Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11.004.0216
Shri Pankaj N. Patel
Vs
United India Insurance Co. Ltd.

Award Dated 13.4.2005

Repudiation of Mediclaim. The Complainant was operated for Right side Ureteric Colic. The Respondent had repudiated the claim on the ground that the said disease existed prior to the inception of the policy and hence attracts Exclusion Clauses. It was observed that the Complainant had 7 years ago been operated for Left Ureteric Calculi with C/o left Ureteric Colic and that he had not disclosed the same in the Proposal Form. Since the non-disclosