per Exclusion clause No. 5.3.

Complainant was having two policies, one P.A policy with Oriental Insurance Company and another Family Floater policy with the Respondent. P.A claim paid by the Insurer but for the subject mediclaim the complainant did not submit original documents in time and not even informed to the Insurer within the stipulated time.

In view of this complaint dismissed.

****

Case No.11-003-0437-13
Mr. Prakash U. Dhandhukiya Vs. National Insurance Co. Ltd.
Award dated 22nd November 2013
Partial repudiation of Mediclaim

A 47 years old complainant treated for Fistula and expense incurred for Rs.44,614/- was partially settled for Rs.30,193/- by deducting an amount of Rs.14,421/- under policy condition No.3.12.

Respondent produced sufficient evidences to prove the deductions made by them hence the Forum also denied the claim so complaint dismissed.

****

Case No.11-003-0435-13
Mr. Kantilal K. Shah Vs. National Insurance Co. Ltd.
Award dated 22nd November 2013
Partial repudiation of Mediclaim

Complainant hospitalized for Knee Replacement and expense incurred for Rs.1,09,132/- was partially settled for Rs.96,850/- by deducting an amount of Rs.39,282/- was not satisfied by the Complainant.

Respondent settled the claim partially under condition No.1, Clause A, B & C of the hospitalization benefit policy and all deductions explained in details were proper and not payable.

In view of this complaint dismissed.

****

Case No.11-002-0440-13
Mr. V.K. Mehta Vs. The New India Assurance Co. Ltd.
Award dated 25th November 2013
Repudiation of interest for delayed payment

Complainant demanded interest @ 12 to 15% + other extra expenses for follow up for mediclaim paid late by 3½ months was rejected by the Respondent.

As per policy Condition No.1 and 9, there is no provision to pay such payments so complainant can approach to any other forum for recovery of these expenses.

Thus complaint dismissed.

****

Case No.11-002-0432-13
Mr. Ashok D. Desai Vs. The New India Assurance Co. Ltd.
Award dated 26th November 2013
Partial repudiation of Mediclaim

Complainant covered a Group Insurance Policy of the Respondent issued to LIC of India for their employees and claim lodged for Rs.1,06,721/- for hospitalization and treatment expense of his wife was partially settled by the Respondent for Rs.96,804/- by deducting 9,917/- on the ground of policy condition No.3.2 – reasonable and customary expenses.

Respondent produced sufficient evidences to prove the deductions made by them hence the Forum also denied the claim so complaint dismissed.

****

Case No.11-003-0443-13
Mr. Sunil N. Shah Vs. National Insurance Co. Ltd.
Award dated 26th November 2013
Partial repudiation of Mediclaim

Complainant hospitalized for fracture in neck of Femur and expense incurred for Rs.1,34,733/- was partially settled for Rs.1,31,798/- by deducting an amount of Rs.5,155/- under various heads of exclusions was not satisfied by the Complainant.

Respondent settled the claim partially under Policy Clause No.4.26, 4.17 & and 4.16 of the hospitalization benefit policy and all deductions explained in details were proper and not payable.

In view of this complaint dismissed.

****

Case No.11-003-0445-13
Mr. Shailesh S. Parmar Vs. National Insurance Co. Ltd.
Award dated 28th November 2013
Repudiation of Mediclaim

Complainant was covered Baroda Health Floater policy issued to account holders of Bank of Baroda by the Respondent for S.I Rs.50,000/-. A claim amount of Rs.66,659/- lodged by the Complainant for his treatment of Neuromylitis Optica was repudiated by the Respondent on the grounds of Clause 4.1 & 4.3. First policy incepted since 2008 but there was a break in renewal of 3rd year policy for 15 days hence policy considered as fresh one.

Thus complaint dismissed.

****

Case No.11-003-0447-13
Mr. Hasmukh Kotecha Vs. National Insurance Co. Ltd.
Award dated 28th November 2013
Repudiation of Interest for late payment

Complainant covered under BOI National Swasthya Bima Policy and claim lodged for his wife's Nosal Polyp treatment for which expense incurred for Rs.47,092/- was first partially paid by the Respondent. Thereafter on representation of complainant's several correspondences, Respondent made balance amount of claim.

Complainant demanded the late payment of remaining amount's 18% interest which was not paid as per terms and conditions of the policy.

Thus Complaint dismissed.

****

Case No.11-002-0438-13
Mr. Rajendra K. Shah Vs. The New India Assurance Co. Ltd.
Award dated 28th November 2013
Partial repudiation of Mediclaim

Complainant treated for accidental fracture and expense incurred for Rs.80,776/- was partially settled for Rs.30,000/- as per PPN rate fixed by the Respondent to the particular treatment.

In view of this complaint dismissed.

****

Case No.11-005-0442-13
Mr. Manmohanjit Singh Vs. Orientile Insurance Co. Ltd.
Award dated 29th November 2013
Repudiation of Mediclaim

Complainant treated for Brain tumor and post operative treatment taken orally as per the advise of the doctor and expense claimed for Rs.1,61,950/- was repudiated by the Respondent as per policy condition No.4.23.

On scrutiny of available documents proved the treatment was fully an outpatient basis. Thus complaint dismissed.

****

Case No.11-004-0367-13
Mr. Pankaj C. Shah Vs. United India Insurance Co. Ltd.
Award dated 1st December 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Liver Cirrhosis and expensed incurred for Rs.1,27,248/- was partially settled for Rs.37,694/- by the Respondent and deducted Rs.89,554/- giving reason that claim settled on the basis of old Sum Insured because disease was pre-existing.

Thus Complaint dismissed.

****

Case No.11-004-0446-13
Mr. Jayesh A. Patel Vs. United India Insurance Co. Ltd.
Award dated 3rd December 2013
Partial repudiation of Mediclaim

Complainant underwent treatment for Cerebral convulsion, Epilepsy, LOC after Head injury and incurred expense for Rs.22,420/- had partially settled by the Respondent for Rs.11,083/- on the basis of terms and condition No.1.2-C of the Mediclaim policy.

Complainant was a polio affected patient since child wood which was not disclosed in the proposal.

Thus complaint dismissed.

****

Case No.11-002-0392-13
Mr. Nainesh J. Panchal Vs. The New India Assurance Co. Ltd.
Award dated 5th December 2013
Repudiation of Mediclaim

Complainant's 68 years old mother hospitalized two times for treatment of UTI + Abdominal pain etc. and incurred total Rs.61,947/- was repudiated by the Respondent as per exclusion clause No.4.1 of the Mediclaim policy.

Policy incepted since 13 years and insured patient having DM since 15 to 20 years, hence current illness has occurred prior to inception of policy.

In view of this complaint dismissed.

Case No.11-002-0497-13
Mr. Vipul N. Patel Vs. The New India Assurance Co. Ltd.
Award dated 5th December 2013
Repudiation of Mediclaim

Complainant treated for enteric fever etc and expense incurred for Rs.24,748/- was repudiated by the Respondent as per policy exclusion No.5.5.

On investigation, the Respondent found out various discrepancies with regard to the claim documents.

Thus Complaint dismissed.

****

Case No.11-004-0403-13
Mr. Mahendra N. Shah Vs. United India Insurance Co. Ltd.
Award dated 6th December 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Gall Bladder Stone operation and expense incurred for Rs.53,054/- was partially settled by the Respondent for Rs.25,037/- by deducting an amount of Rs.28,017/- as per policy clause 1.2 © and 1.2 (d).

Representative of the Respondent clarified all deductions in details to this Forum during the Hearing which is right and proper thus complaint dismissed.

****

Case No.11-002-0448-13
Shri Arvind M. Desai Vs. The New India Assurance Co. Ltd.
Award dated 16th December 2013
Partial repudiation of Mediclaim

Complainant has a member of a Tailor made Group Insurance Policy issued by the Respondent to the employees of LIC of India.

Complainant's wife treated in several dates and claim lodged for several type of treatment for separate amounts.

Respondent investigated the documents and title cleared amounts paid and remaining amounts rejected on various grounds like OPD treatment, in absence of valid stamped receipt etc. Further Complainant was absent during the Hearing scheduled by this Forum.

Looking to all these complaint dismissed.

Case No.11-017-0451-13
Mr. Ranchhodbhai P Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 17th December 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Coronary Artery Disease and expense incurred for Rs.2,05,444/- was repudiated by the Respondent on the basis of pre-existing disease. Treatment was in the second year of the policy.

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

****

Case No.11-019-0458-13
Mr. Pravin M Garange Vs. Appolo Munich Health Insurance Co. Ltd.
Award dated 18th December 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Acute P. Falciparum Malaria, Gastritis and De-hydration and expense incurred for Rs.24,300/- was repudiated by the Respondent on the basis of non availability of supporting documents.

Respondent proved the claim was rightly repudiated thus complaint dismissed.

****

Case No.11-002-0460-13
Mr. Kailash Prasad Chaudhary Vs. The New India Assurance Co. Ltd.
Award dated 18th December 2013
Repudiation of Mediclaim

A 72 years old complainant claimed Rs.1,97,301/- for the treatment expense of Angioplasty was repudiated by the Respondent under policy Clause No,4.1 of pre-existing disease.

Complainant was suffering HTN since 1983 and policy incepted in 1991, the subject disease was a complication of HTN, additional premium was not paying so Respondent's decision is upheld and complaint dismissed.

Case No.11-004-0455-13
Mr. Bhagvanji A Kotak Vs. United India Insurance Co. Ltd.
Award dated 18th December 2013
Repudiation of Mediclaim

Complainant's 30 years old unmarried daughter was treated for Psychiatric Disorder and expense incurred Rs.68,401/- was repudiated by the Respondent as per policy condition No.4.9.

Available claim papers clearly prove the subject treatment was for Psychiatric disorder so complaint dismissed.

****

Case No. 11-003-0462-13
Shri Mananbhai H. Contractor Vs. National Insurance Co. Ltd.
Award dated 19th December 2013
Partial repudiation of Mediclaim

Complainant underwent Endoscopic Septoplastiy and claim lodged for Rs.64,018/- was partially settled by the Respondent for Rs.50,294/- by deducting Rs.13,724/- as per policy clause 3.12 and 4.16/-.

Looking to all available documents, the forum also denied his remaining amount hence complaint dismissed.

****

Case No. 11-003-0459-13
Shri Baldev M. Desai Vs. National Insurance Co. Ltd.
Award dated 23rd December 2013
Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Acute Colitis and expense incurred for Rs.14,810/- was repudiated by Respondent as per the exclusion clause No.5 (Late intimation of hospitalization).

Hospitalization was without advise of any doctor, Treatment Card did not show any treating doctors' signature.

In view of this complaint dismissed.

****

Case No. 11-003-0461-13
Shri Kirit B. Thaker Vs. National Insurance Co. Ltd.
Award dated 24th December 2013
Repudiation of Mediclaim

Complainant covered under Group Travel Insurance Policy for various risk like Medical, P.A, Loss of Passport & Baggage, Delay in Baggage, Emergency dental treatment etc.

During the visit in USA, Complainant taken dental treatment and claimed $181 for purchase of medicine was repudiated by the Respondent on the ground of non emergency treatment. Complainant not attended the Hearing and Respondent not produced the original claim file for verification. Thus complaint dismissed.

Case No.11-002-0472-13
Smt. Ankita B. Joshi Vs. The New India Assurance Co.Ltd.
Award dated 24th December 2013
Repudiation of Mediclaim

A 27 years old female treated for Left Breast Abscess due to Puerperal Mastitis and expense incurred Rs.25,342/- was repudiated by Respondent on the ground of permanent Exclusion Clause No.4.4.13 of the Mediclaim policy.

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

****

Case No. 11-004-0471-13
Shri Jayantibhai P. Makwana Vs. United India Insurance Co. Ltd.
Award dated 24th December 2013
Partial settlement of Mediclaim

Complainant's son hospitalized for treatment of Enteric fever, giddiness etc and expense incurred for Rs.20,737/- was partially settled by the Respondent by deducting an amount of Rs.6000/- as per policy clause 1.2 (c).

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

****

Case No.11-002-0480-13
Mr. Bhupendra S. Kapasi Vs. The New India Assurance Co.Ltd.
Award dated 27th December 2013
Repudiation of Mediclaim

Complainant's wife, 72 years old treated for Osteoporotic wedging with Kyphosis and expense incurred for Rs.35,116/- was repudiated by the Respondent under policy clause No.4.4.11.

On scrutiny of treatment papers, proved that there was no active line of treatment given which could have been on OPD basis. Hence complaint dismissed.

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Case No. 11-004-0481-13
Shri Mahendra B. Solanki Vs. United India Insurance Co. Ltd.
Award dated 27th December 2013
Partial settlement of Mediclaim

Complainant underwent Cataract surgery and expense claimed for Rs,15,000/- was partially settled by the Respondent for Rs.9,526/- and deducted Rs.5,625/- under reasonable clause of the policy.

As per policy condition No.1.2.1, complainant is eligible 25% of S.I Rs.50,000/- it comes to Rs.12,500/- so Forum directed the Respondent to pay balance of Rs.2,974/- to the Complainant. Thus complaint succeeds.

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Case No. 11-002-0476-13

Shri Prashant J. Shah Vs. The New India Assurance Co. Ltd.

Award dated 30th December 2013

Partial Repudiation of Mediclaim

Complainant treated for Acute Pancreatitis and viral infection and expense incurred for Rs.61,909/- was partially settled for Rs.47,542/- by the Respondent as per policy condition No.2.6 note 3.

Complainant not accepted the partial payment, required full amount.

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

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Case No.11-002-0479-13

Mr. Kantibhai R. Rami Vs. The New India Assurance Co. Ltd.

Award dated 31st December 2013

Repudiation of Mediclaim

Complainant treated for Morbid Obesity and claim lodged for Rs.2,60,235/- was repudiated by the Respondent as per policy exclusion clause No.4.4.6.

On scrutiny of available treatment papers proved the claimant underwent for Morbid Obesity which is not admissible as per policy condition No.4.4.6 hence complaint dismissed.

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Case No.11-004-0449-13

Mr. Pravinbhai C. Jariwala Vs. United India Insurance Co. Ltd.

Award dated 31st December 2013

Partial Repudiation of Mediclaim

Complainant lodged 2 claims of Rs.69,000/-each for cataract surgeries of both eyes expense of his wife were partially settled for Rs.35,200/- by deducting an amount of Rs.33,800/- in each claim as per Policy condition No.3.1.

Treating doctor added the multi-focal lens implanted to improve her life style which is not payable hence complaint dismissed.

****

Case No.11-004-0485-13

Shri Umesh R. Patel Vs. United India Insurance Co. Ltd.

Award dated 3rd January 2014

Repudiation of Mediclaim

Complainant lodged a claim of Rs.88,714/- for treatment of multiple fracture on his right hand due to crush injury in machine was repudiated by the Respondent as per terms and condition No.5.7 of the mediclaim policy.

Complainant could not produce any details of hospitalization to prove the treatment was genuine and claimed amount was normal. Thus complaint dismissed.

****

Case No.11-002-0465-13
Smt. Kanan P. Shah Vs. The New India Assurance Co. Ltd.
Award dated 3rd January 2014
Repudiation of Mediclaim

Complainant's 15 years old son hospitalized for treatment of Naevus Sebaceous Jadussohn on right temporal region and incurred expense of Rs.59,905/- was rejected by the Respondent on the ground of Policy Clause No.4.4.16.

As per the available documents like treating doctor's prescriptions, Histopathology Report, Panel Doctor's opinion etc, the Respondent's decision is upheld and complaint dismissed.

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Case No.11-002-0490-13
Mr. Pareshbhai R. Gajjar Vs. The New India Assurance Co. Ltd.
Award dated 7th January 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Osteoporasis and expense incurred Rs.17,598/- was repudiated by the Respondent under exclusion clause 4.3. There is a cap of four years for subject treatment from inception of policy and the claim lodged in 2nd year policy.

In view of this complaint dismissed.

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Case No.11-004-0482-13
Shri Kantilal N. Thakkar Vs. United India Insurance Co. Ltd.
Award dated 7th January 2014
Repudiation of Mediclaim

A 68 years old female insured treated for Chest Pain, Backache and Left hand pain etc. and incurred total expense of Rs.23,891/- was repudiated by the Respondent as per policy condition No.4.1.

Complainant's argument previous policies with other companies continuity benefit should also be given by the Respondent which can not be allowed. Therefore the disease considered as pre-existing hence complaint dismissed.

****

Case No.11-005-0486-13
Mr. Mukundlal N. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 7th January 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of PTCA to CAD and incurred total expense of Rs.1,43,039/- was repudiated by Respondent as per policy condition No.4.1 and 4.3. Complainant was a known case of HT + IHD. Treatment taken in the 2nd year of the policy and there is a cap of two yearsr pre-existing diseases.

In view of this complaint dismissed.

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Case No.11-002-0487-13
Mr. Arvind D. Dholakiya Vs.. The New India Assurance Co. Ltd.
Award dated 7th January 2014
Repudiation of Mediclaim

Complainant lodged two claims for treatment of his both eyes for Rs.67,520/- and Rs.56,813/- were repudiated by the Respondent under clause 1 and condition No.5 of clause 2.

On referring to the documents of both the parties, the forum also denied his claim hence complaint dismissed.

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Case No.11-004-0484-13
Mr. Mansukhbhai K. Patel Vs. United India Insurance Co. Ltd.
Award dated 8th January 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Gastro Enteric Fever and incurred total expense of Rs.6,360/- was repudiated by the Respondent as per terms and condition No.5.7 of the Mediclaim policy.

Respondent has proved after scrutiny of claim papers that there was discrepancies hence complaint dismissed.

****

Case No.11-004-0477-13
Mr. Arvind D. Dholakiya Vs.. United India Insurance Co. Ltd.
Award dated 8th January 2014
Repudiation of Mediclaim

Complainant lodged a claim of Rs.51,563/- for treatment of Intra-Vitreal Lucentis Injection in his both eyes was repudiated by the Respondent as it is an OPD procedure which does not required hospitalization so not covered under mediclaim.

On referring to the documents of both the parties, the forum also denied his claim hence complaint dismissed.

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Case No.11-002-0489-13
Shri Bhuvanesh Chandra Sharma Vs. The New India Assurance Co. Ltd.
Award dated 8th January 2014
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of UI + Fatty Liver disease + HBP and incurred expense of Rs.38,964/- was settled by Respondent for Rs.27,568/- by deducting Rs.11,396/- as per policy condition No.2.1,2.3 & 2.4 and late submission of claim papers etc.

Complainant was a known case of HTN + lever disease since 20 years and policy covered since 17 years but not disclosed in the proposal.

In view of this complaint dismissed.

****

Case No.11-002-0491-13
Mr. Dhirajlal M. Vankawala Vs. The New India Assurance Co. Ltd.
Award dated 9th January 2014
Partial repudiation of Mediclaim

Complainant lodged a claim of Rs.2,08,300/- for his Knee Replacement expense under Senior Citizen Mediclaim Policy was settled by the Respondent for Rs.1,01,250/- and repudiated Rs.1,07,050/- as per policy condition.

Complainant received authority letter for cashless treatment for Rs.1,19,00/- but could not avail because he was required to deposit money before operation. Thereafter claim papers submitted for reimbursement which was sanctioned less than Rs.17,000/- once approved for cashless, so complainant demanded Rs.17,000/- plus interest for late payment.

Respondent proved the amount deducted was for bed charges which was not charged by the hospital so Respondent's decision is upheld and complaint dismissed.
****

Case No.11-002-0493-13
Mr. Yogesh K. Shah Vs. The New India Assurance Co. Ltd.
Award dated 9th January 2014
Repudiation of Mediclaim

Complainant treated for Andocarcinoma Prostate and expense incurred for Rs.35,320/- was repudiated by the Respondent on the basis of pre-existing disease.

Policy issued to the insured with some exclusion clauses in 2009 and insured was renewing the policy in time to time, there was no query was implemented for exclusion clauses. The treatment was taken in 3rd year of the policy and claim lodged was repudiated by the Respondent as per exclusion clause of the Mediclaim policy.

Thus complaint dismissed.
****

Case No.11-004-0483-13
Mr. Kamlelshbhai D. Sagar Vs. United India Insurance Co. Ltd.
Award dated 10th January 2014
Partial repudiation of Mediclaim

Complainant hospitalized for his eye treatment and claim lodged was partially settled and deducted some amount giving reason that as per policy condition, reasonable and customary expenses are paid.

On referring the documents of both the parties, the forum also denied the deducted amount hence complaint dismissed.
****

Case No.11-002-0494-13
Smt. Usha P. Shah Vs. The New India Assurance Co. Ltd.
Award dated 10th January 2014
Partial repudiation of Mediclaim

Complainant lodged claim for her cataract surgeries of both eyes under Senior Citizen Mediclaim Policy was settled by the Respondent for Rs.9,000/-each instead of Rs.24,000/-as affixed red stamp in the policy.

Respondent clarified the red stamp is inadvertently affixed on the face of the policy which is meant for other Mediclaim policies and subject claim is settled as per clause 2.1.1 of the Senior Citizen's policy. Hence complaint dismissed.

****

Case No.11-002-0495-13
Mr. Sunil M. Patel Vs. The New India Assurance Co. Ltd.
Award dated 21st January 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Hysterectomy and expense incurred for Rs.34,480/- was repudiated by the Respondent as per policy condition No.4.3.

There was cap of two years for subject treatment and insured hospitalized in the second year policy so claim repudiated rightly.

In view of this complaint dismissed.

****

Case No.11-005-003-14
Mr. Kirit L Prajapati Vs. Oriental Insurance Co. Ltd.
Award dated 21st January 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Hysterectomy and expense incurred for Rs.48,319/- was repudiated by the Respondent as per policy condition No.4.3.

There was cap of two years for subject treatment and insured hospitalized in the second year policy so claim repudiated rightly.

In view of this complaint dismissed.

****

Case No.11-004-0002-14
Mr. Bhavesh C. Patel Vs. United India Insurance Co. Ltd.
Award dated 21st January 2014
Repudiation of Mediclaim

Complainant's 7years old daughter hospitalized for Abscess Rt. Sole and expense incurred for Rs.6,280/- was repudiated by the Respondent as per policy condition No.5.3 and 5.4.

On scrutiny of available documents proved the claim was suspicious hence complaint dismissed.

****

Case No.11-004-0007-14
Mr. Vadilal K. Patel Vs. United India Insurance Co. Ltd.
Award dated 22nd January 2014
Repudiation of Mediclaim

Complainant lodged a Mediclaim of Rs.36,146/- for his wife treatment expense and Rs.7,036/- for post hospitalization expense was repudiated by the Respondent on the ground of pre-existing disease and non disclosure of material facts.

Policy incepted in 2005 and HTN since 20-25 years, proved from the hospital records. Thus complaint dismissed.

****

Case No.11-004-0004-14
Mr. Jivanlal R. Patel Vs. United India Insurance Co. Ltd.
Award dated 22nd January 2014
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of knee replacement of her both knees and expense incurred for Rs.4,12,158/- was partially settled for Rs.63,000/- by deducting 3,49,158/- as per policy condition eligible amount is 70% of the Sum Insure – 10% for above 60 years old.

The insured patient was 69 years old and Sum Insured was Rs.1,00,000/- hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-005-0412-13
Mr. Ravi H. Thakkar Vs. Oriental Insurance Co. Ltd.
Award dated 22nd January 2014
Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Lt. Ureteric Stone and expense incurred for Rs.5,975/- was repudiated by the Respondent by invoking policy clause 4.3

stating that that there is a cap of two years for subject treatment. The insured treated in the 1st year of the policy.

Referring to available documents of both the parties, the forum also denied the claim hence complaint dismissed.

****

Case No.11-005-0005-14
Mr. Purvish A Parikh Vs. Oriental Insurance Co. Ltd.
Award dated 23rd January 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for High Risk Pregnancy, IUD and Pancreatitis etc. and expense incurred for Rs.55,725/- was repudiated by the Respondent as per policy condition No. 4.12 with a reason that pregnancy related disease can not be paid.

Referring to available documents of both the parties, the forum also denied the claim hence complaint dismissed.

****

Case No.11-002-0014-14
Mr. Sanjay L Bhavishi Vs. The New India Assurance Co. Ltd.
Award dated 24th January 2014
Partial repudiation of Mediclaim

Complainant's father hospitalized for Unstable Angina and expense incurred for Rs.16,072/- was partially settled by the Respondent for Rs.14,668/- by deducting an amount of Rs.1,404/- as per policy clause 2.3 and 2.4.

On referring the documents of both the parties, the forum also denied the deducted amount hence complaint dismissed.

****

Case No.11-004-0009-14
Mr. Vasudev S. Thakkar Vs. United India Insurance Co. Ltd.
Award dated 27th January 2014
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of fever and urine infection and expense incurred for Rs.30,687/- was partially settled for Rs.14,993/- by deducting an amount of Rs.15,694/- by the Respondent as per policy condition No.3.11.

Respondent clarified all deductions in writing, based on this and available claim paper it is observed the deducted amount is not admissible.

Thus complaint dismissed.

****

Case No.11-004-012-14
Mr. Tejas K Bhavsar Vs. United India Insurance Co. Ltd.
Award dated 27th January 2014
Partial repudiation of Mediclaim

Complainant treated for Rt. Buccal Mucosa and expense incurred for Rs.1,68,456/- was partially settled for Rs.70,000/- as policy condition No.1.2.1(a) – 70% of S.A. Complainant increased S.I from 1 Lac to 1.25 Lac but there is a waiting period of 4 years for the subject treatment.

Thus complaint dismissed.

****

Case No.11-004-016-14
Mr. Himanshu S. Vora Vs. United India Insurance Co. Ltd.
Award dated 27th January 2014
Repudiation of Mediclaim

Complainant treated for Echzima, having diabetic foot problem to the policy inception which not mentioned in the proposal hence claim repudiated on the basis of pre-existing as per clause No.4.1. Thus complaint dismissed.

****

Case No.11-003-017-14
Mr. Natwarlal B. Rughani Vs. National Insurance Co. Ltd.
Award dated 28th January 2014
Repudiation of Mediclaim

Complainant operated for CABG and incurred expense of Rs.2,35,146/- was repudiated by the Respondent as per exclusion clause No.4.1.

Discharge summary of the treating hospital clearly mentioned the known case of HTN since 10 years.

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

****

Case No.11-002-013-14
Mr. Chandrakant K Patel Vs. The New India Assurance Co. Ltd.
Award dated 28th January 2014
Repudiation of Mediclaim

Complainant hospitalized for removal of Renal Stone and Gall bladder etc and expense incurred for Rs.1,78,098/- was repudiated by the Respondent as per policy condition No.4.4.6.

Treatment papers reveal the insured patient had habit of tobacco chewing and use of alcohol and know case of Diabetic Mellitus since many years.

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

****

Case No.11-004-019-14
Mr. Hasmukh B. Gediya Vs. United India Insurance Co. Ltd.
Award dated 29th January 2014
Repudiation of Mediclaim

Complainant hospitalized for low grade fever and Vertigo (Giddiness), severe gastritis and unconsciousness for 2-3 minutes etc and expense incurred for Rs.22,323/- was repudiated by the Respondent as per Policy Condition No.4.10.

Complainant was hospitalized only for investigation purpose. There is no active line of treatment given to him. No advice for hospitalization, it is clearly a case of OPD treatment converted in to IPD claim.

Thus complaint dismissed.

****

Case No.11-004-022-14
Mrs. Shardaben B.Shah Vs. United India Insurance Co. Ltd.
Award dated 30th January 2014
Repudiation of Mediclaim

The deceased complainant was hospitalized in April 2010 for treatment of HT+IHD+Bradycardia and expense incurred for Rs.39,000/- was repudiated by the Respondent in June 2010 as per policy condition No.5.3 of the Group Mediclaim Policy. The complainant was expired on 10th January 2011. The Complainant's son represented her claim after two years from the date of repudiation of claim which is time barred case.

Thus complaint dismissed.

****

Case No.11-004-020-14
Mr. Ketankumar N. Vyas Vs. United India Insurance Co. Ltd.
Award dated 30th January 2014
Repudiation of Mediclaim

Complainant hospitalized for treatment of Right hip and Knee femur and incurred expense of Rs.67,714/- was repudiated by the Respondent as per policy condition No.4.1.

Complainant had history of previous operation due to fracture in 2005 and later on reopened in 2007 due to fall down and had sustain infection till date of current treatment. Previous policy was Group Mediclaim and Individual policy started in Feb. 2011.

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

****

Case No.11-004-023-14
Mr. Ullas H Patel Vs. United India Insurance Co. Ltd.
Award dated 30th January 2014
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of fever, vomiting, Abdominal pain, UTI with fungus infection etc and expense incurred for Rs.79,552/- was partially settled by the Respondent as per GIPSA PPN package.

On scrutiny of available documents proved the Respondent rightly settled the claim hence complaint dismissed.

****

Case No.11-002-021-14
Mr. Sureshchandra J Thakar Vs. The New India Assurance Co. Ltd.
Award dated 31st January 2014
Partial repudiation of Mediclaim

Complainant hospitalized for complications of uncontrolled diabetes and incurred expense for Rs.23,856/- was partially settled by the Respondent for Rs.14,824/- and balance Rs.9,032/- rejected under various heads.

During the hearing Respondent agreed to pay out of this amount Rs.1,400/- for RBS Report is payable.

Thus complaint partially succeeds.

****

Case No.11-002-024-14
Shri. Deepack C. Shah Vs. The New India Assurance Co. Ltd.
Award dated 3rd Feb. 2014
Partial repudiation of Mediclaim

Complainant's wife treated for Uterine Fibroid and claim lodged for Rs.1,26,526/- was settled by Respondent for Rs.94,228/- as per PPN limit.

On scrutiny of available documents proved the Respondent rightly settled the claim hence complaint dismissed.

****

Case No.11-003-025-14
Mr. Prabhubhai K. Prajapati Vs. National Insurance Co. Ltd.
Award dated 3rd Feb. 2014
Repudiation of Mediclaim

Complainant hospitalized for the treatment of Sinusitis and expense incurred for Rs.8,180/- was repudiated by the Respondent as per Policy Condition No.4.3.

There is a cap of two years for subject treatment and claim lodged by the complainant was 2nd year of the policy hence complaint dismissed.

****

Case No.11-002-026-14
Smt. Komal A Dhandh Vs. The New India Assurance Co. Ltd.
Award dated 3rd Feb. 2014
Repudiation of Mediclaim

Complainant's 2 years old son was treated for Hydrocele and incurred expense of Rs.20,034/- was repudiated by Respondent as per clause No.4.3 of the policy.

There was a cap of 2 years for subject treatment and claim lodged was in the 1st year of the policy thus complaint dismissed.

****

Case No.11-005-029-14
Mr. Dhanpal J Desai Vs. Oriental Insurance Co. Ltd.
Award dated 4th February 2014
Repudiation of Mediclaim

Complainant hospitalized for treatment of UTI, Pylonephritis, ARF, Hypothyroidism and Hypertension and expense incurred for Rs.99,690/- was repudiated by the Respondent as per clause No.5.4 – late intimation.

Claim intimation was only 16 days late but thereafter Required some queries from complainant which was replied after two years which was inordinate delay on the part of Complainant.

Thus complaint dismissed.

Case No.11-003-0456-13
Mr. Babu George Vs. National Insurance Co. Ltd.
Award dated 4th Feb.2014
Partial repudiation of Mediclaim

Complainant's wife treated for Chemotherapy for Cancer and expense incurred Rs.1,01,495/- was partially settled for Rs.38,915/- after deduction of an amount of Rs.62,580/- by the Respondent on the basis of limit under A, B & C of the Hospitalization Benefit Policy.

Complainant was absent during the Hearing scheduled by this Forum and original claim papers was failed to provide by both the parties for verification.

Thus complaint fails to succeed.

****

Case No.11-005-0463-13
Mr. Piyushbhai K Gandhi Vs. Oriental Insurance Co. Ltd.
Award dated 4th Feb.2014
Repudiation of Mediclaim

Complainant hospitalized for treatment of P. Falciparum Malaria with Gastroenteritis and dehydration for which expense incurred Rs.24,820/- was repudiated by the Respondent under clause 5.9 of the of the policy.

On scrutiny of available documents, the Forum also found the claim seems to be suspicious. Thus complaint dismissed.

****

Case No.11-002-028-14
Shri Dinesh B Choksi vs. The New India Assurance Co. Ltd.
Award dated 4th Feb.2014
Partial repudiation of Mediclaim

Complainant's father (81 years old) treated for Benin Prostate Hyperplasia and expense incurred for Rs.52,947/- was partially settled for Rs.44,906/- by deducting Rs.8,041/- as per clause No.3.13 of policy terms and conditions.

The insured was a known case of HT and DM since 40 years which was not disclosed in the proposal and was not paying extra premium.

Thus Respondent rightly settled the claim.

In view of this complaint dismissed.

****

Case No.11-004-0035-14
Shri Girish G. Mehta Vs. United India Insurance Co. Ltd.
Award dated 6th Feb.2014
Partial repudiation of Mediclaim

Complainant received a partial claim amount of Rs.32,273/- instead of Rs.34,873/- for his Umbilical Hernia treatment. Respondent deducted Rs.2,600/- from his total claim amount as per condition No.3.1 and 1.2 which is right and proper. This complaint dismissed.

****

Case No.11-003-0030-14
Mr. Natwarlal C. Kaptan Vs. National Insurance Co. Ltd.
Award dated 6th Feb. 2014
Repudiation of Mediclaim

Complainant treated for Unstable Angina, Single Vessel Disease and claimed Rs.1,55,853/- was repudiated by the Respondent under pre-existing clause No.4.1.

Complainant was history of DM since 15 years and HTN since 5 years, the current illness is a major complication of these. The policy is in second year policy. Pre-existing diseases will be covered after three consecutive continuous claim free years.

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

****

Case No.11-005-0031-14
Mr. Jiger R. Parikh Vs. Oriental Insurance Co. Ltd.
Award dated 6th Feb.2014
Repudiation of Mediclaim

Complainant's mother underwent Cataract surgery in her both eyes and total expense incurred for Rs.32,000/- was repudiated by the Respondent on the ground of exclusion clause 4.3, 2 years waiting period. The claim was in the 2nd year of the policy.

Complainant was having policy with other Insurance Company but continuity not received so complaint dismissed.

****

Case No.11-017-0468-13
Mr. Xerxes D. Avari Vs. Star Health and Allied Insurance Co. Ltd.
Award dated 6th Feb. 2014
Repudiation of Mediclaim

Complainant treated for therapeutic embolization of left sphenopalatine vessel and expense incurred for Rs.2,16,854/- was repudiated by the Respondent under clause 7 of the Senior citizens Red Carpet Insurance Policy.

Complainant filled portability form Part-III but not disclosed his previous history hence Respondent rejected his claim and also cancelled his policy and refunded his premium paid for renewal.

On scrutiny of available documents, the Forum also denied his request hence complaint dismissed.

****

Case No.11-002-027-14
Shri Keyur Majmudar Vs. The New India Assurance Co. Ltd.
Award dated 6th Feb.2014
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Lower Limb Dvt. with Arthritis and expired on 10-11-2012 during treatment and claimed Rs.1,07,438/- was partially settled by Respondent for Rs.71,999/- by deducting Rs.35,469/- as per terms and condition No.6.

Respondent paid total claim in the year 2009-10 Rs.2,33,942/- and 2010-11 claim paid Rs.1,42,999/- which comes to 94.23% of Sum Insured.

However last claim partially deducted as 25% as per clause No.6 is valid and proper hence complaint dismissed.

****

Case No.11-005-0454-13
Mr. Thakorbhai A. Patel Vs. Oriental Insurance Co. Ltd.
Award dated 7th Feb.2014
Partial repudiation of Mediclaim

Complainant's wife treated cataract surgeries in her both eyes and claimed Rs.45,824/- was partially settled by the Respondent for Rs.25,824/- by deducting Rs.20,000/- as per Exclusion clause No.4.6.

On scrutiny of available documents, the Forum also denied his remaining amount hence complaint dismissed.

****

Case No.11-005-0464-13
Mr. Tirath D. Jani Vs. Oriental Insurance Co. Ltd.
Award dated 7th Feb.2014
Partial repudiation of Mediclaim

Complainant aged 33 years treated cataract surgeries in his both eyes and claimed Rs.1,30,050/- was partially settled by the Respondent for Rs.50,100/- by deducting Rs.80,000/- as per terms and condition No.13.2 and Exclusion clause No.4.6.

On scrutiny of available documents, the Forum also denied his remaining amount hence complaint dismissed.

****

Case No.11-003-036-14
Mr. Narendra Singh Kushwah Vs. National Insurance Co. Ltd.
Award dated 7th Feb.2014
Repudiation of Mediclaim

Complainant's wife hospitalized for Caesarian Section Delivery and expense incurred for Rs.39,138/- was repudiated by the Respondent giving reason that the insured was not completed 9 months policy period.

This is a Tailor Made Group Mediclaim Policy issued to the investors of Bajaj Capital and premium also paid through Bajaj Capital. Premium was increased by the Insurer for Pre-existing and Maternity benefit which was paid later on and usual renewal premium paid in time but Respondent considered the policy period after receiving full payment as 36 days late so fresh policy issued.

In view of this complaint dismissed.

****

Case No.11-004-0037-14
Shri Rameshbhai S. Patel Vs. United India Insurance Co. Ltd.
Award dated 10th February 2014
Repudiation of Supplementary Medical expense

This is Group Mediclaim issued to IRRS group complainant is a member of the policy. Complainant hospitalized for Artery Disease and expense incurred for Rs.70,974/- was paid by the Respondent for Rs.66,674/-.

Thereafter second claim lodged by complainant through IRRS without any original documents and treatment taken by his wife was rejected by the Respondent on the basis of long delay and non submission of original treatment papers.

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

****

Case No.11-004-0040-14
Mr. Hiren V. Gandhi Vs. United India Insurance Co. Ltd.
Award dated 10th Feb.2014
Partial repudiation of Mediclaim

Complainant treated for Ureteric Stone and expense incurred for Rs.46,361/- was partially settled by the Respondent for Rs.18,000/- by deducting Rs.28,361/- as per PPN rate.

Complainant has submitted a copy of treating hospital's letter informing therein that they had withdrawn from PPN network. But Respondent settled the claim as per reasonable charge.

The Forum also agreed the decision of the Respondent thus complaint dismissed.

****

Case No.11-005-0042-14
Shri Ketanbhai V. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 10th Feb.2014
Repudiation of Mediclaim

This is Group Mediclaim policy issued to R.B. Hospitality & Health Services, Mumbai and insured treated for Pre-existing disease which was covered after 4 claim free years.

Claim file closed on the ground of non compliance of required documents under clause 8.3, as also clause 13 – 12 months limit.

Thus complaint dismissed.

****

Case No.11-004-0044-14
Shri Dineshbhai C. Patel Vs. United India Insurance Co. Ltd.
Award dated 10th Feb.2014
Repudiation of Mediclaim

An amount of Rs.17,423/- lodged by the Complainant for his wife's cataract surgery expense was repudiated by the Respondent on the ground of late intimation.

On scrutiny of available documents proved the claim is suspicious thus complaint dismissed.

****

Case No.11-017-0041-14
Shri Lalitbhai M. Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 10th Feb. 2014
Repudiation of Mediclaim

Complainant treated for HTN, Acute Giddiness, Cerebral infarct, Hypothyroidism etc. and expense incurred Rs.44,927/- was repudiated by the Respondent on the ground of pre-existing disease.

The claim was in the first year of the policy and previous history was not disclosed in the proposal thus complaint dismissed.

****

Case No.11-004-0045-14
Shri Bharat P. Patel Vs. United India Insurance Co. Ltd.
Award dated 10th Feb.2014
Repudiation of Mediclaim

An amount of Rs.9,433/- lodged by the Complainant for his 19 years only sons hospitalization expense was repudiated by the Respondent on the ground of surname of the insured different in policy and education record. It attracts policy cancellation clause 5.9.

On scrutiny of available documents proved the claim is suspicious thus complaint dismissed.

****

Case No.11-002-0039-14
Shri Punit D. Bhatt Vs. The New India Assurance Co. Ltd.
Award dated 10th Feb. 2014
Partial repudiation of Mediclaim

Complainant's 70 years old mother hospitalized for treatment of Cataract surgeries of her both eyes and expense incurred Rs.68,400/- was partially settled by the Respondent for Rs.48,000/- as per terms and conditions of policy and Circular of the Company dated 21-06-2010 in which company specially put cap of Rs.24,000/- for each surgery or actual expense whichever is less.

Therefore complaint dismissed.

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Case No.11-002-0034-14
Dr. Ramesh Parekh Vs. The New India Assurance Co. Ltd.
Award dated 11th Feb. 2014
Partial settlement of Mediclaim

Complainant had taken a Group Mediclaim Policy for Hospitalization benefit for five members (his staff persons) and one of the staff member aged 51 years female hospitalized in his own hospital for treatment of Thyroid Adenoma and expense incurred for Rs.46,064/- was settled partially by the Respondent for Rs.33,074/- by deducting Rs.13,100/- giving reason that customary and reasonable charges can be payable.

Complainant is a proposer/doctor, patient is an insured staff member whose name was not mentioned in the policy and treated in his own hospital hence discountable rate should be quoted.

However, Respondent's decision to settle the claim partially is right and proper. Thus complaint dismissed.

****

Case No.11-002-0043-14
Mr. Vinod M. Desai Vs. The New India Assurance Co. Ltd.
Award dated 11th Feb. 2014
Partial settlement of Mediclaim

Complainant treated for Myocardial infarction and expense incurred for Rs.2,16,577/- was partially settled by the Respondent for Rs.69,000/- as per policy terms and conditions 6 (d).

Insured was known case of HTN since 8-to 10 years, Sum Insured increased from 80,000/- to 1.00 Lac since 2008, no additional premium was paid for HTN. Therefore Respondent settled the claim on the basis of old sum insured which is upheld. Thus complaint dismissed.

****

Case No.11-002-0049-14
Mr. Dineshkumar R. Shah Vs. The New India Assurance Co. Ltd.
Award dated 12th Feb. 2014
Partial settlement of Mediclaim

Complainant's wife treated for L4-5 decompression, Laminectomy & Neurolisis and expense incurred for Rs.1,79,347/- was partially settled by the Respondent by deducting Rs.34,980/- as per policy terms and conditions No.4.2.21 & 4.2.22.

Looking to the available documents of both the parties, the forum also denied the complainant's argument and complaint dismissed.

****

Case No.11-025-0050-14
Shri Atul Ajmera Vs. Max Bupa Health Insurance Co. Ltd.
Award dated 12th Feb.2014
Repudiation of Mediclaim

Complainant's son 21 years old student met with an accident and had undergone for dental treatment for post hospitalization and expense incurred Rs.1,02,000/- was repudiated by the Respondent as per policy terms and condition No.2.4.

Insured previously admitted at Baroda and shifted to Surat and thereafter post hospitalization was at New Delhi but previous hospitalization not informed to the Insurer. There is a time limit of 60 days for post hospitalization including all supporting treatment papers against which complainant claimed after 81 days can not be payable.

In view of this complaint dismissed.

****

Case No.11-004-0052-14
Mr. Chinubhai N. Mehta Vs. United India Insurance Co. Ltd.
Award dated 12th Feb.2014
Repudiation of Mediclaim

Complainant treated for IHD+HBP+DM +Anxiety Neurosis and expense incurred for Rs.10,734/- was repudiated by the Respondent as per policy condition No.5.11.

Due to wrong statement of age, Respondent issued Gold policy instead of Senior Citizen policy hence claim rejected on the ground of suppression of material facts. Therefore complaint dismissed.

****

Case No.11-002-0053-14
Shri Bhupendra C. Shah Vs. The New India Assurance Co. Ltd.
Award dated 13th Feb.2014
Repudiation of interest for delayed payment

Complainant covered a Group Mediclaim Policy issued to LIC of India for their employees by the Insurer. Complainant underwent Cataract Surgery and expense claimed for Rs.28,840/-which was fully paid by the Insurer but complainant demanding interest for late payment @ 18% for 42 days which comes to Rs.576/-.

Complainant had not followed policy condition No.5.3 and 5.4 and also not given full particulars of claim documents like without name of recipients and his designation or seal or stamp, without date of Discharge summary etc. These mistakes are not carried out for settling the claim by the Respondent so Complaint dismissed.

****

Case No.11-003-0058-14
Shri Kishorbhai T. Sevak Vs. National Insurance Co. Ltd.
Award dated 13th Feb. 2014
Repudiation of Mediclaim

Complainant treated for chest pain and claimed for Rs.26,346/- was rejected by the Respondent as per policy condition No.4.1. As per treatment papers, complainant has a known case of HT, there is a cap of two years for such treatment. Thus complaint dismissed.

****

Case No.11-002-0054-14
Mr. Bhupndra I Patel Vs. The New India Assurance Co. Ltd.
Award dated 13th Feb. 2014
Repudiation of Mediclaim

Complainant hospitalized for treatment of fever,, Chill, vomiting, headache etc and expense incurred for Rs.17,015/- was repudiated by the Respondent under clause 5.5 on the ground of discrepancies found from the statement of patient and treating doctor during investigation.

Looking to the available documents, the forum also proved the claim was fraud hence complaint dismissed.

****

Case No.11-002-0055-14
Mr. Dipen S. Shah Vs. The New India Assurance Co. Ltd.
Award dated 14th Feb. 2014
Repudiation of Mediclaim

Complainant treated for Central Retina Vein Occlusion and expense incurred for Rs.1,86,197/- was repudiated by the Respondent giving reason that claim intimation was received very late as also condition No.2.6.5 would be applied.

Complainant was a policy holder since 1997 and this is the first claim of his mediclaim policy. But in the initial stage of the treatment, one of the Officers of the Respondent advised him that the subject treatment is not admissible. After confirming from other sources the claim documents submitted was very late hence complaint dismissed.

****

Case No.11-009-0056-14
Mr. Chirag Patel Vs. Reliance General Insurance Co. Ltd.
Award dated 14th Feb.2014
Repudiation of Mediclaim

Complainant treated for URI with fever with Dycentry and claimed for Rs.22,000/- was repudiated by the Respondent as per Policy Terms and Condition No.2 and 15.

There are so many discrepancies found from the treatment papers like name of the disease, time of admission etc.

Looking to the available documents, the forum also proved the claim was fraud hence complaint dismissed.

****

Case No.11-002-0060-14
Shri Sagar A. Parikh Vs. The New India Assurance Co. Ltd.
Award dated 14th Feb. 2014
Partial repudiation of Mediclaim

Complainant's deceased father treated for Carcinoma Right Lung and expense incurred for Rs.45,585/- was partially settled by the Respondent as per condition No.6.

Complainant was not a policy holder and policy holder expired during the treatment. The deceased policy holder claimed 9 claims totaling Rs.3.00 Lac are paid by the Respondent previously to the same treatment.

In view of this the complaint dismissed.

****

Case No.11-004-0061-14
Mr. Chetan M. Patel Vs. United India Insurance Co. Ltd.
Award dated 14th Feb. 2014
Repudiation of Mediclaim

Complainant covered a Tailor Made Group Mediclaim Policy under which complainant's 19 years old son treated for accidental head injury and claimed for Rs.25,424/- was repudiated by the Respondent as per clause No.8.3. Late submission of claim papers by 48 days.

The claim was repudiated by the Respondent on 13-10-2011 but the complaint lodged to this forum on 23-01-2013 so this is a time barred case.

In view of this complaint dismissed.

****

Case No.11-004-0062-14
Mr. Alkeshray H. Brahmbhatt Vs. United India Insurance Co. Ltd.
Award dated 14th Feb. 2014
Repudiation of Mediclaim

Complainant's son hospitalized for treatment of fever and vomiting and expense incurred for Rs.19,091/- was repudiated by the Respondent as per policy condition No.5.3 (late intimation).

Hospitalization from 11-08-2012 to 14-08-2012 but lab report date mentioned as 08-08-2012 wherein referred doctor's consultation papers are not submitted which become suspicious.

Thus complaint dismissed.

****

Case No.11-005-0059-14
Mr. Fuljibhai B. Patel Vs. Oriental Insurance Co. Ltd.
Award dated 18th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Hemiplegia which was in nature of acute and expense incurred for Rs.50,516/- was repudiated by the Respondent as per policy exclusion No.4.1.

Hospital treatment papers shows that it is a case of HTN/DM since last 15 years and Hemiplegia in nature of acute which was not disclosed in the proposal. Thus complaint dismissed.

****

Case No.11-004-0063-14
Mr. Rajesh M. Oza Vs. United India Insurance Co. Ltd.
Award dated 18th Feb.2014
Repudiation of Mediclaim

Complainant's daughter hospitalized for treatment of low grade fever, headache, body ache, nausea, vomiting and sudden onset of tongue bite etc. and expense incurred for Rs.5,563/- was repudiated by the Respondent as per policy condition No.4.9 (mediclaim for Epilepsy is not covered).

Thus complaint dismissed.

****

Case No.11-004-0065-14
Mr. Piyush R. Mehta Vs. United India Insurance Co. Ltd.
Award dated 18th Feb.2014
Partial repudiation of Mediclaim

Complainant treated for Foraminotomy + Dissectomy and claimed Rs.81,835/- was partially settled by Respondent Rs.34,092/- as per condition No.1.2.1. The subject illness falls under major diseases hence payable amount is 70% of S.I.

Thus complaint dismissed.

****

Case No.11-004-0067-14
Mr. Jayendra K Bhavsar Vs. United India Insurance Co. Ltd.
Award dated 19th Feb.2014
Partial repudiation of Mediclaim

Complainant's 13 years old son hospitalized two times for treatment of Acute Renal failure and total expense incurred for Rs.81,407/- was partially settled by the Respondent for Rs.77,047/- by deducting an amount of Rs.4,360/- as per terms and conditions and Exclusion No.1.2 © Note 2, 4.13 & 4.18.

Respondent clarified all deductions in their claim settlement statement which is in order. Thus complaint dismissed.

****

Case No.11-002-0069-14
Mr. Thakorbhai L. Patel Vs. The New India Assurance Co. Ltd.
Award dated 19th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of D.M, sub acute progressive imbalance in walking since 2-3 months, episodes of giddiness on & off, unable to walk without help etc. and expense incurred for Rs.66,153/- was repudiated by the Respondent giving reason that no active line of treatment was given during hospitalization.

Thus the claim repudiated as per clause 4.4.11 of the policy hence complaint dismissed.

****

Case No.11-004-0068-14
Mrs. Lilaben M. Prajapati Vs. United India Insurance Co. Ltd.
Award dated 19th Feb. 2014
Repudiation of claim under Group Mediclaim policy

Complainant's deceased husband was a member of a Tailor Made Group Mediclaim policy. Insured was a vegetable vendor and in the year of 2011 he was admitted to

hospital for treatment of heart attack for 2-3 times and expense incurred Rs.20,804/- was repudiated by the Respondent on the ground of pre-existing disease.

Complainant's husband expired on 04-03-2013 and a petition filed this forum on 12-04-2013 for reimbursement of medical expense of 2011 was beyond the time limit of one year.

Thus complaint dismissed.

****

Case No.11-017-0070-14
Shri Jitendra Koshti Vs. The Star Health & Allied Insurance Co. Ltd.
Award dated 19th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Laparoscopic Cholecystectomy and expense incurred for Rs.74,236/- was repudiated by the Respondent as per condition No.7 and the policy has cancelled as per condition No.12.

Complainant was not disclosed the previous health history of the insured at the time of taking the policy hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-004-0076-14
Mr. Pinakin J Pandya Vs. United India Insurance Co. Ltd.
Award dated 19th Feb. 2014
Repudiation of Mediclaim

Complainant was member of a Group Mediclaim issued to Torrent Cables Ltd for their employees by the Respondent and two claims lodged by the complainant for his son's eye treatment for two times and both claims Rs.67,205/- + Rs.65,959/- were repudiated by the Respondent giving reason that first claim hospitalization was less than 24 hours and second claim treatment was an OPD basis both are not covered under group mediclaim policy.

In view of this complaint dismissed.

****

Case No.11-004-0077-14
Mr. Dashrath M. Prajapati Vs. United India Insurance Co. Ltd.
Award dated 19th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for Diabetic Neuropathy treatment and claimed for Rs.20,823/- was repudiated by the Respondent as per policy condition No.5.4 & 5.5.

Respondent's TPA made several correspondence for necessary requirement which was not submitted hence claim rejected on the basis of non compliance of required documents.

Thus complaint dismissed.

****

Case No.11-004-0074-14
Mr. Prakash K Patel Vs. United India Insurance Co. Ltd.
Award dated 20th Feb. 2014
Repudiation of Mediclaim

Complainant's 7 years old daughter was hospitalized for treatment of Acute Viral Hepatitis E with Pyrexia and expense incurred Rs.19,289/- was repudiated by the Respondent on the ground of policy terms and conditions clause 5.4, late intimation.

Further the insured patient earlier treated doctor has not referred to the subject treatment hence claim looks suspicious.

In view of this complaint dismissed.

****

Case No.11-017-0078-14
Mr. Rakesh M. Agrawal Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 20th Feb.2014
Repudiation of Mediclaim

Complainant's 2 ½ years old son hospitalized for surgery of Hydrocele in Right side and Left Rethratile tests and incurred total expense of Rs.5,704/- was rejected by the Respondent on the ground of congenital disease.

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

****

Case No.11-009-0081-14
Mr. Jimit P. Patel Vs. Reliance General Insurance Co. Ltd.
Award dated 20th Feb. 2014
Repudiation of Mediclaim

Complainant's daughter treated for Pneumonia with Respiratory Distress and claim lodged was repudiated by the Respondent on the ground of as per investigation proved the treatment was on OPD basis.

Hence complaint dismissed.

****

Case No.11-004-0079-14
Mr. Rajendrabhai K Shah Vs. United India Insurance Co. Ltd.
Award dated 20th Feb. 2014
Repudiation of Mediclaim

Complainant treated for RE Cat Ext with Phaco Foldable lens and claimed Rs.11,294/- was rejected by the Respondent as per policy condition No.5.3.

Complainant got consultations well before treatment but no justifiable reason to condone the delay in intimation as well as no documentary evidence to prove the subject treatment.

In view of this complaint dismissed.

****

Case No.11-003-0072-14
Shri Shashikant R. Shah Vs. National Insurance Co. Ltd.
Award dated 20th Feb. 2014
Partial Repudiation of Mediclaim

An 80 years old complainant hospitalized for treatment of Comminated Trochanterie Fracture of Rt. Neck of Femur and total expense incurred for Rs.2,02,222/- was partially settled by the Respondent for Rs.88,535/- by deducting an amount of Rs.1,13,687/- as per terms and conditions of policy and exclusion clause No. 4,11,4.14, 4.17, 4.25 & 4.26.

The complainant preferred to remain absent for Hearing scheduled by this forum hence it was decided to proceed Ex-parte.

On scrutiny of claim documents, it looks fabricated so complaint dismissed.
****

Case No.11-011-0080-14
Ms. Bharti T. Aswani Vs. Bajaj Allianz Gen. Insurance Co. Ltd.
Award dated 21st Feb. 2014
Repudiation of Mediclaim

Complainant is a member of the Health Guard Policy issued to Mr. Thavardas D. Aswani by the Respondent.

A claim lodged by the complainant for Rs.83,000/- for hospitalization expense due to vehicular accident was repudiated by the Respondent on the basis of Investigation report.

Claim intimation was very late, treatment report shows OPD treatment thus as per policy condition No.D-7, Respondent refuse the claim hence complaint dismissed.
****

Case No.11-004-0086-14
Mr. Kevaldeep S. Gandhi Vs. United India Insurance Co. Ltd.
Award dated 21st Feb. 2014
Repudiation of Mediclaim

Complainant's 22 months old son underwent surgery of left side Inguinal Hernia and expense incurred for Rs.25,685/- was repudiated by the Respondent on the ground of policy terms and conditions clause No.4 and 4.1.

Respondent sought expert opinion of a Paediatric Surgeon who opined the subject surgery at this age is congenital which is not payable.

Thus complaint dismissed.

****

Case No.11-004-0082-14
Mr. Jayeshkumar D. Patel Vs. United India Insurance Co. Ltd.
Award dated 21st Feb. 2014
Partial repudiation of Mediclaim

Complainant's wife underwent cataract surgery and expense incurred for Rs.64,295/- was partially settled by the Respondent for Rs.29,720/- as per terms and conditions No.1.2 c of the Mediclaim policy.

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

****

Case No.11-002-0075-14
Mr. Atul M. Chokshi Vs. The New India Assurance Co. Ltd.
Award dated 21st Feb. 2014
Partial repudiation of Mediclaim

Complainant hospitalized Inguinal Hernia and expense incurred Rs.96,626/- was partially paid Rs.68,445/- by deducting Rs.28,078/- by Respondent as per their policy terms and conditions.

Respondent proved with evidences of deductions made is clearly explained in claim discharge voucher which is right and proper.

Thus complaint dismissed.

****

Case No.11-025-0051-14
Shri Nandkishore Agarwal Vs. Max Bupa Health Insurance Co. Ltd.
Award dated 24th Feb. 2014
Partial repudiation of Mediclaim

Complainant's wife treated for Carcinoma (Left Breast) and total expense incurred for Rs.2,30,000/- was partially settled by the Respondent for Rs.2,00,000/- and deducted Rs.30,000/- as per clause 2 of terms and conditions of the policy.

Total Sum Insured was Rs.2.00 Lacs and company paid claim of full sum insured hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-004-0087-14
Mr. Puranchand Keswani Vs. United India Insurance Co. Ltd.
Award dated 24th Feb. 2014
Partial settlement of Mediclaim

Complainant was covered two policies one for Individual and another for Super top up policy. Individual policy for S.I Rs.1,75,000+ C.B 18,750/-. Complainant's wife treated for D.M, HTN, Exertion and Breathlessness and total expense incurred for Rs.3,74,975/- was partially settled for Rs.1,93,750/- under Individual Mediclaim and remaining amount rejected under Super top up policy as per pre-existing disease.

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

****

Case No.11-002-0089-14
Shri Praveen Shah Vs. The New India Assurance Co. Ltd.
Award dated 24th Feb. 2014
Partial settlement of Mediclaim

Complainant hospitalized for headache and high fever with chills and expense incurred for Rs.8,342/- was partially settled by the Respondent for Rs.6,008/- as per policy condition No.2.1.

First consultation is not available in the record so IP admission is not known, thus Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0085-14
Mrs. Bhanumatiben S. Parmar Vs. National Insurance Co. Ltd.

Award dated 25th Feb.2014
Repudiation of Mediclaim

Complainant's husband treated for chronic ailment and he had brain hemorrhage for which incurred Rs.2,34,502/- was repudiated by the Respondent under exclusion clause 4.1. The insured patient hospitalized on 8-11-2013 and discharged on 24-11-2012, after discharge he died. Policy incepted on 3rd September 2012 and her deceased husband was a doctor.

Hospital record reveals that he has chronic ailment of brainstem dysfunction due to steroid refractory idiopathic thrombocytopenia.

Claim reported within two month of policy taken hence complaint dismissed.

****

Case No.11-005-0091-14
Shri Pravinbhai K Patel Vs. Oriental Insurance Co. Ltd.
Award dated 25th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for High Grade fever, Abscess on prostate, UTI, DM etc. and total expense incurred for Rs.45,893/- was repudiated by the Respondent as per policy exclusion No.4.3, 4.1 and 5.9.

This is the first year policy, treatment papers shows previous history of prostate, DM, UTI etc. which was not disclosed in the proposal.

Thus complaint dismissed.

****

Case No.11-002-0092-14
Shri Pradeep K Pancholi Vs. The New India Assurance Co. Ltd.
Award dated 25th Feb. 2014
Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Gall Bladder Stone and Tumor and expense incurred for Rs.52,280/- was partially settled by the Respondent for Rs.33,305/- by deducting and amount of Rs.18,975/- as per policy clause 2.3 and 2.4.

Respondent conveyed all deductions in details in their discharge voucher which is right and proper. Thus complaint dismissed.

****

Case No.11-002-0095-14
Shri Amit H Shah Vs. The New India Assurance Co. Ltd.
Award dated 25th Feb. 2014
Partial settlement of Mediclaim

Complainant hospitalized for Chest pain, gabhraman, perspiration and left hand pain and expense incurred for Rs.16,201/- was partially settled by the Respondent for Rs.10,151/-by deducting 6,150/- as per policy condition No.2.3 note 2.

Complainant's stated that hospital authorities have informed to pay doctors consultation fees and other bills comes to Rs.6,050/-which was not included in the bill.

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

****

Case No.11-004-0097-14
Shri Pravinchandra Pathak Vs. United India Insurance Co. Ltd.
Award dated 26th Feb. 2014
Repudiation of Mediclaim

Complainant was a member of Group Mediclaim Insurance policy issued to Club Veritas by the Respondent since 2008 and continued up to June 2011. Thereafter since 8th June 2011 an Individual policy issued to the complainant through above agent and terms and conditions was different which was not objected by the Complainant immediately.

Complainant lodged claim for hospitalization expense under the Individual policy was rejected by the Respondent on the ground of exclusion clause No.4.1.

Thus complaint dismissed.

****

Case No.11-004-0094-14
Mr. Dineshbhai S. Chaudhary Vs. United India Insurance Co. Ltd.
Award dated 26th Feb. 2014
Repudiation of Mediclaim

Complainant's 7 years old son hospitalized for treatment of tonsil and nasal problem and expense incurred for Rs.32,000/- was repudiated by the Respondent on the ground of non availability of required documents in-spite of three reminders sent to the complainant through agent.

Complainant requested that the reason for delay in submission of required papers was that they are residing to rural area which village far away from hospital and contact on telephonically, due to busy schedule of doctor, not responding well.

These excuses are not accepted by the Respondent hence complaint dismissed.

****

Case No.11-005-0093-14
Mr. Tushar Panchal Vs. Oriental Insurance Co. Ltd.
Award dated 26th Feb. 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for Vaginal Hysterectomy and expense incurred for Rs.58,151/- was repudiated by the Respondent invoking policy clause 4.3.

Complainant argued his policy runs since 1998 but this is not an Individual policy, it is issued to PNB account holders. Continuity benefit will be given if the policy taken from Respondent previously. In this case previous policy was from Star Health and claim lodged under 1st year of the policy.

In view of this complaint dismissed.

****

Case No.11-005-0099-14
Mr. Ashok A Vyas Vs. Oriental Insurance Co. Ltd.
Award dated 28th Feb. 2014
Repudiation of Mediclaim

Deceased complainant hospitalized for treatment of Tongue Cancer and expired on January 2014. Deceased patient's son claimed for hospitalization expense of Rs.25,840/- was repudiated by the Respondent as per policy condition No.4.8.

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

****

Case No.AHD-G-052-1314-0368
Mr. Arvindbhai S. Christian Vs. Universal Sampo Gen. Ins. Co. Ltd.
Award dated 3rd March 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for Bronchial Asthma and incurred expense of Rs.5,620/- was rejected by the Respondent stating that the patient was admitted to hospital for only 17 hours which is not admissible. As per policy terms and conditions of the policy, minimum 24 hours hospitalization expense can claim but the subject claim is for below 24 hours thus complaint dismissed.

****

Case No.11-002-0101-14
Mr. Dinesh H. Kayastha Vs. The New India Assurance Co. Ltd.
Award dated 3rd March 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for chest pain with shoulder pain and expense incurred for Rs.13,063/- was repudiated by the Respondent as per policy exclusion clause No.4.4.11, no active line of treatment.

Hospitalization was only of investigation purpose hence complaint dismissed.

****

Case No. 11-004-0107-14
Mr. Dilip M. Brahmbhatt Vs. United India Insurance Co. Ltd.
Award dated 3rd March 2014
Partial repudiation of Mediclaim

A claim amount of Rs.1,45,448/- was lodged by the Complainant for his wife underwent Right Nephrectomy & Infra Umbilical Hernia repair was partially settled for Rs.56,260/- and deducted an amount of Rs.89,588/- giving reason that Ectopic Kidney is a congenital defect and same is not covered under the policy so claim for only Hernia was paid.

Policy is not individual, it is Tailor made Group Mediclaim policy issued to Torrent Powers Ltd for their employees.

Respondent clarified all deductions in their claim settlement sheet which is right and proper hence complaint dismissed.

****

Case No. 11-002-0096-14
Mr. Pravinbhai P Patel Vs. The New India Assurance Co. Ltd.
Award dated 3rd March 2014
Repudiation of Mediclaim

Complainant treated for Abdominal pain, weakness, fever etc. and expense incurred for Rs.48,018/- was repudiated by the Respondent as per terms and condition No.5.5 of the mediclaim policy.

As per investigation report of the Respondent shows the claim is fraudulent thus complaint dismissed.

****

Case No.11-002-0104-14
Mr. Ashvin C. Trivedi Vs. The New India Assurance Co. Ltd.
Award dated 3rd March 2014
Partial repudiation of Mediclaim

Complainant's wife underwent surgery for Para Umbilical Hernia and expense incurred Rs.46,850/- which was processed by the Respondent for Rs.27,745/-out of which Respondent paid Rs.24,154/- and balance Rs.3,591/- deducted as per Clause No.2.3 and 2.4.

Respondent clarified all deductions in their claim settlement sheet which is right and proper hence complaint dismissed.

****

Case No.11-005-0113-14
Mr. Arvindbhai M. Doshi Vs. Oriental Insurance Co. Ltd.
Award dated 3rd March 2014
Partial Repudiation of Mediclaim

Complainant underwent for Cataract Surgery of her both eyes and expense claimed for Rs.42,024/- and Rs.41,790/- which were settled partially by the Respondent for Rs.28,024/- and Rs.27,790/- by deducting Rs.14,000/ each surgery under clause No.13.2.

Lens used is higher cost of Rs.24,000/- each which was paid only Rs.10,000/- each is right and proper.

In view of this complaint dismissed.

****

Case No.11-002-0118-14
Mr. Indravadan S. Patel Vs. The New India Assurance Co. Ltd.
Award dated 3rd March 2014
Partial settlement of Mediclaim

Complainant and his wife was treated for accidental injury and separate claims lodged four times two for hospitalization expense and two claims for post hospitalization which were paid partially by the Respondent as per policy terms and conditions clause 3.13, 4.4.21 and 4.4.22.

Respondent clarified all deductions in details in their claim settlement sheet which is right and proper.

Thus complaint dismissed.

****

Case No.11-004-0105-14
Smt. Pratiksha P Mehta Vs. United India Insurance Co. Ltd.

Award dated 4th March 2014
Partial repudiation of Mediclaim

Complainant hospitalized for Cataract operation of her both eyes and claimed Rs.1,34,912/- was partially settled by the Respondent for Rs.66,462/- as per policy terms and condition No.15 & 16.

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

****

Case No.11-005-0110-14
Mr.Dushyant M Shah Vs. Oriental Insurance Co. Ltd.
Award dated 4th March 2014
Partial repudiation of Mediclaim

Complainant's father hospitalized for treatment of Acute Symptomatic Seizure and claimed for Rs.1,59,672/- was partially settled by the Respondent for Rs.34,629/- by deducting an amount of Rs.1,25,043/-giving reason that the insured treated for Cancer was an OPD basis which claim is not admissible as per terms and conditions of the policy.

Respondent given clarification for deduction to the Complainant which was right and proper hence complaint dismissed.

****

Case No.11-004-0112-14
Mr. Anantrai R. Kakad Vs. United India Insurance Co. Ltd.
Award dated 4th March 2014
Partial repudiation of Mediclaim

Complainant's wife treated for Hypoglycemia and expense incurred for Rs.16,696/- was partially settled by the Respondent for Rs.5,035/- by deducting an amount of Rs.11,561/- as per terms and condition No.1.2.

Claim settled on 30-03-2011 and complainant lodged case against the settlement on 7th June 2013 which is a time barred case. As per RPG Rules 1998, the complaint can not be entertained by this Forum hence complaint dismissed.

****

Case No.AHD-G-051-1314-0370
Mr. Jenni Narayana Rao Vs. United India Insurance Co. Ltd.
Award dated 4th March 2014

Repudiation of Mediclaim

Complainant's 10 years old daughter under went Femto Second Laser Surgery for both eyes and incurred expense for Rs.7,400/- was repudiated by the Respondent stating that under clause 4.3 (c) (correction of eye sight surgery) is not payable.

The nature of disease suffered to be pre-existing congenital internal disease. Thus complaint dismissed.

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Case No.11-004-0120-14
Mr. Jaysukhlal M Tamakuwala Vs. United India Insurance Co. Ltd.
Award dated 4th March 2014
Partial repudiation of Mediclaim

A 72 years old complainant underwent cataract surgery and lodged a claim of Rs.46,883/- was partially paid by the Respondent for Rs.35,318/- and deducted an amount of Rs.11,470/- as per terms and conditions, treatment for cosmetic purposes is not payable.

Respondent clarified all deductions in details in their claim settlement sheet which is right and proper.

Thus complaint dismissed.

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Case No.11-002-0100-14
Mr. K.C. Sharma Vs. The New India Assurance Co. Ltd.
Award dated 4th March 2014
Partial settlement of Mediclaim

Complainant's wife treated for Mitral Valve replacement and claim lodged for 2,25,000/- was paid partially by the Respondent as cashless in favour of the hospital for Rs.1,77,000/-and remaining amount partially reimbursed for Rs.34,460/- to the Complainant by deducting an amount of Rs.10,418/- as per policy terms and conditions clause 2.0, 2.1 and 2.2.

Respondent clarified all deductions in details in their claim settlement sheet which is right and proper.

Thus complaint dismissed.

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Case No.11-002-0106-14

Mrs. Dhruvalata P Sheth Vs. The New India Assurance Co. Ltd.
Award dated 4th March 2014
Repudiation of Mediclaim

Complainant herself treated for Chest pain and carried out angiography and expense incurred for Rs.22,161/- was repudiated by the Respondent on the ground of policy condition No.3.4, hospitalization was below 24 hours.

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

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Case No.11-002-0108-14
Mr. Rameshchandra Patel Vs. The New India Assurance Co. Ltd.
Award dated 5th March 2014
Partial settlement of Mediclaim

Complainant underwent Hernia in both sides and claim lodged for 1,22,086/- was settled partially by the Respondent for Rs.85,997/-by deducting an amount of Rs.36,089/- as per policy terms and conditions clause 3.13 and 4.21.

Respondent clarified all deductions in details in their claim settlement sheet which is right and proper.

Thus complaint dismissed.

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Case No.11-007-0109-14 (AHD-G-047-1314-0365)
Shri Pranav G. Trivedi Vs. Tata AIG General Insurance Co. Ltd.
Award dated 5th March 2014
Repudiation of Mediclaim

Complainant covered a daily hospitalization benefit policy, complainant hospitalized for severe stomachache, giddiness, weakness etc and daily expense incurred for 8 days @ Rs.5,500/- was rejected by the Respondent informing that the hospitalization was not required.

On scrutiny of available documents, it is observed that the same patient hospitalized three times in 2011 and 2012 and claim paid by the Respondent Rs.86,314/-, 47,511 and 21,000/- but the present claim rejected by the Respondent on the basis of treatment record and opinion of the doctor.

Thus complaint dismissed.

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Case No.11-002-0124-14

Mr. Jaishil V. Master Vs. The New India Assurance Co. Ltd.
Award dated 5th March 2014
Repudiation of Mediclaim

Complainant's mother hospitalized for Osteoarthritis and expense incurred for Rs.1,43,104/- was repudiated by the Respondent as per policy clause No.4.3, there is a waiting period of 4 years. The subject treatment was in the 4th year of the policy, hence complaint dismissed.

****

Case No.11-003-0122-14
Mr. Rajendrakumar B Zala Vs. National Insurance Co. Ltd.
Award dated 5th March 2014
Repudiation of Mediclaim

Complainant hospitalized for treatment of Transitory Ischemic Attach and expense incurred for Rs.23,86/- was repudiated by the Respondent giving reason that the current illness was due to previous Hypertension which was not disclosed in the proposal.

However claim repudiated on the ground of pre-existing disease, hence complaint dismissed.

****

Case No.AHD-G-051-1314-0378
Shri Janak B Dave Vs. United India Insurance Co. Ltd.
Award dated 5th March 2014
Partial settlement of Mediclaim

Complainant's son and daughter-in-law both are hospitalized for treatment of Vivex (Grade IV) and total claim lodged for both Rs.25,230/- was partially settled by the Respondent for Rs.21,575/- by deducting Rs.3,655/- as per policy provisions shown as reasonably and necessary expense incurred.

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

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Case No.AHD-G-048-1314-0381
Shri Jitendra C. Shah Vs. National Insurance Co. Ltd.
Award dated 5th March 2014

Partial repudiation of Mediclaim

Complainant's wife underwent surgery for removal of Fibroids and expense incurred for Rs.65,447/- was partially settled by the Respondent for Rs.40.317/- by deducting an amount of Rs.25,130/- as per policy conditions, reasonable and customary expense paid.

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

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Case No.AHD-G-044-1314-0373
Mr. M.M. Pathan Vs. Star Health and Allied Insurance Co. Ltd.
Award dated 5th March 2014
Repudiation of Mediclaim

A 67 years old female insured hospitalized for DM+HTN+ Acute Renal failure and expired during treatment for which expense incurred for Rs.3,73,668/- was repudiated by the Respondent as per exclusion Clause No.1 and 4 of the Mediclaim policy.

The subject treatment was in the first year of the policy i.e. within 4 months from inception of policy and treating doctors report shows history of 6 to 7 years. Thus complaint dismissed.

****

Case No.11-005-0001-14
Mr. Rasikbhai J Panchal Vs. Oriental Insurance Co. Ltd.
Award dated 5th March 2014
Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Cirrhosis of lever and expired during treatment for which expense incurred for Rs.50,779/- was repudiated by the Respondent under clause No.4.3 (xiii) 2 years waiting period.

Insured was a mill worker and insurance covered since 2008 with another Insurer and switch over to the Respondent since 2011 but fresh proposal form was obtained so continuity benefit not received.

In view of this complaint dismissed.

****

Case No.11-004-0102-14
Mr. Jaswantbhai I Shah Vs. United India Insurance Co. Ltd.

Award dated 5th March 2014
Repudiation of Mediclaim

Complainant hospitalized for Chemotherapy 3 times due to Chest Cancer and total expense incurred for 59,372/- was repudiated by the Respondent on the ground of non submission of required documents (Condition No.1.2(b) & 5.5 of the Individual Health Insurance Policy.

Claim form not signed by policy holder and requirement sent by mail which is not acceptable by the Respondent thus complaint dismissed.

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Case No. AHD-G-050-1314-0389
Mrs. Ruchita D. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 6th March 2014
Partial repudiation of Mediclaim

Complainant's husband treated for Neuroendocrine Cancer of head of Pancreas with Liver Metasis and incurred expense of Rs.2,59,000/- which was partially paid by the Respondent for Rs.2.00 Lacs under Individual Mediclaim policy for S.I of Rs.2.00 Lacs. For remaining amount of Rs.59,000/-, Complainant submitted claim papers under Family Floater policy incepted in 2009 which was repudiated by the Respondent as per policy condition No.4.1.

There is a cap of 4 years for the subject treatment and this is the third year of the policy.

In view of this complaint dismissed.

****

Case No.11-005-0130-14
Mr. Amit M. Chaudhry Vs. Oriental Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant's daughter underwent dental treatment due to accidental injury and claimed Rs.4,000/- was repudiated by the Respondent on the basis of late submission of claim papers and non availability of required documents.

Claim papers submitted after 60 days from the date of treatment taken and no consultation paper, no proof of accident etc.

Thus complaint dismissed.

****

Case No.11-004-0127-14
Mr. Arunkumar A. Patel Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Partial repudiation of Mediclaim

Complainant's wife underwent cataract surgery and expense incurred for Rs.57,900/- was settled by the Respondent for Rs.18,300/- by deducting an amount of Rs.39,600/- on the basis of 10% of Old Sum Insured of Rs.1,75,000/-.

Complainant increased S.I to Rs.5,00,000/- in the current policy year but there is cap of two years for the subject treatment. Thus Respondent's decision is upheld and complaint dismissed.

****

Case No.11-002-0128-14
Mr. Rashmikant K Shah Vs. The New India Assurance Co. Ltd.
Award dated 6th March 2014
Partial settlement of Mediclaim

Complainant treated for Acute Infract involving left tempo-parietal region with Heamatoma and expense incurred for Rs.44,927/- was partially settled by the Respondent for Rs.30,177/- by disallowing an amount of Rs.14,750/- as per clause 2.1, 2.3 and 2.4.

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

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Case No.11-004-0133-14
Mr. Vinod S. Mehta Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant's 7 years old son underwent surgery of Left Congenital Hernia and expense incurred for Rs.7,962/- was repudiated by the Respondent on the ground of Policy exclusion clause No.4.

Respondent was not attended the Hearing scheduled by this Forum and original papers were not available for verification.

Thus complaint dismissed.

****

Case No.AHD-G-048-1314-0390
Shri Alkesh J Shah Vs. National Insurance Co. Ltd.
Award dated 6th March 2014

Partial settlement of Mediclaim

Complainant underwent cataract surgery and expense incurred for Rs.41,392/- was settled by the Respondent for Rs.23,792/- by deducting an amount of Rs.17,600/- under reasonable and customary clause No.3.12.

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

****

Case No.AHD-G-051-1314-0376
Shri Bharatbhai Zala Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Partial settlement of Mediclaim

Complainant's wife hospitalized for Hysterectomy surgery and expense incurred for Rs.37,900/- was partially settled by the Respondent for Rs.10,500/- by deducting an amount of Rs.37,409/- giving reason that the claim considered on the basis of old individual mediclaim policy for S.I Rs.50,000/-. The subject treatment is payable only for 10% of S.I.

The complainant converted in Floater policy for S.I 2.00 Lacs in 2011 and treatment taken in 2012, there is exclusion for two years for the subject treatment.

In view of this the complaint dismissed.

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Case No.AHD-G-051-1314-0391
Shri Navleshbhai J Patel Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant treated for Fistula and expense incurred for Rs.16,198/- was repudiated by the Respondent as per policy exclusion clause 4.3. Complainant covered mediclaim policy since 2007 but not with the Respondent it was with Reliance General Insurance Co. up to 2010 and thereafter policy switched over to the Respondent through IRRS.

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

****

Case No.AHD-G-051-1314-0387
Smt. Geetaben U Shah Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant's husband hospitalized for treatment of Hepatic Encephalopathy + Alcoholic Cirrhosis and during treatment patient was expired for which expense incurred for Rs.20,775/- was repudiated by the Respondent as per exclusion clause No.4.8.

On referring the available treatment papers proved the deceased patient was treated for Alcoholic disease which can not be payable hence complaint dismissed.

****

Case No.AHD-G-051-1314-0395
Shri Rajendra J Parikh Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant underwent his Rt. Cataract and expense incurred for Rs.25,000/- was repudiated by the Respondent as per policy condition 5.3.

Cataract surgery is a planned operation which should be informed to the Insurer in advance as per condition No.5.6.

Thus complaint dismissed.

****

Case No.11-005-0129-14
Mr. Aalok D. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 6th March 2014
Repudiation of Mediclaim

Complainant treated for Superior Sagital Sinus Trombosis+ Frontal Infarct and expense incurred for Rs.62,042/- was repudiated by the Respondent on the ground of clause No.4.14, Genetic disorder and stem cell implantation.

On referring the available treatment papers proved the insured patient was treated for Genetic disorder which can not be payable hence complaint dismissed.

****

Case No.AHD-G-049-1314-0380
Mr. Sanjay J Shah Vs. The New India Assurance Co. Ltd.
Award dated 6th March 2014
Partial settlement of Mediclaim

Complainant's insured mother hospitalized for breast cancer and expense incurred for Rs.70,238/- was partially paid by the Respondent an amount of Rs.37,238/- by deduction an amount of Rs.33,000/- as per condition No.2.1.

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

****

Case No.AHD-G-044-1314-0386
Shri Harshadbhai L Patel Vs. Star Health and Allied Insurance Co. Ltd.

Award dated 6th March 2014
Repudiation of Mediclaim

Complainant hospitalized for bypass surgery and expense incurred for Rs.1,82,595/- was repudiated by the Respondent as per exclusion clause No.1 (pre-existing disease). As per treatment record, insured was habit of smoking and claim lodged in the second year of the policy.

In the proposal form, not disclosed his previous history and also in the claim form treating doctor signed but required report kept blank which showing suspicious.

In view of this complaint dismissed.

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Case No.AHD-G-051-1314-0394
Shri Nimesh B Patel Vs. United India Insurance Co. Ltd.
Award dated 6th March 2014
Partial settlement of Mediclaim

Complainant hospitalized for Inguinal Hernia and expense incurred for Rs.69,941/- was partially settled by the Respondent for Rs.44,206/- by deducting an amount of Rs.25,735/- giving reason that the claim considered on the basis of old individual mediclaim policy for S.I Rs.1,75,000/-. The subject treatment is payable only for 25% of S.I.

The S.I increased in 2013 Rs.2.75 Lacs and treatment taken in the same year, there is exclusion for two years for the subject treatment.

In view of this the complaint dismissed.

****

Case No.11-004-0103-14
Mr. Hiren K Patel Vs. United India Insurance Co. Ltd.
Award dated 7th March 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for Urinary Tract Infection and expense incurred for Rs.41,800/- was repudiated by the Respondent as per condition No.5.3 and 5.4 of the Mediclaim policy.

This is a Group Mediclaim policy issued to the employees of Max New York Life Insurance Co. and claim documents submitted by 32 days late.

In view of this complaint dismissed.

****

Case No.AHD-G-048-1314-0393
Mr. Ramanlal P. Patel Vs. National Insurance Co. Ltd.
Award dated 7th March 2014
Partial repudiation of Mediclaim

Complainant underwent surgery of Rt. Epidemics cyst excision and expense incurred for Rs.44,279/- was partially settled by the Respondent for Rs.29,479/- by deducting an amount of Rs.14,800/- as per condition No.3.12 of the mediclaim policy.

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

****

Case No.AHD-G-049-1314-0399
Mr. Deveshkumar N. Doshi Vs. The New India Assurance Co. Ltd.
Award dated 7th March 2014
Partial repudiation of Mediclaim

Complainant's 7 years old insured son hospitalized for Acute Viral fever (Dengue) and expense incurred Rs.18,655/- was partially settled by the Respondent for Rs.10,455/- by deducting an amount of Rs.8,200/- as per policy clause No.2.3.

Complainant paid Rs.5000/- to doctor's visit charge, admission charge and rent of Rs.3,200/- which were deducted as per terms and condition of the policy.

In view of this complaint dismissed.

****

Case No.AHD-G-051-1314-0403
Smt. Rajeshree M Patel Vs. United India Insurance Co. Ltd.
Award dated 7th March 2014
Repudiation of Mediclaim

Complainant's daughter hospitalized for left side weakness and difficulty in walking and incurred expense for Rs.35,688/- was repudiated by the Respondent invoking clause 5.5 of the policy.

Previous two claims were given on cashless basis and current claim was different and not aware of the rules which were not a valid ground for delay in submission of claim papers. Thus complaint dismissed.

****

Case No.AHD-G-050-1314-0397
Shri Niraj K Mistry Vs. Oriental Insurance Co. Ltd.
Award dated 7th March 2014
Repudiation of Mediclaim

Complainant's father treated for Acute Infarct in it posterior cerebellum, maddula, laccunar infarct etc and expense incurred for Rs.53,287/- was repudiated by the Respondent under pre-existing clause No.4.1.

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

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Case No.AHD-G-050-1314-0401
Mr. Vijay L. Vanigotta Vs. Oriental Insurance Co. Ltd.
Award dated 7th March 2014
Repudiation of Mediclaim

Complainant treated for Rt.eye proliferative Diabetic Ratinopathy and expense incurred for Rs.35,800/-and also treated for both eyes at Retina Foundation centre which expense incurred Rs.1,26,301/- both were repudiated by the Respondent on the ground of policy condition No.2.3.

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

****

Case No.AHD-G-051-1314-0402
Mr. Kamlesh Thakkar Vs. United India Insurance Co. Ltd.
Award dated 7th March 2014
Repudiation of Mediclaim

A claim amount of Rs.29,063/- was lodged by the complainant for hospitalization expense of his 18 years old son for treatment of his little finger due to glass injury was repudiated by the Respondent on the ground of policy condition No.5.3, 5.4 and also policy condition No.5.6.

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

****

Case No.AHD-G-048-1314-0404
Mr. Bhupendra M Shah Vs. National Insurance Co. Ltd.
Award dated 19th March 2014
Partial repudiation of Mediclaim

Complainant treated for severe anemia, round warm infection, abdominal pain etc and expense incurred for Rs.50,377/- was partially settled by the Respondent for Rs.21,459/- by deducting an amount of Rs.28,918/- as per policy condition No.3.12 and 1.00.

Claim form was not signed by the complainant and also the treatment anemia is exclusion of the policy. Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0407
Dr. Gaurang J Banker Vs. The New India Assurance Co. Ltd.
Award dated 19th March 2014

Repudiation of Mediclaim

Complainant treated for spontaneous osteonecrosis of Lt.Knee which was chronic in nature and expense incurred for Rs.57,742/- was repudiated by the Respondent as per terms and conditions No.1 & 3.4 of the policy.

As per panel doctor's opinion, the hospitalization was not required for the subject treatment. Hence complaint dismissed.

****

Case No.AHD-G-049-1314-0427
Mr. Vadibhai K Sheth Vs. The New India Assurance Co. Ltd.
Award dated 20th March 2014
Partial repudiation of Mediclaim

A 72 years old complainant treated for Gall Bladder and incurred expense for Rs.92,682/- was partially settled by the Respondent for Rs.41,919/- by deducting an amount of Rs.50,763/- as per policy clause 2,2.3 and 2.4.

Complainant was having diabetes since last 15 years, Room rent was higher than eligibility and also deducted surcharge, service charge etc.

In view of this complaint dismissed.

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Case No.AHD-G-049-1314-0426
Mr. Vadibhai K Sheth Vs. The New India Assurance Co. Ltd.
Award dated 20th March 2014
Partial repudiation of Mediclaim

A 72 years old complainant treated for Calculus Cholecyctitis and incurred expense for Rs.33,514/- was partially settled by the Respondent for Rs.21,795/- by deducting an amount of Rs.11,719/- as per policy clause 3.13.
As per PPN rate there is ceiling for the subject treatment for Rs.23,000/-.

In view of this complaint dismissed.

****

Case No.AHD-G-048-1314-0408
Shri Pravinchandra Shah Vs. National Insurance Co. Ltd.
Award dated 20th March 2014
Repudiation of Mediclaim

Complainant treated for IHD+SWD+MI and incurred expense claimed was rejected by the Respondent as per policy condition 4.1. On scrutiny of treatment papers, it was

found that the complainant was suffering from DM since last 6 years and treatment was in the 3rd year of the policy. Hence claim treated as 'No Claim' on the ground of pre-existing disease.

In the result complaint dismissed.

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Case No.AHD-G-049-1314-0425
Mr. Hasmukhlal C. Shah Vs. The New India Assurance Co. Ltd.
Award dated 20th March 2014
Repudiation of Mediclaim

Complainant treated for Myocardial Infarction and incurred expense of Rs.11,124/- was rejected by the Respondent as per policy condition 4.1. On scrutiny of treatment papers, it was found that the complainant was suffering from DM since last 10 years and treatment was in the 2nd year of the policy.

Complainant paid additional premium which is only covered after completion of 3rd year of the policy. Hence claim treated as 'No Claim' on the ground of pre-existing disease.

In the result complaint dismissed.

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Case No.AHD-G-051-1314-0437
Shri Ramanlal C. Shah Vs. United India Insurance Co. Ltd.
Award dated 20th March 2014
Repudiation of Mediclaim

Complainant treated for Fistula in ano and expense incurred for Rs.27,704/- was repudiated by the Respondent giving reason that the Ayurvedic treatment is not admissible specially in a private ayurvedic hospital. The claim has rejected as per policy condition No.2.1 (2)- hospitalization expense are admissible if the patient treated in a Govt. Ahurvedic hospital.

In view of this complaint dismissed.

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Case No.AHD-G-044-1314-0432
Mr. Haresh N Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 20th March 2014
Partial repudiation of Mediclaim

The insured patient was covered under Senior Citizens Red Carpet Insurance Policy and hospitalized for Coronary artery disease. Complainant lodged a claim amount of Rs.1,42,952/- for this expense was settled by the Respondent partially for Rs.71,476/-as per policy exclusion clause No.5 (50% of expenses for all pre-existing diseases).

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

****

Case No.11-004-0082-14
Shri Jayesh D Patel Vs. United India Insurance Co. Ltd.
Award dated 21st March 2014
Partial repudiation of Mediclaim

Complainant's wife treated for eye cataract surgery and expense incurred for Rs.64,295/- was partially settled by the Respondent for Rs.29,720/- by deducting an amount of Rs.34,75/- as per terms and condition No.1.2 C.

Complainant's argument S.I is Rs.3.00 Lac so 25% of S.I comes to Rs.75,000/- instead his claim amount was Rs.64,295/-. His earlier claim was fully settled without any deduction.

As per guideline of the company claim amount would be restricted to the reimbursement of cost for uni-focal lens. Thus complaint dismissed.

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CHANDIGARH

CHANDIGARH OMBUDSMAN CENTER
CASE NO. GIC/440/ICICI/12/13

Sonia Checker Vs ICICI Lombard General Insurance Company Ltd.

ORDER DATED : 9th December, 2013 **MEDICLAIM**

FACTS: **This complaint was filed about denial of 'Cumulative Bonus' even though preceding two policies were claim free. Further, on account of one claim under the policy, instead of 10%, which is otherwise applicable, a 30% loading of premium was charged. Moreover, policy from 03.10.2011 to 02.10.2012 was claim free and complainant was not allowed cumulative bonus on its renewal.**

FINDINGS: **The insurer submitted that insured availed first policy in October 2008 which was renewed with entitled cumulative bonus in 2009 and 2010. However, cumulative bonus was not reflected on the policy documents in the year 2010 because an additional member was added. It was pointed out that policy was renewed in one go, for the next two consecutive years, i. e. , 2010 to 2012, wherein a claim was lodged in January 2011. The same resulted in 10% reduction in cumulative bonus at the time of next renewal, i. e., in October 2012. It was clarified that loading of premium for claim lodged was 10% and an enhancement in premium was due to change of age-slab of the husband of the complainant, insured under the policy.**

DECISION: **It was held that though, policy was renewed in one go for two years in 2010, but policy document clearly mentions two distinct policy periods of 03.10.2010 to 02.10.2011 and 03.10.2011 to 02.10.2012 and there is an express policy provision about Cumulative bonus for each completed policy year. Accordingly, directions were given for**

allowing cumulative bonus to the complainant for a claim free year of 03.10.2011 to 02.10.2012. Likewise, her husband was held entitled for cumulative bonus for two claim free years under the policy renewed in October 2012.

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CHANDIGARH OMBUDSMAN CENTER
CASE NO. GIC/356/Royal/11/13

Manjeet Singh Bhatia Vs Royal Sundaram Alliance Insurance Company Ltd.

ORDER DATED : 5th December, 2013 MEDICLAIM

FACTS: This complaint was filed about settlement of a treatment claim for a lesser amount. The ailment of the patient was diagnosed as 'Osa with Apnoea and Hypopnea', wherein a claim for an reimbursement of Rs.92,865/- was settled for Rs.31,750/- only and a major amount spent on CPAP machine was not considered.

FINDINGS: The insurer clarified that CPAP machine is used for the cure of 'sleep disturbance', which is not covered under the policy. He provided a copy of an IRDA circular, wherein inter-alia CPAP Machine certain other medical equipments are listed as excluded items from the scope of health insurance coverage. However, in support of his contention, he did not point out any specific condition/ clause of a policy excluding the said machine. The Complainant pointed out that machine is a life saving device and is essentially a part of the prescribed treatment. He insisted that it was purchased out of a medical necessity on a prescription of the doctor.

DECISION: It was held that out-right denial of claim is not justified as an action of the Company to decline amount spent on CPAP Machine was devoid of an express policy condition mentioned in the policy document. Accordingly, as regards the reimbursement of expenses on the machine, directions were given to allow a payment on partial basis.

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CHADNIGARH OMBUDSMAN CENTER
CASE NO. GIC/ 15/Reliance/11/14

SANJAY PATHANIA Vs Reliance General Insurance Company Ltd.

ORDER DATED: 18th December, 2013 **MEDI-CLAIM**

FACTS: This Complaint was filed about a Medi-claim policy from 15.06.2012 to 14.06.2013. Thereafter, a son, insured under the policy, was hospitalized in Post Graduate Institute Medical Education & Research, Chandigarh for treatment of 'Leukemia'. Though a claim was settled under policy for the year 2011-12 for a sum of Rs.2,00,000/-, further reimbursement of expenses were denied under the successive policy in 2012-13.

FINDINGS: The representative of the company explained that insurance was for a sum insured of Rs. 1,00,000/- and policy provided for an additional amount equivalent to the sum insured towards listed 'critical illnesses'. He clarified that after paying a claim under 'critical section' of the policy, coverage under the section was not available to the particular insured person for all future renewals of the policy. Therefore, the claim was settled for Rs. 2,00,000/- in first policy and thereafter coverage was denied.

DECISION: It was held that company's decision to deny normal coverage of Rs. 1,00,000/- under the renewed policy is not justified as the paraphrasing of the policy is about non-availability of additional coverage under 'critical section' for future renewals. Accordingly, directions were given to the insurance company to settle the hospitalization bills falling under renewed policy, restricting its liability to Rs. 1,00,000/-.

****

CHANDIGARH OMBUDSMAN CENTER
CASE NO. GIC/176/Bharti/11/14

Babita vs. Bharti Axa General Insurance Company Ltd.

ORDER DATED : 26th February, 2014 Medi-claim

FACTS : This complaint was filed against the denial of a hospitalization claim that was about seven days admission in the hospital and despite the visit to the hospital by an investigator, deputed by the Company and verification of treatment record, a claim was rejected.

FINDINGS : During the course of the hearing, the complainant that all the requisite documents were made available and it was wrong that necessary documents to process a claim were not provided. The representative of the Company explained that earlier documents called for processing a claim were not provided. Subsequently, an investigation was arranged through an investigator, which revealed that the patient is an employee of the same hospital wherein treatment was stated to have been taken. In this context, he showed a copy of an Attendance Register of the hospital to highlight that tampering was resorted to in the hospital record for lodging fake claim. However, the complainant insisted that a correction was made in the Attendance Register and it was wrong to ascribe any motive to the same.

DECISION : The Company's decision to deny a claim in the light of the findings of an investigation was held justified because the Complainant was not able to offer a satisfactory reply to a query about cuttings/ over-writings in the Attendance Register. Hence, the complaint was dismissed.

****

CHANDIGARH OMBUDSMAN CENTER
CASE NO. CHD-G-049-1314-0363

Gurpreet Singh vs. New India Assurance Ltd.

ORDER DATED : 17th February, 2014 **Medi-claim**

FACTS : This complaint was filed about the denial of a hospitalization claim, wherein it was stated that patient was given treated for a life threatening complication, whereas a claim was declined by the Company on the ground of hospitalization related to pregnancy or a child-birth.

FINDINGS : During hearing the complainant explained that his wife had experienced an abnormal growth in uterus that could turn malignant. Hence, a timely surgical intervention was necessary for the avoidance of serious complication in future. The representative of the Company pointed out that the patient suffered from 'Hydatidiform Mole', which is a result of an abnormal conception, wherein the treatment is outside the scope of the coverage provided under the policy. He elaborated that any treatment arising from or traceable to pregnancy/ child-birth or its complications is specifically excluded under the medi-claim policy.

DECISION : It was held that problem of the patient was linked to an abnormal conception and since a policy clause provides for a permanent exclusion of treatment arising from or related to pregnancy, Company's decision to deny a claim was justified. Therefore, in view a factual position, the complaint was disallowed.

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CHANDIGARH OMBUDSMAN CENTER
CASE NO. GIC/227/NIA/14/14

Suresh Jain vs. New India Assurance Company Ltd.

ORDER DATED : 17th February, 2014 **Medi-claim Policy**

FACTS : This complaint was filed about the non-settlement of a hospitalization claim for a lesser amount. The complainant had stated that despite the availability of sufficient amount under the policy, his own claim was settled for a lesser amount and a claim of his wife, being organ donor, was altogether denied.

FINDINGS: During hearing complainant said that insurance was taken separately for himself and wife for Rs. 4,00,000/- and a claim about kidney transplant, wherein his wife was kidney donor, was for Rs. 6,03,619/-. However, the same was settled for Rs. 2,20,000/- only and a claim for the reimbursement of expenses of Rs. 62,240/-, incurred on his wife, was not allowed. The representative of the Company explained that as per 'Discharge Summary', Shri Suresh Jain was suffering from chronic kidney disease since 2001. Therefore, for a claim about pre-existing ailment, sum insured of the policy year 2008-2009 along-with cumulative bonus was considered for settling a claim as benefit of enhanced sum insured becomes available for such ailments only after a period of four continuous years. He further clarified that a claim of an organ donor can be looked into only against the sum insured available for the patient.

DECISION: The Company's decision to settle a claim by restricting the payable amount to available sum insured under the terms & conditions of the policy was held justified as benefit of enhanced sum insured could not be given before 48 months for a pre-existing ailment. Hence, the complainant was dismissed.

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GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G2-017/13-14

Dr. Hari Prasad Goenka
- Vs -
The National Insurance Co. Ltd.

Date of Order : 04.03.2014

Complainant: The Complainant stated that he obtained Mediclaim Policy No. 200203/48/10/8500000794 for his entire family members from the National Insurance Co. Ltd. covering the period from 20.03.2011 to 19.03.2012. While the policy was in force, on 25.01.2012 his wife Sunita Goenka and himself met with an accident on N.H. 37, while walking on the roadside at Bokakhat, one vehicle moving at very high speed suddenly knocked down them from the back side and they fell down on the ground and became senseless. They were admitted at Bokakhat Civil Hospital and after providing necessary treatment they were discharged. Then they took treatments in different places like Hojai, Guwahati and Bongaigoan. Thereafter, he lodged a claim for Rs.13,000/- before the Insurer. He has not submit some cash-momos as the Insurer advised him to submit the other cash memos in the second claim. But, the TPA E-Meditek has rejected his claim on the ground that 24 hours hospitalization is must for any claim. Being aggrieved, he has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that they received claim intimation from the Insured on 27.03.2012 under Policy No. 200203/48/10/8500000794 stating that the Insured along with his were injured due to a road accident on 25.01.2012 i.e. after a gap of almost two months from the date of accident which has violated the policy condition No. 53. After going through the entire claim papers, no radiologist report, discharge certificate, case summary are available with them. No surgical procedure were involved under General Anesthesia. Their E-Meditek (TPA) Sevices had repudiated the claims as both of the insured persons were not treated as an inpatient.

Decision : I have carefully gone through the entire documents available on record as well as the statements of the parties. Although the Insurer has alleged that they have received claim intimation from the Complainant after a gap of almost two months from the date of accident but they failed to produce any claim intimation letter before this Authority to justify their allegation. The Complainant has produced some medical documents before this Authority which discloses that the Complainant and his wife were not hospitalized for more than 24 hours. It appears from the copy of Discharge Slip issued from the First Referal Unit,

Bokakhat that Smt. Sunita Goenka was admitted on 25.01.2012 and was discharged on the same day. The Complainant has also stated in his complaint petition that they were admitted in Bokakhat Civil Hospital on 25.01.2012 at around 8.00 PM and after first aid in the late night they were referred to Jorhat Sanjivani Hospital for citiscan of head injury. The Insurer has produced a copy of policy terms and conditions before this Authority where it is clearly mentioned in Condition No. 3.5 that Hospitalization Period : The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours. It is ample clear from the said policy condition that the patient must be treated as inpatient and 24 hours hospitalization is must for any claim. In the instant case, the Complainant and his wife were not hospitalized for 24 hours. Therefore, the Complainant is not entitled to get the claim amounts under the above policy.

Considering the entire facts and circumstances, I am of view that the Insurer has rightly repudiated the claim of the Complainant as the Complainant and his wife were not hospitalized for 24 hours. Finding no ground to interfere with the decision of the Complainant, the complaint is treated as dismissed and is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G11-003/13-14

Mr. Bablu Dey
- Vs -
ICICI Lombard General Ins. Co. Ltd.

Date of Order : 01.11.2013

Complainant : The Complainant stated that he procured 'Critical Care' – Secure Mind Policy No. 4065/CCSM/70495104/00/000 from the ICICI Lombard General Insurance Co. Ltd. covering the period from 28.03.2012 to 27.03.2013. While the policy was in force, he suffered from minor stroke in brain on 04.10.2012. At first, he took treatment in Jorhat. Then he took treatment in A.M.C., Dibrugarh. Thereafter, he lodged a claim for Rs.6.00 lacs before the Insurer along with all supporting documents. But, the Insurer has repudiated the claim. Being aggrieved, he has lodged this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that they received a claim from the Complainant stating that he was hospitalized in Assam Medical College and Hospital from 06.10.2012 to 09.10.2012 for the treatment of CVA (Ischemic) Right Sided Hemi paresis. On perusal of the claim documents, they found that the Complainant was a known case of Loss of Consciousness since February, 2010. It is evident through the treatment paper dated 14.02.2010 of Dr. Narayan Upadhayay that the Complainant was diagnosed with Loss of Consciousness since 4 years which is before the commencement of the policy. At the time of proposal, the Complainant had not disclosed the material facts that he was suffering from "Loss of Consciousness". The Complainant has suppressed material fact from the Company that he had pre-existing disease as Loss of Consciousness. Hence, the policy was terminated by the Company on the ground of pre-existing disease and non-disclosure of material facts.

Decision : I have carefully gone through entire documents available on record as well as the statements of the parties. It is apparent from the copy of Discharge Certificate that the Insured Mr. Bablu Dey was admitted in Assam Medical College Hospital, Dibrugarh on 06.10.2012 and was discharged on 09.10.2012. Disease of the Complainant was diagnosed with CVA (Ischemic) with Right Sided Hemi paresis The Complainant made a claim with the Insurance Company and submitted all the claim related documents. But, Insurance Company has rejected the claim on the ground of concealment of Pre-existing illness. On scrutiny of claim papers, they detected that the Insured was suffering from "Loss of Consciousness". In support of the contention of the Insurer, they produced some treatment particulars of the Insured Mr. Bablu Dey like the prescription dated 14.02.2010 issued by Dr. Narayan Upadhyaya and the statement made by the Complainant on 08.12.2012 before the Insurer. The said documents makes it ample clear that the Insured was suffering from "Loss of Consciousness" prior to the date of commencement of the policy. It is alleged by the Insurer that the Insured did not disclose his above disease in the proposal form. Due to suppression of material information regarding his illness at the time of filling in the proposal form, the Insurer has repudiated the claim of the Insurer.

Under the above facts and circumstances, I have no hesitation to hold that the Insurer has rightly repudiated the claim of the above policy and no interference is called for from this Authority. With the above observation, the complaint is dismissed and is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G13-092/12-13

Mr. Jitmal Agarwala
- Vs -
Cholamandalam MS Gen. Ins. Co. Ltd.

Date of Order : 02.12.2013

Complainant: The Complainant stated that he procured INDUS FAMILY HEALTH - PLATINUM Policy No. IBL-IPLAT-004534 including spouse from the above Insurer covering the period from 15.05.2012 to 14.05.2013. During the period covered under the policy, he was hospitalized in Rahman Hospital, Guwahati on 22.10.2012 due to Brain Hemorrhage and was discharged on 04.11.2012. After completion of usual treatments, he lodged a claim seeking reimbursement of the expenses incurred in connection with his hospitalization and treatment before the Insurer along with all supporting documents. But the Insurer has repudiated the claim without any justified ground. Feeling aggrieved, the Complainant has lodged this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that they issued Individual Health Insurance Policy to Mr. Jitmal Agarwala vide Policy No. IBL-IPLAT-004534 under the product name, INDUS FAMILY HEALTH - PLATINUM PLAN for the period from 15.05.2012 to 14.05.2013 basis of the information and proposal form provided by the Insured with utmost good faith. Prior to this policy Mr. Jitmal Agarwala was also covered under the Policy No. IBL-IPLAT-002592 for the period from 08.04.2011 to 07.04.2012. Thus, as there was a 38 days breakage and the later issued policy is considered as fresh. The Patient Mr. Jitmal Agarwala got admitted for treatment at two instances during the currency of the Policy No. IBL-IPLAT-004534 and claiming in each instance i.e. hospitalization at Max Health Care Superspeciality Hospital, New Delhi for the period from 04.06.2012 to 14.06.2012 and at Rahman Hospital, Guwahati for the period from 22.10.2012 to 04.11.2012. In his complaint the Complainant is trying to create confusion by mixing the two claims as a single claim. Further, he is a known case of hypertension and diabetes mellitus since 10 months on regular medication. On evaluation of his MRI revealed bleed in right thalamic and periventricular region with ventricular extension and was treated conservatively as per doctor advice and was discharged on 04.11.2012. Through investigation they had evidence of patient was admitted in Marawari Hospital, where he received primary treatment and MRI was done, later admitted to Rahman Hospital in the evening of 22.10.2012. Hence, they have repudiated the claim under general exclusion clause C-1.

Decision : I have carefully gone through the entire documents available on record as well as the statements of the parties. It appears from the "Self Contained Note" as well as from the statement of representative of the Insurer that the

Insured Mr. Jitmal Agarwala took first policy bearing Policy No. IBL-IPLAT-002592 with effect from 08.04.2011 to 07.04.2012. Thereafter, the Insured renewed the said policy bearing Policy No. IBL-IPLAT-004534 covering the period from 15.05.2012 to 14.05.2013. In proof of their contention, they have produced the copies of certificates of insurance taken by the Insured before this Authority for perusal which discloses that there was a gap of 38 days between the above two policies. The copy of Discharge Summary from Rahman Hospital, Guwahati shows that the Insured Mr. Jitmal Agarwala was admitted in the Hospital on 22.10.2012 with the history of sudden onset of (Left) side weakness since 22.10.2012 and was discharged on 04.11.2012. It is also mentioned in the Case Summary that the patient is a known case of HTN, DM. The disease of the Complainant was diagnosed as DM Type – II, HTN, CVA with (Left) hemiparesis. The Insurer has also produced a copy of Discharge Certificate from Down Town Hospital, Guwahati wherein it is mentioned that the Insured Mr. Jitmal Agarwala was admitted on 17.12.2011 and was discharged on 04.01.2012 and the disease was diagnosed with Fracture distal sheft femur with comminution, HTN, CDG – Bifascicular block & Type 2 DM. Hence, it appears that the Complainant is a known case of HTN & DM - II. As per the Insurer, the claim attracts the Policy Exclusion Clause C - 1. In support of their contention, they produced terms and conditions of the policy before this Authority which is marked as Annexure – D. On a close perusal of Annexure – D that the Policy Exclusion Clause C - 1 reads as under :

C-1, "No indemnity is available or payable for claim directly of indirectly or indirectly caused by arising out of or connected to any pre-existing condition benefits will not be payable for any condition(s) as defined in the policy until 24 consecutive months of coverage for the insured person have elapsed, since inception of the first policy with the insurer."

From the above policy conditions, it is ample clear that the Insured who is suffering from HTN & CAD whether it is treated / untreated, declared / not declared in the proposal form, is not entitled to get the claim amount for the said diseases within 24 months from the date of inception of the policy. In the instant case, the Complainant was treated for HTN & CAD within first year from the date of commencement of the policy as the second policy i.e. Policy No. IBL-IPLAT-004534 is treated as fresh policy. Therefore, the Complainant is not eligible to get the claim amount as per terms and conditions of the policy.

Considering the above conditions, I am of the view that the decision of the Insurer in repudiating the claim of the Complainant appears to be proper and justified. Finding no material to interfere with the decision of the Insurer.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-236/2012-13

C Jayaraja Panicker

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/98/2013-14 dated 03.10.2013

The complainant and his wife were covered under FFMA Health Insurance policy issued by the Respondent-Insurer. The complainant's wife underwent Cataract surgery in the left eye. The insurer limited the claim to Rs. 25000/- and Rs.3278/- was disallowed. Therefore, the complaint.

The complainant submitted that the claim submitted by him included pre and post hospitalization expenses. The denial of such expenses is against policy conditions. He is entitled to the entire claim amount.

The insurer submitted that there was no hospitalization for 24 hours. So there was no hospitalization as contemplated under the policy conditions. Pre and Post hospitalization expenses are payable if only there is hospitalization. Also it is included in the package rate provided in the policy. So, the complainant is not entitled to any further amount.

Decision:- As per Clause 2.3 of the policy conditions, as far as eye surgery is concerned, the minimum period of 24 hrs admission is not necessary to treat the same as hospitalization. So, there was hospitalization as defined in Clause 2.3 of the policy conditions in the case of the wife of the complainant in connection with Cataract surgery. The contention raised by the insurer in this regard can not be sustained. As per Clause 3.1 and 3.2 , pre and post hospitalization expenses are payable. In Clause 1.2.1 , there is no mention that the package rate provided therein is inclusive of pre and post hospitalization expenses. Whereas Clause 1.3 provides that pre and post hospitalization expenses will be limited to a maximum of 10% of the sum insured. So, it is seen that there is no provision either in Clause 1.2 or in Clause 1.2.1 which excludes payment of pre and post hospitalization expenses. In the result, an award is passed directing the insurer to pay a further amount of Rs. 3278/- with 9% interest from the date of filing of the complaint till the date of award to the complainant within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-101/2012-13

Murukeshkumar M K

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/102/2013-14 dated 04.10.2013

The complainant had taken Individual Health Insurance policy from the Respondent-Insurer covering himself, his wife and daughter. During the policy period 2011-12 his daughter was admitted at AIMS, Kochi for treatment in connection with Low grade malignant carcinoma with liver mets. The hospitalisation was for Chemotherapy. The Insurer had not settled the claim. Therefore, the complaint.

The complainant submitted that his daughter, was admitted in Hospital for second line Chemotherapy. All the medical documents and bills were produced along with the claim form. The Insurer is delaying the settlement of the claim without any valid reason. The claim is to be allowed.

The insurer submitted that the TPA of the Insurer requested the complainant to produce a Certificate from the treating Doctor showing the duration of ailment. The complainant did not produce the required document. Therefore, the claim could not be settled.

Decision:- As per Clause 1.2(D) of the policy conditions, the insured is entitled to reimbursement of expenses related to Chemotherapy, Radiotherapy etc. The TPA of the Insurer demanded the complainant to produce a certificate from the treating Doctor showing the duration of the illness. Duration of the ailment assumes importance when the Insurer has a case that the ailment for which the daughter of the complainant underwent treatment was a pre-existing ailment. The first policy with the Insurer incepted on 08.03.2006. So, if at all the daughter of the complainant had suffered a pre-existing ailment, it ceased to be a 'pre-existing ailment' on the expiry of 48 months from the date of inception of the policy. So, the duration of the ailment is not a relevant factor to consider whether the ailment was a pre-existing one or not. Further, this is not a case where Clause 4.3 is attracted. The Insurer had not revealed the actual reason or cause for calling for a Certificate from the treating Doctor showing the duration of the ailment. As per Discharge Summary relating to hospitalisation for the period from 07.02.2011 to 27.02.2011, the treatment given to the daughter of the complainant during the hospitalisation was Whipples procedure on 15.02.2011. In the 'Past History' portion, there is no mention regarding previous history of Carcinoma. So, there is no evidence that the daughter of the complainant had undergone treatment for Carcinoma prior to 2011. As per the available medical evidence, the daughter of the complainant was not suffering from a pre-existing disease. The Insurer did not settle the claim merely clinging on to technicality of non-production of a certificate from the treating Doctor. In the

result, an award is passed directing the Insurer to pay an amount of Rs.31,905/- to the complainant with 9% interest from the date of filing of the complaint till the date of award within the prescribed period failing which, Rs.31,905/- shall carry further interest at 9% per annum from the date of award till payment is effected.No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-112/2012-13

P R Mohanan

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/103/2013-14 dated 08.10.2013

The complainant had been taking Senior Citizen Mediclaim policy from the Respondent-Insurer from 2008 onwards. In 2011, he was admitted at Amrita Hospital in connection with severe low back pain The claim for the same was repudiated by the Insurer stating that he was hospitalized for treatment of a pre-existing ailment. Therefore, the complaint.

The complainant submitted that he was admitted in Hospital not for treatment of CVA, but for treatment of low back pain. Low back pain suffered by him is not a pre-existing ailment. The repudiation of the claim is illegal and against the policy conditions.

The insurer submitted that there is sufficient medical evidence that the complainant suffered CVA in 2001 and underwent treatment. He contracted CVA on account of Hypertension. The ailment suffered by the complainant during the relevant hospitalisation is a manifestation of pre-existing CVA. Therefore, the claim was rightly repudiated under Clause 4.1 of the policy conditions.

Decision:- The repudiation of the claim was based on Clause 4.1 of the policy conditions. In the repudiation letter it is stated that the complainant was hospitalized for a pre-existing ailment and therefore, not payable. It is further noted in the said letter that the complainant is a known case of CVA since 2001. Clause 4.1 would reveal that a pre-existing disease will not be considered as a pre-existing disease after the expiry of 18 claim free months from the inception of the first policy. It is noted in the Discharge Summary that the complainant is an old case of CVA and DM. Earlier CT-Brain done showed chronic infarct in the right MCA territory. MRI Brain showed infarcts involving right PCA territory and corona radiata. It is stated therein that the complainant was presented with history of low back pain. Spinal bulge was noted at C3-C6 level causing

Spinal canal stenosis. So, evidently, low back pain was due to Spondylotic and disc degeneration and bulge at C3-C6 levels causing Spinal canal stenosis. If at all the complainant had suffered CVA, there is no evidence that it was due to DM and Hypertension. So, even if CVA is a pre-existing ailment, as there was no claim in the first 18 months from the inception of the policy, it is no more a pre-existing ailment. Inspite of that, the present ailment suffered by the complainant is not at all related to CVA or Diabetes or Hypertension. So, exclusion Clause 4.1 of the policy conditions is not at all attracted. Therefore, repudiation of the claim cannot be justified In the result, an award is passed directing the Insurer to pay an amount of Rs.18,411/- with cost of Rs.1,000/- to the complainant within the prescribed period failing which, Rs.18,411/- shall carry interest at 9% per annum from the date of filing of the complaint (14.05.2012) till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-129/2012-13

P O Johny

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/104/2013-14 dated 08.10.2013

The complainant had taken Janata Mediclaim policy from the Respondent-Insurer. He was hospitalized and the insurer settled the claim only partially. Therefore, the complaint.

The complainant submitted that he spent an amount of Rs.16730/- over and above the cash less facility of Rs. 25459/- allowed by the insurer. He is entitled to receive the same also.

The insurer submitted that as per Clause 2.10 of the policy conditions, specific limit for re-imbursement is provided for specified items of treatment and the payment of this claim was effected based on the said policy provision. The complainant is not entitled to any further amount.

Decision:- Discharge summary shows the diagnosis as L4-L5 intra vertebral disc prolapse with radiculopathy. Lumbar traction and Physiotherapy were provided. Lumbar traction involves surgical procedure. The complainant had spent Rs. 2200/- towards traction charge and Rs. 300/- towards procedure charge. As per Clause 2.3, the complainant is entitled to re-imbursement of these expenses. He is also entitled to X-ray charge of Rs. 330/-. All the other already allowed expenses are found in order. Further liability of the insurer is therefore, fixed at Rs. 2830/-. In the result, an award is passed directing the

Insurer to pay a further amount of Rs.2830/- to the complainant within the prescribed period failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-008-083/2012-13

Sabu Paul

Vs

Royal Sundaram General Insurance Co. Ltd

AWARD No. IO/KCH/GI/107/2013-14 dated 11.10.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer on 26.11.2010. In February 2012, the complainant suffered heart disease and was admitted at Medical Trust Hospital, Kochi. The claim for the same was repudiated by the insurer stating that the claim came under second year exclusion. Therefore, the complaint

The complainant submitted that he had taken Mediclaim policy from M/s Reliance Insurance Co. for the policy years 2008-2009 and 2009-2010 and had taken Mediclaim policy from the Respondent-Insurer in continuation of his policy with M/s Reliance Insurance Co. Hospitalisation was in the 4th year of his medical insurance cover. So, the exclusion Clause urged by the Respondent-Insurer is not at all attracted. Also, the heart ailment suffered by him is an unexpected one and therefore, it is an accident. Exclusion Clause urged by the Respondent-Insurer is not applicable in the case of an accident. He is entitled to reimbursement of Rs. 2 Lakhs .

The insurer submitted that the complainant cannot claim continuity of the policies taken from M/s.Reliance Insurance Co. He suffered heart disease during the second policy year as far as the policy issued by the them is concerned. Heart disease is excluded for the first two policy years. The heart ailment suffered by the complainant is not an accident. The claim was repudiated by the them based on the policy conditions.

Decision:- The rights and liabilities of the parties to the contract of insurance are governed by the terms and conditions of the policy. Here, the policy Clause D(2)(b) is very definite that, heart disease and other named ailments are not covered for two years from the commencement date of cover with the Respondent-Insurer. Evidently, the complainant suffered heart disease and took treatment in the second policy year. So, Heart disease suffered by the complainant is not covered under Clause D(2)(b) of the policy conditions. As per the exception clause, the heart disease suffered by the

complainant must be caused directly due to an accident in order to be eligible for exception. The term used is not 'as an accident' but 'due to an accident'. There is vast difference between the meaning of the terms 'as an accident' and 'due to an accident'. The heart disease suffered by the complainant may be an accident. But it is not due to an accident. In other words, there must be an accident and because of that accident, the insured must suffer heart disease. When the heart disease suffered by the complainant is not due to an accident, the exception Clause to Exclusion Clause D(2)(b) is not at all attracted. So, the contention raised by the complainant is not acceptable and is not covered by the policy conditions. So, the repudiation of the claim by the insurer is sustainable. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-148/2012-13

Bijoy P Pulipra

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/108/2013-14 dated 11.10.2013

The complainant had taken family Medicare policies from the Respondent-Insurer covering himself and his family members. The complainant, his wife, son and mother were diagnosed for dog bite by a rabid dog. They were treated at KIMS Hospital, TVM with vaccination and serums containing Immunoglobulin. The claim for the same except that of his son was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that the treatment given to himself and his family is covered as per Clause 2.3(b) of the policy conditions. Since the insurer had settled the claim of his son, there is no reason to deny the claim of others. The repudiation of the claim is illegal and against policy conditions. He is entitled to get the full claim amount.

The insurer submitted that the claims were repudiated as there was no hospitalization for a continuous period of more than 24 hrs. Sub Clauses (b) and (c) of Clause 2.3 are not attracted in this case. The claim of the son was settled as there was hospitalization for more than 24 hrs . The repudiation of the claim is legal and based on policy conditions.

Decision:- Admittedly, all the four were treated for dog bite and suspected rabies at KIMS Hospital. No special reason is stated in the Claims payment statement regarding admissibility of the claim relating to the son of the complainant and also no documents

have been produced by the insurer to show that he was treated as in-patient in the hospital. In all the four cases, the diagnosis as well as the treatment period shown are the same. When the insurer had provided the benefit of exception Clause (b) to Clause 2.3 of the policy conditions, in allowing the claim of the son of the complainant, there is no reason for not providing the same benefit in the case of the claims relating to the other three claimants. There is no justifiable excuse for the differential treatment by the Respondent-Insurer. They have shown discrimination against the complainant, his wife and mother. The same treatment was provided to the complainant, his wife, mother and son. A treatment which is necessary for the ailment is adequate/active treatment for that particular ailment. So, the new contention of the insurer that there was no active line of treatment during hospitalization can not be sustained. So, the repudiation of the claims of the complainant, his wife and mother are not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.100316/- to the complainant within the prescribed period failing which, the entire amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-133/2012-13

P A Sakeer

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/109/2013-14 dated 17.10.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 2000. He was involved in an accident on 02.01..2012 and was treated at a Hospital in Coimbatore. The claim for the same was only partially settled by the insurer. Therefore, the complaint.

The complainant submitted that he was treated in connection with his left knee dislocation. It is not true that he underwent Arthroscopy alone during the hospitalization.. Discharge Summary gives the full details. Partial repudiation of the claim can not be sustained.

The insurer submitted that during hospitalization Arthroscopy was done and a package rate of Rs. 10800/- is provided for the same as per Clause 2.10 of the policy conditions. They have paid the package rate and nothing more is payable now.

Decision:- Discharge Summary shows the diagnosis as ACL insufficiency, Medial Meniscus tear, lateral Meniscus tear, chondromalacia medial femoral condyle and chondromalacia lateral femoral condyle. The procedures done are Arthroscopy, ACL reconstruction, Partial lateral meniscectomy and Partial medial meniscectomy. Arthroscopy is basically a diagnostic procedure whereas the others are surgical procedures. Here Arthroscopy was done for proper diagnosis and followed by further surgeries. So, this is not a case where Arthroscopy alone was done. So, settlement of the claim on package rate under Clause 2.10 of the policy conditions is not sustainable. Certain hospital expenses met by the complainant are covered under the package rate of Rs. 10800/- provided to the complainant for Arthroscopy. The surgical procedures underwent by the complainant would come under the caption "Intermediate surgery". Here also package rates are provided for different items. A scrutiny of the bills reveals that the complainant is entitled to a total amount of Rs. 29641/- out of which Rs. 10800/- was already paid. In the result, an award is passed directing the insurer to pay a further amount of Rs.18841/- to the complainant within the prescribed period failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-191/2013-14

Chacko George & Achamma Chacko George

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/101/2013-14 dated 04.10.2013

Complainants took Mediclaim policy from the Respondent-Insurer in continuation of their Mediclaim policy taken from M/s New India Assurance Co.Ltd. Complainants were having Mediclaim insurance cover continuously from 1999. The First complainant was admitted at Christian Medical College, Vellore for treatment from 22.01.2010 to 28.01.2010. The Second complainant was also admitted at CMC, Vellore for treatment from 22.01.2010 to 29.01.2010. The Insurer only partially settled the claim in relation to the the First complainant. The claim relating to the Second complainant was repudiated by the Insurer without any valid reason. Therefore, the complaint.

The complainant submitted that no material fact was suppressed by them while taking policy from the Insurer. Even if there is any suppression of material fact in the proposal form, it would render the policy voidable only. The Insurer had continued to renew the policy without any break till issuance of policy for the period 2013-2014 and this amounts to confirmation of the contract by the insurer.. The Insurer had cancelled the policy in

relation to the first complainant misquoting the award of the Insurance Ombudsman that he had found that the policy had become void ab-initio. The cancellation of the policy is against the policy conditions and without notice to the complainants. There must be a direction to the Insurer to keep alive the Mediclaim policy issued for the policy period 2013-14. The learned counsel argued based on Section 65 of the Indian Contract Act that the complainants are eminently entitled to receive back the entire premium paid in relation to the second complainant in case it is found that the policy had become void ab-initio. It is because the premium is an advantage received by the Insurer by virtue of the contract of insurance.

The insurer submitted that the repudiation of the claim relating to the second complainant on the ground of suppression of material facts in the proposal form was found in favour of the Respondent-Insurer in the earlier award passed by this Forum. No new evidence has been submitted from the side of the complainants to enter a finding that there was no suppression of material fact in the proposal form. The Sum Insured was enhanced to Rs.1,50,000/- from Rs.One Lakh on the written request submitted by the complainants. Therefore, the complainants cannot now contend that though the complainants sought policy with Sum Insured of Rs. One Lakh, they had been issued with a policy wherein the Sum Insured is Rs.1,50,000/-. The policy issued for the period 2013-2014 was cancelled as the Insurer was satisfied that the complainants had suppressed material facts in the proposal form for taking the first policy from the Insurer and therefore, the policy had become ab-initio void. The Insurer had refunded the premium paid in relation to the second complainant. The complainants cannot seek

refund of the premium paid in the previous policies as the Insurer had provided insurance cover for the entire period. Section 65 of the Contract Act cannot be applied in the case of the complainants as the Insurer had not derived any advantage out of the contract of insurance. The complainant is not entitled to any relief in the complaint.

Decision:- It cannot be believed that the fact that the second complainant was hypertensive, she had undergone hysterectomy and was suffering from low back pain were not within their knowledge at the time of submission of the proposal form. Even while the First complainant was having sufficient knowledge regarding the pre-proposal ailments suffered by the Second complainant, those facts were not revealed in the proposal form. So, the non-disclosure of pre-proposal ailment is with knowledge of the First complainant. In the instant case, there is clinching evidence that the actual health status of the Second complainant was not disclosed in the proposal form inspite of definite questions relating to health condition of the person to be insured. If the actual health status of the Second complainant was disclosed, definitely the underwriting would have been different. An identical situation came up for consideration before the Hon'ble Apex Court in Satwant Kaur Sandhu Vs. M/s New India Assurance Co. Ltd reported in 2009(8) SCC 316. The principles laid down by the Apex Court in that case are squarely applicable in the case in hand. So, without any further discussion, it can be safely

concluded that the repudiation of the claim on the ground of suppression of material fact is well founded and therefore, sustainable.

The Hon'ble High Court had quashed the award in relation to the Second complainant. So, if at all there was any finding regarding voidability of the policy issued in the year 2002-2003, the cancellation decision taken based on the award which is no more in existence has become infructuous. Also, the termination/cancellation of the policy is not in compliance with the mandatory procedural formality provided in Clause 5.9 of the policy conditions. When the cancellation of the policy is against the policy conditions, the cancellation decision cannot be sustained. The cancellation decision is liable to be set aside. In the light of these finding , an award is passed as follows:-

1. **The Respondent-Insurer is ordered to pay further amount of Rs.1,114/- to the First complainant which was allowed vide award dated 05.04.2011.**

2. **Cancellation of Policy No.100204/48/12/20/00001730 for the period from 19.03.2013 to 18.03.2014 is set aside. The Respondent-Insurer is directed to keep alive the said policy in relation to the second complainant as well.**

3. **The complainants shall return the cheque for Rs.10,517/- received by them towards refund of premium, if not already returned.**

4. **No order as to cost.**

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-013-162/2012-13

C J Subin

Vs

HDFC ERGO General Insurance Co. Ltd

AWARD No. IO/KCH/GI/111/2013-14 dated 18.10.2013

The complainant had taken Critical Illness policy from the Respondent-Insurer. His left kidney was surgically removed as there was tumor in the kidney. The treatment was done at PVS Hospital, Ernakulam. The claim for the was repudiated by the Insurer. Therefore, the complaint.

The complainant submitted that at the time of taking the policy, he was given to understand that the waiting period was only 30 days from the inception of the policy. Surgery underwent by the complainant related to Critical illness and therefore, he is entitled to the entire Sum Insured. The waiting period of 90 days urged by the Insurer was not made known to the complainant. The repudiation cannot be sustained.

The insurer submitted that the relevant policy is the first policy taken by the complainant from the Insurer. As the claim arose within 90 days from the inception of the policy, the claim was validly repudiated under Section 2(i) of the policy conditions. The repudiation is in accordance with the policy conditions.

Decision:- The first policy inception date is 12.12.2011. Sum Insured is Rs. Two Lakhs Fifty thousand under Silver plan. Eight critical illnesses are covered under the policy. As per the Discharge Summary, he was admitted in the hospital on 03.02.2012 and discharged on 10.02.2012. On 04.02.2012, the complainant was subjected to laparoscopic radical Nephrectomy. Nephrectomy is the surgical removal of kidney. In the policy schedule issued to the complainant, there is a provision that the policy provides lumpsum payment on completion of 30 days survival period after the first diagnosis of the listed critical illnesses. It is also stated in the policy schedule that the above provision is subject otherwise to the terms, exclusions and conditions of the policy. The above mentioned provision would indicate that after the first diagnosis of the critical illness, the insured must survive for 30 days for making the claim. That provision is subject to the other policy conditions. Section 2 of the policy conditions deals with exclusions. Section 2(i) reads :- …….. A waiting period of 90 days will apply to all claims unless the insured person has been insured under this policy continuously and without any break in the previous policy year". In this case, everything related to the claim happened within 90 days from the inception of the first policy. So, this is a clear case where Section 2.1 of the policy conditions is attracted. So, the repudiation of the claim is sustainable. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-146/2012-13

N K K Nair

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/112/2013-14 dated 23.10.2013

The complainant had taken CAN Mediclaim insurance policy from the Respondent-Insurer. The complainant submitted a claim for reimbursement. The claim was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that his wife was admitted at Triveni Nursing Home on the advice of the treating Doctor and he had incurred a total expense of Rs.9,093/-. The treatment provided could not have been done on OPD basis and In-patient treatment was essential. The repudiation of the claim is illegal and irregular. The entire claim amount is to be allowed.

The insurer submitted that the Discharge Summary would reveal that the treatment provided to the wife of the complainant could have been done on OPD basis. The TPA of the Insurer considered the entire claim documents and rightly found that there was no necessity for In-patient treatment.The claim was repudiated based on the policy conditions.

Decision:- The Discharge Summary shows the diagnosis as 'Greevapaka sheruka'. At the time of admission for treatment, the patient had complaint of pain in neck region radiating towards the upper limbs, pain in knee joints since 6 months. The Discharge Summary would further reveal that she underwent the following procedures during hospitalisation:- Patrapotala sweda for seven days, Nasyam for five days and Lepam. It also reveals that she underwent one or the other procedure on all the seven days of hospitalization and at the time of discharge, she was advised to take complete rest and to continue the medicines for next two weeks. The advice to take complete rest for next two weeks itself is a clear indication that hospitalisation of the complainant was essential for the treatment of the ailment suffered by her. There is nothing to show that the treatments provided to the wife of the complainant could have been done on OPD basis. In this connection, it is very pertinent to note that the TPA had not highlighted any policy condition for repudiating the claim. Discharge Summary would reveal that the hospitalisation was purely based on the advice of the treating Doctor. There is no ground to doubt the integrity and credentials of the treating Doctor. So, it can be safely found that the In-patient treatment provided to the wife of the complainant was based on the symptoms shown by her at the time of admission and also based on the procedures underwent by her during the course of hospitalisation. Therefore, the repudiation of the claim is without any basis. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.9,093/- with cost of Rs.500/- within the prescribed period , failing which, Rs.9,093/- shall carry interest at 9% per annum from the date of filing of the complaint(25.05.2012) till payment is effected.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-166/2012-13

P K Rajamma

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/113/2013-14 dated 24.10.2013

The complainant had taken Arogya Raksha policy from the Respondent-Insurer covering herself and her family. The Sum Insured was Rs.50,000/-. Husband of the complainant was admitted for treatment of Pneumonia on 31.07.2011 and he died on 07.08.2011. The complainant spent an amount of Rs.14,010/- for his treatment. The claim was repudiated by the Insurer. Son of the complainant was admitted in the hospital for treatment in connection with his nose. He underwent surgery and an amount of Rs.13,308/- was spent for his treatment. The claim was not settled by the Insurer. She is eligible for the entire hospital expenses. Therefore, the complaint.

The insurer submitted that the claim relating to the husband of the complainant was repudiated under exclusion Clause 4.1 of the policy conditions. The claim relating to the son of the complainant was repudiated under exclusion Clause 4.3 of the policy conditions. The son of the complainant was hospitalized for treatment of Sinusitis related disorder and therefore, it is excluded during the first year of insurance cover.

Decision:- Admittedly, the husband and son of the complainant were taken ill and admitted in hospital. In the case of the husband of the complainant, the diagnosis is Chronic Obstructive Pulmonary Disease (COPD). Date of first consultation is noted as 31.07.2011. In Column 8 of the Medical Certificate there is a specific question, "Whether the present ailment is a complication of pre-existing disease ?". The answer given is 'No'. So, as per the available medical document, the ailment suffered by the husband of the complainant is not a complication of a pre-existing ailment. The policy incepted on 30.10.2010 and the hospitalisation was on 31.07.2011. There is no evidence that the husband of the complainant was diagnosed and treated for COPD earlier to 31.07.2011 or 30.10.2010. So, it is not a pre-existing ailment. Therefore, repudiation of the claim under Clause 4.1 of the policy conditions is not sustainable. As per the Discharge Summary, the son of the complainant was diagnosed with Deviated Nasal Septum (DNSP). Medical Certificate issued by the treating Doctor in the prescribed form would reveal that Septoplasty under general anaesthesia was done during hospitalisation. The age of the ailment is noted as three months. Nasal Septum is the division between the two parts of nasal cavity. Septoplasty is being done for the correction of nasal septum. It is not related to Sinusitis. Septoplasty relates to nasal cavity only. There is no evidence before this Forum that Septoplasty was done in relation to Sinusitis or any related disorder suffered by the son of the complainant. So, exclusion Clause 4.3 of the policy

conditions is not attracted. The repudiation of the claim cannot be sustained. In the result, an award is passed directing the Insurer to pay a total amount of Rs.25,437/- to the complainant within the prescribed period, failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint (06.06.2012) till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-187/2012-13
P P Thomas

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/114/2013-14 dated 25.10.2013

The complainant had been taken Individual Health Insurance policy from the Respondent-Insurer from 14.07.2001 with Sum Insured is Rs.1,75,000/-. He was hospitalized twice and two claims were submitted. On both occasions, he was admitted at PVS Hospital, Kaloor for the treatment of Acute on chronic Pancreatitis and Coronary Artery Disease. Both claims were repudiated by the Insurer. Therefore, the complaint.

The complainant submitted that the claims were repudiated by the Insurer alleging that he suffered Pancreatitis on account of consumption of alcohol. Pancreatitis suffered by him is not an alcohol related ailment. Treatment for Pancreatitis is not excluded under the policy. The second hospitalisation was for follow up treatment. So, the repudiation of the claim under Clauses 4.9 and 4.11 of the policy conditions cannot be sustained.

The insurer submitted that there is specific mention in the medical documents that the complainant was in the habit of consuming alcohol. The ailments were alcohol induced. So, the first claim was repudiated under Clause 4.9 of the policy conditions. In the second claim the hospitalisation was only for investigations. So, the claim was repudiated under Clauses 4.9 and 4.11 of the policy conditions.

Decision:- The diagnosis in the 1st hospitalization is 'acute on chronic pancreatitis and CAD. In the Discharge Summary it is stated that the complainant was continuing alcohol consumption and he had CAD for the past 11 years, on treatment. So, it is evident that though the complainant is a known case of CAD, his admission was in connection with Pancreatitis. The insurance cover incepted on 14.07.2004. The complainant was having continuous insurance cover thereafter for more than 48 months. Therefore, if at all the complainant was treated for CAD during the relevant hospitalisation, that ailment was no more a pre-existing disease attracting exclusion Clause 4.1 of the policy conditions. The second Discharge Summary would reveal that he had already been diagnosed for acute on chronic Pancreatitis. So, it is evident that the second admission was not for diagnosis or investigations but for follow up treatment. So, repudiation of the second claim under

Clause 4.11 of the policy conditions is not sustainable. There is no mention in the 1st Discharge Summary that pancreatitis suffered by the complainant was alcohol induced None of the medical documents shows that alcohol consumption by the complainant had caused CAD and Pancreatitis. Presumptions and assumptions have no role while deciding a claim based on policy conditions. The policies were issued based on a contract of insurance. So, the policy conditions are to be construed strictly. As already stated, there is no positive evidence in the medical records that Pancreatitis and Coronary Artery Disease suffered by the complainant were caused on account of alcohol consumption. So, repudiation of the claim under Clause 4.9 of the policy conditions is also not sustainable. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.41,069/- with cost of Rs.1,000/- within the prescribed period failing which, Rs.41,069/- shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-209/2012-13

S Antony

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/115/2013-14 dated 29.10.2013

The complainant had taken Health Insurance policy from the Respondent-Insurer continuously for three years. He suffered stroke and was admitted at Ananthapuri Hospital, Tvm. The claim was repudiated by the Insurer stating that the ailment suffered was a pre-existing one . Therefore, the complaint.

The complainant submitted that he was having valid insurance cover. Hemorrhage suffered by him was due to fall. The repudiation of the claim based on policy conditions 4.1 and 4.3 cannot be sustained. The entire claim is to be allowed.

The insurer submitted that the relevant policy period was from 16.02.2011 to 15.02.2012. Two earlier policies were renewed with break of more than two months. So, he cannot claim the benefit of continuous insurance cover. Hypertension suffered by the complainant was a pre-existing ailment. The claim was repudiated under Clauses 4.1 and 4.3 of the policy conditions.The repudiation is strictly based on the policy conditions.

Decision:- Though Clause 4.3 would state that Hypertension and other ailments named therein are not payable for first two years of operation of the policy, it is not mentioned in the policy condition that the insurance cover must be continuous without break. The 1st

policy was for the period from 07.10.2008 to 06.10.2009. The 2nd policy was for the period from 18.12.2009 to 17.12.2010. The 3rd policy (the relevant policy) is for the period from 16.02.2011 to 15.02.2012. So, the claim arose in the third year of operation of the policy. As per the repudiation letter, the insurance cover incepted on 18.12.2009. The repudiation letter clearly shows that the break in between the relevant policy and previous policy was not taken into consideration by the Insurer. The same analogy adopted by the Insurer in considering the second policy which incepted on 18.12.2009 is to be adopted by the Insurer in the case of the policy which incepted on 07.10.2008 also. The Treatment Certificate does not reveal that Hypertension suffered by the complainant had resulted in Intra Cerebral Hemorrhage. Even if the complainant was diagnosed as hypertensive and was on treatment from 30.10.2008, that diagnosis is after the inception of the first policy on 07.10.2008. So, it is not a pre-existing disease as defined in Clause 3.5 of the policy conditions.So, exclusion Clause 4.1 is not attracted. Fall of the complainant on 30.10.2011 is stated in the treatment certificate and medical certificate. So, hospitalisation was mainly for the treatment of Intra Cerebral Hemorrhage. Intra cerebral Hemorrhage is not excluded under Clause 4.3 of the policy conditions. The conclusion that can be arrived at is that repudiation of the claim under exclusion Clauses 4.1 and 4.3 is not sustainable. Here the Sum Insured for mediclaim is Rs.15,000/-. In the result, an award is passed directing the Insurer to pay an amount of Rs.11,580/- to the complainant within the prescribed period, failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-222/2012-13

P B Syamlal & Deepa

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/116/2013-14 dated 30.10.2013

The complainant had taken Swasthya Bima policy from the Respondent-Insurer covering himself and his family. Wife of the complainant was subjected to surgery of breast for carcinoma at AIMS, Kochi. She underwent Chemotherapy and Radiation treatment. The claim was repudiated by the insurer stating that the ailment was a pre-existing one. Therefore, the complaint.

The complainant submitted that the Biopsy Report dated 08.03.2010 would reveal that there was no malignancy. After one year, it was revealed that she had been afflicted with Carcinoma and underwent Mastectomy. Thereafter, Chemotherapy and Radiation therapy were done. He submitted that the ailment was not a pre-existing one and

Carcinoma was first diagnosed only on 01.04.2011. The repudiation of the claim is against policy conditions.

The insurer submitted that the first specimen for Biopsy was taken on 04.03.2010 and therefore, the ailment suffered by the wife of the complainant is a pre-existing disease. So, the claim is hit by Clause 4.1 of the policy conditions. The factum of excision of lump was not disclosed by the complainants in the proposal form. So, the complainants are guilty of suppression of material facts. The repudiation of the claim is legal and proper.

Decision:- As the 2nd complainant was not suffering from any ailment as on the date of submission of the proposal form, the complainants cannot be found guilty of suppression of material facts in the proposal form. The insurance cover incepted on 13.04.2010. Hospitalisation of the second complainant was for the period from 27.03.2011 to 05.04.2011. The diagnosis is Carcinoma-right breast. Right radical Mastectomy was done. In the 'History' portion it is stated that earlier specimen was taken seven months back and the result was that the lump was benign. Biopsy Report dated 08.03.2010 would reveal that there was no malignancy. Biopsy done immediately prior to hospitalisation revealed Infiltrating Carcinoma. In the Discharge Summary issued from Amrita Hospital, there is no mention of pre-existence of the ailment. The Medical Certificate specifically shows that the ailment suffered by the second complainant is not a complication of any pre-existing ailment. So, Hospitalisation of the second complainant was not for a pre-existing disease and hence, Clause 4.1 of the policy conditions is not attracted. In the result, an award is passed directing the Insurer to pay to the first complainant an amount of Rs.1,87,613/- within the prescribed period, failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-009-195/2012-13

N N Gopi

Vs

Reliance General Insurance Co. Ltd

AWARD No. IO/KCH/GI/118/2013-14 dated 31.10.2013

The complainant had been taking Reliance HealthWise policy from the Respondent-Insurer from 2008 onwards. At the time of taking the policy, he was informed that the policy will cover pre-existing diseases after completion of two policy years. He raised a claim in December 2011. The claim was rejected by the Respondent-Insurer. Therefore, the complaint.

The complainant submitted that as per the policy issued to him, pre-existing ailments will be covered on completion of two continuous policy years. The claim arose in the 4th policy year. So, the claim was illegally rejected by the Insurer. He is entitled to get reimbursement.

The insurer submitted that the policy issued for the period from 21.01.2011 to 20.01.2012 was the fourth policy issued. There is medical evidence that the complainant underwent surgery and Pacemaker Implantation in December 2002. So, the ailment for which the complainant was admitted in the hospital is a pre-existing ailment.. Pre-existing ailments will not be covered for the first four years (48 months). So, the claim was validly repudiated by them.

Decision:- The Discharge Summary would reveal that during hospitalisation, Pulse Generator change was done on 02.01.2012. In the 'History' portion it is stated that the complainant underwent Pacemaker implantation at Amrita Hospital in December 2002 in connection with complete AV block. The first policy incepted on 21.01.2008. As per the medical evidence (Discharge Summary), the complainant was treated for heart ailment and Pacemaker implantation in 2002. So, the ailment was diagnosed and treated beyond 48 months prior to the inception of the policy, i.e., the earlier treatment and diagnosis were not within 48 months prior to the inception of the first policy. Therefore, the ailment for which the complainant was hospitalized in January 2012 is not a pre-existing disease coming under Definition Clause 17 of the policy conditions. As the hospitalisation was not in connection with a pre-existing ailment as defined in the policy conditions, exclusion No.1 is not attracted. So, repudiation of the claim is not sustainable. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.14,365/- with cost of Rs.1,000/- within the period prescribed, failing which, Rs.14,365/- shall carry interest at 9% per annum from the date of filing of the complaint (19.06.2012) till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-009-200/2012-13

Sanjo Varghese

Vs

Reliance General Insurance Co. Ltd

AWARD No. IO/KCH/GI/119/2013-14 dated 01.11.2013

The complainant had been taking HealthWise policy from the Respondent-Insurer. He submitted a claim for reimbursement of hospital and medical expenses. The Insurer had partially settled the claim and had not paid the expenses met by him for dental treatment taken in continuation of his hospitalisation. Therefore, the complaint.

The complainant submitted that he was involved in an accident and suffered injuries on the face and fracture of three teeth. He was treated at Medical Trust Hospital as In-patient. Further dental treatment was continued as Out-patient. The expense for further treatment will come under post-hospitalisation expense. Repudiation of the claim under exclusion No.5 of the policy conditions cannot be sustained.

The insurer submitted that dental treatment on OPD basis is not covered under the policy. Such treatment will attract exclusion no.5 of the policy conditions. When dental treatment can be taken on OPD basis, the complainant cannot contend that dental treatment taken by him be treated as post-hospitalisation treatment/expense. The claim was repudiated based on the policy conditions.

Decision:- In the 'History' portion of the Discharge Summary, it is stated that the complainant had history of fall on 10.03.2012 and sustained injury of upper lip and suffered fracture of teeth. So, from the Discharge Summary, it can be discerned that his admission was in connection with injuries in the upper lip and fractured teeth. . As per exclusion No.5 of the policy conditions, what is excluded is dental treatment/surgery which does not require hospitalisation for less than 24 hours. So, dental treatment on IP basis for more than 24 hours is payable by virtue of the policy. Here hospitalisation of the complainant was essential for treatment of injury to the lip and fractured teeth. Further treatment taken by the complainant on OPD basis was in continuation of the treatment taken on IP basis which was taken within 60 days after the hospitalisation for treatment. When hospitalisation is there and it is followed by OP treatment for the same ailment, the provision for post hospitalisation expenses is attracted. It is to be remembered that every post-hospitalisation treatment by its nature is OP treatment after hospitalisation. The above discussion would lead to the conclusion that the denial of expense met by the complainant for dental treatment is not in order. In the result, an award is passed directing the Insurer to pay a further amount of Rs.16,500/- to the complainant within the

prescribed period, failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-009-188/2012-13

Nafeezath Salam

Vs

Reliance General Insurance Co. Ltd

AWARD No. IO/KCH/GI/120/2013-14 dated 01.11.2013

The complainant had been taking HealthWise Policy from the Respondent-Insurer for the last so many years. She submitted a claim for reimbursement of Ayurvedic treatment expenses. The TPA of the Insurer repudiated the claim stating that Ayurvedic treatment expenses are not eligible for reimbursement. The repudiation of the claim is against natural justice and policy conditions. Therefore, the complaint.

The complainant submitted that in the previous policy period, she had submitted a claim for reimbursement of Ayurvedic treatment expenses. That claim was settled by the Insurer. So, there is no reason for not settling the present claim. Change in policy conditions, if any, was not notified to her. The repudiation of the claim is illegal and improper.

The insurer submitted that that by virtue of exclusion No..29 of the policy conditions, Ayurvedic treatment expenses are not covered under the policy. Earlier claim was allowed based on the then prevailing policy conditions. Exclusion No.29 was newly incorporated in the policy conditions. The complainant is bound by the new policy conditions. They had acted based on the policy conditions. The repudiation of the claim is legal and proper.

Decision:- The claim was repudiated stating that Ayurvedic treatment is excluded under Exclusion No.29. The fact that an earlier claim in the previous policy period for reimbursement of Ayurvedic treatment expenses was allowed by the Insurer is not disputed by them. So, in the policy issued during the previous policy period, there was no exclusion provision for Ayurvedic treatment. Exclusion No.29 was newly introduced in the policy conditions. From a close reading of exclusion No.29, it could be discerned that there is no intention to exclude Ayurvedic treatment. Otherwise, there would have been mention of Ayurvedic treatment along with Naturopathy treatment. So, it cannot be said that Ayurvedic treatment is excluded under exclusion No.29 of the policy conditions. No

intimation had been sent to the insured regarding the change in policy conditions. So, the insured bona fide believed that for the relevant policy also, existing policy conditions would apply. Any change in policy conditions must be brought to the notice of the insured especially when the change in policy conditions goes to the prejudice of the insured .So, Insurer cannot dis-own their liability based on a provision which was newly incorporated/introduced without proper notice to the insured. Issuance of policy conditions, if any, after the renewal of the policy is not sufficient. In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.33,358/- within the prescribed period, failing which, the amount shall carry interest at 9% p.a. from the date of filing of the complaint (18-06-2012) till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-206/2012-13

M A Muhammed

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/121/2013-14 dated 05.11.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer from 2000 onwards. Complainant's wife was admitted at Najath Hospital, Aluva in connection with back pain. The claim for the same was repudiated by the insurer under Clause 4.10 of the policy conditions. Therefore, the complaint.

The complainant submitted that his wife was hospitalized for treatment of Intra Vertebral Disc Prolapse and during hospitalisation, there was active line of treatment. Hospitalisation was on the advice of the treating Doctor. The medical evidence available would clearly indicate that exclusion Clause relied on by the Insurer to repudiate the claim is not at all attracted. He is entitled to get the entire hospital expense with interest and cost.

The insurer submitted that the contents of the Discharge Card would reveal that hospitalisation was mainly for diagnosis. There was no active line of treatment during hospitalisation. The treatment could have been done on OPD basis. A treatment which could be done on OPD basis, even if converted into In-patient is not covered under the policy vide Note to Clause 2.3 of the policy conditions. The repudiation is in accordance with the policy conditions.

Decision:- Discharge Summary shows the diagnosis as 'Intra Vertebral Disc Prolapse with L5 nerve root compression. Presence of Sciatica was observed. Medical Certificate would

reveal that the patient first consulted the doctor on 01.03.2012. She was treated with Analgesics and bed rest. It is further noted that for providing such treatment, hospitalisation was required. Investigations are being done for proper diagnosis. In the case of the wife of the complainant, investigations were done and ultimately it was diagnosed that she was having Intra Vertebral Disc Prolapse. Details of the ailment are noted in the MR Report. The diagnosis revealed positive existence of the ailment. So, the investigations were not for diagnosis alone. No given ailment can be classified as one which requires OP treatment only. Treatment will depend on the gravity of the ailment, general condition of the patient and need for constant observation. In the instant case, the competent treating Doctor had decided to treat the patient as In-Patient. Wisdom of the Doctor cannot be challenged by the Insurer unless there are other circumstances questioning the authenticity of the treatment provided during hospitalisation. It is clear that the claim of the complainant is not hit by Clause 4.11 and Note to Clause 2.3 of the policy conditions. Therefore, the repudiation of the claim is not sustainable. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.10,991/- with cost of Rs.1,000/- within the prescribed period, failing which, Rs.10,991/- shall carry interest at 9% per annum from the date of filing of the complaint (22.06.2012) till payment is effected.

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<u>OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI</u>

Complaint No. IO/KCH/GI/11-002-218/2012-13

P P Dileep Kumar

Vs

New India Assurance Co. Ltd

<u>AWARD No. IO/KCH/GI/125/2013-14 dated 06.11.2013</u>

The complainant had taken Union Health Care policy through Union Bank from the Respondent-Insurer. The first policy incepted on 01.03.2007. Wife of the complainant was hospitalized in 2008 at Mannarkkadu Nursing Home. The claim for the same was not settled by the insurer Therefore, the complaint.

The complainant submitted that his wife was admitted at Mannarkkad Nursing Home and underwent Appendicectomy and Hysterectomy. He submitted a claim for reimbursement in 2008. Even after a lapse of five years, the Insurer had not settled the claim. He is entitled to interest and cost.

The insurer submitted that the claim was to be settled either from the Mumbai Office or Kolkatta Office. No information is available from those offices regarding settlement of

the claim. They are taking steps to settle the claim as per the policy terms and conditions and Clause 4.3 is attracted as far as Hysterectomy is concerned.

Decision:- Medical evidence available consists of Discharge Card, Medical Certificate and Histopathology Report. Discharge Card would reveal that wife of the complainant underwent Appendicectomy and Hysterectomy on 12.06.2008. Medical Certificate issued by Dr. Bhadra A.P. would reveal that the wife of the complainant was admitted in the hospital with abdominal pain. Clinical examination revealed that she was having Appendicitis. Further investigation revealed that she was having multiple fibroid uterus. The first policy ended on 01.01.2008. The second policy incepted on 02.01.2008 and expired on 01.01.2009. The medical records would reveal that the wife of the complainant underwent Hysterectomy on 12.06.2008, after her admission in the hospital on 11.06.2008. So, the wife of the complainant underwent Hysterectomy in the second policy year. Arithmetically also, hospitalisation was beyond 12 months from the inception of the policy on 01.03.2007. So, Clause 4.3 of the policy conditions is not at all attracted. As far as Appendicectomy is concerned, there is no waiting period. No other exclusion Clause is attracted in the case of the complainant. So, the claim is payable. For the delay caused, the complainant is entitled to reasonable interest on the claim amount and also cost for the inconvenience caused. In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.15,225/- with interest @ 9% per annum from the date of filing of the complaint (28.06.2012) till the date of award and cost of Rs.2,000/- within the prescribed period, failing which, Rs.15,225/- shall carry further interest at 9% per annum from the date of award till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-179/2012-13

Dixon Pynadath

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/126/2013-14 dated 06.11.2013

The complainant had taken Health Care Floater policy from the Respondent-Insurer in 2007. He had been renewing the policy from time to time. On 20.04.2012, he was admitted at Little Flower Hospital, Angamaly due to severe chest pain. He underwent Angioplasty. Requisition for Cashless facility was sent from the hospital. Cashless request made was rejected by the TPA. At the time of discharge from the hospital, the hospital authorities demanded full payment of the hospital expense. The complainant and his family members were demoralized and humiliated and they had to seek the help of their relatives to pay the hospital bill. This instance had affected his dignity and status and therefore, he is seeking a compensation of Rs.20 Lakhs.

The insurer submitted that the hospital authorities made a request for Cashless facility in relation to the treatment for the complainant. After consideration of relevant factors, the TPA declined to allow Cashless facility. There was no reason or occasion for causing humiliation to the complainant and his family members. After discharge from the hospital, the complainant submitted a claim for Rs.1,50,480/-. That claim was settled to the satisfaction of the complainant. The complainant had not made out any acceptable ground for allowing compensation on account of the alleged mental agony and humiliation. The complaint is only to be dismissed.

Decision:- Cashless facility is an added service apart from reimbursement benefit provided under the policy conditions. Cashless facility is being implemented through the TPA of the insurer. It is not mandatory that Cashless facility is to be authorized on mere asking/making of requisition. Admissibility of the claim in relation to policy conditions dealing with exclusions, waiting period, etc are to be taken into consideration before allowing Cashless facility. If the request for Cashless facility relating to a particular ailment is of doubtful nature as to whether the same would be hit by any of the policy conditions, then the TPA is not bound to allow Cashless facility. Cashless facility is not an absolute right provided under the policy. The complainant has no case that Cashless facility once allowed was later withdrawn by the TPA to his disadvantage. The provisions of the policy would lead us to the conclusion that Cashless facility is an exception whereas reimbursement is the rule. Both are subject to the policy conditions. Bald allegations are insufficient to conclude that the complainant had suffered humiliation and mental agony on account of denial of Cashless facility. The complainant had not succeeded in making out any ground that he had suffered humiliation and mental agony on account of denial of Cashless facility and he is entitled to compensation on account of that. In the result, the complaint is dismissed. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-203/2012-13

Bindu Zachariah

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/127/2013-14 dated 06.11.2013

The complainant is covered under Union Health Care Insurance Policy issued by the Respondent-Insurer. A claim submitted for reimbursement of hospital expenses was repudiated by TPA under clause 4.1 of the policy conditions. Therefore, the complaint.

The complainant submitted that the first policy incepted on 02-04-2008. She had disclosed mild Diabetes Mellitus at the time of taking the policy. That policy was being renewed from time to time without any break. The relevant hospitalization was for the treatment of 'Carbuncle'. I.P. treatment was followed by O.P treatment. As three policy years were over, the claim ought to have been allowed by the Insurer. The entire claim is to be allowed.

The insurer submitted that the complainant suffered Diabetes Mellitus prior to the inception of the policy. Diabetes Mellitus is a pre-existing disease. Pre-existing disease is excluded under clause 4.1 of the policy conditions. The repudiation of the claim was based on the policy conditions. The complainant is not entitled to reimbursement.

Decision:- The Discharge Summary shows the diagnosis as 'Carbuncle over back with Diabetes Mellitus'. In the history portion it is noted that patient is a known case of Diabetes Mellitus on treatment. Incision and drainage were done on general anaesthesia. The Discharge Summary would further reveal that a review was advised after one week and follow up treatment from 04-04-2011. So, there is evidence that Diabetes Mellitus is a pre- existing ailment. A reading of Clause 4.1 of the policy condition would clearly indicate that exclusion clause relating to pre-existing diseases will be deleted after three consecutive claim free policy years In the case of the complainant, the first policy year ended on 01-01-2009. 2nd policy year ended on 01-01-2010 and third policy year ended on 01-01-2011.The 4th policy incepted on 02-01-2011. That policy covers the period from 02-01-2011 to 01-01-2012. The hospitalization of the complainant was from 30-03-2011. So, hospitalization was in the fourth policy year. The Insurer has no case that the complainant had raised any claim in the first three consecutive policy years. As the first claim arose in the fourth policy year and three previous consecutive policy years were claim free, definitely, clause 4.1 is not attracted. Therefore, repudiation of the claim cannot be sustained. Also, follow up treatment taken by the complainant on OPD basis will squarely come under clause 3.2 dealing with post hospitalization expenses. On account of delay occasioned in the settlement of the claim, she is entitled to cost of Rs.1,000/-. In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.38,501/- with cost of Rs.1,000/- within the prescribed period, failing which, Rs.38,501/- shall carry interest at 9% p.a. from the date of filing of the complaint (21-06-2012) till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-562/2012-13

Latha Madampath
Vs
New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/128/2013-14 dated 07.11.2013

Complainant, her husband, two children and in-laws are covered under Group Mediclaim policy issued for the employees of L.I.C. by the Respondent-Insurer. Mother-in-law of the complainant suffered back ache radiating to lower limbs and was admitted for treatment in an Ayurvedic Hospital. The claim for the same was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that her mother-in-law suffered back pain and was admitted at Sarathy Ayurvedic Hospital for treatment. The claim was rejected by the Insurer alleging that the patient underwent Panchakarma and Heat therapy, which are excluded under Clause 2.3.2 of the policy conditions. The repudiation is against the medical evidence available and the policy conditions. She is entitled to receive the entire claim.

The Insurer submitted that as per the medical documents, mother-in-law of the complainant underwent Panchakarma with Yoga and Heat therapy. Panchakarma and Heat therapy are excluded under Clause 2.3.2 of the policy conditions. After considering the medical documents and the policy conditions, they had rightly repudiated the claim.

Decision:- A close reading of Clause 2.3.2 would reveal that an exclusion provision had been carved out for certain Ayurvedic courses of treatment for which there is no liability for the Insurer to make reimbursement. So, generally Ayurvedic/ Homeopathic/ Unani Treatment are admissible provided they are taken in the specified hospitals. Regarding the status of the hospital, wherein mother-in-law of the complainant was admitted for treatment, there is no dispute from the side of the insurer. The claim was rejected mainly on the ground that the patient underwent Panchakarma with Yoga and Heat therapy. The treatment details would reveal that the patient had undergone Choorna swedam, Kayasekam, Shashtikapinda swedam, Kateevasthy, Matravasthy and Kashayavasthy. None of these courses of treatment forms part of Panchakarma treatment. The Discharge Record also does not reveal that the patient was given Heat therapy during hospitalisation. Heat therapy is entirely different from Steam bath. In this connection, it is to be remembered that Yoga and Heat therapy are not included in the named exclusions in Clause 2.3.2 of the policy conditions. From the above discussed medical evidence, it could be seen that the patient was not given Panchakarma treatment during hospitalisation. The contents of the Medical Certificate go against the contents of the Discharge Record and treatment details. So, the treatment 'Panchakarma' noted in the

Medical Certificate can only be an inadvertent inclusion or mistake committed on the part of the treating Doctor. The words 'similar ayurvedic treatment' included in the exclusion portion of Clause 2.3.2 cannot be given an extended meaning to include all courses of treatment not mentioned in the policy conditions. So, the repudiation of the claim cannot be sustained. In the result, an award is passed directing the Insurer to pay an amount of Rs. 24,491/- to the complainant within the prescribed period, failing which, the amount shall carry interest at 9% per annum from 31.10.2012 till payment is effected. No cost.
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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-207/2012-13

N P Varghese

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/130/2013-14 dated 12.11.2013

The complainant had taken Family Health Optima Insurance policy from the Respondent-Insurer. On 11.04.2012 while he was working as head-load worker at North Railway Station, he had an accidental fall and suffered disc prolapse. He was treated at Lisie Hospital as In-patient. He submitted a claim for reimbursement of hospital expense. The claim was repudiated by the Insurer. Therefore, the complaint.

The complainant submitted that while he was at work, he fell down and was taken to Lisie Hospital. As the injury was due to an accident, waiting period of two years is not applicable. Repudiation of the claim is not legal and proper. He is entitled to get reimbursement of the hospital expenses as well as post-hospitalisation expenses.

The insurer submitted that the medical records issued from Lisie Hospital do not indicate that the complainant suffered injury/disc prolapse in an accident. There is evidence that there were degenerative changes in the disc. As Exclusion Clause relating to waiting period for disc prolapse is attracted, the repudiation of the claim is in accordance with the policy conditions.

Decision:- The Insurer had repudiated the claim relying on Exclusion No.3 of the policy conditions. A reading of this Clause, would indicate that waiting period of two years is not applicable if intervertibral disc prolapse is due to an accident. In the Discharge Summary and the treating Doctor's Certificate, there is no specific mention that the complainant suffered the ailment on account of accidental fall. The diagnosis is acute IVDP L4-L5 with L5 radiculopathy. Date of first consultation is noted as 11.04.2012. Also, the Discharge Summary and the Medical Certificate do not reveal any past history of intervertibral disc prolapse and earlier treatment. In these medical documents, there is no mention at all that

IVDP was on account of degenerative changes. The Insurer is relying on the MRI Report dated 12.04.2012 for contending that the ailment was due to degenerative changes. Of course, degenerative changes might have accelerated the prolapse of disc. But the finding in MRI study had not been confirmed clinically by the treating Doctor. There is no contra evidence produced from the side of the Insurer to challenge the truthfulness of the contents of the Certificate issued by the Chief Parcel supervisor of Railway. So, the contents of the medical documents are to be read in conjunction with the Certificate issued by the Chief Parcel Supervisor. So, it can be concluded that the complainant suffered disc prolapse on account of accidental fall. Fall is an accident. So, the case of the complainant comes under exception to Exclusion No.3 of the policy conditions. Repudiation of the claim is therefore, not sustainable. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.11,441/- within the prescribed period, failing which, the amount shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/12-023-194/2012-13

George Mathew

Vs

Max Bupa Health Insurance Co. Ltd

AWARD No. IO/KCH/GI/129/2013-14 dated 11.11.2013

The complainant had taken a Platinum Card Mediclaim policy from the Respondent-Insurer. He applied for an overseas policy and the Respondent-Insurer declined to issue the policy. The complainant who had been cheated by the Insurer is entitled to refund of the premium paid in Heart Beat Platinum Insurance policy .Therefore, the complaint.

The complainant submitted that he had submitted proposal forms for two policies. After medical examination, Heart Beat Platinum policy only was issued. At the time of applying for the policy, the definite understanding was that the policy will provide full cover without exclusions. His claim for reimbursement for purchase of medicines was declined stating that the claim arose within the waiting period of 90 days. It is thereafter, he knew that as far as pre-existing diseases are concerned, there is a waiting period of 48 months from the inception of the first policy. The complainant demanded cancellation of the policy and refund of premium. The Insurer had not provided refund of the premium.

The Insurer submitted that there was no understanding between the complainant and the Insurer that he will be provided full cover without exclusion provisions. Pre-existing diseases are not covered for the first 48 months from the inception of the policy. The

policy was issued with exclusions. In the policy schedule, pre-existing conditions of the complainant as well as his wife are noted. The policy is governed by the policy conditions. He had made the request for refund of the premium beyond 180 days and therefore, he is not entitled to receive any refund as per policy conditions.

Decision:- Admittedly, there was no request from the side of the complainant for cancellation of the policy within the free-look period. The very fact that he had raised a claim based on the policy issued to him would clearly indicate that he had accepted the policy received by him. He had accepted the policy and had acted based on the policy, by raising a claim for reimbursement. Policy schedule is the formal document evidencing a contract of insurance between the insured and the insurer. The policy conditions form part of the contract of insurance. As per Clause 4 of the policy conditions pre-existing conditions are not covered until the expiry of 48 months continuous insurance cover since the inception of the policy with the Insurer. As per Cancellation/Termination provision in the policy conditions, If the request is made beyond 180 days, refund of premium is '0%', i.e., no refund is available. Here request for cancellation had been made beyond 180 days from the commencement of the policy. So, the complainant is not entitled to refund of the premium. The complainant is not entitled to any relief in the complaint. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/14-020-205/2012-13

N Prasanna

Vs

Universal Sompo General Insurance Co. Ltd

AWARD No. IO/KCH/GI/131/2013-14 dated 12.11.2013

The complainant had been taking Health Care policy continuously from 2007 onwards. In connection with the hospitalisation of her husband for by-pass surgery, she submitted a claim for reimbursement of hospital expense. The insurer did not settle the claim. Therefore, the complaint.

The complainant submitted that the claim was repudiated by the Insurer stating that it was a pre-existing ailment. According to the complainant, the ailment suffered by her husband was not a pre-existing one. Exclusion Clause of the policy conditions is not attracted. The reimbursement is to be limited to the Sum Insured only.

The Insurer submitted that they demanded production of further documents from the side of the complainant. Such documents were necessary to ascertain whether she was entitled to the benefit of continuous insurance cover on account of transfer of insurance cover to the Respondent-Insurer. The complainant did not produce the said documents. So, the claim was closed. It was also argued that the ailment suffered by the husband of the complainant was a pre-existing one. So, exclusion Clause relating to pre-existing disease is applicable

Decision:- Discharge Summary shows the diagnosis as CAD, TVD, LMCAD, NSTEMI, ...etc. He underwent surgery on 05.05.2011. CABG was done. In the 'History' portion it is noted that the husband of the complainant is an old IWMI (1993). So, husband of the complainant had undergone treatment in connection with heart ailment in 1993. There is no evidence of treatment for heart ailment after 1993 till his admission in the hospital on 03.05.2011.The Insurer has no case that the complainant had raised any claim in the previous policies. As per the contention of the Insurer, the policy incepted on 29.10.2009. Husband of the complainant contracted heart ailment in 1993. So, that ailment was contracted by him atleast 16 years prior to the inception of the policy with the Respondent-Insurer. So, the ailment was contracted much prior to 36/48 months period prescribed in the definition and exclusion Clause No.1 of the policy conditions relating to 'pre-existing ailment'. Therefore, the ailment for which the husband of the complainant underwent treatment is not a pre-existing ailment as defined in the policy conditions. The second paragraph of exclusion No.1 becomes applicable if only the ailment is a pre-existing one. So, it can be safely concluded that the repudiation of the claim on the ground that the ailment was a pre-existing one cannot be sustained. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.One Lakh with 9% interest per annum from the date of filing of the complaint till the date of award within the prescribed period, failing which, Rs. One Lakh shall carry further interest at 9% per annum from the date of award till payment is effected. No cost.
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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-175/2012-13

C A Chaly
Vs
Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/132/2013-14 dated 13.11.2013

The complainant and his wife are covered under Senior Citizens Red Carpet Insurance policy from 03.02.2010 onwards. The complainant was admitted at Lisie Hospital on 30.09.2011 for Angiogram and was admitted again on 10.10.2011 for Angioplasty. The claims were rejected by the Insurer alleging that the complainant had suppressed existing ailments in the proposal form submitted for taking the policy. Therefore, the complaint.

The complainant submitted that he had undergone Bypass Surgery in 1990 and while applying for the policy in 2010, after a lapse of 20 years, he did not think it material to state the same in the proposal form. There was no mala-fide intention on the part of the complainant in not disclosing the same in the proposal form. After 1990, the complainant had not suffered any ailment connected with heart and he had not undergone any treatment. The repudiation of the claims is unfair and illegal.

The Insurer submitted that medical records revealed that the complainant had undergone Bypass Surgery in 1990. That fact was not disclosed by the complainant in the proposal form submitted by him for taking policy in February 2010. As far as Health Insurance policy is concerned, disclosure of pre-proposal illness is very important. The non-disclosure had affected the underwriting and issuance of the policy. As the complainant is guilty of non-disclosure of material fact in the proposal form, Insurer has no liability to make reimbursement. They had acted in good faith and in accordance with the legal principles.

Decision:- The complainant had admitted that he had undergone CABG (Coronary Artery Bypass Graft) in 1990. CABG undergone by the complainant in 1990 finds place in the Discharge Summaries issued from Lisie Hospital in connection with the First and Second hospitalizations of the complainant in 2011. The complainant submitted at the time of hearing that he did not feel it so important to mention a surgery underwent in 1990 in the proposal form submitted 20 years thereafter. All the legal principles governing a general contract are applicable in the case of contract of insurance also. An added feature of a contract of insurance is 'good faith'. Distance of time does not dilute the gravity of materiality of the fact to be disclosed by the insured in the proposal form. Here, the complainant had suppressed a material fact in the proposal form submitted by him for taking the policy in 2010. The answers given by the complainant in the proposal form that he had not suffered any illness within 12 months and prior to 12 months are untrue. An identical case came up for consideration before the Hon'ble SC in Satwantkaur Sandhoo Vs. New India Assurance (2009) 8 SCC 316. In that decision, the Hon. SC upheld the repudiation decision of the insurer on the ground of non-disclosure of material fact relating to health in the proposal form. In these circumstances, the -Insurer has every right to avoid their liability to make reimbursement. The repudiation of the claims is fair and legal. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-228/2012-13

John Mathew

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/136/2013-14 dated 21.11.2013

The complainant had taken Medi-Guard policy from the Respondent-Insurer covering his mother, since 1986. She was admitted at AIMS, Ernakulam for treatment of Symptomatic tachy-brady Syndrome, CAD, Type II Diabetes Mellitus etc The claim for the same was rejected by the Insurer under Clause 4.1 of the policy conditions. Therefore, the complaint.

The complainant submitted that his mother did not undergo treatment for a pre-existing ailment as stated in the policy conditions. The repudiation of the claim is irregular and against the policy conditions. It is also against the medical evidence. The complaint is to be allowed and an award may be passed for reimbursement of Rs.1,50,000/- with interest and cost

The insurer submitted that the relevant policy was for the period from 25.03.2011 to 24.03.2012. There was break in the continuity of insurance cover. So, the claim submitted by the complainant was rightly repudiated by the Respondent-Insurer under Clause 4.1 of the policy conditions.

Decision:- As per the Discharge Summary, the main diagnosis is Symptomatic tachy-brady Syndrome, CAD, Type II Diabetes Mellitus, Systemic hypertension etc. In the 'History' portion it is stated that patient was hypertensive, Dyslipidemic for 10 years and she had an episode of syncope 8 years ago. She was having dyspnea on exertion Class II for the last 12 to 14 years. The patient underwent pacemaker implantation during hospitalization. The complainant is not disputing existence of ailment prior to 25.03.2008. But his contention is that Clause 4.1 of the policy conditions is not at all attracted. Even according to the Insurer, insurance cover under Medi-Guard policy incepted on 25.03.2008. There is no case for the Insurer that the complainant had raised any claim relating to the treatment of his mother for the pre-existing ailment between 25.03.2008 and presentation of the disputed claim. Hospitalisation of the mother of the complainant

was in the fourth policy year.The exclusion clause will be deleted after three consecutive continuous claim free policy years as there was no hospitalisation for the pre-existing ailment during these three years of insurance. So, exclusion Clause 4.1 is not at all attracted. Therefore, it can be safely concluded that rejection of the claim invoking Clause 4.1 of the policy conditions is not sustainable. As per the policy schedule, the Sum Insured is Rs.1,25,000/-.Cumulative bonus is 20% of the Sum Insured. So, the total Sum Insured available during the policy period was Rs.1,50,000/-. In the result, an award is passed directing the Insurer to pay to the complainant an amount of Rs.1,50,000/- with 9% interest from the date of filing of the complaint till the date of award, within the prescribed period, failing which, Rs.1,50,000/- shall carry further interest at 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI
Complaint No. IO/KCH/GI/11-003-121/2012-13

S J Wakefield

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/137/2013-14 dated 21.11.2013

The complainant had taken Accident and Health Care policy from the Respondent-Insurer. His wife, Smt. Lata, who is covered under the policy had undergone D&C on 19.08.2010 at Jubilee Memorial Hospital, Tvm. The claim was repudiated by the insurer on the ground that the patient was not hospitalized for a minimum period of 24 hours. Therefore, the complaint.

The complainant in his Argument Note submitted that in the policy conditions issued to him, there is no Exclusion Provision as Clause 4.3. He is entitled to get reimbursement of the entire hospital expense and also Rs.5,000/- as compensation and cost of the proceedings.

The insurer submitted that Exclusion Clause 2.3.2 in the policy conditions was wrongly quoted as 4.3 in the repudiation letter sent by the Grievance Cell of the Insurer. Clause 4.3 which normally finds place in other Mediclaim policies issued by them is similar to Clause 2.3.2 of the policy conditions The wife of the complainant did not undergo D&C procedure. In fact, she had undergone Polypectomy. The surgery/ procedure underwent by her is related to genito-urinary system and therefore, it is excluded in the first two years. The repudiation is legal and proper.

Decision:- The case of the complainant is that his wife underwent D&C and therefore, minimum period of 24 hours of hospitalisation is not required as per the policy. The Discharge Summary would reveal that the patient underwent Polypectomy. In the 'History' column it is noted :- 'A case of mass coming down per vagina- one month'. In the Medical Certificate issued by the attending Doctor also, the procedure underwent by the patient is noted as Polypectomy. D&C is Dilatation and Curettage. Dilatation is the expansion of a hollow space. Curettage is scraping inside of a hollow organ to remove growth, very often in the uterus. Uterus of the wife of the complainant is not involved in the procedure done during hospitalization. The Discharge Summary would reveal that Polypectomy was done under general anesthesia. As per definition No.4 relating to hospitalisation, if surgical procedure involved has to be done under general anesthesia, the condition of minimum 24 hours hospitalisation will have no application. So, the repudiation of the claim on the ground that there was no minimum hospitalisation for 24 hours is not sustainable. While repudiating the claim, the Insurer had only quoted Clause 4.3. It can be considered as a clerical error only. Clause 2.3.2 specifically states that if the procedure is in relation to genito-urinary system, the same is not covered for the first two years from the date of inception of the policy. The treatment provided to the patient is related to genito-urinary system. So, exclusion Clause 2.3.2 is attracted. Therefore, the repudiation of the claim under Clause 2.3.2 of the policy conditions (wrongly quoted as Clause 4.3 in the repudiation letter) is sustainable. The complainant is not entitled to any relief.. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI
Complaint No. IO/KCH/GI/11-005-116/2012-13

C P Joshy

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/138/2013-14 dated 22.11.2013

The complainant who had taken Mediclaim Policy from the Respondent-Insurer preferred a claim for reimbursement of hospital expenses. The claim was repudiated by the Insurer. Therefore, the present complaint.

The complainant submitted that he had been taking Mediclaim Policy from the Insurer from 2003 onwards without any break. He suffered severe cervical pain and was admitted at Little Flower Hospital, Angamaly on 05-11-2011. The repudiation of the claim is against policy conditions. There was no intentional laches on his part. The complaint is only to be allowed.

The insurer submitted that for no valid reason, the complainant submitted the claim beyond the period prescribed under clause 5.5 of the policy conditions. During hospitalisation, there was no active line of treatment and it was only for diagnosis and evaluation. So, the claim is hit by clause 4.10 of the policy conditions. The repudiation is based on the policy conditions.

Decision:- As per the repudiation letter of the TPA, there was a delay of seven days in submitting the claim form. Time limit is prescribed in the policy conditions to weed out false claims. In the instant case, the Insurer has no case that the medical documents submitted by the complainant are not genuine. The authenticity of the documents is not disputed. In such a situation, it may not be just and proper to reject a claim merely on the technical ground of limitation/delay. Therefore, the repudiation of the claim under clause 5.5 of the policy conditions cannot be sustained. As per the Discharge Summary, the diagnosis is Acute Cervical Disc Prolapse with severe root pain (left C6 – C7 Area). Soft Cervical Collar was advised. He was also advised to continue medication. At the time of admission, neck movements were restricted and painful. The pain was radiating to the left upper limb. MRI taken showed disc prolapse with compression over the C7 over the left side. The Mediclaim Medical Report signed by the attending doctor, gives the details of the diagnosis and period of treatment. It is specifically noted that disease suffered was acute in nature. So, here is a patient who was taken to the hospital with severe neck pain radiating to the left upper limb, the pain was acute in nature. Cervical disc prolapse was diagnosed. Taking into consideration the seriousness of the situation, the attending doctor advised hospitalization of the patient. The wisdom of the doctor in deciding so, cannot be questioned by the TPA or the Insurer without any valid ground. The Discharge Report would reveal that during hospitalization, the complainant was provided sufficient treatment required for the ailment diagnosed. The hospitalization was not merely for diagnosis or investigation. So, the contention of the Insurer that the claim is hit by exclusion clause 4.10 of the policy conditions cannot be accepted. In the result, an award is passed directing the Insurer to pay an amount of Rs.8,180/- to the complainant within the prescribed period, failing which, the amount shall carry interest at 9% p.a. from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-172/2012-13

K S Menon

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/139/2013-14 dated 25.11.2013

Complainant and his wife have taken policy from the Respondent-Insurer for the period from 02-06-2011 to 01-06-2012. They were earlier covered under Group Mediclaim Policy as dependants of their son from 2006 onwards. The claim in connection with Cataract Surgery of his wife was repudiated by the Insurer. Therefore, the complaint

The complainant submitted that he had made a representation to the Insurer seeking continuity of insurance cover in relation to the earlier insurance cover provided under Group Insurance Policy. The denial of 'continuity of insurance coverage' is against the policy conditions and legal principles. The repudiation of the claim is to be set aside

The insurer submitted that the Policy was issued w.e.f. 02-06-2011 noting Cataract as a pre-existing ailments/conditions. So. the claim relating to Cataract Surgery underwent by the wife of the complainant was rightly rejected under clause 4.1 of the policy conditions. Insurance cover under the earlier Group Mediclaim Policy was terminated w.e.f. 11-02-2011. So, there is a break of more than three months. As per clause 3.24, break upto seven days can only be condoned. In the above circumstances, complainant cannot claim the benefit of 'continuous insurance cover' based on the earlier Group Mediclaim Policy

Decision:- There was no insurance cover for the complainant and his wife under the Group Mediclaim Policy after 11-02-2011. Admittedly, the complainant had submitted a new proposal form for taking HOPE Policy. Policy schedule would reveal that as far as the complainant's wife is concerned, Hypertension and Cataract in both eyes are noted as pre-existing disease. Clause 3.24 states that break in insurance upto seven days may be condoned at the discretion of the Company and in such a case, the No Claim Bonus and Health Check-up benefits shall be unaffected. Admittedly, the new HOPE policy incepted on 02-06-2011 based on the proposal form submitted on 01-06-2011. Insurance cover under Group Policy expired/terminated on 11-02-2011. So, there is a break of more than three months. In such a situation, there is no question of deemed condonation of the break occasioned in taking HOPE policy on 02-06-2011. So, the complainant cannot claim 'Continuous Insurance Cover' based on the policy which was terminated on 11-02-2011. In the HOPE policy, a pre-existing condition is not covered for the first two years of insurance cover. The complainant cannot claim a benefit not provided under the policy conditions. In other words, he cannot claim a benefit beyond the policy conditions. As

the surgery underwent by the complainant's wife related to a pre-existing ailment and the claim arose in the first policy period, the claim is hit by clause 4.1/4.2 of the policy conditions. Repudiation of the claim is legal and proper. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-979/2011-12

C U Baby Jose

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/133/2013-14 dated 15.11.2013

Complainant's husband took Mediclaim policy from the Respondent-Insurer in 2000 with Sum Insured of Rs.1.25 Lakhs. He took additional policy in 2007 for Sum Insured of Rs.2.25 Lakhs. He had been renewing both the policies from time to time. He was taken ill and was admitted in various hospitals for treatment. Claims amounting to Rs. 9 Lakhs submitted were repudiated by the Insurer Therefore, the complaint.

The complainant submitted that Clause 4.1 of the policy conditions is not at all attracted as her husband was having insurance cover from 2000 onwards. Her husband was diagnosed with Carcinoma in October 2007 only. The diagnosis was after the inception of the Individual Health Insurance policy on 01.10.2007. So, Clause 4.1 is not attracted. It is not a pre-existing ailment. The entire claim amount subject to the Sum Insured may be allowed.

The insurer submitted that Individual Health Insurance policy which incepted on 01.10.2007 was based on a new proposal. It is not a renewal of the policy issued under Medi-Guard plan. So, it is a fresh policy issued under Individual health Insurance plan. Husband of the complainant was diagnosed with Carcinoma prior to 01.10.2007. So, as far as the policy which incepted on 01.10.2007 is concerned, Carcinoma is a pre-existing ailment. Therefore, Exclusion Clause 4.1 of the policy conditions is attracted.The repudiation of the claim is strictly based on the policy conditions. The claims which arose under Medi-Guard policies had been settled by them. No further amount is payable.

Decision:- The medical records would reveal that the husband of the complainant was treated for Metastatic Adenocarcinoma and other related ailments at different hospitals till he died on 07.06.2011 at Lourdes Hospital. Seeking reimbursement of hospital expenses met for his treatment, claims were submitted under the policies. Admittedly, first policy under Individual Health Insurance plan incepted on 01.10.2007. In the Medical Certificate by the attending Doctor issued from Department of Medical Oncology,

CMC, Vellore, there is mention in Column 12 relating to 'History of Illness' that the ailment was diagnosed in September/October 2007. So, the attending Doctor is not sure as to the advent of Metastatic Adenocarcinoma. That confusion is set at rest by the Certificate issued by Dr. Jacob George, Consultant Medical Oncologist attached to Medical Trust Hospital, Kochi. In that Certificate, the Doctor had stated that the complainant's husband had Adenocarcinoma with unknown primary in the month of October 2007. As stated elsewhere, first policy incepted on 01.10.2007. So, the diagnosis cannot be prior to 1st October 2007. The Certificate issued from CMC, Vellore relates to hospitalisation for the period from 06.07.2008 to 17.07.2008.

There is no medical evidence available before this Forum or with the Respondent-Insurer that the complainant's husband was treated for Adenocarcinoma prior to 06.07.2008. So, the first course of treatment taken by the husband of the complainant is for the period from 06.07.2008 to 17.07.2008 at CMC, Vellore. If actually the ailment was diagnosed in October 2007, quite naturally, there would have been treatment for the same prior to 06.07.2008. So, there is no positive evidence before this Forum that the ailment was diagnosed in October 2007 or earlier. If at all the husband of the complainant contracted the ailment in October 2007, it is not prior to the inception of the first policy on 01.10.2007. So, it is not a pre-existing ailment. The ailment was contracted after the inception of the first policy on 01.10.2007. Therefore, Clause 4.1 of the policy conditions is not attracted. The complainant is claiming continuous insurance cover under Medi-Guard policy atleast from 01.10.2005 onwards. A close reading of Clause 4.1 would reveal that what is needed is continuous insurance cover for 48 months. There is no mention in Clause 4.1 or in any of the policy provisions that continuity of insurance cover is confined to renewal of previous policies only. So, what is important is continuous insurance cover. When we go by that interpretation, there is evidence that the complainant was having continuous insurance cover from 01.10.2005 onwards. So, Individual Health Insurance policy from 01.10.2007 with Sum Insured of Rs.2.25 Lakhs can also claim continuity. If that be the case, the ailment contracted in 2007 was while the complainant's husband was having valid insurance cover. It is not a pre-existing disease. The embargo contained in Exclusion Clause 4.1 is not attracted in the case of the claims submitted in relation to treatment of the husband of the complainant. The repudiation of the claims under Clause 4.1 of the policy conditions cannot be sustained. In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.6,35,874/- with cost of Rs.5,000/- within the prescribed period, failing which, Rs.6,35,874/- shall carry interest at 9% per annum from the date of filing of the complaint (09.03.2012) till payment is effected.

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MUMBAI CENTRE

MEDICLAIM

Complaint No. GI-2016 of 2011-2012

Complainant: Shri Abhay Virkud
V/s
Respondent: Star Health & Allied Insurance Co. Ltd.,

Complainant, was covered along with his wife and son under the Family Health Optima Insurance of the Star Health & Allied Insurance Co.Ltd. The policy was valid for the period 8.9.2010 to 7.9.2011. Claim arose under the policy when the complainant got admitted to Bethany Hospital on 28.7.2011 with complaints of giddiness, headache, vomiting and altered sensorium. He was diagnosed to be a case of lone atrial fibrillation with cardioembolic stroke with right cerebellar infarct. The claim when lodged on the Company was denied by them under the ground of pre-existing diseases contending that the complainant was suffering from hypertension and heart ailments prior to the inception of the policy - one of the 2D Eco cardiogram dated 28.7.2011 showed old myocardial infarction and hence the illness was pre-existing.

During the hearing, the forum observed that the submitted papers did not show that the complainant was a known case of heart ailments though it was clear from the hospital papers that he was a known case of hypertension which was not disclosed by him. Hence the complainant was directed to submit the treatment papers of hypertension to the Company under information to the forum. He was also directed to submit 4-5 years of the policy coverage in the past.

The Company was directed to obtain an independent opinion from any leading cardiologist to confirm whether it was possible for the complainant to be unaware of the cardiac problems opined in the 2D Echo cardiograph of 28.7.2011 and also to obtain a definitive opinion as to whether the hypertension was the cause of his present problems for which he was admitted in the instant case. The Company vide their letter dated 16.1.2014 enclosed an opinion dated 10.1.2014 obtained from one Dr.Arunkumar Krishnaswamy and the same is reproduced here for better understanding: " …This records has been referred to me for the opinion regarding the chronicity of cardiac illness and hypertension in relation to present cardiac illness. According to available treatment records, it has been noted that the 2D Echo reports dated 28.7.2011, 5.8.2011 and 12.11.2011 are inconsistent and contrary to medical facts. Reason being, once scarred myocardial will not become normal. Left ventricular hypertropy never resolves within 15 days – one month. Over the present illness – lone atrial fibrillation with cardio embolic stroke with right cerebellar infarction, the cause could be due to long standing hypertension or old myocardial infarction. With all available medical evidence, hypertension is one among the important risk factor for coronary artery disease. Thus I strongly feel this patient has long standing heart illness…"

Whilst the doctor has commented that the ventricular hypertrophy would never resolve within 15-30 days and a scarred myocardial heart would never trace a normal report, the reason for a clear unqualified 2D echo cardiograph dated 12.11.2011 is left unaddressed. Nevertheless, the fact that the complainant was suffering from hypertension cannot be overlooked and could be the reason for ventricular hypertrophy.

In lone atrial fibrillation where the cause is often unclear, hypertension is stated to be one of the causative factors and unless all possibilities of underlying or concomitant reasons are ruled out, it cannot be called as a lone atrial fibrillation.

It is also noted from the submitted documents that the complainant has not disclosed about his hypertension in the proposal form at the time of taking the policy. It should be noted by him that all details regarding one's health condition, however insignificant it may seem needs to be disclosed to the insurer. It is their right to know for taking an informed decision.

Therefore in the facts and circumstances of the case, as there is sufficient evidence to conclude that the illness suffered by the complainant was triggered by his underlying condition of hypertension, which was pre-existing, the forum is constrained to uphold the decision of the Company.

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Complaint No. GI- 2360 of 2011-2012

Award No. IO/MUM/A/GI /2013-2014

Complainant : Shri Dattaram L. Bandekar

Respondent: United India Insurance Co. Ltd.

Shri was covered under Individual Mediclaim Policy bearing No. 120100/48/10/20/00007544 issued by United India Insurance Co. Ltd. for the period 21.9.2010 to 20.9.2011 for Sum Insured of Rs.75,000/- 45% CB. He suffered from chest pain as such underwent Angiography in Apex Hospital on 13.1.2011. Thereafter, he was hospitalized in Navjeevan Global Heart Center from 28.3.2011 to 30.3.2011 for the complaints of Ischaemic Heart Disease/Coronary Artery Disease and underwent Chelation Therapy. When he reported a claim for Rs.69,947/- towards the expenses incurred on the said treatments, Insurance Company rejected the claim stating that the expenses incurred on Chelation Therapy are not payable under the Policy. Being aggrieved complainant approached this Forum for redressal of his grievance.

The complainant submitted that he underwent Angiography procedure in Apex Hospital which revealed blockages in arteries; hence on the advices of a doctor, he was hospitalized in Navjeevan Global Heart Centre from 28.3.2011 to 30.3.2011 for Chelation Therapy. When he lodged a claim for Rs.69,000/- under the Policy, Company rejected the claim. He said that the decision of the Insurance Company is not acceptable to him as the same Insurance Company had earlier settled the claims in respect of similar treatment

taken in Navjeevan Global heart Centre. He submitted copies of the Claim Payment Statements in support of his contention.

Insurance Company submitted that the chelation therapy is not a scientifically proven treatment and it is also not FDA approved. Further, the information downloaded from Internet site states that this treatment is a combination of Naturopathy treatment and Allopathy Treatment. The claim lodged by the complainant was repudiated by them on the ground that Naturopathy treatment, acupressure, acupuncture, experiental and unproven treatments/therapies are excluded from the scope of the Policy. During hearing when the Company official was asked as to whether the Policy issued to the complainant has a specific clause to exclude Unproven, Alternative and Experimental Treatments, he replied in negative.

<u>Observations of the Forum</u> :

1) **The Individual Mediclaim Policy has an exclusion of "Naturopathy Treatment".**
2) **Although the Company & TPA Official contended that the treatment underwent by the complainant is an Unproven, Alternative and Experimental Treatment; but the policy issued to the complainant did not have express clause to exclude the same.**
3) **During hearing Complainant submitted copies of claim settlements done by United India in respect of treatments taken at Navjeevan Global Heart Center.**

Whilst denying the claim, Insurance Company invoked exclusion clause 4.13 of the Policy. Although, the Company has stated that the said clause excludes "Naturopathy treatment, acupressure, acupuncture, experimental and unproven treatment/thereapies", but on scrutiny of the policy document issued to the complainant, it is noted that the said exclusion clause speaks only about "Naturopathy treatment". Hence, during hearing, this Forum directed the Insurance Company to re-examine the case in the light of the said observations. Pursuant to hearing, vide their letter dated 11.3.2014, Insurance Company submitted their reply along with an opinion sought by them from their In-house Medical Officer Dr. Rupesh Avhale. In the said opinion it is stated as "..The said therapy, as per standard textbooks of Medicine, used by students studying MBBS (i.e. allopathic modality of treatment), like McGraw Hill Medical (International standard book number 0071488693), the chelation therapy is an approved therapy for the poisonings involving metals like acute mercury, iron, arsenic, lead, uranium, plutonium and other forms of toxic poisoning. However, the said therapy is being used by the modalities of alternative medicine as a non-standard treatment for some ailments, including heart disease and autism where the therapy is not approved. Hence, Food & Drug Administration dept., in 2010, warned various Companies for the production of such chelating agents (used during chelation therapy) due to lack of their proven efficacy. Now, alternative medicine includes Homeopathy, naturopathy, chiropractic, energy medicine & acupuncture. Also, Naturopathy or naturopathic medicine, is a form of alternative medicine based on a belief in vitalism, which posits that a special energy called vital energy or vital force guides bodily processes such as metabolism, reproduction, growth and adaption. The Naturopathy modality includes Chelation thereapy for Atherosclerosis (as mentioned in the standard allopathic textbook of medicine publication : Medscape, Name of the book: General Medicine, Volume 6)….Since there is a specific exclusion (cause No.4.13) which specifically excludes Naturopathy treatment in the policy issued to Mr. Bandekar, the said claim is not payable".

Naturopathy, or naturopathic medicine, is a pseudoscientific form of alternative medicine based on a belief in vitalism, which posits that a special energy called vital energy or vital force guides bodily processes such as metabolism, reproduction, growth, and adaptation. Naturopathy favors a holistic approach with non-invasive treatment and generally avoids the use of surgery and drugs. Practitioners of naturopathy often prefer methods of treatment that are not compatible with evidence-based medicine, and in doing so, reject the tenets of biomedicine and modern science. The particular modalities used by an individual naturopath varies with training and scope of practice. These include: Acupuncture, applied kinesiology, botanical medicine, brainwave entrainment, chelation therapy for atherosclerosis, colonic enemas, color therapy, cranial osteopathy, hair analysis, homeopathy, iridology, live blood analysis, *nature cures*—i.e. a range of therapies based upon exposure to natural elements such as sunshine, fresh air, heat, or cold, nutrition (examples include vegetarian and wholefood diet, fasting, and abstention from alcohol and sugar, ozone therapy, physical medicine (e.g., naturopathic, osseous, and soft tissue manipulative therapy, sports medicine, exercise, and hydrotherapy), Psychological counseling (e.g., meditation, relaxation, and other methods of stress management, public health measures and hygiene,http://en.wikipedia.org/wiki/Naturopathy - cite note-ECHP-25 reflexology, rolfing, and traditional Chinese medicine. (downloaded from internet site)

Thus, going by the information downloaded from the Internet Site as above, the contention of the Insurance Company that the treatment underwent by the complainant falls under "Naturopathy Treatment" cannot be totally set aside.

Not let us examine the medical literature available on Chelation Thereapy. Chelation therapy is a technique, used primarily in alternative medicine, which involves the administration of chelating agents to remove heavy metals from the body. Chelation therapy has a long history of use in clinical toxicology and remains in use for some very specific medical treatments, although it is administered under very careful medical supervision due to various inherent risks. The use of chelation as alternative therapy can prove fatal, and medical evidence does not support the effectiveness of chelation therapy for any other purpose than the treatment of heavy metal poisoning. Alternative medicine uses chelation therepy as a non-standard treatment for some ailments, including heart disease and autism. In 2010 the U.S. Food and Drug Administration (FDA) warned companies who sold over-the-counter (OTC) chelation products and stated that such "products are unapproved drugs and devices and that it is a violation of federal law to

make unproven claims about these products. There are no FDA-approved OTC chelation products. The use of EDTA chelation therapy as a treatment for coronary artery disease has not been shown to be effective and is not approved by the U.S. Food and Drug Administration (FDA). The American Heart Association states that there is "no scientific evidence to demonstrate any benefit from this form of therapy" and that the "United States Food and Drug Administration (FDA), the National Institutes of Health (NIH) and the American College of Cardiology all agree with the American Heart Association" that "there have been no adequate, controlled, published scientific studies using currently approved scientific methodology to support this therapy for cardiovascular disease."

From the analysis of the case made as above, it is clear that "Chelation Therapy" fits into the definition of unproven treatment and is an alternative therapy. Although it is noted that the policy issued to the complainant does not have an express clause to exclude "Unapproved/Unproven Treatments", but it should be appreciated that "Mediclaim Policy" is basically designed to cover the treatments which are approved by the appropriate authorities and the same does not envisage to cover unapproved treatments.

Considering the above facts, the forum do not find any reason to intervene in the decision of the Insurance Company to repudiation the claim in respect of Chelation treatment taken by the complainant from 28.3.2011 to 30.3.2011. Insurance Company however is advised to examine the documents pertaining to Angiography charges and if found to be in order, the Company to settle the expenses incurred on Angiography.

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Complaint No.GI-2294 of 2011-2012
Award No.IO/MUM/A/ GI /2013-2014
Complainant : Shri Rajkumar Charkha
Respondent : The Oriental Insurance Co. Ltd.

Complainant was covered under Individual Mediclaim Policy bearing No. 182100/48/2011/3423 issued by The Oriental Insurance Co. Ltd for the period 30.9.2010 to 20.9.2011 for Sum Insured of Rs.2,50,000/-. He was hospitalized in Kamalnayan Bajaj Hospital from 9.7.2011 to 11.7.2011 where he underwent PTCA/Stent to LAD, for which he received cash less facility of Rs.1,75,000/-. When complainant lodged a claim for Rs.69,622/- towards reimbursement of balance hospitalization expenses, M/s MDIndia Healthcare Services (TPA) Pvt. Ltd., TPA of the Insurance Company repudiated the same stating that applicable Sum Insured exhausted for the current year. Being aggrieved, complainant approached this Forum and sought compensation of Rs.69,622/- with costs

towards mental harassment & misc. expenses. The total expenses incurred were Rs.2,44,622/- out of which he received cash less facility of Rs.1,75,000/-. He stated that Insurance Company's decision to restrict the claim amount to Rs.1,75,000/- is not acceptable to him as he is covered under the Policy for Sum Insured of Rs.2.50 lacs. He further mentioned that in the year 2007, he underwent Angiography which revealed blockages in the arteries, but the same cannot be taken as heart ailment as normal person will also have some blockages. He also mentioned that had this been an ailment, the doctor would have advised him to go in for surgery at that point of time itself. Hence, he is entitled for full claim amount.

Insurance Company submitted that in the pre-authorisation form submitted by the Hospital, the duration of "Effort angina" has been mentioned since last 3-4 years. He said that the pre-authorisation form is also countersigned by the insured. He further mentioned that in the year 2007, insured underwent the procedure of Angiography for the complaints of heart ailment. He said that since the insured was suffering from the heart ailment since the year 2007, the claim amount is restricted to Rs.1,75,000/-. He mentioned that whenever the policy gets renewed for enhanced Sum Insured, then the additional Sum Insured becomes a fresh contract and is subject to exclusion of pre-existing ailment clause. In the instant case, since the additional Sum Insured which was increased after the year 2007 has not completed four years, the claim amount is restricted to Rs.1,75,000/-.

All the documents submitted to the Forum have been scrutinized. It is seen that Shri. Charkha was insured under the Policy issued for the period 30.9.2006 to 29.9.2007 for Sum Insured of Rs.1,75,000/-. In the year next year, i.e. under the Policy issued for the period 30.9.2007 to 29.9.2008, the Sum Insured was increased to Rs.2,00,000/- and again under the Policy issued for the period 30.9.2009 to 29.9.2010, the Sum Insured was raised to Rs.2,50,000/- and the same Sum Insured was continued for the period 30.9.2010 to 29.9.2011.

Let us examine the case, the complainant was admitted to Kamalnayan Bajaj Hospital on 9.7.2011 with complaints of Dyspnoea on exertion and chest pain. The discharge card of the Hospital states that he is a k/c/o DM/HTN/IHD. Shri. Charkha was diagnosed a case of – "DM, IHD-CSA, CAD – LAD 95% RCA 60%". He underwent PTCA (Stent to LAD done). The claim in respect of this hospitalisation has been restricted by the Company to Rs.1,75,000/- which was the maximum Sum Insured available under the Policy issued for the year 30.9.2006-07. The balance claim of Rs.69,622/- has been denied by the Company under exclusion clause 4.1 of the Policy based on the history recorded in the Pre-authorization form submitted to the TPA for the purpose of availing Cash less facility. In the said form, against the duration of presenting complaints, it is stated as "Effort Angina 3-4 years". Company took a stand that increased Sum Insured of Rs.2.50 lacs would not be available for the present claim as complainant had history of Effort Angina of 3-4 years which has been recorded in the pre-authorisation form filled in by the Hospital and countersigned by the complainant. Complainant however contended that he was not suffering from heart ailment prior this hospitalisation since the blockages observed in the Angiography Test done in the year 2007 were of insignificant nature, Tread Mill Test was negative and no immediate angioplasty was required at that time.

On scrutiny of the copy of pre-authorisation form it is not proved for certain since how long the complainant was suffering from Effort Angina as the history of the same is

noted as "3-4 years". If we go by 4 yrs history noting, the history falls under the policy period 30.9.2006-07 where the Sum Insured was Rs.1.75 lacs and if we consider the history of 3 yrs, then it falls under the policy period 30.9.2007-08 where the Sum Insured was Rs.2.00 lacs. Thus, in absence of confirmed history, to meet the ends of justice, it would be appropriate to go by the actual medical records made available to the Forum. Let us examine the Discharge Card summaries of the year 2007. Shri. Charkha was admitted to Aaditya Bal Raugnalaya & Critical Care Centre on 29.10.2007 with complaints of chest pain since 2 hours in Lt. Precordium, chest discomfort off & on while walking. His ECG reading was – WNL and the diagnosis was ?IHD. He was advised to undergo Stress Test & CT Angiography and to continue Insulin Inj. (Mixtard), Tab.
Cardace & Tab. GP2. The MSCT was done on 31.10.2007 and the Bruce Stress Test was done on 24th November, 2007. Thereafter, on 13.12.2007 complainant was hospitalized in Manik Hospital & Research Centre, where he underwent Coronary Angiography and was diagnosed to have "DM, IHD – CSA, CAD – LAD 70%, RCA 40%, Good LV function". The Bruce Stress Test was also done on 1.9.2008.

From the medical papers as examined above, it is quite clear that complainant was first admitted to the hospital on 29.10.2007 with the complaints of chest pain with no previous history of heart ailment. The said hospitalisation falls under the policy period 30.9.2007 to 29.9.2008 where the Sum Insured for Mr. Charkha was Rs.2,00,000/-. Considering this fact, the decision of the Insurance Company to restrict the claim amount to Rs.1,75,000/- is not correct and hence not acceptable to the Forum.

Now, let us see whether the complainant was entitled for a full Sum Insured of Rs.2,50,000/-. The examination of clinical papers makes it clear that the complainant had chest pain for the first time on 29.10.2007, for which he underwent various tests viz. Stress Test, Cardiac MSCT, Coronary Angiography. The MSCT Report revealed "Mild to moderate areas of narrowing in the proximal and mid LAD, Proximal RCA and proximal PDA". Whilst the Bruce Test done on 24.11.2007 turned out to be negative, but the Coronary Angiography done thereafter on 13.12.2007 revealed – "LAD : Type III, 70% stenosis in proximal LAD after D1. RCA : Dominant 40% plaque in mid RCA. PDA – Small artery. Has a 50% proximal plaque."

Although the complainant has contended that he was not suffering from the heart disease in the year 2007 since the Bruce Test was negative but the diagnosis of Manik Hospital is noteworthy. Angiography revealed ""LAD : Type III, 70% stenosis in proximal LAD after D1. RCA : Dominant 40% plaque in mid RCA. PDA – Small artery. Has a 50% proximal plaque" and he was diagnosed to have DM, IHD – CSA, CAD. It should be noted that a Coronary Angiogram is the "gold standard" for the evaluation of coronary artery disease (CAD), which can be used to identify the exact location and severity of CAD . Further, the discharge summary has a mention " k/c/o DM - continue Insulin Inj. Tab (Mixtard), Cardace 2.5 mg". Thus, going by the medical papers of the year 2007 one would be tempted to conclude that some of the medicines were being taken by the complainant as Diabetic drugs even before the admission in the hospital in the year 2007 and it is a well-known fact that diabetes is one of the major risk factors to cause Heart Disease.

The Angiography done in the present hospitalization revealed that – LAD Type III 95% proximal stenosis. The diagnosis was "DM, IHD-CSA, CAD – LAD -95% RCA 60% for which PTCA/Stent to LAD was done. Coronary artery disease (CAD) is characterized by atherosclerosis in the epicardial coronary arteries. Atherosclerotic plaques, the hallmark of atherosclerosis, progressively narrow the coronary artery lumen and impair antegrade myocardial blood flow. It is a fact that the process of stenosis is a slow process. In the instant case the complainant was a diagnosed case of 70% stenosis in LAD in the year 2007 itself and the same Left Anterior Descending coronary artery (LAD) which had 70% stenosis has developed to a stage of 95% stenosis in the year 2011. Whilst the PTCA surgery was required to be done after 4 years, but the very fact that he had history of IHD, CAD - 70% Stenosis in LAD implies that he was suffering from the heart ailment since the year 2007 and moreover in the discharge card of the hospital it is clearly mentioned that he was a k/c/o DM/HTN/IHD.

It should be noted that when the increase in Sum Insured is effected, the increased sum insured becomes a fresh contract and any ailment pre-existing prior to it becomes pre-existing ailment as per general exclusion 4.1 of the policy. Under the present claim, from the hospital papers, it is very clear that Mr. Charkha was suffering from the heart ailment since October, 2007, it becomes pre-existing for the Sum Insured of Rs.2.50 lacs which was enhanced on 30.9.2009.

Considering the above facts, the decision of the Company to restrict the claim amount to Rs.1.75 lacs is not sustainable. However, since the complainant was diagnosed to have IHD, CAD in the month of October, 2007, i.e. after inception of the Policy issued for the year 30.9.2007-08, he is entitled for reimbursement of expenses upto the limit of Rs.2,00,000/-.

The decision of the Insurance Company is thus intervened by the following order.

The Oriental Insurance Company is directed to pay Rs.25,000/- to the complainant, the balance claim amount in respect of his hospitalisation in in Kamalnayan Bajaj Hospital from 9.7.2011 to 11.7.2011 for PTCA/Stent to LAD.

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Complaint Nos.GI-1506 of 2011-2012

Award No.IO/MUM/A/GI /2013-2014

Complainant : Shri Chetan M. Parekh

Respondent : National Insurance Co. Ltd.

The son of the complainant was covered under Mediclaim Policy bearing No.260500/48/10/8500002465 issued by National Insurance Co. Ltd. for the period 24.9.2010 to 23.9.2011 for bifurcated Sum Insured of Rs.50,000/- (Rs.25,000/- CB), Rs.25,000/- (3,750/- CB), Rs.25,000/- (Rs.2,500/- CB) & Rs.50,000/- (Rs.2,500/- CB). Shri. Kumar underwent Wavefront guided bladeless Femto-LASIK LE surgery in Samyak Drishti Eye Centre on 29.4.2011. When complainant lodged a claim for Rs.53,500/- under the

Policy, Insurance Company invoked clause 4.6 of the Policy and repudiated the claim stating that treatment for correction of eye sight is not payable under the Policy. Not satisfied with this decision, when complainant represented to the Company, he did not get any reply from them. Being aggrieved he approached this Forum and sought compensation of Rs.53,500/-.

The complainant stated that the decision of the TPA is not acceptable to him as the surgery was neither done for correction of refractive error nor it was done for cosmetic purpose. He said that his son developed squint prior to surgery and hence was not feeling comfortable whilst reading, he had frequent headaches & vision imbalance and hence the operation was done only for improving the vision. He further mentioned that the LASIK is the only treatment available to treat various problems his son was suffering as listed in the discharge card of the hospital.

Insurance Company submitted that the claim has been repudiated under clause 4.6 of the policy which states that surgery for correction of eye sight is not payable under the Policy.

When the Company official was asked as to whether the Company intends to exclude all the eye surgeries from the scope of the Policy under exclusion "correction of eye sight", she could not give any satisfactory reply.

Hence, the Company official was directed to provide their explanation on the following points to this Forum, within a period of 7 working days : 1) Vide exclusion 4.6, policy excludes surgery for correction of eye sight. What is the definition of "correction of eye sight"? What the Company intends to exclude under "surgery for correction of eye sight"? Provide the list of treatments included and excluded under "surgery for correction of eye sight", 2) What are the eye surgeries payable under the Policy, in the light of exclusion 4.6, 3) Company to revisit the case in the light of - problems suffered by the insured prior to surgery as listed in the medical papers based on their replies to the queries raised as above and inform their decision to this Forum within a period of 7 working days

In response, on 5th August, 2013 Company submitted their reply as under :-

1) **The key treatments covered under Mediclaim Policy are – Keratoplasty, Cataract, Buckle Extrusion, Collagen Cross Linking, Corneal Transplant, Entropion, Extropion, Intravitreal Injection, Corneal repair/wound with conjuctival flap, Retinal repair, Sceral repair, Silicon Oil repair, Vitrectomy, Yagcapsulectomy, Dacryocystorhinostomy, Manipulation of Lachrymal damage, Operation for Pterigium, Removal of deeply embedded foreign body from cornea with incision, removal of foreign body from lens, removal of foreign body from posterior chamber of eye, repair of canaliculus punctum, Repair of post operative wound dehiscence of cornea, Penetrative or Non-penetrative surgery for treatment for Glaucoma, Corrective surgery for blepharoptosis when not congenital/cosmetic.**

   The treatments not included in the policy – 1) Correction of Refractive Error, Surgery for Myopia and Hypermetropia, 2) Any surgery for correction of vision, 3) Any surgery undergone for cosmetic purposes.

2) **As per list given above.**
3) **The surgery undergone by Master Chetan Parekh falls under both 1 & 3 of the**

excluded list. Hence we find that repudiation was in order.

Post rejection of claim, complainant submitted another certificate from the treating doctor wherein it is stated as – "..Only one eye has been operated for a Therapeutic correction and not a cosmetic correction. In cases of such imbalance, this is the only treatment option to correct the anisometropia and therefore correct the amblyopia and squint…"

Insurance Company has also sought an opinion from Dr. Jugal Shah, Opthalmologist. The extract of which is reproduced below :

Queries raised by the TPA	Replies of the doctor
Whether it is a cosmetic surgery?	Yes it may be cosmetic surgery.
It is surgery for correction of eye sight?	It is for correction of eyesight.
As said above there are 10 diagnosis written, whether we can call in short for all Squint rather than divided into many diagnosis?	It is amblyopia (lazy eye) with Squint.
Squint correction is cosmetic surgery?	It is NOT a squint surgery.
Squint can happen since childhood?	It is most probably would be since childhood.
Can you say this is not treatment for correction of eye sight.	Point No.2 for eyesight.

Let us examine the case. In the instant case, complainant's son had left eye Myopia, Astigmatism, Anisometropia, left eye Anisometropic amblyopia, for which the LASIK surgery was done. A diagnosis of spectacle intolerance due to astigmatism was also made. Anisometropia refers to the situation where there are unequal refractive errors between the both eyes. Although, the medical papers submitted to the Forum has indicated that Shri. Parekh had Anisometropia, but the details about refractive errors of both the eyes i.e. left & right eye prior to the surgery are not made known to the Forum. Company/TPA did not even bother to collect these details from the complainant. Under the circumstances, this Forum has no option but to go by the medical records available with the Forum.

Vision correction refers to one of several methods used to improve blurred vision caused by refractive error. Myopia, Hyperopia, Presbyopia and Astigmatism are the most common refractive errors, the common symptoms of which are blurred vision, double vision, haziness, squinting or eye strain. In the instant case, Shri. Parekh was suffering from refractive errors, for which he underwent LASIK surgery. However, since the Policy issued to the complainant has a specific exclusion clause which empowers the Company to exclude the expenses incurred on "Correction of Eyesight", the decision of the Company to reject the claim appears to be technically correct.

However, I would like to go deep into the crux of the real issues. I strongly feel that the exclusion clause 4.6. as incorporated by the Insurance Company in the Policy wording is too vague. The Insurance Company has not defined the term "correction of eye sight". Generally all the eye surgeries are performed for the correction of eye sight. Hence, it is not known as to what the Company intends to exclude under "surgery for

correction of eye sight". Whether, Company intends to exclude all the eye surgeries except arising out of an accident? When this Forum directed the Company to provide their explanation on this issue, Company submitted a list of 24 eye treatments covered under Mediclaim Policy with a list of eye treatments which are not included in the policy. Company has mentioned that the correction of Refractive errors is not payable under the Policy. However, the fact remains that high myopia is one of the risk factors to cause the disorders like Cataract, Retinal detachments, Glaucoma. Hence, the basis and the logic for covering only these 24 eye treatments is not known to the Forum as the details of which has not been provided by the Company. Further, the list given by the Company may not be exhaustive. The next question that comes to my mind is whether these details have been made known to the policyholders? If their intention was to specifically exclude – correction of refractive errors, surgery for myopia and hypermetropia then the same should have been clearly spelt out in their policy conditions. The terms and conditions attached to the Policy document should be very specific and it should not mislead or be likely to mislead by ambiguity. By simply mentioning "correction of eye sight" is not payable under the Policy, it would be highly inappropriate on the part of the Company to decide at a later stage, especially when the claim arises, as to what treatment they would pay & exclude from the scope of the Policy. It is strongly felt that there is indeed an ambiguity in the exclusion 4.6 of the policy leaving scope for interpretation.

There is no doubt that LASIK can eliminate a lifetime dependence on glasses and contact lenses. However, in the instant case it is felt that Shri. Parekh underwent the surgery to correct astigmatism, Anisometropic emblyopia in left eye. Further, he was diagnosed to have Binocular imbalance and spectacle intolerance, hence to term the surgery purely for cosmetic purpose would also be a little harsh as intolerance day in and out with serious vision problem, headache and other complications cannot be forced upon a person, hence he has resorted to LASIK surgery. Moreover, the doctor to whom the Company referred the case also has not conclusively opined that the surgery underwent by Shri. Parekh was indeed a cosmetic surgery. Hence, the surgery underwent by Shri. Parekh could be taken as corrective surgery and not a cosmetic one. Considering these facts and also the ambiguities in the policy wording as pointed out above, the forum is inclined to give relief to the complainant by awarding a part of the claim on Ex-gratia basis.

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Complaint No. GI-1910 of 2011-2012

Award No. IO/MUM/A/ GI /2013-2014

Complainant : Shri Aftab S. Harianawala

Respondent : The New India Assurance Co. Ltd.

Award dated : 12/2013

Complainant was insured under Mediclaim policy (2007) bearing No. 111100/34/09/11/00009522 issued by The New India Assurance Co. Ltd. for the period 7.1.2010 to 6.1.2011 for Sum Insured of Rs. 2,50,000/-. Complainant underwent CABG (Coronary Artery By-pass Graft) x 2 Grafts in Asian Heart Institute where he was hospitalized from 14.3.2010 to 21.3.2010. When complainant reported a claim for 3,49,789/- under the Policy, MDIndia Healthcare Services (TPA) Pvt. Ltd., TPA of the Insurance Company settled the same only for Rs.1,25,000/- stating that as per policy condition for pre-existing DM (for which loading was paid in premium), claim amount is restricted to 50% of the Sum Insured. Not satisfied with the disallowance of balance claim amount, complainant represented to the TPA and the Insurance Company for re-consideration of balance claim. Being aggrieved complainant approached this Forum for redressal of his grievance.

Complaiannt said that for this hospitalisation when he lodged a claim for Rs.3,49,789/- under the Policy, TPA settled his claim for Rs.1,25,000/- only on the ground of pre-existence of his DM. He said that even non-diabetic person can get a heart attack, hence disallowance of claim amount on the ground that IHD is the complication of DM is not correct. He also made a reference to his earlier complaint (No.797/2009-10) and said that he was reimbursed full claim amount at that time.

Insurance Company submitted that the hospital papers indicate that the insured is suffering from pre-existing DM, for which he is paying a loading in premium. As per Policy exclusion 4.1 & definition of Pre-existing Disease/Condition, if the claim is reported on the third year of the policy for the pre-existing DM & its complications, 50% of the admissible claim becomes payable under the Policy. He said that in the instant case since the insured had history of pre-existing DM, his claim has been settled by their TPA for Rs.1,25,000/- (50% of Sum Insured).

During hearing, Insurance Company representative submitted a copy of write-up on the complications of DM, a copy of the same was also provided to the complainant. Post hearing, complainant vide his letter dated 19th November, 2013 submitted his comments on the write-up submitted by the Company.

As regards the Insurance coverage of the complainant is concerned, it is noted that his policy was incepted on 7.1.2008 and the same has been continuously renewed thereafter. The instant claim has been lodged under third year of the policy i.e. the policy issued for the period 7.1.2010 to 6.1.2011 for Sum Insured of Rs.2,50,000/-. The claim reported by the complainant in respect of the above hospitlaisation has been restricted by

the Company to Rs.1,25,000/- on the ground that the ailment suffered by the complainant is the complication of DM which he is suffering since last 29 years and which is pre-existing to their policy. Whilst deciding the claim, Company relied on exclusion clause 4.1 of the Policy.

Complainant pointed out that prior to this hospitalisation, he underwent PTCA in Jaslok Hospital in the year April, 2009 and the claim for this hospitalisation also had been initially repudiated by the Company on the ground of pre-existence of HTN & DM; however on the intervention of the Ombudsman, the said claim had been fully reimbursed to him.

The analysis of the records submitted to this Forum would reveal that the complainant has past history of Diabetes Mellitus since 29 years. While granting the cover under the Policy to the complainant, on the face of the policy document, Insurance Company mentioned "Diabetes" as Pre-existing Disease and for coverage of the said condition, complainant had paid loading in premium. However, policy exclusion clause 4.1 states that – "…On payment of additional premium, which is compulsory for persons suffering from the pre-existing conditions of Diabetes and Hypertension, these specific pre-existing conditions only are covered in the following manner – 1st year : No claim, 2nd year : No claim, 3rd year : 50% of the admissible claim or 50% of the Sum Insured set for the individual, whichever is less". Further, the Pre-existing Disease/Condition is defined under the Policy as – "any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment, within 48 months prior to his/her first policy with us". In the instant case medical papers on record clearly indicates that complainant was suffering from Diabetes since 29 years and further he was insulin dependent. Hospital Bill has a mention that the complainant was charged Rs.2,37,000/- towards "CABG + Diabetic - Procedure Charges".

Diabetes has been identified as an independent and major risk factor for the development of Coronary Artery disease. In the instant case, as per hospital records, the complainant was suffering from Diabetes Mellitus and that too since 29 years. Although there is no dispute that the complainant had disclosed his diabetic condition before taking a policy from New India and he has been paying loading premium for coverage of the said condition, but as per policy clause 4.1, Insurance Company is liable to pay only 50% of the admissible claim amount. Accordingly the Insurance Company has settled the claim for Rs.1,25,000/-. Since the Company's decision is based on policy clause 4.1, the same is found to be in order. Hence, the forum do not find any reason to intervene in their decision.

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Complaint No. GI-1247 of 2012-2013
Award No. IO/MUM/A/ GI/ /2013-2014
Complainant : Shri. N.C. Aurangabadwala
Respondent : The New India Assurance Company Ltd.
Award dated 01/2014

The complainant, along with his wife was covered under New India's Staff Mediclaim Policy for the period 2012-2013 for Sum Insured of Rs.3,00,000/- each. Complainant's wife was hospitalised in Matangi Nursing Home from 17.8.2012 to 22.8.2012 for the treatment of Viral Fever with Gastritis. When complainant submitted a claim for Rs.25,869/- to the Insurance Company, they requested him to furnish his clarification on the various queries raised to him. Based on the clarifications & documents submitted by the complainant and Investigator's report, Insurance Company repudiated the claim stating that there was no justification for admission to hospital nor have any explanation been offered for various discrepancies noted in the submitted papers. When complainant represented to the Grievance Cell of the Insurance Company for reconsideration of his claim, he did not receive any reply from them. Being aggrieved, complainant approached this Forum for redressal of his grievance. The complainant submitted that his wife suddenly started vomiting continuously and hence he telephonically contacted Dr. Kunde, who telephonically advised him get his wife admitted in the hospital immediately. Accordingly, his wife was admitted to Matangi Hospital on 17.8.2012 itself and she was discharged from the Hospital on 22.8.2012. He said that when he lodged a claim under the Policy, Insurance Company repudiated the same giving various reasons viz. bills are not proper, hospitalisation was not required etc.

Insurance Company submitted that complainant's wife is covered under Staff Mediclaim Insurance Scheme. He said that on scrutinity of the claim papers, their office noted various discrepancies. The Hospital papers states that Dr. Kunde has visited the hospital only on 17.8.2012 and 20.8.2012, whereas the bill issued by Dr. Kunde on his letterhead stated that he visited the hospital from 17.8.2012 to 22.8.2012. Although Dr. Kunde is not attached to the hospital, he has signed the discharge card of the hospital. Insurance company further mentioned that the medicines given during hospitalisation were routine medicines prescribed by General Physician. Further, the investigations done during hospitalisation were turned out to be normal. He also said that the patient was admitted in the hospital on the telephonic advices of the doctor; whereas their policy strictly states that claim under the policy becomes payable only when the patient is admitted in the hospital on the written advice of the doctor. He stated that before taking a final decision in the matter, their Office had appointed an investigator to check the genuineness of the bills submitted by Dr. Kunde. Their Investigator was also of the view that the hospitalisation was not required. Shri. Bose mentioned that the claim has been rejected by them on the ground that hospitalisation was not warranted and also there was an attempt by the insured to convert the domiciliary treatment into hospitalisation claim. During hearing Shri.

During hearing the Company representative was asked to explain :

- **Whether they have got any documentary evidence to indicate that there was an attempt by the complainant to convert domiciliary treatment into hospitalisation claim and hospitalisation was not necessary.**
- **Whether their investigator has checked whether the hospital has a room having rent of Rs.2,000/-.**
- **Whether the patient was really admitted in the hospital or not?**
- **The hospital has given explanation that Dr. Kunde visited the hospital on all the six days. If this explanation is not acceptable to the Company, then whether they have got any evidence to contradict the contention of the hospital.**

To all the above questions, company replied that patient was in fact admitted in the hospital and they do not have any doubts about it. However, looking to the medicines given during hospitlaisaiton and the discrepancies noted by them, their Office came to the conclusion that there was an attempt by the complainant to convert domiciliary treatment into hospitalisation claim.

During hearing Insurance Company was directed to submit their explanation on the following issues :

- **To check whether the said hospital has a room having rent of Rs.2,000/-.**
- **The hospital has given explanation that Dr. Kunde visited the hospital on all the six days. If this explanation is not acceptable to the Company, to submit appropriate documentary evidence to contradict this statement.**

In response, Company filed their reply vide letter dated 26th December, 2013.

. Although, Insurance Company has accepted that the patient was in fact admitted to the Hospital but they are of the strong opinion that there was an attempt by the insured to convert the domiciliary treatment into hospitalisation claim and there is no justification for admission in hospital for 6 days. Insurance Co. pointed out the following discrepancies/observations in support of their stand :

- **Without physical examination, the patient was admitted in the hospital on the telephonic advices of the doctor.**
- **Hospitalisation was not warranted and the treatment could have been possible on OPD basis as - the temperature of the patient varied between 98f to 101f, all the investigation reports were normal and the medicines given to the patient were normal medicines generally recommended by the family physician.**
- **No noting of severity of the condition of the patient is mentioned in the discharge card and indoor case papers.**
- **Although Dr. Arvind Kunde was not attached to the hospital, he signed the discharge card of the hospital.**
- **Bill of Matangi Hospital does not bear any stamp of the hospital.**
- **Consultation charges of Rs.6,000/- of Dr. Kunde have not been included in the main hospital bill; doctor has raised separate bill for the said amount on his letterhead.**
- **As per hospital papers, Dr. Kunde had visited the hospital only on 17.8.2012 and 20.8.2012; however the bill raised by him is for his visits to Hospital from 17.8.2012 to 22.8.2012.**

Complainant however submitted clarification from Dr. Kunde as under : "Mrs. Vimala N. Aurangabadwalla was admitted under my care in Matangi Nursing Home on

17.8.2012 due to persistent vomiting, fever. She did not respond to oral therapy which was suggested by me on phone. In view of age 63, creatinine – kidney function in dehydrated condition will deteriorate hence IV fluids and antibiotics for vomiting was absolutely essential to prevent complication; hence admission was done…".

Dr. Mahesh Doshi of Matangi Nursing Home clarified as : "Mrs. Vimala Aurangabadwalla has varying temperatures along with vomiting during her stay (one of common indication of PUO for admission for investigation and observation in elderly persons) and hence she was admitted on 17.8.2011. Dr. Arvind Kunde has visited all days and put his remarks wherever required on indoor papers (copy of which was given to the patient for mediclaim at time of discharge) and I accept responsibility of my nursing staff for lapse on their part of not making appropriate entries on admission papers….Discharge cards of the patients in ALL open nursing homes are filled with discharge advised and signed by respective consultants under whom they are admitted, hence Dr. Kunde has signed the discharge card. All indoor papers of Mrs. Vimala Aurangabadwalla were shown to your investigating officer when he visited nursing home on 14.9.2012…".

Company however refused to accept the clarifications given by the respective doctors stating that post facto clarifications cannot be considered for justifying hospitalisation. As regards clarification of Dr. Kunde Company stated that without examining and ascertaining the condition of a patient, how could he decide for admission to hospital assuming that her kidney function in dehydrated condition will deteriorate. Company also stated that on their visit to the hospital for verification of room rent details, the hospital authorities refused to hand over a copy of the rate chart and Dr. Doshi stated that they do not have a standard list and the charges are decided when other doctors are invited to attend the patient and it is the attending doctor who decides the charges.

Let us examine the case. Smt. Vimala was admitted to Matangi Nursing Home on 17.8.2012 on the telephonic advice of a doctor. Although, the policy under which Smt. Vimala was insured states that a person should be hosptalised on a written advice of a qualified doctor, but this may not be possible in each and every case. In case of an emergency, a person needs to be shifted to the hospital immediately without consulting a physician/doctor and waiting for his written advice. However, such an emergency has to be recorded in the hospital papers. In the instant case, although Dr. Doshi has stated that Smt. Vimala was admitted to the hospital in an emergency condition and the complainant during hearing stated that his wife was suffering from persistent vomiting prior to admission in the hospital, but these presenting complaints have not been clearly recorded in the discharge card and indoor case papers of the hospital. Mere mention of Vomiting + does not prove the emergency condition of the patient. During hospitalisation, complainant admitted that his wife did not take any medication prior to her admission in the hospital, whereas Dr. Kunde in his letter has stated that since the patient did not respond to oral therapy which was suggested by him over phone, she was required to be hospitalized. Thus, an obvious discrepancy is noted in the statements given by the complainant and the treating doctor.

Further, Smt. Vimala had fever only for two days i.e. on 17th & 18th August, 2012 and that too her temperature was between 100 to 101f. She had complaints of vomiting upto 20.8.2012 only. Bill of Matangi Hospital does not bear any stamp of the hospital. In the indoor case papers it is stated that Dr. Kunde had visited the hospital only on 17.8.2012 and 20.8.2012 whereas the bill raised by him is for his to Hospital from

17.8.2012 to 22.8.2012. Thus, this Forum agrees with the Company's contention that there are in fact various discrepancies in the medical papers submitted by the complainant.

Nevertheless, this Forum also notes that Smt. Vimala aged 63 years was admitted to the hospital at 11.00 p.m. and the Company has no doubts about her admission in the hospital. Further, during hospitalisation, she was administered IV fluids and injection Monocef (IV). As regards the line of treatment to be given during hospitalisation, doctor is the best judge to decide about it. To this extent, the need for hospitalisation is justified and hence the total rejection of claim is not proper.

Hence, to strike a reasonable balance and to resolve the dispute under the present complaint it would be in order to settle the claim for the 50% of the admissible expenses.

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Complaint No. GI-1074 of 2012-13
Award No. IO/MUM/A/GI /2013-2014
Complainant : Shri. Prashant B. Jain
Respondent : United India Insurance Co.Ltd

complainant who was covered under Health Insurance Policy – 2009 bearing No. 020500/48/10/97/00010310 issued by United India Insurance Co. Ltd. for the period 13.3.2011 to 12.3.2012 for Sum Insured of Rs.2,50,000/- was hospitalized in Lilavati Hospital from 26.12.2011 to 30.12.2011 for the complaints of ACL Tear. When he lodged claim for Rs.1,37,197/- under the Policy, M/s Heritage Health TPA Pvt. Ltd. , TPA of the Insurance Company settled the same for Rs.1,18,707/-. Not satisfied with the disallowance of balance claim, when complainant represented to the Insurance Company, they upheld TPA's decision. Being aggrieved complainant approached this Forum for redressal of his grievance.

Complainant was submitted that he was hospitalized in Lilavati Hospital 26.12.2011 to 30.12.2011 for the treatment of ACL Tear, for which he lodged a claim of Rs.1,37,198/- under the Policy. He said that the said claim has been settled by the Company for Rs.1,18,707/- after disallowing an amount of Rs.18,491/-.

Insurance Company was stated that they have settled the claim of the Insured for Rs.1,18,707/-.

The complaint was regarding deduction of Rs.18,491/-, the details of which are as follows:

Let us examine if the same are sustainable.

Sr.No	Description	Amount claimed in Rs	Amount deducted in Rs	Remarks
1	Surgeon's fees	57500	15,000	Based on the rate list of the Hospital. It was noted that Company restricted the Surgeon's fees based on the rate chart of the Hospital. However, the surgeon's fees was restricted taken into account the fees which was applicable to TPA Patients. In the instant case, complainant footed the bill of the Hospital as he did not receive cash less facility. Further, TPA admitted that Lilavati Hospital is not their PPN Hospital. Hence, the charges applicable to the Self-payee patient should be allowed to the complainant i.e. "As agreed between the Doctor & Patient". Hence, Company's stand to disallow an amount of Rs.15,000/- is not sustainable. Company to consider Rs.15000
2	Mask, Tegaderm, Knee Brace	1146	1146	Non-medical expenses Not sustainable as part of medical treatment. Company to consider Rs.1146
3	Registration & Miscellaneous charges	100	100	Non-medical expenses. Company's stand is sustainable.
4	Improper Bill	1300	1300	Improper bills. Not sustainable. Since the expenses were actually incurred on the consultation of the doctor. Company to consider Rs.1300
5	Camera cover, DVD	580	580	Non-medical expenses. Company's stand is sustainable.
6	Pack charges	165	165	Non-medical item. Not sustainable. Since the

				expenses were actually incurred on the treatment. Company to consider Rs.165
7	**Blanket**	**200**	**200**	**Non-medical expenses. Company's stand is sustainable.**

Company to pay Rs.17,611/- to the complainant towards his balance claim within a period of 10 working days.

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Complaint No. GI-1970 of 2011-2012
Award No. IO/MUM/A/GI /2013-2014
Complainant : Shri. Ganesh Palande
Respondent : The New India Assurance Co. Ltd.

Award dated 01/2014

Complainant's father of the complainant was insured with The New India Assurance Co. Ltd. under Mediclaim Policy(2007) bearing no. 111900/34/09/11/00010602 which was issued for the period 8.3.2010 to 7.3.2011 for bifurcated Sum Insured of Rs.50,000/- 5% CB & Rs.50,000/- 5% CB. Shri. Parshuram Palande was hospitalized in Anand Maternity & Nursing Home from 4.3.2011 to 12.3.2011 where he was diagnosed to have CVA in k/c/o DM + HTN + CVA in past with IT fracture of Rt. Femur. When Shri. Palande preferred a claim for Rs.1,02,826/- under the Policy, M/s MDIndia Healthcare Services (TPA) Pvt. Ltd., TPA of the Insurance Company restricted the claim amount to the basic Sum Insured of Rs.50,000/- based on the pre-existence of DM. Not convinced with the disallowance of balance claim, when complainant took up the matter with the Insurance Company they upheld TPA's decision by stating that claim amount is restricted to Sum Insured of Rs.50,000/- as the ailment suffered by the insured is a complication of Hypertension which has a waiting period of 2 years. Being aggrieved complainant approached this Forum for redressal of his grievance.

Insurance Company submitted that insured is on their books since 1990 with Sum Insured of Rs.50,000/-. The Sum Insured had been increased to Rs.1,00,000/- in the year 2008. He said that insured lodged a claim for Rs.1,02,826/- under the Policy for his hospitalisation in Anand Maternity Nursing Home from 4.3.2011 to 12.3.2011. Dr. Trupti said that the hospital papers indicated that insured was a diagnosed case of Cerebrovascular Accident and also had history of DM of 10 years and HTN since two years. During hospitalisation he had a fall and in the hospital he was treated both for CVA and fracture. Dr. Trupti further mentioned that DM & HTN are the risk factors to cause CVA and CVA patients are more prone to imbalance whilst walking and in the instant case patient had a fall during hospitalisation. Considering the fact that the fracture has

resulted due his condition of CVA and CVA in turn is a complication of pre-existing DM & HTN, his claim has been restricted to the original Sum Insured of Rs. 50,000/-.

During hearing when the Company/TPA doctor was asked – On what basis the Company/TPA has arrived at a conclusion that the fall was due to the pre-existing conditions of the Insured, Company official replied that in the hospital papers, the history has been recorded as "slurred speech since 2 days, deviation of mouth to left side since two days, loss of balance whilst walking", which clearly indicates that his history of fall was due to his pre-existing conditions.

Although, during hearing complainant submitted that his father had a fall after admission in the hospital, but in the indoor case papers dated 4.3.2011, it is mentioned as – Pt. admitted for medical problem, H/o fall injury to Rt. Hip, C/o pain ® Hip and Inability to lift R. L.L. In the certificate forming part of claim form, Dr. Tiwaskar of Anand Hospital has mentioned – k/c/o T2 DM on OHA since 10 years, k/c/o HTN on regular medication since two years. Shri. Palande underwent Rt. Hip DHS under SA + GA and was discharged from the hospital on 12.3.2011.

As regards Insurance Coverage of Shri. Purshuram Palande, it is noted that he is covered with New India since 8.3.1990 continuously for Sum Insured of Rs.50,000/- and the Sum Insured was increased to Rs.1,00,000/- from 8.3.2008. The present claim has been lodged under the policy issued for the period 8.3.2010 to 7.3.2011. Thus, it can be seen that when the claim arose under the Policy, the increased Sum Insured had just completed two policy years. Whilst restricting the claim amount to Rs.50,000/-, TPA took a stand that the fracture has resulted due to CVA and CVA in turn is the complication of pre-existing DM & HTN.

Post rejection, complainant submitted a certificate dated 10.9.2011 from the treating doctor stating as – "This is to inform you that Mr. Parshuram Palande was admitted here on 4.3.2011 for c/o loss of balance & fall with TIA & also had a fracture of Rt. Femur i.e. is only due to weakness and was not complication of hypertension".

In the hospital papers, the history of HTN is recorded as "2 years". However from the information provided by the Company it is noted that they had settled one claim in the year 2005 in respect of hospitalisation of Shri. Parshuram Palande in Holy Spirit Hospital from 3.6.2005 to 11.6.2005 for the complaints of TIA with DM with HT. From the records furnished by the Insurance Company it is quite clear that complainant was in fact suffering from TIA, DM and Hypertension prior to 2008 and hence these ailments/conditions would he treated as pre-existing conditions/ailment to the increased Sum Insured of Rs.50,000/-.

The analysis of the case reveals that the Company tried to establish that the insured, a known case of DM & Hypertension and having suffered from stroke was vulnerable to fall as hemiplegic patients are prone to fall. They wanted to medically establish the co-relation between the three. On proper examination at this Forum it is felt that the co-relation cannot be doubted as a person with diabetes, high blood pressure, or high cholesterol is more at risk for a Stroke/Cerebrovascular Accident, Transient Ischemic Attack, Hemiplegia. It is a fact that post stroke patients are more prone to fractures resulting from a combination of increased fall frequency and reduced bone strength. The next issue is whether the history of DM, HTN & TIA being the proximate cause, the claim arising out of fracture should also not be paid. Although the nexus between the two

is medically proved but whether it has contributed to the fall in this case needs to be examined.

The available papers on record clearly indicate that Shri. Palande was suffering from TIA, DM & HTN prior to 2008. As the patient had a history of Cerebrovascular Accident and also he was affected by Hemiplegia, he was all along vulnerable to decreased postural stability. Here the question would be whether the fall was proximately caused either by hemiplegia. If so whether the specific result namely the fracture of femur would also be excluded. Even accepting for a moment that fracture is a separate incident, the contributory factors like hemiplegia, Hypertension, Diabetes cannot be overlooked. Yet a question would also arise as to how to conclusively conclude that the fall was due to the disease and not by accidental slip, for which it would be appropriate to rely on the hospital papers. In the hospital papers, it is clearly mentioned that the patient had complaints of "Loss of balance while walking" and in the past also i.e. in June, 2010 he was hospitalized for giddiness & loss of balance. It is a fact that post stroke patients are prone to fractures presumably resulting from a combination of increased fall frequency and reduced bone strength. In the instant case therefore the co-relation between the episode of fall and the pre-existing conditions of the patient cannot be doubted.

It should be noted that when the increase in Sum Insured is effected, the increased sum insured becomes a fresh contract and as per exclusion clause 4.1 of the policy, any ailment & its related condition/complication which is pre-existing prior to it becomes pre-existing ailment and the same gets covered only after completion of four continuous policy years with loading in premium for DM & HTN. Under the present claim, from the documents on record, it is quite clear that Mr. Parshuram Palande was suffering from the TIA, DM & HTN prior to 2008, hence these ailments were pre-existing for the Sum Insured which was enhanced on 8.3.2008 and this enhanced Sum Insured cannot be considered for the treatment of TIA, DM & HTN or its related complications. Since the increased Sum Insured had not completed four continuous policy periods, for settlement of claim, Company restricted their liability to the basic Sum Insured of Rs.50,000/-.

<u>The decision of the Company to restrict the claim amount to the original Sum Insured of Rs. 50,000/- thus cannot be faulted.</u>

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Complaint Nos.GI-1952 of 2011-2012

Award No.IO/MUM/A/GI /2013-2014

Complainant : Smt. Parul Rambhia

Respondent : The Oriental Insurance Co. Ltd.

Award dated 10/2013

complainant was covered under Individual Mediclaim Policy bearing No.124200/48/2011/6319 issued by The Oriental Insurance Co. Ltd. for the period 29.7.2010 to 28.7.2011 for Sum Insured of Rs.1,00,000/-. Complainant underwent Corneal reshaping surgery for both of her eyes in Ojas Laser Eye Vision Pvt. Ltd. on 14.3.2011, for which she lodged a claim for Rs.25,505/- under the Policy. M/s Dedicated Healthcare Services TPA (India) Private Ltd., TPA of the Insurance Company however repudiated the claim stating that surgeries for correction of eye sight are permanently out of scope of the Policy. Not satisfied with this decision, when complainant represented to the Company, she did not get any reply from them. Being aggrieved she approached this Forum for redressal of her grievance and sought compensation of Rs.25,505/-. Insurance Company submitted that since their Policy specifically excludes the treatment incurred on the correction of eye sight, the claim has been repudiated by them. In the discharge card it is stated that Smt. Rambhia had c/o headache especially while seeing at distance, discomfort with glasses, difficulty in seeing at distance as to what a student is doing in the last. The claim has been repudiated by the Company on the ground that the expenses incurred on correction of eye sight are not payable under the Policy as per exclusion clause 4.6.

Vision correction refers to one of several methods used to improve blurred vision caused by refractive error. Astigmatism is a refractive error that prevents sufferers from seeing objects clearly from a distance or up close. It is a refractive error, meaning it is not an eye health problem; it simply is a problem with how the eye focuses light. Myopia, Hyperopia, Presbyopia and Astigmatism are the most common refractive errors, the common symptoms of which are blurred vision, double vision, haziness, squinting or eye strain. In the instant case, Smt. Rambhia was suffering from refractive error, for which she underwent Corneal Reshaping/LASIK surgery. During hearing, complainant submitted that she had spectacle and contact lenses intolerance and to get rid of spectacle/contact lenses she underwent Lasik surgery and the same was not done for luxury purpose. There is no doubt that LASIK can eliminate a lifetime dependence on glasses and contact lenses. However, since the Policy issued to the complainant has a specific exclusion clause which empowers the Company to exclude the expenses incurred on "Correction of Eyesight", the decision of the Company to reject the claim is in order.

It should further be noted that Mediclaim Policy is a contract of Insurance for one year and the same is governed by the terms & conditions prevailing at the time of inception/renewal of the Policy. As in the present case since the complainant was covered under Mediclaim Policy which was issued on 29.7.2010, she will be governed by the terms & conditions existing on that date.

The Insurance Company rejected the claim based on the exclusion clause 4.6 of the Policy, hence I do not find a justifiable reason to intervene in the decision of the Company.

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Complaint No. GI- 1830 of 2011-2012
Award No. IO/MUM/A/GI/ /2013-2014
Complainant : Shri. Shrikant Salgaonkar
Respondent : The New India Assurance Co. Ltd.
Award dated ; 12/2013

Smt. Sudha Salgaonkar, mother of the complainant was covered under Dhanlaxmi Suraksha Patra Mediclaim Group Insurance Certificate No. DSP001147 (Policy No.121400/34/09/87/00004015) issued by The New India Assurance Co. Ltd. for the period 4.3.2010 to 3.3.2011 for floater Sum Insured of Rs.3,50,000/-. When complainant lodged a claim for Rs.14,595/- under the policy towards hospitalisation of his mother in Sadanand Danait Hospital from 16.9.2010 to 17.9.2010 for the complaints of Ischaemic Heart Disease and Hypertension, M/s Medi Assist India TPA Pvt. Ltd., TPA of the Insurance Co. rejected the same under Pre-existing ailment clause by stating that patient is a known case of hypertension since thirteen years and Ischaemic heart disease is the complication of prolonged Hypertension which is pre-existing to the policy. TPA also took a stand that the ailment is not payable during the first two years of the Policy.

Not convinced with the decision of the TPA, complainant represented to the Insurance Co. stating that his mother was continuously covered under Mediclaim Policy since 1994 and for the year 1.1.2010 to 31.12.2010, he had paid the premium on 25th December, 2009 to the Agent of the Company. He contended that the policy should be treated in continuity and he should not be held responsible for the errors made by the Company/Agent in issuing the policy in time. Company however upheld TPA's decision. Being aggrieved complainant approached this Forum with a request for the intervention of the Ombudsman in the matter of settlement of his claim with interest.

Complainant submitted that his mother is 87 years old and was continuously covered under Mediclaim Policy since last 25 years. He said that earlier his mother was covered under Individual Mediclaim Policy; however since she reached to an age of 80 years, the Company refused to renew her policy as Individual Mediclaim Policy. Therefore, he was forced to insure his mother under Apat Bandhav Policy issued to the members of Saraswat Bank through one Mr. Vijay Shah. He said that his insurance coverage always commenced from 1st January every year and this has been continued upto 31.12.2009. He said that for renewal of the Policy for the year 2010-11, he paid the premium in advance on 25th December, 2009 to M/s Dhanlaxmi Co-op Credit Society. However, despite his paying the premium before time, he was given the Insurance coverage from 4.3.2010 to 3.3.2011 by New India, which has created a break of 3 months in the renewal of his policy. He said that this has not only resulted in denial of his claim but has also affected the next four years as due to the three months' gap all the ailments prior to 4.3.2010 will be treated as pre-existing ailments for the next four years. He requested for settlement of claim and regularization of his policy.

Insurance Company submitted that the Policy on which the claim is reported has

not been directly issued to Mr. Salgaonkar but has been issued to M/s Dhanlaxmi Co-op Credit Society Ltd. Since the premium has been received late from M/s Dhanlaxmi, it created a gap of three months in the insurance coverage; hence the present claim has been rejected on the ground of pre-existing ailment clause.

During hearing the representative of the Insurance Company was asked to submit – 1) The full details about M/s Dhanlaxmi Co-op Credit Society Ltd., the details and name of promoters of this Society. The details as to - who are the members of this society & who can become members of this society? Whether Shri. Salgaonkar is a member of this Society?, 2) Name of the intermediary through which the Policy has been issued to M/s Dhanlaxmi?, 3) Whether full facts about earlier Insurance Coverage has been collected before issuing this Group Mediclaim Policy?, 4) Who paid the premium for issuance of this Policy?, 5) The date on which the premium was due and the date on which it was received by the Insurance Company?, 6) From the records it was noted that a cheque amounting to Rs.15,00,000/- had been received by the Company on 1.1.2010 and the premium was adjusted and the policy was issued w.e.f. 4.3.2010. Further the Company has issued a letter dated 8.1.2010 to M/s Fun N Joy stating that the "Continuity benefits on renewal without break subject to proof of Insurance". However, now the Company has repudiated the claim on the ground of break in Insurance. Whether the Company has obtained further confirmation from M/s Dhanlaxmi and particularly from the members covered under the Policy to the effect that any claim falling during the intervening period will not be payable in view of the resultant gap and no continuity benefits will accrue to them.

Insurance Company vide their letter dated 29th October, 2013 submitted their reply as under – "The GMC Policy was issued to M/s DCCS Ltd. as our Insured. No intermediary was ever utilized while negotiating/operation of the policy. Policy was issued under a Direct Business Code. No brokerage/Commission was paid in the business. The GMC proposal from M/s DCCS Ltd. was offered to us for the first time. Our Office was never informed about earlier GMC Insurance coverage of DCCS Ltd. before commencement of the risk. The premium was paid by cheque by DCCS. The premium was due on 4.3.2010 i.e. commencement date of the Policy. Though the lumsum amount of 15.00 lacs received to us but that was not banked due to correct premium calculation basing on risk data was not available to us from M/s DCCS. Further it is to be noted here that M/s DCCS Ltd. was not loss of interest for the period from 1.1.2010 to 4.3.2010 as the amount was taken from their account till the proposal got sanctioned by our competent authorities. To keep DCCS Ltd. informed about our acceptance process which has taken time, we have informed them through mail on the above delay. While negotiation of proposal was in process, we have replied to one of DCCS Ltd. letter dated 8.2.2010 in which we have stated on continuity benefits on renewal of insurance without break in insurance which exclusively mean renewal of insurance business related to our Divisional Office. Business of other insurance company or other office of same insurance company does not mean renewal of our divisional office. It is the duty of DCCS Ltd. to inform and obtain confirmation from its members to the effect that policy is renewed with different insurance company under new terms & conditions and also the reason for such change to be informed to individual persons from whom premium was collected. It is also to be noted here that M/s DCCS has not informed its members for discontinuity from earlier Insurer and changing over to New India Assurance – 120400 Office……"

Let us examine the case. Complainant's mother is stated to have been covered under Mediclaim Policy since the year 1994. However as per records produced by the complainant, the details of policies are available since the year 2004 as under :

Policy No.	Period	Insurer	Group to whom the policy was issued	Sum Insured(Rs.)
112900/48/03/01653	1.1.2004-31.12.2004	New India	Apat Bandhav Group Mediclaim Policy	50,000
121200/48/2005/05088	1.1.2005-31.12.2005	Oriental	Sanjivani Global Service Club	2,00,000
124100/48/2006/1382	1.1.2006-31.12.2006	Oriental	Sanjivani Global Service Club	3,00,000
130400/34/06/41/00000033	1.1.2007-31.12.2007	New India	Masters Minds	3,00,000
130400/34/07/87/00000352	1.1.2008-31.12.2008	New India	Masters Minds	3,00,000 Floater
130400/34/08/87/00000603	1.1.2009-31.12.2009	New India	Charlette Healthcare Solution	3,50,000 Floater
121400/34/09/87/00004015	4.3.2010-3.3.2011	New India	Dhanlaxmi Suraksha Patra	3,50,000 Floater

From the above, it is quite clear that Smt. Salgaonkar was covered continuously under Mediclaim Policy since 2004 and it was only in the year 2010-11 that there happened to be a break in the Policy.

Company took a stand that M/s Dhanalaxmi Co-op Credit Society Ltd. approached them for the first time to avail the policy for their depositors, thus the question of continuity does not arise and the policy is subject to Pre-existing Disease exclusion clause. It is however noted that the policy has been continuously in force since the year 2004 and as per the documents submitted by the complainant, for renewal of policy for the year 2010-11, complainant had issued the premium cheque to Charlette Healthcare Solution as early as on 25.12.2009. Hence, I cannot find fault with the complainant in the matter of payment of premium which has been given well before the previous expiring policy. The scrutiny of the case further reveals that Insurance Company has accepted a deposit premium cheque bearing No.707531 dated 1.1.2010 amounting to Rs.15 lacs from Mr. Veejhay Shaah, Managing Director of Fun N Joy on 1.1.2010 i.e. much prior to the seeking approval from their Head Office for issue of the subject Policy. Since granting of approval took some time as the same was granted on 26.2.2010, a CD A/c was opened on 4.3.2010 after the approval was obtained; it resulted into a gap of three months since the earlier cover expired on 31.12.2009. It is strongly felt that the gap in the renewal has occurred due to non-regularizing of the policy before time. It is noted that the group had deposited a cheque of Rs.15 lacs to the Office and it was the duty of the Company to regularize the policy in time. Although, the Company has contended that on 5.2.2010

M/s Dhanlaxmi was informed through mail that the proposal is under scrutiny and Company do not hold the Insurance risk, but the said mail was addressed to charletteglobal@nifundz.com and not to M/s Dhanlaxmi. Further, if at all the intention of the Company was so, then the same should have been conveyed to M/s Dhanlaxmi in writing immediately whilst accepting the proposal and cheque of Rs.15 lacs and not after a months' time and therefore the issues raised by the Company that the cheque was not banked by the Company upto 4.3.2010 and the DCCS was not at loss of interest become irrelevant as the fact remains that the deposit cheque of Rs.15 lacs has been accepted by the Company on 1.1.2010.

Further, vide their letter dated 8.1.2010 issued to M/s Fun N Joy Company has promised continuity benefits on renewal without break subject to proof of insurance. When this Forum sought clarification from the Company on this issue, Divisional Manager clarified that continuity benefits on renewal of insurance without break in insurance exclusively mean renewal of insurance business related to their DO. This argument of the Company is not at all acceptable in view of the fact that the Company was well aware that the business accepted by them was not the renewal of their own DO and further their letter dated 8.1.2010 does not convey so. After promising continuity in writing and having such an evidence on record, at a later date the Company cannot take a stand that the policy issued was a fresh policy. The later communication with the group facilitator confirming that no continuity can be given becomes redundant in the light of the letter dated 8.1.2010.

It is further noted that the complainant was earlier covered under different groups viz. Sanjivani Global Service Club (2005 & 2006), Masterminds (2007 & 2008), Charlette Healthcare Solution in 2009 and the recent one being Dhanlaxmi. Further, for the renewal of policy for the year 2010-11 complainant has issued a premium cheque to M/s Charlette Healthcare Solution whereas he was given the cover under the policy issued to M/s Dhanlaxmi. Thus, this Forum really does not know whether the persons covered under these groups have relation to the said agencies in the capacity of either depositors or employees or members. During hearing when the Company was asked to clarify whether the complainant was a member of this Society, the Company chose to remain silent. Although the Company has clarified that they have never dealt with any of DCCS members directly, but whilst granting the coverage to 377 depositors, it was the responsibility of the Company to at least ensure that the members covered under the Policy are related to that particular Group. Further, the Company has simply said that their Office was never informed about earlier insurance Coverage. It is quite surprising that at no point of time while accepting the fresh proposal, the Officials of the Company verified about the issues like homogeneity of the group, their past insurance record, moral hazard etc. The underwriting norms have been given a go by and only marketing of insurance and collection of first premium has become the priority for the Insurance Company. The complainant should not be penalized for the omissions and commissions of the group organizer or for that matter that of the Company.

Under the facts and circumstances, the decision of the Insurance Company to repudiate the claim under pre-existing ailment/two years' waiting period clause is not tenable for the reasons stated above. However, the request of the complainant for regularizing of the policy cannot be entertained since the same is beyond the scope of the Forum. The New India Assurance Co. Ltd. was directed to settle the claim for the

admissible expenses in respect of hospitalization at Danait Hospital from 16.9.2010 to 17.9.2010 for the complaints of Ischaemic Heart Disease and Hypertension

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Complaint No. GI-2462 of 2011-2012
Award No. IO/MUM/A/GI /2013-2014
Complainant : Smt. Sangita Gupta
Respondent : The New India Assurance Company Limited
Award dated 03/2014

Complainant who was covered under Mediclaim Policy (2007) bearing No.140100/34/10/11/00004915 issued for the period 16.7.2010 to 15.7.2011 for Sum Insured of Rs.1,00,000/- 10% CB was hospitalized in Holy Spirit Hospital from 23.10.2010 to 29.10.2010 for the treatment of P. Vivax malaria and then in Shri. Mangal Nursing Home from 1.11.2010 to 2.11.2010 for check curettage. When complainant lodged a total claim for Rs.22,642/- under the Policy, M/s Medi Assist India TPA Pvt. Ltd., TPA of the Insurance Company settled it for Rs.12,847/- only disallowing the expenses incurred on the second hospitalisation on the ground that the discharge card was not available. When complainant submitted the discharge card of the hospital for the second hospitalisation, Insurance Company disallowed the expenses incurred on the said hospitalisation stating that the hospitalisation was done for MTP (Medical Termination of Pregnancy), which is not covered under the policy.

Being aggrieved complainant approached this Forum for settlement of her balance claim. Insurance Company was submitted that insured was hospitalized in Holy Spirit Hospital from 23.10.2010 to 29.10.2010 for the treatment of Malaria and thereafter she was hospitalized in Mangal Nursing Home from 1.11.2010 to 2.11.2010 where she underwent termination of pregnancy. For both the hospitalizations, insured lodged a single claim for Rs.22,642/- under the policy and the said has been settled for Rs.12,847/-. Dr. Bhavna explained that the expenses incurred on the hospitalisation of Holy Spirit Hospital has been settled in full as the insured underwent the treatment of malaria in the said Hospital; whereas, the expenses towards the hospitalisation in Mangal Nursing Home have been disallowed by them under exclusion clause 4.4.13 of the policy, which states that the treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section are not payable under the Policy. She stated that insured was 20.5 weeks pregnant when she was admitted in the hospital and the indoor case papers of Mangal Nursing Home indicates that she underwent termination of pregnancy. She was given Tablet Miso Prost and thereafter on 2.11.2010, she underwent check curettage and was discharged from the hospital.

Considering the fact that complainant was 20.5 weeks pregnant when she underwent termination of pregnancy, Dr. Bhavna was asked as to explain the necessity for termination of pregnancy. Dr. Bhavna explained that the indoor case papers of the hospital are totally silent on this aspect. The hospital authorities have not recorded the

reason for termination of pregnancy; hence it indicates that it was a voluntary termination of pregnancy. She further explained that the sonography which was done in Holy Spirit Hospital revealed normal readings.

Observations of the Forum :

The dispute in the present complaint is regarding the quantum of claim sanctioned. Complainant lodged one claim for the expenses incurred on two hospitalizations i.e. hospitlaisations in Holy Spirit Hospital and Mangal Nursing Home. As regards the admission in Holy Spirit Hospital is concerned, the same was done for the treatment of P. Vivax Malaria. Insurance Company has accepted their liability in respect of the expenses incurred on this hospitalisation and settled the claim for Rs.12,847/-.

With regard to second hospitalisation, i.e. admission in Shri. Mangal Nursing Home from 1.11.2010 to 2.11.2010, Insurance Company denied the expenses incurred on this hospitalisaiton. The scrutiny of the discharge summary of the said hospital reveals that the important columns viz. Diagnosis, Operation Performed, Investigations etc. are kept blank. As the discharge card of Shri. Mangal Nursing Home absolutely did not reveal any details as to for what treatment, Smt. Gupta was admitted therein, this Forum advised the Company to forward the indoor case papers of the Hoispital. On perusal of the same, it is observed that the noting in the in-door case papers are also meager. Although, it is stated that Miso Prost tablet was started on 1.11.2010 and Curettage was done on 2.11.2010, other important details like details of her pregnancy, the reasons for which the curettage was done etc. are not mentioned therein. However, from the discharge summary of Holy Spirit Hospital, it was noted that Smt. Gupta was 20.5 weeks pregnant with two living children. The Sonography done in the said hospital revealed –

"Intrauterine pregnancy with a single live fetus of 20-21 weeks gestation. Hypoplastic Left Heart Syndrome is noted. Choroid Plexus Cyst is seen".

The Hospital papers produced before the Forum by the Company indicates that Smt. Gupta underwent Medical Termination of Pregnancy when she was 20.5 weeks pregnant; however, the hospital authorities have not mentioned the reasons/neeed for the same, for the reasons best known to them. Generally, doctors use medications, surgery or a combination of both to end a pregnancy. MTP (abortion) during early pregnancy, before 9 weeks, can be done safely with medications, between 9 and 14 weeks usually are done surgically, although medications may be used to help soften and open the cervix. After 14 weeks, MTP can be done using labor inducing medications that cause uterine contractions or by using these medicines in combination with surgery.

Insurance Company rejected this portion of claim under exclusion clause 4.4.13 of the Policy, which states that treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section….are not payable under the Policy. Insurance Company denied the expenses incurred on Medical Termination of Pregnancy (Abortion) based on the Policy terms & conditions, hence their decision cannot be faulted with.

Despite the best efforts to contact the complainant on the address given on the P-II form, the complainant could not be contacted as the notice sent to her for her personal appearance for the hearing, was returned back to the Forum "undelivered". Further, when this Forum sent a copy of the minutes of the hearing to her vide letter dated 1.2.2014, the same was also returned back to the Forum "undelivered".

Under the facts & circumstances, this Forum has no option but to dismiss the case.

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Complaint No. GI-531/ 2012-2013
Award No. IO/MUM/A/ GI /2013-2014
Complainant : Shri. Pradeep S. Sheldenkar
Respondent : Universal Sompo General Insurance Co. Ltd.

Award dated 01/2014

Complainant was covered under IOB - Health Care Plus Policy bearing No. 2817/50746289/01/000 issued by Universal Sompo General Insurance Co. Ltd. for the period 22.6.2011 to 21.6.2012 for Floater Sum Insured of Rs.5,00,000/-. Shri. Sheldenkar was hospitalized in Grace Intensive Cardiac Centre & General hospital from 11.7.2011 to 17.7.2011 & in Vivus SMRC Heart Centre from 17.7.2011 to 31.7.2011 where he underwent CABG with 3 vessel grafts. When he lodged a claim for Rs. 3,34,331/- under the Policy, M/s TTK Healthcare TPA Pvt. LTD., TPA of the Insurance Company repudiated the claim under pre-existing ailment clause. Not satisfied with the decision, when complainant represented to the Company, they conveyed their inability to re-consider the claim on the ground of pre-existing ailment clause and also on the ground of non-disclosure clause of the Policy. Being aggrieved, complainant approached this Forum for redressal of his grievance.

Complainant submitted that earlier when he was working with HDFC Bank, he was covered under Group Mediclaim Policy issued to Bank's staff members by The New India Assurance Co. Ltd. upto his retirement i.e. November, 2009. After retirement from HDFC Bank, in the year 2010 whilst he was on a visit to Indian Overseas Bank, where he was working prior to joining HDFC Bank, he was persuaded by his colleague to take a Mediclaim Policy from Universal Sompo, with whom the Indian Overseas Bank had tie-up arrangement. Accordingly he took the first policy from Universal Sompo for the period 22.6.2010 to 21.6.2011 and the same was renewed for a further period of one year. Whilst issuing the policy, the Branch Manager rejected his request for pre-medical check-up. In July, 2011, when he underwent routine medical check-up, the concerned doctor advised him to get admitted in the hospital and accordingly on 23.7.2011, he was hospitalized in Vivus SMRC Heart Centre and underwent CABG surgery. He stated that his claim had been rejected by the TPA of the Company and not convinced with this decision, when he submitted to the TPA two medical certificates from his treating doctor and family physician certifying that the disease was not a pre-existing ailment, the TPA maintained their earlier stand. When he represented to the Company, they conveyed their decision of repudiation under pre-existing ailment clause and non-disclosure of material facts. He said that rejection of claim on both these grounds is not acceptable to him since the ailment suffered by him was not pre-existing. He mentioned that during hospitalisation when doctors asked him whether he had any pain anywhere, he replied that he had occasional pain in the jaw for over five years. He also maintained that he never suffered from the complaints of Hypertension and the history of diabetes is wrongly recorded in the hospital papers, as he is not at all suffering from diabetes. He stated that since 1991 he is regularly undergoing blood check-up investigation and only once his blood sugar level was found to be elevated. He finally said that he was not suffering from pre-existing pain in jaw, hypertension or diabetes. As regards Bell's Palsy, he said that he suffered from the same in the year 1982 and not in 1987 and it was due to viral infection. He also

mentioned that during his entire policy coverage with New India, he did not report a single claim on New India.

Insurance Company submitted that insured purchased IOB Health Care Policy for the first time from their Company on 22.6.2010, by submitting a proposal form wherein the details about pre-existing medical conditions have not been disclosed. This Policy has been renewed for a further period of one year i.e. 22/6/2011 to 21/6/2012, on which insured reported a claim towards his hospitalisation in Vivus SMRC Heart Centre from 23.7.2011 to 31.7.2011. He said that the scrutiny of the medical papers revealed that insured was suffering from pre-existing conditions i.e. Hypertension (10 years), Type II Diabetes Mellitus (2 ½ years), Bell's Palsy (1987). Hence, the claim was repudiated on the grounds of pre-existing ailment and mis-representation/non-disclosure of material facts. He further mentioned that the subsequent doctors' certificates submitted by the insured have not been considered by their Company considering the fact that these certificates are contradictory to what has been mentioned in the discharge summary and also is an after thought on the part of the insured.

During hearing Insurance Company was asked : 1) Whether their underwriting policy permits them to issue a policy to a 60 years's old person without medical check-up?, 2) Whether they have got any other documentary evidence to indicate that complainant was in fact suffering from Hypertension and Diabetes prior to issuing the first policy?, 3) Whether they have carried out any investigation to prove that the complainant had lodged any claims on previous Insurer?

To the above queries, Co. representative replied that their underwriting procedure allows them to issue a policy to a person above 60 years' of age provided the proposal form does not reflect any adverse medical history. He said that in this case, they have got clean proposal form from the insured, hence he was issued a policy without any medical examination. He further mentioned that Discharge card of the hospital is the enough medical evidence to indicate that insured was suffering from pre-existing hypertension and diabetes and apart from discharge card, they do not have any other medical evidence and further they have not carried out any other investigations in the matter.

When the complainant was asked as to why the certificate given by the treating doctor has not contradicted about the past history of diabetes, if it had been wrongly recorded, he could not give a satisfactory reply. The complainant was therefore directed to produce within a period of 7 working days : 1) His previous Insurance Coverage and claim details, on his own life, 2) His blood check-up reports for the last ten years, if any, 3) Any medical record pertaining to hypertension in his possession.

In response, Complainant submitted blood test reports and a copy of claim information sheet from Family Health Plan (TPA) P Ltd. As regards Hypertension, he stated that – "I am unable to provide any record pertaining to hypertension, as I was not taking any medicines although my blood pressure level sometimes, due to work stress used to be 135/85 as was told to me by doctors when I visited thrice in the 10 years period. The doctors had advised me that my pressure at that level was more of WHITE Coat Syndrome requiring no medication."

All the documents submitted to the Forum have been scrutinised. In the discharge card of Grace Intensive Cardiac Care Centre & General Hospital it is mentioned as – "c/o pain in jaw….k/c/o HTN on medication…" The 2DECHO revealed – Mild cons. Left ventricular hypertrophy consistent with hypertension. He was diagnosed to have "DM,

HTN, Acute Coronary Syndrome". In the discharge card of Vivus SMRC Heart Centre against - history, it is stated as : "Patient is a 61 years old male, hypertensive (10 years), diabetic (2 ½ years), presented with c/o pain in jaw radiating to interscapular region and left upper limb exertion or stress or post prandial since 5 years". He underwent Angiography which revealed Left Main Coronary Artery & Triple Vessel Disease. He was diagnosed to have – Coronary Artery Disease, LMCA + Triple Vessel Disease, Unstable angina, Systemic Hypertension (10 Years), Type II Diabetes Mellitus (2 ½ years), Dyslipidemia, Bell's Palsy(1987).

During hearing complainant admitted that up to November, 2009, he was insured under Group Mediclaim Policy issued to the employees of HDFC Bank. Then, he opted IOB Health Care Plus Policy for the first time w.e.f.. 22.6.2010 by submitting a fresh proposal form to the Company. In the proposal form, against the policy type, it is stated as "New". Thus, it is evident that there was indeed a break of about 6 months in the Policy coverage. Post hearing, complainant submitted a copy of "Claim Information" sheet issued by M/s Family Health Plan (TPA) Pvt. Ltd. , wherein it was certified that there were no claims reported from October 2007 to March 2010 on the life of complainant. Even going by this information, it can be seen that there is a gap in the Insurance coverage and hence the first policy issued by M/s Universal Sompo should be treated as a fresh policy. The present claim has been lodged on the second year of the Policy.

Based on the history recorded in the hospital papers, Insurance Company denied the claim on the grounds of pre-existing ailment clause and non-disclosure/misrepresentation of material facts. Company took a stand that complainant had pre-existing conditions of Hypertension and Diabetes; however these conditions had not been disclosed to them. Pre-existing exclusion clause of the Policy states that - "All diseases/injury which are pre-existing when the cover incepts for the first time. This exclusion will be deleted after three consecutive continuous policy years provided there was no hospitalisation for the pre-existing ailment during these three years of insurance....." The complainant however contested that he never suffered from pre-existing hypertension or diabetes prior to inception of the policy and the history related to the same has been wrongly recorded in the hospital papers.

The analysis of the entire case reveals that in the discharge card of VIVUS hospital, patient's history is systematically written stating that patient was hypertensive for 10 years, diabetic since 2 ½ years with c/o pain in jaw radiating to interscapular region and left upper limb exertion or stress or post prandial since 5 years. Although the complainant has contended that he was not taking any medicines for hypertension, but in the discharge card of Grace Hospital, it is mentioned - "k/c/o HTN on medication". When a patient is admitted in the hospital, the history is recorded with care to get to the clear cause of the ailment and for correct treatment. Usually patient/relatives explain and expose all the symptoms to the doctors which is absolutely necessary to help the Doctor to arrive at a correct diagnosis. The facts of hospital case history is a recorded evidence and hence the same cannot be simply set aside. Further, the certificates issued by the two hospitals subsequently has not commented on the history of diabetes/hypertension. As regards the contention of the complainant that his blood sugar was within normal range, it should be noted that if the ailment is well under control due to regular medication the same may not be revealed in the investigation reports. Further, blood test report dated 5.6.2010 i.e. done immediate prior to taking the policy showed blood sugar

level above the normal range. Hence complainant's contention that that he did not have hypertension and diabetes prior to incept of the policy and the history was wrongly recorded in VIVUS Hospital papers is not sustainable.

It is well established fact in Medical Science that Hypertension & DM are the major risk factors for Cardiac diseases and coronary artery & cerebral vascular diseases are much more frequent in those who have elevated BP than in those who are normotensive. The combination of diabetes and hypertension produce the quickest atherosclerosis or blockages in the arteries to cause insufficient flow of blood to heart and consequently cause the artery blockage.

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, the Forum is of the view that the decision of the Insurance Company to repudiate the claim cannot be faulted.

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Complaint No. GI-1818 of 2011-2012

Award No. IO/MUM/A/GI /2013-2014

Complainant : Shri. Marshal Tuscano

Respondent : The New India Assurance Co.Ltd

Award dated 12/2013

son of the complainant was covered under Janata Mediclaim Policy bearing No. 140501/34/10/14/00000289 issued by The New India Assurance Co. Ltd. for the period 19.6.2010 to 18.6.2011 for bifurcated Sum Insured of Rs.15,000/- & Rs.35,000/-. Complainant approached this Forum with a complaint against the Insurance Company that when he lodged a claim under the policy towards the procedure of Radio Frequency Ablation underwent by his son in Piramal Diagnostic on 14.12.2010, M/s MDIndia Healthcare Services (TPA) Pvt. Ltd., TPA of the Insurance repudiated the claim stating that there was no hospitalisation and as per NIA Mediclaim circular, expenses incurred on the same treatment are not payable under the Policy.

Complainant submitted that his son underwent CT guided RF ablation of the distal left ulnar osteoid osteoma in Piramal Diagnostic on 14.12.2010, for which he lodged a claim for Rs.1,33,233/- under the Policy. He said that his claim has been repudiated by the Company stating that the said treatment is not covered under the Policy. He requested for settlement of claim.

Insurance Company submitted that insured is covered under the Policy for Sum Insured of Rs.50,000/- and the said claim has been repudiated by them on the ground that Rotational Field Quantum Magnetic Resonance is excluded under the Policy.

During hearing when the attention of the TPA doctor was invited to the fact that the procedure underwent by the complainant's son is "Radiofrequency Ablation" and not

"RFQMR", he said that the said treatment is done under CT & MRI guided magnetic field and hence can be considered at par with RFQMR. When the Company official was asked as to why the said treatment is not considered as "Radiotherapy" procedure, she said that their higher Office was of the view that since this treatment was not followed by a surgery, the same cannot be considered as "Radiothereapy" procedure.

Observations of the Forum :

1) **Radiofrequency is a medical procedure in which part of the electrical conduction system of the heart, tumor or other dysfunctional tissue is ablated using the heat generated from high frequency alternating current.**
2) **If the TPA was of the view that the Radiofrequency Ablation can be treated at par with "RFQMR", then their decision should have been supported by an expert's independent opinion.**
3) **Policy has an exclusion clause for "RFQMR". Radiofrequency Ablation is not clearly excluded under the Policy.**
4) **It was also noted that the Policy Issuing Office of the Company had in fact taken up the matter with the TPA to contact the higher Office of the Company to re-look into the case considering the treatment being a modern technique. However, TPA maintained their stand of repudiation. There is no evidence on record to indicate the efforts taken by the TPA after getting instructions from the Operating Office.**
5) **Under the facts & circumstances, this Forum has no option but to give the benefit of doubt in favour of the complainant.**

Insurance Company was therefore directed to settle the claim of the complainant for the admissible expenses based on the terms & conditions of the Policy, within a period of 10 working days.

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Complaint No. GI-1473 of 2011-2012

Complainant: Smt.Kulsum Maredia
V/s
Respondent: Reliance General Insurance Co. Ltd.,

Award dated 03/2014

Complainant, was covered under the Reliance Health wise policy vide policy bearing number 1108/792825004574 for a sum insured of Rs.5 lacs, valid for the period 22.11.2009 to 21.11.2010.

Claim arose under the policy, when the complainant got admitted to Jaslok hospital from 25.10.2010 to 26.10.2010 for treatment of bilateral varicose veins by way of endovenous laser therapy.

When a claim of Rs.2.60 was preferred on the Company, the same was denied by them stating that laser treatment was not payable as per exclusion clause no 7 of their policy.

The complainant represented but the Company however upheld their stand of rejection and aggrieved by the same, the complainant approached this forum for redressal. The hearing took place at the appointed hour and place but the complainant however was neither contactable over phone nor did our written communication reach her and as a result she was not present for the deposition and the hearing of respondents was taken on record.

The forum made the following observations during the hearing after the deposition of the Company:

Exclusion clause 7 of the policy reads as " routine medical eye and ear examination, cost of spectacles, laser surgery, contact lenses or hearing aids, vaccination, issue of medical certificates and examination as to suitability of employment or travel". Hence it is clear that the clause relates to Eye and ENT disease and as such it is inappropriate for the Company to deny the claim picking out the word laser from the clause which is totally not applicable to the present case and hence not acceptable. As regards the second ground of rejection stating that it is an OPD treatment, the Company has cited evidence from the website of the treating surgeon, ie. Dr.Shoaib providing his literature along with his photograph which shows him performing the laser Ablation on a patient, to prove that the procedure does not require hospital admission. However, in this case the insured was admitted to the hospital by the said doctor as an inpatient with 24 hours stay in the hospital which is contradictory to their contention.

Although the Company's contention regarding the denial of the claim under exclusion no 7 is not tenable, the question whether the said treatment where the hospitalization was done requires impatient stay is not answered. The Company was hence given 15 days time to provide relevant case papers substantiating their stand of rejection.

The Company sent in the copies of the indoor case papers. The scrutiny of the same reveals that the complainant underwent laser therapy for bilateral varicose veins on 25.10.2010 and was discharged on 26.10.2010. The Company has contested the need for admission. They have drawn attention to a remark in the indoor case papers where full diet is written in the papers as against NBM (nothing by mouth) instructions which are generally given to patients undergoing procedures under regional or general anesthesia.

In the instant case, all the other protocol like taking consent for the procedure, preparation of the parts etc have been followed and only the procedure of fasting has not been followed.

In this procedure, the great sephaneous vein is percutaneously cannulated and the laser fibre is introduced under ultrasound guidance. Continuous waves laser therapy is then used to close the vein. This definitely cannot be done in an OPD setting and does need aseptic conditions.

The Company should note that this procedure is a day care treatment though in the instant case, the insured has been admitted to hospital for over 24 hours. Their policy covers day care treatment and the list of day care treatment given by them such as dialysis, radiation therapy, chemotherapy, eye surgery etc are only indicative and illustrative and is not exhaustive. The Company cannot insulate itself by listing out a few, old day care procedures without including new day care procedures that are being added each day. In fact some of the policies of other insurers list out as many as 156 day care procedures that are covered under their policies.

If the Company does not include important treatments such as this, then as rightly pointed out by the complainant, the definition of surgery which means manual and or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life as intended to be covered by them will be breached.

Therefore in the facts and circumstances of the case, I am unable to agree with the contention of the Company. The insurer is directed to pay to the complainant the admissible expenses under her claim for her admission to Jaslok hospital from 25.10.2010 to 26.10.2010 for treatment of bilateral varicose veins under policy number 1108/792825004574.

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Complaint No. GI-598 of 2010-2011

Complainant: Shri Madhavji Gori
V/s
Respondent: Reliance General Insurance Co. Ltd.,

Complainant, was covered along with his family members under the individual mediclaim policy of the Company vide policy bearing number 1103382811100659, valid for the period 16.9.2008 to 15.9.2009 for a sum insured of Rs.250,000 for self. From the submitted/available records, it is seen that the complainant was covered with Oriental Insurance Company from the year 2000-2001.

Claim arose under the policy, when the complainant got admitted to Nanavati Hospital on 10.6.2009 with headache and imbalance. He was investigated and found to be suffering from MCA aneurysms with subarachnoid hemorrhage. He was treated accordingly and discharged on 18.6.2009.

The claim when preferred on the Company, was denied on the grounds of pre existing diseases contending that as per the papers available with them, the complainant was a known case of heart ailments and hypertension. Hence the Company contended that the ailments were pre-existing prior to the inception of their policy and declined the claim.

The complainant represented but the Company however upheld their stand of rejection and aggrieved by the same the complainant approached this forum for redressal. Accordingly after perusing all the relevant papers on record, both the parties to the dispute were called for a personal hearing.

The crux of the matter is the refusal of the claim on the basis of pre-existing disease. The stand of the Company is that the complainant approached them for cover in the year 2008 and they issued a fresh policy. They have not confirmed if they knew about his earlier coverage and whether they have taken cognizance of the same. In fact they have confirmed to this office in writing that they could not trace the copy of the proposal

form which was submitted by the complainant when he switched over to Reliance in the year 2008. They have made reference to the past medical admissions of the complainant and have contended that the complainant was a known case of hypertension and heart ailments and the present ailment was a fall out of such illnesses and as the policy was accepted as fresh, the same was treated as preexisting disease. From the records available, it is evident that the complainant was covered with Oriental Insurance Co.Ltd continuously since last eight years before migrating to Reliance Insurance Co.Ltd.,

Some of the salient features of the guidelines sent by the complainant are as follows:

- **Company to seek medical reports for all individuals above the age of 45 years and also seek additional reports in case of adverse medical history.**
- **The guidelines also strictly prohibits acceptance of rollover business meaning proposals from other PSU/Pvt. Insurance companies.**

Generally, these guidelines are followed by most companies at the time of underwriting. Whether these guidelines were prevalent at the time of accepting the proposal in the year 2008 is not clear. However, the Company just could not have covered an insured of 47 years of age without seeking proof of earlier coverage and claims history or conducting a pre-acceptance medical evaluation. If the Company chose to ignore these points and issued the policy, then it can only be reasonably concluded that the policy was accepted as a renewal of the earlier insurer, which means they have forsaken their right to deny the claim under the pre-existing disease condition.

Let us now examine the medical papers of the complainant.

Name of hospital	Period of admission	Complaints for which admitted	Observations of the forum
Nanavati Hospital	7.8.2007	c/o chest pain radiating to shoulder	However, the Troponin T test came out negative ruling out the possibility of heart ailments
Nanavati Hospital	13.8.2007	H/o pain in left shoulder and hand and back since yesterday. k/c/o IHD. H/o Angiography done 4 months ago. Outside ECG done on 3.4.2008 shows LBBB.	How can there be reference to an ECG done on 3.4.2008 in the case papers dated 13.8.2007? There seems to be some inconsistency and this document cannot be taken on record as defense.
Nanavati Hospital	4.4.2008 to 5.4.2008	H/o pain at nape of neck and upper back since one day. h/o similar pain 3 months back. No h/o chest pain, dyspnoea, palpitations. No h/o DM/HTN/BA/PTB. No	There has been no diagnosis in the instant case. The hospital records also clearly indicate that the insured was not a known case of DM,HTN or any other

		h/o any other med/surgical illness	**major illness.**
MK's Heart Centre	**21.4.2008**	**Stress test done on Bruce protocol. The final impression is test inconclusive for exercise inducible ischemia.**	**This means that the diagnosis of heart ailments was not confirmed.**
Nanavati Hospital	**10.6.2009 to 18.6.2009**	**Right MCA aneurysm with sub arachnoid hemarrohage. Patient was brought by relatives with h/o headache since yesterday. no h/o DM/HTN, any surgery in the past**	**With such notings on record, it is not clear from where the Company has got the history of HTN. The recording of Suvidha hospital of k/c/o of IHD/htn to which they are referring is a diagnosis under query for hypertension which means that they were not sure of the diagnosis then.**

Hence, in the light of all the above facts, the opinion of the forum is as follows:

- **Neither the diagnosis of IHD nor the HTN is definitive or confirmatory with diagnostic evidence. Hence the said illnesses cannot be called as existing let alone pre-existing. Hence, at the outset, the present claim cannot be related to IHD/HTN.**
- **The Company could not produce the copy of the proposal form to prove the basis of acceptance of the insurance in the year 2008.**
- **The Company could also not submit the underwriting guidelines prevalent then to prove that they could accept proposers above the age of 45 years as fresh without examining the previous insurance coverage, claims history, and a pre-acceptance medical report.**
- **The Company has not taken cognizance of the earlier policy copies of the complainant. By not doing this, they have reduced the cumulative benefits of several years to that of a fresh policy.**

It is to be noted here by the Company that a person who is covered continuously since last so many years cannot be made to forfeit the benefits of such continuous coverage at the time of his need. It was their duty to have called for the details of such previous insurance in writing and inform him in writing that even in the instance of there being past insurance coverage, their policy would still be treated as fresh for treatment of claims. It would have then helped the complainant to take an informed decision whilst shifting. The Company could not prove that they have done so in the instant case. The Company by not doing so, cannot now take shelter by simply stating that the proposal was accepted as fresh.

The Reliance General Insurance Co.Ltd was directed to pay to the complainant the admissible expenses under the claim up to the limit and extent of available sum insured

under the instant policy for his admission to Nanavati hospital from 10.6.2009 to 18.6.2009 for treatment of right MCA aneurysm with sub arachnoid hemorrhage.

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Complaint No. GI-1774 of 2011-2012

Complainant: Smt.Prabha Nagarsenkar
V/s
Respondent: Bharti Axa Gen.Insurance Co. Ltd.,
Award dated 03/2014 -----------------

Complainant, was covered under the Smart Health Basic policy of the Bharti Axa General Insurance Co.Ltd vide policy bearing number BIH/Q0026304/11/05 for a sum insured of Rs.2 lacs. The policy was valid for the period16.5.2011 to 15.5.2012.

Claim arose under the policy, when the complainant got admitted to Goa Medical College hospital for right breast lump from 5.7.2011 to 8.7.2011 for breast lumpectomy, which when investigated turned out to be malignant. She was thereafter admitted from 19.7.2011 to 23.7.2011 to Manipal Hospitals where she underwent BCT treatment and filed a claim of Rs.54,065 on the Company. The said claim was denied by them under two grounds. The first one was that the complainant was suffering from diabetes and hypertension since last two years but she had not disclosed the same in the proposal form leading to misrepresentation of material facts by her. The second one was that the expenses for the treatment of the illness/diseases were incurred within 30 days of policy inception.

The complainant represented that she was not suffering from diabetes and hypertension since last two years and that the history was recorded erroneously by the hospital. Secondly, she stated that she was diagnosed as a case of breast carcinoma only on 5.7.2011 which was after 30 days of policy inception.

The Company however upheld its stand of rejection and aggrieved by the same, the complainant approached this forum for redressal. The hearing took place at the appointed hour and place between the parties to the dispute, where Smt.Prabha Nagarsenkar who unfortunately was no more, was represented by her husband, Shri Jaiprakash Nagarsenkar.

The contention of Shri Jaiprakash Nagarsenkar was that his wife was diagnosed for breast carcinoma only in July 2011 which was well after 30 days of policy inception. Let us now examine the chronological sequence of the events leading to the claim rejection.

Sr. No	Description of the events	Date of occurrence
1	Inception of policy	16.5.2011
2	Visit to Goa Medical College hospital for complaint of lump in breast, where she was advised Mammogram and FNAC.	19.5.2011
3	Mammogram and FNAC tests conduction	21.5.2011

4	**Investigations, consultations and treatment continues**	**June 2011**
5	**Lumpectomy admission at Goa Medical college hospital**	**05.7.2011 to 08.7.2011**
6	**BCT treatment at Manipal Hospitals**	**19.7.2011 to 23.7.2011**

Having gone through the same, let us now examine the relevant history recorded in the medical papers of the complainant.

Sr. No	Date of recording	Name of the hospital	History recorded therein
1	**19.5.2011**	**Goa Medical College hospital**	**History of lump in the right breast – upper & inner quadrant, right axillary LN +, Left breast Normal.**
2	**05.7.2011**	**Goa Medical College hospital**	**k/c/o HTN x 3 years on Enam 2.5, k/c/o DM x 1.5 years on T.glycomat**
3	**06.7.2011**	**Goa Medical College hospital**	**k/c/o HT (hypertension) 2 yrs on T.Enam 2.5 OD, k/c/o DM (diabetes) on OHps, presently on insulin.**
4	**08.7.2011**	**Goa Medical College hospital**	**Lump in right breast for 3m, no H/O pain in the breast.**
5	**11.7.2011**	**GMC hospital-histopath report**	**Infiltrating duct carcinoma grade II.**

From the above, it is evident that the complainant was having lump in the breast as on 19.5.2011, if not earlier. The complainant in the cashless approval form has stated that the lump was first noticed on 5.07.2011. Similarly, in the health insurance claim form, to a question of "Date first noticed symptoms of disease/illness", the complainant has replied as "5.7.2011", which is not correct. In fact, the symptom of the illness which was breast lump was noticed as early as 19.5.2011 and the investigations immediately began. Though initially, the lump was diagnosed as benign in the preliminary tests, subsequently, the confirmatory test of lumpectomy in July 2011 has confirmed the diagnosis of carcinoma. This does not mean that the disease incepted in July 2011. Further, in one of the papers dated 8.7.2011 of Goa Medical College, the duration of the breast lump is given as 3 months which dates the history of the lump prior to the inception of the policy. This only leads me to believe that the carcinoma was perhaps misdiagnosed due to incorrect results of the FNAC and Mammogram tests. Had the lumpectomy been done immediately after the mammogram or FNAC, the diagnosis of carcinoma would have been confirmed in May 2011 itself and the treatment would have commenced. It would not be incorrect to surmise that the treatment started late due to the incorrect results.

Coming to the history of hypertension and diabetes, the contention of the complainant is that the said conditions were diagnosed just prior to the lumpectomy. However, the history of hypertension/diabetes recorded during lumpectomy is consistently of two to three years duration even mentioning the medicines that the complainant was taking for the same. If the history recorded was found to be incorrect, the complainant should have taken up the matter with the hospital at the appropriate

time or should have registered her objection in writing then. On the contrary, there are no papers on record to support the contention of the complainant that the said conditions were diagnosed only prior to the lumpectomy. It is needless to mention that the hospital papers are legally contestable documents and the history stated therein cannot be simply set aside without any documentary evidence to prove to the contrary.

Therefore, in the facts and circumstances of the case, there are no justifiable grounds to intervene in the decision of the Company and their stand is tenable.

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Complaint No. GI-2008 of 2011-2012

Complainant: Ms.Sahana Siddiki
V/s
Respondent: Bharati Axa General Insurance Co. Ltd.,

<u>Award dated 03/2014</u>

Complainant, was covered under the Smartcare High Deductible mediclaim policy vide policy bearing Q0023306 for sum insured of Rs.7 lacs with a deductible of two lacs. The said policy was valid for the period 17.3.2011 to 16.3.2012. From the submitted documents (proposal form copy), it is seen that the policy incepted for the first time in the year 2011.

Claim arose under the policy when the complainant got admitted to Fortis hospitals from 4.10.2011 to 11.10.2011 for complaints of acute pain in right hypochondriac region with fever and nausea. She was diagnosed as ?enterocolitis with UTI infection with ?malaria fever in a k/c/o DM and HTN.

When the claim was lodged on the Company, the same was denied by them contending that the complainant was a known case of hypertension and diabetes which were not disclosed by her whilst taking the policy thus leading to misrepresentation/suppression of material facts.

The complainant represented that she never had any history of diabetes and hypertension and that the said notings were due to the mistake of the hospital staff. The Company however upheld their stand of rejection and aggrieved by the same, the complainant approached this forum for redressal.

The crux of the matter here is the history of the pre-existing illness of hypertension and diabetes. The representative of the complainant vehemently denied the history of diabetes and hypertension and emphasized that the recording in the hospital papers were due to the oversight of the hospital staff. He also submitted a clarification received from one Dr.Akshay stating as follows: " Kindly note regarding patient by mistake it was recorded that she is DM & HTN. Actually she is not a k/c/o DM or HTN.."

However, this forum makes the following observations regarding the recording of diabetes and hypertension of the complainant.

- **The admission history and physical assessment sheet dated 4.10.2011, which is the date of admission records as follows: "...k/c/o DM + HTN on regular medicines." Under the column current medications, (which is prior to the admission), it written**

as T.Glucomet SR (500mg), T.X-tor 10 mg. It is a known fact that tablet Glucomet is taken for treatment of diabetes and tablet X-tor, which is Atorvastatin is taken for cholesterol control.

- **One copy of the discharge card copy submitted shows under the past history column ' k/c/o DM with HTN'.**
- **The complainant has been given tablet glucomet SR 500mg on every day of her admission.**
- **Glucotest which is a test for monitoring blood glucose has been done on every day of confinement to the hospital.**
- **There is one other certificate issued on the letter head of the hospital where duration of HTN & DM is written as ' since 2-3 years'.**
- **The syrup 'ALEX' given to her on 6.10.2011 is also sugar free.**
- **Surprisingly, there is one other copy of discharge card which states under the past history column ' no past history of DM/HTN/ or Bronchial Asthama'**
- **Even the diagnosis in the two discharge card copies differ. In one discharge card, the diagnosis is stated as " ?Entercolitis with ?malarial fever with urinary tract infection". In one other card the diagnosis is stated as " ?Entercolitis with ?malarial fever with urinary tract infection in a k/c/o DM and HTN ". This appears to be very strange.**

With such evidence in the file, I am surprised to note that Dr.Akshay has given a certificate that the patient was not k/c/o DM & HTN. In fact the medicines that she was taking prior to the admission have also been recorded in the hospital papers. Further the said recording of the pre-existing DM/HTN has been repeated in several sheets of the hospital papers and she has been continuously investigated and monitored for blood glucose and was also treated every day with tablet Glucomet 500mg. This being so, I am also surprised by the way in which the representative of the complainant repeatedly contended during the hearing that his sister was never a case of these disorders either at the time of admission or now. There appears to be no documentary evidence to his having objected then to such recording by the hospital either. Generally, no hospital and especially a tertiary care hospital of repute like wockhardt hospital would ever treat a patient for a disorder that she is not suffering from.

Hence, based on the available papers on record, this forum has reasonable grounds to conclude that the complainant has a past history of DM and HTN and the same have also not been disclosed to the Company in the proposal form. It is to be noted here that the contracts of insurance are contracts of utmost good faith and as reiterated by the Company in the declaration under the proposal form, if after the insurance is effected, it is found that any of the statements, answers of particulars are incorrect or untrue in any respect, the Company shall have no liability under the insurance.

Therefore in the facts and circumstances of the case, there are no justifiable reasons to intervene with the decision of the Company and their stand is sustainable.

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Complaint No. GI-1356 of 2011-12
Award No. IO/MUM/A/GI /2013-2014
Complainant : Shri. S. Arunkumar
Respondent : The Oriental Insurance Co.Ltd

Award 10/2013

Son of the complainant was covered under Group Mediclaim (Floater) Policy bearing No. 111600/48/2011/237 issued for the period 4.9.2010 to 3.9.2011 by The Oriental Insurance Co. Ltd. to the employees of M/s Heurtey Petrochem India Pvt. Ltd. Master Adarsh met with an Road Traffic Accident and was hospitalized in S.S. Institute of Medical Sciences & Research Centre, Davangere from 1.9.2011 to 2.9.2011 for the complaints of CLW over forehead and soft tissue injury to Lt. elbow. When complainant lodged a claim for Rs.4039/- under the Policy, M/s Paramount Health Services (TPA) Pvt. Ltd., TPA of the Insurance Company repudiated the same stating that indoor treatment given did not necessitate hospitalisation. Not convinced with the decision of the Company, when complainant represented to the Insurance Company, they upheld TPA's decision. Being aggrieved complainant approached this Forum for redressal of his grievance.

Complainant however did not turn up for the hearing. When he was telephonically contacted, he requested to take his written statement on record.

Insurance Company submitted that insured's family met with an accident whilst travelling in a bus on 1.9.2011 on the way to Bangalore. He said that insured submitted three claims under the Policy, out of which two claims have been settled by their office in respect of his wife & son's hospitalisation. He said that the claim reported for the hospitalisation of Master Adarsh has been rejected by them under exclusion clause 4.10. He said that during hospitalisation only few investigations were done and hence it was observed that hospitalisation as such was not warranted.

Observations of the Forum :

1) **The hospitalisation was aftermath of an accident, where the other family members also suffered injuries. It was not a planned hospitalisation.**
2) **The claim in respect of other family members have been settled by the Company.**
3) **In the hospital papers, against the History, it is clearly mentioned as RTA on 1.9.2011 and MLC number has also been mentioned.**
4) **The Hospital papers indicate that the child suffered from CLW over forehead and had soft tissue injury to left elbow. To arrive at final diagnosis, it is necessary to carry out the necessary investigations.**
5) **It is well understood that the expenses incurred on the tests done for a mere check-up are not payable under Mediclaim Policy. However, in the instant case, the child suffered from the injuries due to Road Traffic Accident. He did not voluntarily entered the Hospital for a check-up.**
6) **The decision as to whether to treat a person as an inpatient or in OPD is a sole prerogative of a doctor/hospital where he was taken and a patient/his relatives hardly has any say in it.**

7) **The circumstances under which the child was hospitalized were beyond the control of the complainant.**

Thus, considering the above facts, the Insurance Company was directed to settle the claim of the complainant for Rs.4,039/- on Ex-gratia basis within a period of 7 working days under intimation to this Forum.

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Complaint No. GI-1395/2011-2012
Complainant: Shri Birbal R. Chauhan
Respondent: The Oriental Insurance Company Ltd.
Award dated :10/2013

Complainant Shri Birbal R. Chauhan alongwith his wife and daughter, covered under Individual Mediclaim Policy No. 124600/48/2012/1367 for the period 18.06.2011 to 17.06.2012 for Sum Insured Rs.1,00,000/- each, issued by The Oriental Insurance Co. Ltd., approached this Forum with a complaint against the Insurance Company in respect of reduction in Sum Insured of his daughter Ms. Varsha Chauhan from Rs.2.5 lacs to Rs.1 lac effective from the policy year 2010-11.

Records were perused and a joint personal hearing of the parties to the dispute was held. Shri Birbal R. Chauhan appeared and deposed before the Ombudsman. He submitted that upto the year 2004-05 he alongwith his wife and daughter were covered for Sum Insured of Rs.1 lac. In the year 2005-06 he requested the Company's agent to increase the SI for his daughter Ms. Varsha Chauhan to Rs.2.5 lacs for which he paid an additional premium. However, the Company increased the SI only to Rs.2 lacs in the said year and despite his repeated requests, the policy for the subsequent year i.e. for 2006-07 was also issued with the same S.I. of Rs.2 lacs. On his protest, the S.I. in the following year policy i.e. for the year 2007-08 was increased to Rs.2.5 lacs which continued till the year 2010. But again, during the policy renewals for the years 2010-11 & 2011-12, the S.I. was reduced to Rs.1 lac. He stated that such reduction in the SI for his daughter done by the Company without his consent and without giving any notice to him was not acceptable to him. He requested the Forum to intervene in the matter.

Shri Chandrasen U. Kalkhair, Asst. Manager, The Oriental Insurance Co. Ltd. stated that Shri Chauhan along with his family members was covered with another D.O. of their Company since the year 2004. In the year 2006, their Head Office issued a circular and as per the provisions of the said circular, the sum insured must be identical for primary insured and the dependants. However, despite this Ms. Varsha Chauhan continued to be insured for S.I. of Rs.2.5 lacs which was higher than the SI of the primary insured, for reasons not known to him. He further mentioned that till the year 2010, their computer system was allowing manual changes to be done to the SI upto any amount. However since the year 2010, their computerized system does not allow any manual change to be made in the S.I. The policy was transferred to their D.O. in the year 2011-12 and they

have issued the policy on the basis of the previous policy issued by another D.O. which mentioned the S.I. for Ms. Varsha as Rs.1 lac.

On hearing both the parties, the Ombudsman raised the following queries to the Company:

1. **The Circular dt. 23.08.2006 referred to by the Company does not mention as to what happens to the existing dependant members who are enjoying a higher S.I. than the primary insured as on the date of the circular.**
2. **Why was the higher S.I. for Ms. Varsha continued upto the year 2010 when the said circular restricting the SI for dependent members was issued in the year 2006?**
3. **On what basis was the S.I. suddenly reduced to Rs.1 lac in the year 2010?**
4. **Whether any circular issued by the Company will be applicable prospectively or with retrospective effect?**

Shri Kalkhair submitted that since the previous policies were issued by another D.O. of their Company, he was not in a position to reply the above queries.

The Company was directed to submit their reply to the same within 7 days to this Forum.

The Insurance Company vide their letter dt. 04.09.2013 replied as under:

1. **We do agree that the circular issued dt. 23.08.2006 is silent on the subject. But according to circular, this policy was effective from 15.09.2006 accordingly all the policies whether new or renewals were to be issued as per circular.**
2. **It might be a clerical mistake on our part that the office has overlooked the guidelines of the said circular.**
3. **The Policy was renewed with reduced sum insured since year 2010. The basis of reduction in sum insured was as per said circular which was effective from 15.09.2006. The insured paid premium for sum insured of Rs.1 lac only and accordingly we renewed the policy with reduced sum insured. The insured also did not raise any objection as sum insured reduced since 18.06.2010 and paid the lesser amount of premium as per demand.**
4. **The circular dt. 23.08.2006 issued above is clearly mentioned that it was effective from 15.09.2006.**

On scrutiny of the papers coupled with the depositions made on behalf of both the parties, it is observed that Shri Birbal Chauhan along with his family members, was covered for S.I. of Rs.1 lac each upto the year 2004-05. While renewing the policies for the years 2005-06 & 2006-07, on the insured's request for enhancement of SI to Rs. 2.5 lacs in respect of his daughter, Ms. Varsha Chauhan, her S.I. was increased to Rs. 2 lacs. Thereafter, while renewing the policies for the years 2007-08 & 2008-09, the S.I. for Ms. Varsha was enhanced to Rs.2.5 lacs as per Shri Chauhan's request. However, in the policies for the years 2010-11 & 2011-12, the S.I. was again reduced to Rs.1 lac. Shri Chauhan represented to the Insurance Co. vide his letter dt. 16.10.2011 against the arbitrary reduction in S.I. without his consent, but to no avail. The Insurance Company,

on the other hand, has stated that during the renewal for the year 2010-11 the S.I. for Ms. Varsha Chauhan was reduced to Rs. 1 lac as per the Circular dt. 23.08.2006 issued by the Company, which provided that the SI for primary insured and the dependants must be identical; however children may be covered for 50% SI. The Company has further stated that the said circular was effective from 15.09.2006; however, the S.I. for Ms. Varsha might have been continued to be higher than the primary insured till the year 2010 due to oversight.

Thus, the dispute centers on the issue of reduction of S.I. enjoyed by Ms. Varsha Chauhan from Rs.2.5 lacs to Rs.1 lac. In this connection, it has to be noted that Mediclaim policy is an annual policy and each renewal is a fresh contract. In an Insurance contract, the proposer puts an application to the Insurance Company, requesting for certain coverage and it is up to the Insurance Company to accept the terms, condition and exclusions suitable to them as per their underwriting guidelines and practice. If such an offer is not acceptable to the insured, he has the option to get the contract cancelled. Of course, there was definitely a lapse on the part of the Company in continuing higher S.I. than that permitted by its circular during the years 2007-08, 2008-09, 2009-10. However, just because there was an error on the part of the Company, they cannot be forced to continue the same mistake by ignoring their underwriting guidelines. It is to be borne in mind that this Forum has the inherent limitations in going beyond its purview and would not interfere with the underwriting decisions of the Companies in terms of renewals, fixing the terms of renewals including enhancement of sum insured etc.

No doubt, it would have been a customer-friendly approach on the part of the Company if they would have given prior notice of reduction in S.I. to the policy-holder.

In the facts and circumstances of the case, the complaint of Shri Birbal R. Chauhan against The Oriental Insurance Co. Ltd. for restoring the Sum Insured of Ms. Varsha Chauhan to its original status is not sustainable.

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Complaint No. GI-1797/2011-2012
Complainant: Shri Dilip Natekar
Respondent: United India Insurance Co. Ltd.

Award dated : 12/2013

The complainant was covered under Individual Health Insurance Policy No. 021200/48/10/97/00001223 for the period 15.06.2010 to 14.06.2011 for S.I. of Rs.1,00,000/-, issued by United India Insurance Co. Ltd. He approached this Forum with a complaint against repudiation of the claim lodged for Rs.85,200/- under the policy for his hospitalization at Anand Hospital, Nallasopara, Dist. Thane from 27.05.2011 to 01.06.2011 for the treatment of Bacterial Meningitis.

Records were perused and a joint hearing of the parties to the dispute was held. The complainant stated that he is insured with United India Insurance Co. Ltd. since the last 6-7 years. On 27.05.11 he suffered from fever with chills and vomiting following which he was admitted by his uncle to Anand Hospital, Nallasopara. He had given immediate intimation of hospitalization to the TPA. During the course of hospitalization his blood sample tests were done several times and he was examined by the doctor and treated with medicines and injections. After treatment he was discharged from the hospital on 01.06.2011. The claim lodged with the Insurance Company for the said hospitalization was rejected by their TPA stating that there were discrepancies in the claim documents.

The company representative submitted that on receiving the claim documents, the TPA's doctor visited the hospital for verification, but the hospital authorities neither refused to show him the indoor case papers nor allowed him to inspect the ICU ward and basic facilities at the hospital. Thereafter the doctor visited Medicare Laboratory for cross-verification; however the lab technicians could not show him records of any tests conducted relating to the said patient, either on their system or in their Registers. Thereafter, the Company appointed an independent investigator who pointed out the following discrepancies in the claim:

1. **The hospital was 12-bedded with no ICU facility whereas the patient was charged for ICU admission.**
2. **The hospital staff did not co-operate to confirm infrastructure of ICU and other basic facilities for treating critical patients.**
3. **All the Indoor case papers were recorded in single handwriting.**
4. **The recordings in the ICPs showed that the patient was afebrile with temperature of 98 throughout the period of hospitalization.**
5. **Though the patient was diagnosed of bacterial meningitis, there was no imaging evidence of meningeal infection.**
6. **Pathology investigations lacked authenticity.**

In view of the foregoing, the claim was repudiated as per clause 1.3 of the policy.

However when asked by the Ombudsman for documentary evidence viz. written confirmation from the hospital/pathological laboratory in support of their contentions, the Company/TPA representative was not in a position to produce the same. The Company requested for some time to enable them to submit the necessary documentary evidence, which was acceded to. The Company was advised to obtain a letter from the complainant authorizing them to visit and inspect the relevant hospital records which was given by the complainant. The hearing was re-scheduled to 02.12.2013 at 2.30 p.m. when both the parties were directed to be present before the Forum with proper documentary evidence.

As per directions given during the hearing held on 19.11.2013, both the parties' alongwith representative of the TPA re-appeared before the Ombudsman. He submitted that as instructed by the Forum, with the insured's written authority, he himself visited Anand Hospital, Nallasopara to verify the facts and obtain documentary evidence about the case;

however the hospital authorities refused to give him any information and stated that they could do so only if he brings an authority letter from the BMC. He then went to the insured's residence to seek his assistance only to be informed that he does not reside at the said address. His attempts to contact the complainant over telephone several times also did not yield any response. He however managed to obtain photographs of the hospital premises which show that the hospital does not have the requisite infrastructure of ICU and other basic facilities. The complainant replied stating that as he was pre-occupied due to his business, he could not accompany the TPA's doctor to the hospital.

After hearing the depositions on behalf of both the parties, it was observed that the discrepancies in the claim documents pointed out by the Company/TPA could not be grossly overlooked. The documentary evidence sought from the Company was essential to arrive at an appropriate decision in the matter. However, since the hospital authorities refused to part with the required information and also since there was no co-operation from the complainant's side in this regard, this Forum is not in a position to adjudicate in the matter and is therefore constrained to dismiss the case.

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Complaint No. GI-2619/2011-2012
Complainant: Shri Guruprasad M. Lahoti
Respondent: The New India Assurance Company Ltd.

Award dated : 03/2014

Smt. Indubai M. Lahoti, mother of the complainant Shri Guruprasad M. Lahoti was covered under Individual Mediclaim Policy No.140702/34/10/11/00003858 for the period 30.07.2010 to 29.07.2011 for Sum Insured Rs.1,00,000/- plus 5% C.B., issued by The New India Assurance Co. Ltd. Shri Guruprasad Lahoti approached this Forum with a complaint against the Insurance Company on account of non-settlement of the claim lodged under the policy for CT Angiography undergone by Smt. Indubai Lahoti at P.D. Hinduja Hospital, Mumbai on 09.10.2010.

Records were perused and parties to the dispute were called for a personal hearing on 13.02.2014 at 2.45 p.m. Shri Guruprasad Lahoti appeared and deposed before the Ombudsman. He submitted that his mother was under the care of Dr. Joglekar from J.J. Hospital for heart problems. He further submitted that thereafter his mother experienced dyspnoea and he consulted the same doctor who took an ECG and on finding some variations, he advised CT Angio. They then approached Hinduja Hospital for the same and the tests were conducted. He stated that Angiography was covered under the policy and there was no need for admission to a hospital. He also complained that the denial letter was received by him after nearly 15 months because of which his chance of claiming with his office was forfeited. He hence requested for justice in the case.

The Company was represented by Smt. Kalpana Pednekar, A.M. She was assisted by Dr. Prakash Ghag from the TPA. They submitted that the insured was not admitted to Hinduja Hospital and the CT Angio which is an imaging technique was carried out under OPD basis. Hence the claim was denied under the policy as the policy pays for only hospitalization expenses.

Thus the dispute is about denial of claim by the Insurance Company for CT Angio undergone by Smt. Lahoti on the ground that it is an OPD procedure not payable under the policy. It is the contention of the complainant that CT Angiogram was advised by her treating cardiologist in order to evaluate coronary arteries of heart and is covered under the policy.

Let us examine what CT Angiogram is all about. A computerized tomography (CT) coronary angiogram is an imaging test to look at the arteries that supply the heart muscle with blood. Unlike a traditional coronary angiogram, CT angiograms do not use a catheter threaded through the blood vessels to the heart. Instead, a coronary CT Angiogram relies on a powerful X-ray machine to produce images of the heart and heart vessels. CT angiogram does not require the recovery time needed with traditional angiograms. Angiography carries the same risks as major surgery, including blood clots, cardiac arrest and infection. A CT angiograph, however, does not pose these risks. Coronary CT angiograms are becoming a common option for people with a variety of heart conditions.

The fact cannot be denied that Mediclaim Policy basically grants reimbursement of hospitalization expenses under certain conditions and in all these cases, 24 hours hospitalization as such is not compromised but only relaxation of minimum period of hospitalization is granted to specific treatments in view of lesser time taken now for these treatments as compared to earlier times due to advancement of medical science. From the above, it can be seen that CT angiogram is a non-invasive test done on OPD basis and does not require confinement to a hospital. Further, unlike the conventional angiography, this is only an investigation aid and is not therapeutic.

Under the facts and circumstances of the case, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, I do not find any valid ground to intervene with the decision of the Insurance Company in the matter and hence no relief can be granted to the complainant.
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Complaint No. GI-1480/2011-2012

Complainant: Shri Bansee Kukreja
Respondent: The New India Assurance Co. Ltd.

Award dated : 10/2013

Shri Bansee Kukreja was covered under Individual Mediclaim Policy No.140300/34/09/11/00022362 for the period 23.02.2010 to 22.02.2011 for S.I. of Rs.1,00,000/- with C.B. Rs.32,500/-, issued by The New India Assurance Co. Ltd. Shri Kukreja approached this Forum with a complaint against repudiation of the claim lodged for Rs.1,11,304/- under the policy for his hospitalization at Surgicare Hospital, Andheri (W), Mumbai from 10.03.2010 to 15.03.2010 for the treatment of Acute Urinary Tract Infection with severe Viral Myositis.

Records were perused and a joint hearing of the parties to the dispute was held . Shri Bansee Kukreja appeared and deposed before the Ombudsman. He submitted that he is insured with The New India Assurance Co. Ltd. since 20 years. In January 2010 he suffered from Myositis and was admitted to Surgicare Hospital, Andheri and was discharged after 21 days of treatment. The claim lodged for the said hospitalization was paid by the Insurance Company. He suffered from similar symptoms again in March 2010 and had to be re-admitted to the hospital for treatment. He stated that immediate intimation of hospitalization was given to the TPA for both the hospitalizations. However, this time the Company rejected the claim citing the reason that his clinical features contradicted the diagnosis of Myofascitis as mentioned in the Discharge Card. He wrote to the Company clarifying that the ailment for which he was treated was "Myositis" and not "Myofascitis"; but the TPA/Company kept on rejecting the claim repeatedly stating the ailment as Myofascitis. He averred that his ailment was Myositis and not Myofascitis as considered by the TPA and requested the Forum for settlement of the claim.

The New India Assurance Co. Ltd. was represented by Smt. Kanyakumari Hari, A.M. along with Dr. Bhavna of TPA. She submitted that since the claim amount appeared to be on the higher side, the claim was investigated by the TPA through two independent agencies when the following discrepancies were observed:

- **The treatment given was only by way of medical management and removal of catheter which did not necessitate hospitalization. Also the symptoms noted did not require use of such high dosage of antibiotics.**
- **The dosages of different medicines mentioned in the ICP papers did not match with the quantities shown as purchased and charged by the hospital which were on the higher side. The bill for medicines issued by the chemist M/s Ratika Medical &**

General Stores was not date-wise but was issued at one go without any supporting prescriptions.

- **As per ICP records, Dr. Satej Sabnis, Urologist had visited the patient only once whereas the hospital had charged for four visits by Dr. Satej. The hospital is known for giving inflated bills.**
- **As per ICP, the patient was discharged on 13.03.2010 whereas the Discharge Card mentioned the date of discharge as 15.03.2010.**
- **During the course of investigation, Shri Kukreja mentioned to their investigator that he had consulted Hinduja Hospital for second opinion; however the papers of the said consultation as well as those related to his previous hospitalization in January 2010 were not provided to the investigator.**

In view of the aforesaid discrepancies observed in the claim papers, the claim was rejected by their TPA and the Company's Grievance Cell upheld the decision of the TPA.

On hearing the depositions of the parties, the Forum observed as under:

- **Shri Kukreja had given intimation of hospitalization to the TPA. Despite this, the TPA doctor did not visit the hospital anytime during the course of his hospitalization.**
- **Though the discrepancies pointed out by the TPA/Company could not be overlooked, the same were not supported by any clinching evidence.**
- **The TPA/Company chose to reject the claim without calling for any clarification from the insured on the anomalies observed by them, thus denying him a fair chance to explain his position. Even the Company's Grievance Cell did not look into the matter in its right perspective and ignored all his pleas thereby forcing him to approach this Forum for redressal of his grievance, which was very unfortunate.**

In view of the above, the Complainant was directed to submit to the Company clarification from the hospital within 15 days on the following discrepancies:

1. **In date of discharge from the hospital as mentioned in the ICPs and that in the Discharge Card.**
2. **In prescription by the hospital and medicines purchased for Rs.42,762/-.**
3. **In number of visits done by Dr. Satej Sabnis .**

The Company was directed to relook into their decision in the light of the clarifications submitted by the complainant and inform the Forum about their decision with supporting documents within 7 working days. The hearing was re-scheduled to 04.10.2013.

As per directions given during the hearing held on 11.09.2013, both the parties alongwith the representative of the TPA re-appeared before the Ombudsman on 04.10.2013 at 12.30 p.m. Shri Kukreja stated that as advised by the Forum during the previous hearing, he had submitted to the TPA, a letter from the hospital clarifying that the difference in the date of discharge mentioned in the ICPs and that on the discharge card was due to clerical error and the correct date of discharge was 15.03.2010. As regards, the discrepancies in the medicines prescribed by the hospital and bills issued for the same and also in the no. of visits of Dr. Satej Sabnis, Shri Kukreja informed that the

hospital was not in a position to give any clarification as the hospital management had since undergone a change and the old records were not easily retrievable.

Smt. Kanyakumari stated that the clarification about date of discharge as submitted by the complainant was acceptable to them. However, the discrepancies in the medicine bills and no. of doctor's visits still remained unexplained.

After hearing the depositions on behalf of both the parties, it was observed that the fact, duration and cause of hospitalization were not disputed by the Insurance Company. Under the circumstances, with a view to arrive at an amicable settlement between the parties, the Insurance Company was directed to settle the claim for the admissible expenses including medicines recorded in the indoor case papers and restricting visit fees of Dr. Satej Sabnis to the no. of visits as recorded in the ICPs. In the event of the insured submitting the required details at a later date to the Company's satisfaction, the claim may be re-opened and settled for the balance amount.

Both the parties expressed their consent to the recommendations given by the Forum.

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Complaint No. GI-1591/2011-2012
Complainant: Smt. Beena Valia
Respondent: United India Insurance Co. Ltd.

Award dated : 11/2013

Smt. Beena Valia was covered under Individual Health Insurance Policy-2009 No.120900/48/10/97/00004181 for the period 24.08.2010 to 23.08.2011 for S.I. of Rs.1,25,000/-, issued by United India Insurance Company Ltd. She lodged a claim under the policy for Rs.86,870/- in respect of her hospitalization at Surgicare Hospital, Andheri (W), Mumbai from 16.02.2011 to 22.02.2011 for the treatment of injuries caused to her following a road accident on 16.02.2011. The claim was repudiated by M/s. TTK Healthcare TPA Pvt. Ltd. citing clause no.5.5 of the policy stating that the ICPs and the claim had been manipulated. Smt. Valia represented to the Insurance Company against the TPA's decision; however the Company upheld the stand taken by the TPA. Aggrieved, she approached this Forum requesting intervention in the matter of settlement of the claim.

Records were perused and a joint hearing of the parties to the dispute was held. Smt. Beena Valia appeared and deposed before the Ombudsman. She submitted that on 16.02.2011 she had a fall on the road due to skidding of her scooter near Lotus Petrol Pump, Andheri and sustained deep injury on her leg and contusion on the chest. As her

wound was bleeding profusely, she was immediately admitted by the passers-by to the nearby Surgicare Hospital. The hospital authorities then informed the Police who came to the hospital and took her statement. Whilst in the hospital, her wound was sutured very meticulously by the doctors so that it leaves a minimum scar on the skin and she was also given physiotherapy. After treatment, she was to be discharged from the hospital in a couple of days; however on the 4th day of admission she developed infection on the wound which required monitoring and frequent dressings and was also having tremendous backache. As her place of residence was far away from the hospital and there was nobody at home to look after her, she was advised to continue her stay in the hospital and was discharged only on 22.02.2011. The claim lodged under the policy was rejected by the Insurance Company stating it to be fraudulent. She pleaded that the accident and injuries for which she was treated in the hospital were genuine and requested for settlement of the claim.

United India Insurance Co. Ltd. was represented by Smt. Samiksha Agnihotri, Dy. Manager alongwith Dr. Shruti of TPA. She submitted that while processing the claim, it was observed that there was no mention of any injuries in the Police papers but only of contusion, while the hospital papers mentioned that Smt. Valia had sustained Deep lacerated Wound of 8cmx2cmx2cm on the left leg. In view of the said discrepancy, the claim was investigated through M/s. HI-TECH Medical Services who visited the insured's residence at the given address alongwith a lady doctor to enquire about the accident. The insured narrated the incident to them. The investigator then with the insured's permission, took photographs of the site of injury which revealed that there was no mark of the injury except a single stitch mark of about an inch. Dr. Shruti submitted that if Smt. Valia had suffered a lacerated deep wound, it was unlikely that it would leave such a small scar as not to be visible after 6 months when the investigation was done. Also, it was felt that the nature of injuries did not warrant such prolonged hospitalization for six days for which necessary clarification was sought from the treating doctor. In view of the said discrepancies observed, the claim was rejected under clause 5.5 of the policy.

After hearing both the parties, the Company was asked as to if they were of the view that the claim papers were manipulated in as much as there was no accident/injury and consequently no hospitalization at all or there was no necessity for such prolonged hospitalization and the insured had influenced the hospital to produce inflated bills, why did the Company not find it fit to approach the hospital and question the treating doctor or obtain the statement of hospital authorities to substantiate their stand that the claim was a fabricated one. The Company representative requested the Forum to grant them a week's time to obtain necessary documentary evidence from the hospital, which was agreed to by the Ombudsman. Both the Insurance Company and the complainant were directed to submit further documents, if any in support of their stand, within 7 days, failing which the Forum would proceed in the matter based on the available papers.

The Company's TPA vide their e-mail dt. 11.09.2013 informed the Forum that as per directions, their investigator approached the hospital authorities on 05.09.2013 when it was observed that the hospital was undergoing renovation and change in management and Dr. Shetty was not available in the hospital. Thereafter he called Dr. Umesh Shetty and met him for obtaining a written clarification with regard to the case; however the doctor expressed his inability to do so since it was an old case stating that it would take time since the hospital was undergoing renovation.

On perusal of the documents produced on record, it is observed that Smt. Beena Valia was admitted to Surgicare Hospital on 16.02.2011 with h/o skid from Activa Bike at Lotus Petrol Pump, Andheri. As per notings in the hospital papers, she had c/o Deep CLW 8cm X 2 cm at upper 1/3 rd medial aspect left leg, contusion Chest left 8-9 ribs, severe low back pain, headache, giddiness & nausea. She underwent Debriment + suturing, strapping chest + Rib binder, Epidural Intrafacetal Block Injection Tens Back and Physiotherapy for back pain. ICP notings on 20.02.11 show that patient was better with no fresh complaints and was advised discharge. Notings on 21.02.11 also showed the same remarks. There were no notings for 22.02.11 on which date she was discharged from the hospital. When asked by the Company to justify hospitalization for such a prolonged period, her doctor clarified stating that as her wound had superficial infection, she had to be on I.V. Antiobiotic Tazact thrice a day for 5 days – hence prolonged stay. During hearing, the complainant also stated that she had tremendous backache and was unable to move, hence was advised to continue her stay in the hospital. However, notings in the hospital papers reveal that her back pain had reduced from 20.12.11 and there were no fresh complaints.

Analysis of the case reveals that there are certain obvious discrepancies in the claim as pointed out by the Insurance Company to which the complainant could not provide any satisfactory clarification. Further, it is also observed that there is no mention of any suturing material in the medical bills which is also quite surprising and raises doubts about the injury and treatment. But, at the same time, the Company has also not been able to substantiate their stand of rejection of the claim with cogent documentary evidence. In view of the same, taking a balanced view of the situation, United India Insurance Co. Ltd. is directed to settle the claim of the complainant Smt. Beena Valia on ex-gratia basis for 50% of the admissible expenses incurred in respect of her hospitalization at Surgicare Hospital

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Complaint No. GI-2021/2012-2013
Complainant: Shri Bhavesh K. Vora
Respondent: United India Insurance Co. Ltd.
Award dated : 10/2013

Shri Bhavesh K. Vora alongwith his wife Smt. Niva B. Vora was covered under Individual Health Insurance Policy – 2010 No.020400/48/11/97/00008518 for the period 30.11.2011 to 29.11.2012 for S.I. of Rs.4,00,000/-, issued by United India Insurance Co. Ltd. Shri Vora approached this Forum with a complaint against the Insurance Company in respect of short-settlement by an amount of Rs.2,00,688/- of the claim lodged for Transcatheter ASD closure undergone by his wife at Nanavati Hospital Mumbai on 01.06.2012.

Records were perused and a joint hearing of the parties to the dispute .Smt. Niva Vora duly authorized by Shri Bhavesh Vora, appeared and deposed before the Ombudsman. She submitted that she was admitted to Nanavati Hospital from 31.05.2012 to 02.06.2012 and underwent Tanscatheter ASD closure. The claim lodged under the policy for a total amount of Rs.3,83,788/- was settled by the Company for Rs.1,83,100/- deducting Rs.2,00,688/-. Out of the total deductions, major amount of Rs.2 lacs was towards Surgeon fees and anesthetist charges as these were not included in the main hospital bill. She stated that she thereafter personally met the hospital authorities a couple of times and also the surgeon Dr. Bharat Dalvi with a request to include the charges in the hospital bill; however her request was turned down stating that this was the usual practice followed by the hospital since the doctor's charges are negotiable. She stated that the Surgeon and anesthetist had issued her proper receipts for the payments made to them directly and since their services were required for the surgery undergone by her, she requested for directions to the Company to settle the balance amount of claim.

United India Insurance Co. Ltd. was represented by Smt. Rupali Chaubal, A.O. alongwith Dr. Mukesh of TPA. She stated that the claim of the insured was settled after deducting Surgeon & Aneshthetist fees not forming part of the main hospital bill as per condition no. 1.2 of the policy. She defended the decision of the Company.

After hearing the depositions of both the parties it was felt that though technically speaking, the Company's stand to disallow doctors' fees charged outside the hospital bill from the claim amount being as per policy terms and conditions, cannot be faulted with, it is very unfortunate to find that hospitals of the standard of "Nanavati Hospital" encourage such practices thereby causing unnecessary hardship and monetary loss to their patients for no fault of theirs. Even the surgeons of high repute are resorting to such practices which work to the detriment of the patients who seek their services. It is high time that all concerned authorities take congnizance of such malpractices and take appropriate measures to curb the same. In the instant case, it was observed that Smt. Vora has undergone a heart surgery of serious implications and has genuinely incurred huge expenses for the same for which she is also adequately covered under the policy and the payments are made by cheque. In view of the same, the Company was requested to revisit the case by taking a considerate approach with a view to mitigate the hardship caused to the insured and inform their final decision in the matter to the Forum

within 10 days. The complainant was also suggested to approach the hospital authorities and try to obtain a consolidated bill for the total amount including doctor charges and submit the same to the Insurance Company.

The Insurance Company vide their letter dt. 10.03.2014 informed this Forum that the insured has not provided them the consolidated bill as required from the hospital and hence they were unable to admit the balance amount of claim for Surgeon fees. Under the circumstances, the decision the Company to disallow Surgeon fees not forming part of the main hospital bill from the total claim amount being as per policy terms and conditions, cannot be faulted with. I therefore do not find any valid ground to intervene with the decision of the Company and no relief can be granted to the complainant in the matter.

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Complaint No. GI-2274/2011-2012
Complainant: Shri Bipin Meghi Haria
Respondent: Cholamandalam MS General Insurance Co. Ltd.

Award dated : 03/2014

The complainant along with his family members was covered under Individual Health Policy No.2828/00022704/000/02 for the period 21.10.2010 to 20.10.2011 for Sum Insured of Rs.50,000/- each, issued by Cholamandalam MS General Insurance Co. Ltd. The complainant approached this Forum with a complaint against the Insurance Company in respect of rejection of the claim lodged for Rs.4,854/- towards expenses incurred on his admission to Citizen Hospital, Bhiwandi, Thane from 12.10.2011 to 13.10.2011 for the treatment of Severe Bodyache.

Records were perused and parties to the dispute were called for a personal hearing. The complainant stated that he is insured with Cholamandalam Insurance Co. since the year 2008. He had complaints of severe bodyache in June 2011 for which he was hospitalized and the claim for the same lodged under the policy was settled by the Insurance Company. Thereafter, he was again admitted to Citizen Hospital, Bhiwandi from 12.10.2011 to 13.10.2011 for the treatment of bodyache. A claim lodged for Rs.4,854/- under the policy for the said admission was however rejected by the Company stating that there was no need forhospitalization. He even forwarded a certificate from his treating doctor stating that hospitalization was necessary to avoid further complications; however the Company refused to reconsider the claim.

The company representative confirmed that the complainant is insured with them since the year 2008 and till date had lodged four claims with the Company. As regards the subject claim, he pointed out that as per the papers submitted by the insured had visited the hospital on OPD basis on 12.10.11 and was prescribed certain medicines. Thereafter he was admitted on the same day at 11.40 a.m.; however on perusal of the papers, it was

observed that the signs and symptoms suffered by him did not warrant inpatient hospitalization. During hospitalization, he was made to undergo certain basic blood tests and Widal test the reason for which is not clear as the patient did not suffer from fever at the time. Also the treatment given during hospitalization did not match with the OPD prescription and consisted only of oral tablets and injections which could have been given on outpatient basis. Hence the claim stood inadmissible under the policy and was repudiated.

On perusal of the documents produced before the Forum, it is observed from the copy of hospital Discharge Summary that the complainant was admitted only with complaints of Severe Body ache since 2 days. During hospitalization, he was treated with oral tablets and injections. Also, all the tests conducted during hospitalization were not consistent with the symptoms suffered by him and were also possible on OPD basis. The Company has contended that for this treatment, confinement to the hospital as an in-patient was not warranted. The certificate dt. 25.11.2011 issued by the hospital's treating doctor stating that "hospitalization was required for his severe bodyache with ?fever, to avoid any further complication and observation for one day" is not substantiated by any such noting in the hospital papers and such a certificate issued post rejection of the claim cannot be accepted.

Hence, the forum is inclined to agree with the Company's stand that the presenting symptoms or the tests done or the treatment advised did not establish that confinement was required in the hospital for diagnosis and treatment. In the facts and circumstances of the case, the company's decision to repudiate the claim, cannot be faulted with.
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Complaint No. GI- 1977 of 2011-2012
Complainant: Shri Harbhansingh Khalsa
<u>Respondent: Bajaj Allianz General Insurance Co.Ltd.</u>

Complainant had availed of Travel Age Elite Gold Policy No. OG-12-1904-6302-00000397 for the period 08.06.2011 to 04.12.2011 for his visit to U.S., from the insurer. Shri Khalsa approached this Forum with a complaint against the Insurance Company in respect of non-settlement of a claim lodged under the policy for his admission to University of Michigan Hospitals and Health Centres, US from 21.07.2011 to 23.07.2011 for complaints of syncopal episodes.

Records were perused and a joint hearing of the parties to the dispute was held. The complainant stated that while in U.S., during the 2nd week of July, he suffered from 2-3 episodes of fainting which occurred for the first time ever in his life. After number of such episodes he was taken to Michigan Hospital on 21.07.2011 where he was

investigated. The multiple tests carried out on him did not reveal any major abnormality and he was not given any treatment during his stay in the hospital but his condition was only monitored. Soon after discharge from the hospital, he returned to India on 30.07.2011 and underwent CAG and Angioplasty at Asian Heart Institute on 04.08.2011 but is still facing fainting problems. After 20 days of coming back to India, he received a letter from Michigan Hospital stating that 'Bajaj Allianz' had rejected the claim lodged under his policy. On enquiring with the Company he was given a copy of an e-mail which mentioned that Shri Harbansingh was admitted to the hospital with "complaints of high fever, shivering, breathlessness and nausea and had a past history of Kidney transplant, Mitral Valve Replacement and Gall Bladder removal". He stated that they were shocked to note the contents of the said letter as all the facts of ailments mentioned therein were totally wrong and not at all related to Shri Singh. Thereafter, only after rigorous follow-up with the Company, they were issued a letter rejecting the claim on the ground that his medical condition during his stay in U.S. had arisen due to complications of his pre-existing disease. Shri Surendra Singh stated that they completely disagreed with the Company's decision as Shri Harbansingh had not undergone any treatment for Seizure disorder, Arrhythmia or CAD during the said hospitalization which were his existing diseases. He averred that though he had undergone Angioplasty in the year 1995, he was not suffering from Hypertension or Diabetes. He pointed out that the discharge report of the hospital also mentioned that he did not have a heart attack and he was placed on a heart monitor with no explanation found. He even forwarded to the Company, a certificate from Dr. Tushar Shah, renowned Physician & Cardio Consultant in Mumbai under whom he has been taking treatment since several years, stating that the American

hospital did not mention the cause of his syncopal episodes as being related to his previous ailments but it said that the events were of unclear etiology and in fact, they ruled out seizure disorder and IHD as the cause of syncopes after doing multiple investigations. Shri Khalsa requested for settlement of the claim.

Bajaj Allianz Gen. Insce. Co. Ltd. was represented by Shri Sandip Jadhav, Executive-Claims alongwith Dr. Rashmi Sachdev. Dr. Rashmi stated that as per the overseas hospital papers, Shri Harbansingh Khalsa presented to the hospital with complaints of repeated episodes of syncope. The papers mentioned that he had past medical history of epileptic seizure disorder, coronary artery disease (angioplasty in 1995), Hypertension, Piles and Diabetes controlled with diet, none of which were mentioned in the Proposal form submitted by him at the time of taking the policy. For syncope he was evaluated for cardiac cause like ischemia predisposing to arrhythmia. His EEG revealed posterior and apex abnormality and hence he was subjected to Stress test. Therefore, based on the findings of the investigations and the fact that he had failed to disclose material information about his pre-existing diseases at the time of proposing for insurance, the claim stood repudiated. Dr. Rashmi stated that had he disclosed his pre-existing diseases in the proposal form, the Company could have taken an appropriate decision on whether an insurance cover was to be given and if so, with relevant exclusions. She defended the decision of the Company.

When Shri Khalsa was asked the reason for not disclosing his pre-existing ailments in the proposal form, Shri Surendrasingh replied that they had verbally informed about the same to the Company official, but they are not aware as to why it was not mentioned in the proposal form.

The Company representatives were directed to submit to the Forum within 7 working days, their clarification as to under what circumstances was the e-mail reply initially given to Shri Harbansingh which mentioned all the wrong facts about his health for rejection of his claim. The Insurance Company vide thier letter dt. 24.01.2014 furnished the following clarification to the same:

"The company's procedure for processing the claim requires registration of claim with Customer care and a unique I-track is logged with every new claim. When the complainant reached our Branch office and enquired for his claim, the status of the same was checked with the I-track number in the system, that time we found that the policy number was wrongly mentioned against the I-track which was later on corrected. The complainant asked for the copy of the I-track which was then denied by us but then the complainant started panicking in the office which forced us to give him copy of the details, hence we were left with no other option than giving the details of wrong I-track number lodged under wrong policy number in the word format. Thus, the circumstances that arose at that time led to submission of erroneous information to the complainant."

On perusal of the papers submitted or record coupled with the arguments advanced by both the parties, it is observed that Shri Khalsa was admitted to the hospital on 20.07.2011 for evaluation of several episodes of passing out over the last several days with past medical history of CAD status post angioplasty in 1998 & 2002, seizure disorder and hypertension. During hospitalization, he underwent CT Scan, EKG & Chest X-ray which did not show any significant abnormal findings except a PVT and slightly enlarged cardiac silhouette. However, his stress test was found to be positive and he was advised cardiac catheterization. His principal diagnosis was Seizure disorder, Arrhythmia possible

& CAD with +ve Stress test and Co-morbidities were recorded as CAD s/p LAD proximal stent & DM controlled with diet.

Thus, though his primary admission to the hospital was following several episodes of syncope, during the course of hospitalization he was also evaluated for seizure disorder, possible heart blockages and lower GI bleed secondary to hemorrhoids which were his pre-existing conditions although finally, the cause of his syncopal episodes could not be established. Further, though Shri Khalsa has denied that he was suffering from HTN or DM, the hospital papers make a specific mention of the same to which he has not objected at the appropriate time and hence there is no reason to disbelieve the same.

All these were important health conditions and the proposer ought to have declared the same at the time of proposing for insurance. As far as the duty of disclosure is concerned, it is certainly the duty of a person proposing for insurance to reveal all the important facts about the health status and pre-existing conditions of the persons to be insured, if any to enable the insurer to evaluate the risk in its proper perspective and decide about acceptance or otherwise of the same. It is this information furnished in the Proposal Form which forms the basis of the contract of insurance between the Company and the insured person. Failure on the part of the complainant to mention these facts to the Insurance Company certainly amounts to non-disclosure/suppression of material information entitling the Company to deny liability arising under the policy. Under the facts and circumstances of the case, the decision of the Company to repudiate the claim cannot be faulted with and I find no valid ground to intervene with the said decision.

If this Award is not acceptable to the complainant, he is at liberty to approach any other Forum for redressal of his grievance, as deemed fit.

ORDER

The complaint of Shri Harbansingh Khalsa against Bajaj Allianz General Insurance Co. Ltd. in respect of rejection of the claim lodged for his hospitalization at University of Michigan Hospitals and Health Centres, US from 21.07.2011 to 23.07.2011 for complaints of syncopal episodes, does not sustain. The case is disposed of accordingly.

A.K. DASGUPTA
INSURANCE OMBUDSMAN

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Complaint No. GI-802/2012-2013
Award No. IO/MUM/A/ GI- /2013-14
Complainant: Shri Kirti K. Mehta
Respondent: United India Insurance Co. Ltd.

Award dated : 10/2013

The Complainant was covered under Individual Mediclaim Policy No.020500/48/10/20/00007187 for the period 10.12.2010 to 09.12.2011 for S.I. of Rs.1,75,000/- plus 50% C.B., issued by United India Insurance Co. Ltd. Shri Mehta approached this Forum with a complaint against United India Insurance Co. Ltd. in respect of short-settlement of the claim lodged for his hospitalization at Joy Hospital, Chembur, Mumbai from 13.06.2011 to 04.07.2011 for the treatment of Diverticulitis.

Records were perused and a joint hearing of the parties to the dispute was held . The complainant submitted that against the claim lodged for a total amount of Rs.3,03,516/-, the TPA had reimbursed only Rs.2,48,194/-, disallowing the balance amount under various heads. He requested for settlement of the balance claim amount.

The company representative stated that that as per their records, the total claim amount was Rs.2,80,725/- out of which they had disallowed an amount of Rs.32,531/- on account of certain non-medical expenses, Consultation papers not submitted, Family doctor's fees for hospital visits and expenses falling beyond post-hospitalization period of 60 days.

On hearing the depositions of the parties, it was observed that there was some discrepancy in the actual amount claimed by the complainant and the bills available with the TPA. The complainant was therefore directed to provide the details of the bills for the differential amount to the TPA and the TPA was advised to re-process the claim after

obtaining all the required details and pay the balance amount of admissible expenses under the policy within 10 days. Both the parties to confirm the payment particulars to the Forum immediately thereafter.

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complaint No. GI-1346/2012-2013
Complainant: Shri Kishor Pai Kane
Respondent: The New India Assurance Company Ltd

Award dated : 11/2013

Complainant was covered under Individual Mediclaim Policy (2007) No.141400/34/10/11/00000911 for the period 15.01.2011 to 14.01.2012 for Sum Insured Rs.2,00,000/- with 20% C.B., issued by The New India Assurance Co. Ltd. Shri Kane approached this Forum with a complaint against the Insurance Company in respect of repudiation of the claim lodged under the policy for his hospitalization at Hinduja Hospital from 19.11.2011 to 26.11.2011 for the treatment of CAD with DM.

Records were perused and parties to the dispute were called for a personal hearing Shri The complainant submitted that he was insured since the year 2003. In November 2011, he was admitted to Hinduja Hospital for CAD + DM and underwent CABG. The claim lodged under the policy for the said hospitalization was rejected by the Company stating that he was suffering from DM since 7 years for which loading premium was not paid. He stated that in the year 2004 he had undergone Angioplasty and was also detected with DM and the Company had settled the claim for the same; as such the company had knowledge of the said disease but they failed to charge the loading on premium which he would have paid if asked to. He argued that there was no suppression of fact on his part. He further mentioned that in the year 2011 he suffered from stroke; however he was not allowed to lodge a claim for the same since his earlier claim was pending with the Company.

The company representative submitted that while renewing the policy in 2007, there was a gap of 12 days in renewal and hence the Company has treated it as a fresh policy. During the processing of the current claim lodged for CABG undergone by the complainant, it was observed by the TPA from the indoor case papers that the patient was suffering from DM since 7 years, which fell prior to the policy taken after a break, in the year 2007. As per policy terms and conditions, in case of pre-existing HTN or DM, the insured has to pay an extra loading on the premium. Since the complainant had not paid the extra loading for DM, the claim was repudiated by the TPA as per clause 4.1 of the policy. He defended the decision of the Company. After hearing the depositions advanced on behalf of both the parties, the Forum observed as under:

- **The complainant has been insured with the Company continuously since the year 2003 except for the break of 12 days in renewal of the policy in the year 2007.**

- **He was detected of DM and treated for the same in the year 2004 for which the Company had settled the claim. As such, the Company had knowledge that he was suffering from DM at the time of issuing the policy in the year 2007 which they have treated as a fresh one.**
- **In view of the same it was the duty of the Company to inform the policy-holder that he was liable to pay the loading on premium for DM. If the Company has failed to do so, it was very unfortunate on their part to pass the burden of their responsibility on to the insured and penalize him for not paying the loading after the claim has occurred.**
- **The Company was also not justified in disallowing the complainant to lodge the 2nd claim under the pretext that his previous claim was not settled which only reflects the insensitive approach of the Company towards their policy-holders.**

Under the circumstances, the Company was directed to settle the 1st claim of the complainant for the admissible expenses with interest @ 10.5% p.a. from one month after the date of submission of final claim till the date of actual payment after collecting the applicable amount of loading on premum within 10 days and inform payment particulars to the Forum. The Company was further directed to process the 2nd claim of the complainant on merits and settle the same, if otherwise admissible, expeditiously failing which the complainant is at liberty to lodge a fresh complaint with the Forum in respect of the same.

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complaint No.GI-1935/2011-12
Complainant : Shri M.Y. Patil

Respondent : The New India Assurance Co. Ltd

Award dated : 03/2014

The complainant was covered under Individual Mediclaim Policy (2007) No.141600/34/11/01/00003143 for the period 03.09.2011 to 02.09.2012 for S.I. of Rs.2,00,000/- with 10% C.B., issued by The New India Assurance Co. Ltd. He requested the Insurance Company to allow him to continue the said policy as per the terms and conditions of the Individal Mediclaim Policy 1996 since he was a senior citizen and the terms and conditions of the revised Mediclaim Policy 2007 were to his disadvantage; however the Company did not accede to his request. Aggrieved, he approached this Forum with a request for appropriate directions to the Insurance Company in accordance with the Circular issued by IRDA for Senior Citizens in this regard.

Records were perused and a joint hearing of the parties to the dispute was scheduled to be held before the Forum on 17.01.2014 at 12.00 p.m. However, the complainant Shri Patil vide his letter dt. 10.01.2014 expressed his inability to appear for the hearing and requested the Forum to decide the matter based on the documents submitted by him. The deposition of the representative of the Insurance Company was taken on record.

The company representative submitted that the complainant aged 68 years is covered under the Company's Mediclaim policy since the year 2001. On 28.09.2011 the insured represented to the Company expressing his unwillingness to migrate to Mediclaim policy 2007 referring to their H.O. Circular dt. 31.03.2009 which stated that in the light of IRDA's instructions, in cases of senior citizens who have expressed their unwillingness to migrate to Mediclaim Policy 2007, the old terms and conditions would continue to be applicable. The company representative stated that however, since the complainant had already renewed the policy for the period 03.09.2011 to 02.09.2012 and had approached them 25 days after the renewal, they expressed their inability to give him the benefit of old terms and conditions under the said policy and advised him to make a fresh request for non-migration before the next renewal. The company representative further stated in the meantime their Mediclaim policy 2007 was replaced by Mediclaim policy 2012 and while renewing the policy w.e.f. 03.09.2013, a fresh proposal form for the revised Mediclaim policy 2012 was obtained from the complainant wherein he has not made any such specific request for non-migration but has accepted the terms and conditions of the revised Mediclaim Policy 2012. He stated that they have not received any further guidelines from their Head Office regarding allowing senior citizens to continue with the old terms and conditions under the revised Mediclaim Policy 2012.

All the documents produced before the Forum have been scrutinized and it is observed that the policy of the complainant was already renewed for the period 03.09.2011-12 when his request for restoration to the terms and conditions of the old Policy 1996 was received by the Company. Hence they advised him to approach them with the said request at the time of subsequent renewal; however it appears that no such specific request was made by the complainant to the Company at the time of renewing the policy for the year 2012-13. Thereafter the policy of the complainant was further duly renewed w.e.f. 03.09.2013 by which time the Company had introduced Mediclaim Policy 2012 with further revision in the terms and conditions. As stated by the Company, a fresh proposal form was obtained from the complainant while issuing this revised Policy to him effective from 03.09.2013 and at that time also there was no request from the insured for continuing the old terms and conditions.

In view of the given facts and circumstances, the complaint of Shri M.Y. Patil for application of old terms and conditions to Mediclaim Policies 2007 issued to him, becomes infructuous and therefore the complaint stands closed at this Forum. The case is disposed of accordingly.

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Complaint No. GI- 2227 of 2011-2012

Complainant: Smt. Mary Fernandes

Respondent: Bajaj Allianz General Insurance Co.Ltd.

Award dated : 03/2014

Complainant had availed of Travel Age Elite Gold Policy No. OG-11-1904-9910-00007645 for the period 11.03.2011 to 08.06.2011 from the insurer. The complainant approached this Forum with a complaint against the Insurance Company in respect of rejection of a claim lodged under the policy for her hospitalization at the Northern Hospital from 14.03.2011 to 30.03.2011 for Acute Respiratory Distress, during her visit to Australia.

Records were perused and a joint hearing of the parties to the dispute was held. Shri Albert Fernandes, husband of the complainant Smt. Mary Fernandes appeared and deposed before the Ombudsman. He informed the Forum that Smt. Mary Fernandes expired on 07.05.2013 and hence he would be representing the case on her behalf. He submitted that Smt. Mary had availed of Overseas Travel Elite Gold Policy from 'Bajaj Allianz' for the period 11.03.2011 to 08.06.2011 through the Company's agent, for her visit to Australia. While in Australia, on 14.03.11 she was hospitalized for Acute Cough/Pneumonia for which a claim was preferred under the policy. However, the Insurance Company denied the payment stating that her ailment was a complication of her pre-existing condition and also for non-disclosure of material facts. He stated that the proposal form was filled in by the Company's agent and though she had mentioned her past history of Hodgkin's Lymphoma and the fact that she had undergone stem cell transplant in the year 2010, since she was completely cured, the agent deemed it not necessary to mention in the proposal form. He further stated that Dr. Samir Shah who had treated her of Hodgkin's Lymphoma had certified that she was in complete metabolic remission and was fit to travel; however the Company refused to reconsider the claim. .

The company representative stated that as per the overseas hospital papers, Smt. Mary Fernandes was admitted and treated for Acute Respiratory Distress secondary to pneumonia with past history of Hodgkin's Lymphoma, DM Type II & Asthma, none of which were mentioned in the Proposal form submitted by her at the time of taking the policy. Therefore, based on the fact that she had failed to disclose material information about her pre-existing diseases at the time of proposing for insurance, the claim stood repudiated. Dr. Rashmi stated that had she disclosed her pre-existing diseases in the proposal form, the Company could have taken an appropriate decision on whether or not an insurance cover could be given at all.

On perusal of the papers submitted or record, it is observed that Smt. Fernandes was admitted to The Northern Hospital, Australia on 14.03.2011 with complaints of lethargy, acute or chronic cough, functional decline. Her past history was mentioned as Hodgkins Lymphoma (2006) – remission, T2DM, Chronic renal impairment, Asthma and Hypothyroidism. She was investigated and diagnosed as suffering from Acute Respiratory distress and septic shock and required ICU management. After treatment, she was

discharged from the hospital on 30.03.2011. The claim lodged under the policy for AUD 29781.84 was rejected by the Company stating that the ailment for which she was treated, was a complication of her pre-existing ailments occurred before policy inception and also on the ground of non-disclosure of material information stating that the said history had not been disclosed in the proposal form. Smt. Fernandes then represented to the Insurance Company requesting reconsideration of the claim denying that she had past history of Asthma and DM Type 2 while agreeing to the history of Hodgkin's Lymphoma (cancer), but averred that she had received stem cell transplant in the year 2010 and was in complete metabolic remission. In support of her contention, she forwarded certificate dt. 14.06.2011 issued by Dr. Samir S. Shah and a letter dt. 30.03.2011 of Dr. Lachie Hays addressed to the Company. She further stated that the said past history of cancer was disclosed to the Company's agent who incidentally filled in the proposal form.

Dr. Samir S. Shah vide his certificate dt. 15.06.2011 has certified that Smt. Mary Fernandes was seen by him on 05.03.2011 and he confirmed that she could travel to Australia as she was in good health. He has further stated that the problems that she developed in Australia had no relation to her condition in India. Similarly, Dr Lachie Hayes, Clinical Haematologist, The Northern Hospital, Australia vide his letter dt. 30.03.2011 addressed to the Insurance Company, opined that Mrs. Fernandes's condition that resulted in her prolonged stay in the hospital was not directly related to her previous diagnosis of Hodgkin's lymphoma or secondary to any possible complication of treatment she had previously undergone. The Insurance Company however maintained their stand of rejection of the claim.

Analysis of the case reveals that while in Australia, Smt. Fernandes was hospitalized and treated for severe pneumonia and a subsequent episode of cardiac failure. Post-rejection of the claim by the Insurance Company, both her doctors in India and abroad have certified that the ailment for which she was hospitalized was not related to her earlier condition of Hodgkin's Lymphoma or treatment she received for the same. Further, Smt. Fernandes has denied that she was suffering from Asthma or T2DM; however the hospital papers make a specific mention of the same to which she has not objected at the appropriate time and hence there is no reason to disbelieve the same. Even accepting that her present ailment may not be related to Hodgkin's Lymphoma earlier suffered by her, but the fact remains that all these were important health conditions and the proposer ought to have declared the same at the time of proposing for insurance.

Insurance contracts are governed by the principle of utmost good faith which requires both parties to the contract to deal in good faith and, in particular, it imparts on the insured a duty to disclose all material facts which relate to the risk to be covered. It is certainly the duty of a person proposing for insurance to reveal all the important facts about the health status and pre-existing conditions of the persons to be insured, if any to enable the insurer to evaluate the risk in its proper perspective and decide about acceptance or otherwise of the same. It is this information furnished in the Proposal Form which forms the basis of the contract of insurance between the Company and the insured person. Such mutual comprehension is essential to a valid contract. It is provable by the express provisions of a written contract, without reference to any statements or hidden

thoughts outside the writing. Failure on the part of the complainant to mention these facts to the Insurance Company certainly amounts to non-disclosure/suppression of material information entitling the Company to deny liability arising under the policy.

Under the facts and circumstances of the case, the decision of the Company to repudiate the claim on the ground of "non-disclosure of material facts" cannot be faulted with and I find no valid ground to intervene with the said decision.

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Complaint No. GI-1773/2011-2012
Complainant: Shri Narendra Rege
<u>Respondent: The New India Assurance Co. Ltd.</u>

<u>Award dated :12/2013</u>
The complainant alongwith his family members was covered under Individual Mediclaim Policy No.140100/34/10/11/00013323 for the period 20.02.2011 to 19.02.2012 for Sum Insured of Rs.1.25 lacs each for himself and his spouse and Rs.1 lac each for both his sons , issued by The New India Assurance Co. Ltd. Shri Rege approached this Forum with a complaint against the Insurance Company in respect of rejection of the claim lodged for Rs.25,061/- towards expenses incurred on the hospitalization of his son Mast Suyash Rege at Mahavir Medical Research Centre, Khar (W), Mumbai from 18.04.2011 to 19.04.2011 for Excision fo Neuroma on his left elbow.

Records were perused and parties to the dispute were called for a personal hearing. The complainant submitted that his son Mast. Suyash Rege was admitted to Mahavir Medical Research Centre from 18.04.2011 to19.04.2011 for Excision of Neuroma Swelling on lt. elbow. The claim lodged under the policy for Rs.25,061/- in respect of the said hospitalization was rejected by the TPA stating that the treatment was possible as an OPD procedure and did not require hospitalization. He stated that they had previously taken OPD consultations at the same hospital and were advised certain investigations including MRI after which considering his young age, the doctor decided to admit him and carry out the operation.

The company representative that the subject claim was repudiated by their TPA under Clause no. 1.0 of the policy since hospitalization was not justifiable. Dr. Bhavna stated that the neuroma was only 2.5 cm x 1.5 cm. in size which was operated under local BB anesthesia and after the procedure, the patient was treated only with oral medicines without any I.V. administration or any other treatment as would require confinement to the hospital. As such, the procedure was possible on OPD basis and did not warrant hospitalization.

On perusal of the documents produced before the Forum, it is observed that Mast Suyash consulted Dr. V.K. Khanna at Mahavir Medical Research Centre on OPD basis on 24.03.11 with c/o pain and swelling over antero-lateral Aspect of lt. Elbow since 6 months when he was advised certain investigations including MRI of the lt. elbow. He was admitted to the said hospital on 18.04.11 and underwent Excision of Neuroma under BB. After undergoing the procedure, he was administered only oral medicines during the course of his stay in the hospital. He was discharged from the hospital on the next day i.e. on 19.04.11. The total hospital bill amounted to Rs.16,596/-. The Company has contended that for this treatment, confinement to the hospital as an in-patient was not warranted.

Neuroma excision is the surgical removal of a swollen nerve, or neuroma. The developing neuroma can put pressure on the surrounding nerves causing sharp, shooting pains. Treatment usually begins with corticosteroid injections into the painful area to reduce the size of the neuroma. If the neuroma continues to increase in size or cause pain after the injection therapy, the physician may recommend a neuroma excision to surgically remove it. The surgery for neuroma excision is usually performed in an outpatient setting. First, the affected nerve is located through a small surgical incision in the skin. Next, the edges of the incision are pulled back with a small retractor, and the neuroma is carefully removed. The wound is then closed with absorbable sutures and will need to remain wrapped for a period of about two weeks.

In view of the available information, strictly speaking, the Forum does not find any fault with the Company's decision to reject the claim on the ground that the treatment was possible on OPD basis. At the same time, after hearing the contentions of both the parties and perusal of the papers, it was also not established that the patient in the instant case had in any way influenced the doctor's decision of hospitalizing him. It was therefore felt that outright rejection of the claim would result into injustice to the complainant. Hence taking a balanced view of the situation, the Forum is of the opinion that it would be in the fitness of things to allow 50% of the admissible claim on ex- gratia

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Complaint No. GI-1763/2011-2012
Complainant: Shri Pranav B. Shah
Respondent: ICICI Lombard General Insurance Co. Ltd.

Award dated : 12/2013

The complainant was covered under Group Health (Floater) Insurance Policy No.4016/005165/00/000 for the period 01.04.2010 to 31.03.2011 issued by ICICI Lombard General Insurance Co. Ltd. to cover employees (and their family members) of State Street Syntel Services Pvt. Ltd. Shri Pranav Shah approached this Forum with a complaint against the Insurance Company in respect of rejection of the claim lodged for Rs.74,628/- towards expenses incurred on treatment for bilateral fallopian tubal blockage undergone by his wife Smt. Deepika Shah at Sanjeevani Maternity and General Nursing Home, Kandivali (E), Mumbai on 18.07.2011.

Records were perused and parties to the dispute were called for a personal hearing. The complainant stated that he was covered under the Group Health (Floater) Policy issued by ICICI Lombard Gen. Insurance Co. Ltd. to his employers M/s. State Street Syntel Services Pvt. Ltd. Shri Pranav's wife Smt. Deepika Shah was diagnosed of bilateral tubal blockage for which she was admitted to Sanjeevani Maternity & General Nursing Hospital, Kandivli, Mumbai on 18.07.2011 for laproscopy and hysteroscopy. They had given prior intimation of hospitalization to the Company on 17.07.2011 and the final claim documents were submitted on 27.07.2011. However, there was no response from the Company till 04.08.2011 on which date he inquired about the claim with the Company. On 05.08.2011 he received a communication from the Company stating that the claim was rejected as infertility-related treatment is not covered under the policy. He argued that they had informed the Company about the diagnosis well in advance and were repeatedly following up with them via e-mail as well as on telephone regarding the scope of coverage. However, instead of giving any satisfactory reply, the Company asked them to send all the treatment papers along with supporting documents which were also immediately scanned and mailed to them. Despite this the Company kept them in dark and finally rejected the claim leading to unnecessary mental tension.

The company representative submitted that upon analysis of the claim documents, it was found that the insured had undergone treatment for infertility. As per Special Condition no. xii of the policy infertility and related ailments are not covered under the policy. Hence the claim stood repudiated as per policy terms and conditions. As regards the insured's complaint of not informing him about the admissibility or otherwise of the claim beforehand, she stated that it is difficult to comment on the same without examining the entire set of claim documents. When the Company representative was asked as to on receiving an enquiry from the insured, why was he not advised by the Insurance Company to refer to the master policy document issued to the employer for information on the

policy terms, conditions and exclusions, she admitted that this was an administrative lapse on the part of the Company.

On perusal of the documents produced before the Forum, it is observed that Smt. Deepika Shah was admitted to Sanjeevani Maternity and General Nursing Home, Kandivali (E), Mumbai on 18.07.2011 with diagnosis of 'Infertility' and underwent Bilateral Wall Netroplasty & Laparoscopic Rt. Cornual Canulation with Fulguration of Endometriotic spots. The claim lodged under the policy for the said treatment was rejected by the Insurance Company citing the reason that Infertility & Related ailments was out of the scope of the policy. The complainant argued that prior to taking the treatment he had enquired with the Company specifically whether Laproscopy & Hysteroscopy were covered under the policy; however the Company kept on asking for a copy of the doctor's consultation paper mentioning the etiology, signs and symptoms, diagnosis etc. and despite forwarding the same to them, did not inform him about the relevant exclusion under the policy before going in for the treatment. The Company, on the other hand, maintained that on receiving an enquiry from the insured, at no point of time they had either confirmed to him that the surgery shall be covered and it is only once all the bills & documents are received at their end and the same are analyzed and verified by their processing team, the decision regarding approval/rejection of the claim is taken by them. The Company's contention appears to be acceptable since it is difficult to decide on the fate of a claim based on incomplete documents and the final decision regarding admissibility of a claim or otherwise could be taken only after examining the entire set of claim documents.

Shri Shah also stated that since this was a corporate policy, the individual employees were not given any policy document except I.D. Cards and the main exclusions mentioned on the card do not include that of 'infertility'. In this connection, it may be stated that it is not expected to reproduce the entire terms and conditions of the policy on the I.D. card but in such cases, it is the duty of the employer who is the master policy-holder, to keep all concerned employees informed about the same by whatever means available. Notwithstanding the said fact, when an enquiry as well as intimation was received from the insured, it is also expected on the part of the Insurance Company to guide him properly and it would have been appropriate if the Company's concerned representatives had advised him at that point of time, to refer to the terms and conditions of the Master policy document issued to his employer. It is unfortunate that the Company has failed to render this basic service to its customer causing unnecessary anxiety and ambiguity in the whole process which could have been avoided.

Though the Forum is able to appreciate the concern of the complainant in this regard, but it has also to be borne in mind that whenever any dispute arises, it is settled based on the terms & conditions of the policy under which a claim has arisen since these form the very basis of the contract between the parties. Under the circumstances, the decision of the Company to repudiate the claim being as per policy terms and conditions, cannot be faulted with.

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Complaint No. GI-2021/2012-2013
Complainant: Shri Bhavesh K. Vora
Respondent: United India Insurance Co. Ltd.

Award dated : 03/2014

The complainant alongwith his wife was covered under Individual Health Insurance Policy – 2010 No.020400/48/11/97/00008518 for the period 30.11.2011 to 29.11.2012 for S.I. of Rs.4,00,000/-, issued by the insurer. He approached this Forum with a complaint against the Insurance Company in respect of short-settlement by an amount of Rs.2,00,688/- of the claim lodged for Transcatheter ASD closure undergone by his wife at Nanavati Hospital Mumbai on 01.06.2012.

Records were perused and a joint hearing of the parties to the dispute was held. The complainant submitted the claim lodged under the policy for a total amount of Rs.3,83,788/- was settled by the Company for Rs.1,83,100/- deducting Rs.2,00,688/-. Out of the total deductions, major amount of Rs.2 lacs was towards Surgeon fees and anesthetist charges as these were not included in the main hospital bill. He stated that he thereafter personally met the hospital authorities a couple of times and also the surgeon Dr. Bharat Dalvi with a request to include the charges in the hospital bill; however his request was turned down stating that this was the usual practice followed by the hospital since the doctor's charges are negotiable. He stated that the Surgeon and anesthetist had issued her proper receipts for the payments made to them directly and since their services were required for the surgery undergone by her, he requested for directions to the Company to settle the balance amount of claim.

The company representative she stated that the claim of the insured was settled after deducting Surgeon & Aneshthetist fees not forming part of the main hospital bill as per condition no. 1.2 of the policy.

After hearing the depositions of both the parties it was felt that though technically speaking, the Company's stand to disallow doctors' fees charged outside the hospital bill from the claim amount being as per policy terms and conditions, cannot be faulted with, it is very unfortunate to find that hospitals of the standard of "Nanavati Hospital" encourage such practices thereby causing unnecessary hardship and monetary loss to their patients for no fault of theirs. Even the surgeons of high repute are resorting to such practices which work to the detriment of the patients who seek their services. It is high time that all concerned authorities take congnizance of such malpractices and take appropriate measures to curb the same. In the instant case, it was observed that Smt. Vora has undergone a heart surgery of serious implications and has genuinely incurred huge expenses for the same for which she is also adequately covered under the policy and the payments are made by cheque. In view of the same, the Company was requested to revisit the case by taking a considerate approach with a view to mitigate the hardship caused to the insured and inform their final decision in the matter to the Forum within 10 days. The complainant was also suggested to approach the hospital authorities

and try to obtain a consolidated bill for the total amount including doctor charges and submit the same to the Insurance Company.
The Insurance Company vide their letter dt. 10.03.2014 informed this Forum that the insured has not provided them the consolidated bill as required from the hospital and hence they were unable to admit the balance amount of claim for Surgeon fees. Under the circumstances, the decision the Company to disallow Surgeon fees not forming part of the main hospital bill from the total claim amount being as per policy terms and conditions, cannot be faulted with. The forum therefore does not find any valid ground to intervene with the decision of the Company and no relief can be granted to the complainant in the matter.

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Complaint No. GI-2305/2011-2012
Complainant: Shri Upendra T. Sheth
Respondent: Star Health & Allied Insurance Co. Ltd.

Award dated : 03/2014

The complainant was covered under Diabetes Safe Insurance Policy No. P/1711130/01/2011/002669 for the period 11.06.2010 to 10.06.2011 for S.I. of Rs.3,00,000/-, issued by Star Health & Allied Insurance Co. Ltd. He approached this Forum with a complaint against repudiation by the Insurance Company of the claim lodged for Rs.73,378/- under the policy for his hospitalization at Anand Hospital, Nallasopara, Dist. Thane from 06.03.2011 to 15.03.2011 for the treatment of Leptospirosis with enteric fever.

Records were perused and a joint hearing of the parties to the dispute was held He stated that he was detected of diabetes after which he availed of a Mediclaim policy from Star Health & Allied Insurance Co. to cover the said disease. He submitted that on 06.03.2011 while he was at his sister's residence at Vasai, he experienced sudden giddiness and was admitted to Anand Hospital, Nallasopara where he was treated and discharged on 15.03.2011. The claim lodged under the said policy for reimbursement of hospitalization expenses was not settled by the Insurance Company nor was he given any reason for non-settlement of the claim.

The company representative stated that the complainant had lodged a claim with their Company for his admission to Anand Hospital, Nallasopara from 06.3.11 to 15.3.11 for the treatment of Leptospirosis with enteric fever. On scrutiny of the claim papers it was observed that all the indoor case papers were written in a single handwriting suggesting that the papers were prepared at one stretch. The admission papers did not make a

mention of complaints of "giddiness" though the insured claims to have been admitted to the hospital for the said reason. Further on investigating the case, it was established that Dr. Sankett M. Doshi has not issued the pathological reports as claimed by the insured. Dr. Doshi himself confirmed that Anand Hospital is using his name as consultant pathologist without his knowledge. Dr. Thakkar stated that in view of the above discrepancies, genuineness of the claim was in doubt and hence the same stood repudiated. He further mentioned that the policy issued to Shri Sheth is a Diabetic Safe Policy which covers only Diabetic Retinopathy, Diabetic Nephropathy and Diabetic Foot Ulcer while the insured was treated for Leptospirosis with enteric fever which falls outside the scope of the cover.

Since the complainant denied having received any Claim Rejection letter from the Company, the company representative was advised to hand over a copy of the Repudiation letter to him.

After hearing the depositions on behalf of both the parties and scrutiny of the documents produced on record, it is observed that the complainant availed of Diabetes Safe Insurance Policy of Star Health & Allied Insurance Co. Ltd. w.e.f. 11.06.2010. In March 2011, he was hospitalized for the treatment of Leptospirosis with enteric fever at Anand Hospital for which he lodged a claim under the policy. The Insurance Company denied the claim under condition no. 7 of the policy pointing out certain discrepancies in the hospital papers suggesting that the claim was supported by fraudulent means. During hearing, the Company further pointed out that the policy availed of the complainant was a Diabetes Safe Insurance Policy and covered one or more of the following complications of Diabetes Mellitus Type II : 1) Diabetic Retinopathy requiring Laser treatment, 2) Diabetic Nephropathy leading to Chronic Renal Failure, and 3) Diabetic Foot Ulcer requiring Micro Vascular surgery.
Thus, it is found that the policy issued to the complainant covers only the named ailments arising out of Diabetes Mellitus Type II while the subject claim lodged under the policy was pertaining to the treatment taken for Leptospirosis with Enteric fever. Since the policy basically does not cover the ailment for which the claim was made, this Forum does not find any valid ground to intervene with the decision of the Company to repudiate the claim and hence would not go into the other aspects of the claim as raised by the Insurance Company. Under the circumstances, no relief can be granted to the complainant.

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Complaint No. GI-2430/2011-2012
Complainant: Smt. Sangita Achar
Respondent: The Oriental Insurance Co. Ltd.

Award dated : 03/2014

The complainant alongwith her parents was covered under Happy Family Floater Policy No.121700/48/2011/8391 for the period 20.01.2011 to 19.01.2012 for S.I. of Rs.2,00,000/-, issued by the insurer. The complainant approached this Forum with a complaint against the Insurance Company on account of non-settlement of the claim lodged in respect of hospitalization of her mother Smt. Sunanda Achar to Sion Hospital from 25.11.2011 to 03.12.2011 for CABG.

Records were perused and a joint hearing of the parties to the dispute was held. Shri Srikant Achar, father of the complainant Smt. Sangita Achar duly authorized by her, appeared and deposed before the Ombudsman. He submitted that he and his wife alongwith their daughter had opted for the Happy Family Floater Policy issued by The Oriental Insurance Co. Ltd. w.e.f. 20.01.2011 which they have been renewing continuously till date. His wife Smt. Sunanda Achar was admitted to Sion Hospital from 25.11.2011 to 03.12.2011 and underwent CABG. A claim lodged under the policy for the said hospitalization was rejected by the TPA stating that the ailment was a complication of Hypertension which was pre-existing to inception of the policy and also Diabetes for which there is a Waiting period of 2 years under the policy. He stated that his wife was suffering from Hypertension at the time of taking the policy and they had disclosed the said fact in the proposal form submitted to the Company whereas she did not suffer from diabetes at that time.

The company representative submitted as per the certificate issued by her treating doctor, she was suffering from Diabetes since 6 months and HTN since 5 years. As per Exclusion clause 4.1 of the policy, expenses on treatment of a pre-existing ailment or its complications are not payable upto 4 years of the policy being in force continuously. She stated that Smt. Sunanda Achar was covered with them since 20.01.2011 and the subject claim has been lodged in the first year since inception of the policy. Since the present ailment is a complication of her pre-existing HTN, the claim stood inadmissible as per exclusion clause 4.1 of the policy.

On hearing the depositions of both the parties and scrutiny of the documents produced on record, it was observed as under:

- **The fact that Smt. Sunanda Achar was suffering from HTN prior to the inception of her first policy with the Company is not in dispute.**
- **The subject claim for CABG undergone by the claimant has been lodged in the first year of the policy inception.**
- **The policy vide clause 4.1 excludes payment of expenses incurred for pre-existing ailments (treated/untreated, declared/not declared in the proposal form) and any**

complications arising therefrom until completion of four years of continuous coverage.

In view of the same, the decision of the Company to repudiate the claim being as per policy terms and conditions, cannot be faulted with and hence no relief can be granted to the complainant. The complaint therefore stands closed at this Forum.

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Complaint No. GI- 2469/2011-2012

Complainant : Shri Sanjay P. Vadagbalkar

Respondent: Bharti Axa General Insurance Co. Ltd.

Award dated :03/2014

The complainant was covered under SmartHealth Group Insurance Policy No. Q0025811 issued by the insurer to SHAW India Ltd. for its members. Shri Vadagbalkar was diagnosed as suffering from Ischemic Heart Disease for which he underwent External Counter Pulsation therapy starting from 30.11.2011 to 07.12.2011 at IPC Heart Care Centre. Shri Vadagbalkar lodged a claim under the policy for Rs.1,24,130/- towards reimbursement of expenses incurred on his treatment against which M/s. Paramount Health Services (TPA) Pvt. Ltd. reimbursed only Rs.14,030/- and disallowed the balance expenses for EECP treatment citing clause 27 & 16 of the policy, stating that it was an unproven treatment. Aggrieved, he approached this Forum seeking intervention of the Ombudsman in the matter of settlement of the balance claim amount.

Records were perused and parties to the dispute were called for a personal hearing.The complainant submitted that in November 2011 he suffered from a heart attack and was admitted to Dr. Karwa's hospital for treatment. On investigations, he was diagnosed as suffering from IHD with Single Vessel disease and was advised to undergo Angioplasty. However, since he did not wish to undergo any invasive procedure, he opted for EECP treatment consisting of total 35 sessions of daily one-hour sitting on OPD basis at IPC Heart Care Centre. After completion of the treatment, he lodged a claim for a total amount of Rs.1,24,130/- under the Mediclaim policy held by him with Bharti Axa General Insurance Co. The Company however, settled the claim only for Rs.14,030/- disallowing the balance claim citing the reason that EECP is an unproven and experimental treatment. He stated that the reason cited by the Company was not acceptable to him.

The company representative stated that the TPA had settled the claim for Rs.14,030/- after deducting Rs.100/- towards blood test report not submitted and Rs.1,10,000/- EECP charges as the same are not payable as per exclusion clause no.27 of the policy which excludes experimental and unproven treatment from the scope of the policy. He pointed out that the hospitalization records of Karwa Hospital did not have any evidence of recommendation for EECP treatment by the principal consultant. Dr. Sridhar further stated that EECP treatment is more of a rehabilitation programme comprising of one-hour daily sittings and of late though is being practiced in many centres across the country and abroad, the same is not recognized as a proven treatment in India as the procedure is not published in the Medical books which is of prime consideration for the Insurance

Companies. He also drew the attention of the Forum to the written consent taken from the insured by IPC Heart Care Centre which mentioned that "he knew that the practice of medicine, the use of medical mechanical devices and procedures is not an exact science and he has not asked for or received any guarantee from anyone associated with EECP at the Center as to the results which may be obtained". Under the circumstances, he reiterated the decision of the Company.

On hearing the depositions of both the parties, the Forum observed that since the Insurance Company could not produce any documentary evidence to support their stand that the treatment undergone by the complainant was an experimental/unproven treatment, they were directed to submit a certificate/opinion from an independent senior Cardiologist not on their panel or a reference from IMC/FDA to substantiate their stand of repudiation of the claim, within 15 days to the Forum.

The Insurance Company vide e-mail dt. 04.02.2014 reiterated their stand of rejection of the claim and forwarded a copy of certificate from Dr. Sudha Menon, M.D. Internal Medicine, Fortis Hospital, Bangalore confirming that EECP is not an evidence based therapeutic regime as per medical text books/journals for cardiac ailments. This Forum then vide its letter dt. 06.02.2014 addressed to the Company as well as to the complainant called for clarifications as to : 1) Whether IPC Heart Care Centre is not a registered hospital with the Authority in Mumbai where complainant has taken the EECP treatment; and 2) Whether the treatment is not approved/banned by any of Governing body of Drugs/Medical practices in India. In response to the same, Shri Vadagbalkar clarified as under:

1. **IPC Heart Care Center is a Day care center providing non-surgical treatment for heart in support of which a copy of certificate issued by the Office of the Inspector under Maharashtra Shops and Establishments Act, 1948 has been produced.**
2. **Dr. Pratiksha Gandhi who is the owner of the IPC Heart Care Centre has the copyright for EECP which is the published work as stated in the Extract from the Register of copyrights; copy of the said Registration with Copyright office, Government of India has been produced by him.**

The complainant has also forwarded copies of Orders given by different Consumer courts wherein the Forum has decided in favour of the insured persons and directed the Insurance Companies to reimburse their claims for similar treatment.

The Insurance Company, on the other hand, replied stating that the Center is not registered as per Bombay Nursing Act as was confirmed by one of the staff members of the Centre.

All the documents submitted before the Forum have been scrutinized. It is noted that the claim of the complainant has been denied by the Insurance Company basically on the ground that the treatment taken by him is an unproven/experimental treatment. The said fact has been corroborated by Dr. Sudha Menon of Fortis Hospital. Also, as rightly pointed out by the Company, the Consent form obtained by IPC from patients before administering the treatment itself states that "the practice of medicine, the use of

medical, mechanical devices and procedures is not an exact science and the Centre does not give any guarantee as to the results which may be obtained". Besides, it is also seen that though the Centre is said to be a Day Care Centre, it is not registered as a hospital/Nursing Home with the local authorities and merely being registered under the Shops & Establishment Act so also having a copyright for the published work would not suffice to establish that the treatment administered is an approved treatment.

This Forum has received similar complaints in the past wherein the Insurance Companies, in support of their decision have forwarded doctor's opinion stating that while EECP treatment is recognized by US FDA, there is no approval for this treatment by DGHS or Indian FDA and it is still an experimental treatment in India.
Though accepting that EECP or Enhanced External Counter Pulsation is a non-invasive treatment, does not require a hospital stay, is economical compared to other treatments for heart diseases, giving good results and the said treatment is US-FDA approved in 1995 for treatment of Coronary Artery Disease and angina and in 2002, EECP was approved as a treatment for congestive heart failure also and is being recommended in India by reputed heart institutes. However, there is no information about approval of the same by its Indian counterpart which would be significant for our consideration. Besides, it is also observed that this treatment is administered on day-to-day sittings basis which implies that it is an out-patient procedure. Some Insurance Companies have settled a few claims in the earlier years in respect of EECP treatment, the reasons whereof are best known to them. However, this Forum is not bound by the decision of the Company or any other Forum in similar cases, as the same would depend on the merits of the individual case. Whenever any dispute arises it is settled based on the terms & conditions of the policy under which a claim has arisen. Since the policy vide Clause no. 27 specifically excludes experimental and unproven treatments from its scope, the decision of the Company to deny the claim cannot be faulted with. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and also approved by the Regulator.

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Complaint No. GI-357/2013-2014
Complainant: Shri Sevantilal M. Morakhia
Respondent: United India Insurance Co. Ltd.

Award dated : 03/2014

The complainant was covered under Individual Mediclaim Policy No.020100/48/12/20/00002716 for the period 06.06.2012 to 05.06.2013 for S.I. of Rs.2,50,000/- plus 40% C.B., issued by United India Insurance Co. Ltd. Shri Morakhia approached this Forum with a complaint against the Insurance Company in respect of short-settlement of the claim lodged for R.F. Ablation undergone by him at Breach Candy Hospital, Mumbai on 24.12.2012.

Records were perused and a joint hearing of the parties to the dispute was held. The complainant stated that TPA settled the claim for Rs.1,18,567/-, deducting Surgeon fees of Rs.75,000/- from the claim amount on the ground that the same was not included in the main hospital bill. He stated that they were advised by the hospital to pay the fees directly to the surgeon and the same was paid in cash as demanded by the doctor against which they were issued a proper stamped receipt. He pleaded that they were not aware of any such provision which requires doctor's fees to be included in the hospital bill itself.

The company representative stated that the claim of the insured was settled after deducting Surgeon fees as the same were not forming part of the main hospital bill as required as per policy condition. She defended the decision of the Company.

On hearing the depositions advanced on behalf of both the parties it was observed as under:

- **The Company has settled the claim for the hospitalization expenses incurred by the complainant based on the main hospital bill, thus there is no doubt about the genuineness of the claim. During hearing, Company official confirmed that the policy issued to the complainant does not expressly require doctor fees to be part of the main hospital bill. In view of the same the Company is hereby directed to revisit their decision and inform the Forum about the same within 7 days.**
- **The Complainant was suggested to approach the hospital authorities and try to get a consolidated bill for the total amount including doctor charges and revert to the Forum within 7 days.**
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Pursuant to the hearing the complainant vide his letter dt. 03.03.2014 informed the Forum saying that as suggested, he approached the hospital authorities to get a consolidated bill; however his request was rejected by them stating that the hospital can only provide a bill for the amount that it has received and since the amount of Rs.75,000/- was not paid to the hospital, they were not in a position to provide a bill inclusive of the said amount.

The Insurance Company vide e-mail dt. 19.03.2014 reconfirmed their stand of disallowing doctor fees of Rs.75,000/- paid other than main hospital bill.
Analysis of the case reveals that Shri Morakhia has undergone the surgery and has genuinely incurred huge expenses for the same for which he is also adequately covered under the policy. However, the Company has denied him reimbursement of fees paid directly to the surgeon for which a stamped receipt has been issued to him, on the ground that the same is not included in the main hospital bill. It is very unfortunate to find that reputed hospitals encourage such practices thereby causing unnecessary hardship and monetary loss to their patients for no fault of theirs. Even the surgeons of high repute are resorting to such practices which work to the detriment of the patients who seek their services. It is high time that all concerned authorities take congnizance of such malpractices and take appropriate measures to curb the same.

At the same time, it has also to be borne in mind that whenever any dispute arises, it is settled based on the terms & conditions of the policy under which a claim has arisen since these form the very basis of the contract between the parties. In the instant case, it is observed that the policy issued to the complainant does not specifically lay down the condition that doctor fees would be reimbursable only if forming part of the main hospital bill and not otherwise. In view of the same, it can be concluded that the decision of the Company to disallow the said expenses is not supported by policy terms and conditions and therefore cannot be upheld by the Forum.
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Complaint No. GI-257/2012-2013
Complainant: Shri Suhas J. Kulkarni
<u>Respondent: The New India Assurance Co. Ltd.</u>

The complainant had covered his parents under Individual Mediclaim Policy No.111400/34/09/11/00006885 for the period 24.07.2009 to 23.07.2010 for S.I. of Rs.1 lac each, issued by The New India Assurance Co. Ltd. Shri Kulkarni approached this Forum with a complaint against the Insurance Company on account of short-settlement by Rs.26,136/- of claim lodged under the policy for the hospitalization of his mother Smt. Shailaja J. Kulkarni to Shushrusha Hospital, Mulund, Mumbai from 13.01.2010 to 25.01.2010 for the treatment of Hemiplegia.

Records were perused and a joint hearing of the parties to the dispute was held.The complainant submitted that on 13.01.2010 his mother was admitted to Manoj Clinic, Pune following a paralytic attack from where she was shifted to Shushrusha Hospital, Mulund, Mumbai where she unfortunately expired on 25.01.2010. Against the claim lodged by him on 16.02.2010 for the said hospitalization under the policy held with The

New India Assurance Co. Ltd. for a total amount of Rs.1,34,114/-, the TPA initially paid him Rs.72,364/- on 27.03.2010. After follow-up with the TPA for the balance claim amount, a further amount of Rs.21,500/- was released only on 10.02.2011. He argued that his mother was covered for S.I. of Rs.1 lac plus C.B. of Rs.20,000/- despite which the TPA short-settled his claim citing various reasons viz. 'Reasonable & Customary charges' etc. which was not acceptable to him.

The company representative submitted that Smt. Shailaja Kulkarni was covered with them for S.I. of Rs.75,000/- since the year 2006 and the S.I. was enhanced by further Rs.25,000/- w.e.f. 23.07.2008. The subject claim was lodged for the treatment of Hemiplegia and as per hospital papers, the patient had history of HTN and was on regular medication. Since the policy carries a Waiting period of 2 years for HTN, the benefit of enhanced S.I. could not be given to her and hence the claim was settled upto the full amount of pre-enhanced S.I. of Rs.75,000/- plus available C.B. of Rs.18,750/-.

The complainant pointed out that the TPA had nowhere in the correspondence made with him, mentioned the reason for short-settlement as restriction of pre-enhanced S.I. but had quoted different reasons for deductions from the claim amount. He requested the Forum to allow him some time to verify the exact date on which the enhancement in S.I. was made.

On hearing the depositions of both the parties, the Forum observed as under:

- **In case the S.I. was enhanced in the year 2008 as contended by the Insurance Company, their decision to restrict the claim amount to the pre-enhanced S.I. of Rs.75,000/- plus the available C.B. relying on Condition 4.3 of the policy, cannot be faulted with.**
- **However, there was a definite lapse on the part of the TPA in not informing the complainant about the exact reason for restricting the claim amount, leaving scope for ambiguity.**
- **Also, there was a delay of almost one year in releasing the part-payment of Rs.21,500/- which was paid to the complainant only after follow-up from his side.**

In view of the above, the Company was directed to pay interest on delayed payment of Rs.21,500/- @ 10.5% p.a. from one month after lodging of the claim till the date of actual payment within 7 days and confirm payment particulars to the Forum. The complainant was advised to confirm the exact date of enhancement in S.I. with documentary evidence to the Forum latest by 15.11.2013 to enable the Forum to take appropriate final decision in the matter. However, there was no communication to the Forum from the complainant's side thereafter and hence the date of enhancement of S.I. as stated by the Insurance Company can be accepted as correct. The Forum therefore finds no valid reason to intervene with the decision of the Company to restrict settlement of the claim upto the limit of the pre-enhanced S.I plus the applicable amount of C.B. The Company however is liable to pay interest on delayed payment of claim as directed during the personal hearing.

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Complaint No. GI-1634/2011-2012
Complainant: Smt. Usa G. Kandoi
Respondent: Reliance General Insurance Co. Ltd.

Award dated : 01/2014

The complainant was covered under Reliance Healthwise Policy No.1105702825003631 for the period 30.12.2010 to 29.12.2011 for S.I. of Rs.4,00,000/-, issued by Reliance General Insurance Co. Ltd. Smt. Kandoi approached this Forum with a complaint against the Insurance Company on account of short-settlement by Rs.96,240/- of the claim lodged in respect of her hospitalization at Bombay Hospital from 26.07.2011 to 05.08.2011 for the treatment of Diverticular Disease of Sigmoid Colon.

Records were perused and a joint hearing of the parties to the dispute was held. Shri Gopal Kandoi, husband of the complainant Smt. Usha Kandoi duly authorized by her, appeared and deposed before the Ombudsman. He stated that Smt. Kandoi was insured under two separate policies viz. Reliance Healthwise Policy with Reliance General Insurance Co. Ltd. for S.I. of Rs.4 lacs and Individual Mediclaim Policy with Oriental Gen. Insurance Co. Ltd. for S.I. of Rs.5 lacs. Smt. Kandoi was admitted to Bombay Hospital from 26.07.2011 to 05.08.2011 for the treatment of Diverticular Disease of Sigmoid Colon for which they lodged a claim for a total amount of Rs.3,72,721/- under both the policies. While they received Rs.1,23,035/- from "Oriental", "Reliance" reimbursed an amount of Rs.1,57,844/- and thus they received a total amount of Rs.2,80,879/- in settlement of the claim. There was a short-settlement to the tune of Rs.91,842/- from the total claim amount out of which Rs.59,563/- were disallowed under the head of "Surcharge" and certain other expenses were deducted as "non-medical expenses". He argued that Surcharges were included by the hospital in the main bill itself which were paid by them and hence there was no justification for disallowing the said expenses. Also, the items such as Gloves, Strips, Tag etc. were necessary and used for the procedure undergone by the patient. He requested for payment of the balance claim amount.

The company representative submitted that from the total claim amount of Rs.3,72,721/-, Rs.65,829/- were deducted by them towards non-medical expenses. Since Smt. Kandoi had lodged the claim under two separate policies held with two Companies, out of the balance claim payable of Rs.3,06,892/- they paid 50% which worked out to Rs.1,57,844/-, being their share of the liability while "Oriental" paid Rs.1,23,035/-. He pointed out that their policy being for S.I. of Rs.4 lacs against "Oriental's" policy for S.I. of Rs.5 lacs, they had settled the claim for an amount higher than their proportional liability.

On hearing the depositions of both the parties the Forum made the foll. observations:

- **The complainant had lodged the claim under both the policies held by her, but the complaint for short-settlement was filed only against Reliance General Insurance Co. Ltd.**

- **"Reliance" had settled the claim for 50% of the admissible amount after deducting expenses which were "non-medical" according to them. It was observed that a major portion of the deductions comprised of Surcharge of Rs.59,563/-. Further, certain items such as Gloves, Strips, Lancet, etc. were disallowed as non-medical expenses though the same were required for the treatment of the patient. Besides, the Company had disallowed Pvt. Nursing charges of Rs.3,000/-. When the Company representative was asked as to whether the policy carried a specific exclusion to that effect, he replied in the negative. To a question whether these were Nursing charges of the hospital or for a private nurse employed by the insured, he stated that he would have to verify the records for confirming the same.**
- **The TPA being common for both the Companies, the TPA representative was asked to explain the calculation of claim amount under "Oriental's" policy; however she expressed her inability to do so as she was not in possession of the records pertaining to "Oriental".**

Under the above circumstances, it was thought fit to call the representative of Oriental Insurance Co. Ltd. as well for a joint personal hearing with a view to decide the case in its entirety. The complaint was therefore adjourned to 24.12.2013.

As per the said directions, all the parties alongwith representative of the TPA appeared before the Ombudsman on 24.12.2013 at 10.30 a.m. Shri Gopal Kandoi pointed out that the total amount claimed by them was Rs.3,77,119/- and not Rs.3,72,721/- as mentioned during the previous hearing, out of which they have received a total amount of Rs.2,80,879/- from both the Insurance Companies leaving an unpaid balance of Rs.96,240/-.

Shri Sawant gave details of deductions from the claim amount as under:

Head of Expense	Amt. (in Rs.)
Surcharges excluded under the pol.	59563
Non-medical expenses	3266
Pvt. Nursing charges	3000
10% co-pay for non-surgical Digestive diseases	11743
10% Co-pay on each claim	10568

When asked whether the policy issued by 'Reliance' excludes Surcharges, Shri Kar replied that the policy did not have any such express exclusion.

On hearing the depositions of all the parties, it was held as under:

- **Since both the policies did not expressly exclude Pvt. Nursing charges, deduction of Rs.3,000/- against this head was not acceptable.**
- **As the policy issued by 'Reliance' does not exclude Surcharges, the Company was liable to pay their part of the liability under this head which comes to Rs.26,472/-.**
- **Also, as the procedure undergone by the insured was surgical, deduction of 10% co-pay as non-surgical procedure by 'Oriental' was not sustainable.**
- **The deductions towards non-medical expenses of Rs.3,266/- and 10% Co-pay by 'Oriental' (on the revised payable amount) was held to be in order.**

Thus the final payable amount worked out to Rs.3,23,301/- (Oriental: Rs.1,57,145/- & Reliance: Rs.1,66,156/- out of which they have already paid Rs.1,23,035/- & Rs.1,57,844/- respectively).

Under the circumstances, both the Companies were directed to pay further amounts as under over and above the payment already made by them, in full and final settlement of the claim:

1. **Oriental Insurance Co. Ltd. to pay Rs.34,110/-**
2. **Reliance General Insurance Co. Ltd. to pay .... Rs. 8,312/-**

However, pursuant to the hearing, Reliance General Insurance Co. forwarded to this Forum a clarification in respect of "Surcharge" given by Bombay Hospital which was also sent by the Forum to the complainant for his perusal. The complainant again pointed out that the policy issued by Reliance did not exclude surcharge and hence felt that the same should be reimbursed by the Company as these charges are incurred on the treatment of sickness covered under the policy.

This aspect was again reviewed and it was noted that Health policy reimburses only medical/surgical treatment expenses incurred by the insured as an inpatient under different heads of expenses like Room & Boarding, OT charges, Surgeon/Anesthetist fees, Nursing charges, cost of diagnostic tests etc. as mentioned in the policy up the limit of sum insured under the policy. Surcharge is an internal matter of the hospital and it covers normally the hospital's administrative and maintenance charges like electricity, water, staff, salary etc. which cannot be the liability of the Insurance Companies, as they are the handling charges of the hospital. Most of the Insurance Companies do not pay surcharge, service charges or any other charges levied by the hospital. Further, the IRDA has included surcharge in the list of excluded items as per Annexure IV pertaining to list of excluded expenses in Hospitalization Policy.

Hence, after deliberating on the issue, the following points emerge:

- **Although there is no express exclusion of "surcharge" in the policy issued by 'Reliance', the said policy specifically lists out the expenses which are payable under the policy in the event of hospitalization under which list, 'surcharge' is not mentioned.**
- **Surcharge mainly covers the hospital's administrative and maintenance charges.**
- **Surcharge has been specifically excluded by IRDA under Hospitalization Policy.**

After taking into consideration the above aspects, I do not find any valid reason to differ from the Company's stance to disallow Surcharge from the payable claim amount.

In view of the above, the revised share of 'Reliance' out of the total payable claim now works out to Rs.1,39,684/- (i.e. excluding their share of surcharge). However, since they have already settled the claim for Rs.1,57,844/- which exceeds their proportional liability, they need not pay the balance amount of Rs.8,312/- as directed during the re-hearing held before this Forum, while the Award for balance payment against 'Oriental' stands unaltered.

Oriental Insurance Co. Ltd. to pay to the complainant Smt. Usha Kandoi, the balance amount of Rs.34,110/- in full and final settlement of their proportion of liability under the claim lodged for her hospitalization at Bombay Hospital from 26.07.2011 to 05.08.2011 for the treatment of Diverticular Disease of Sigmoid Colon .

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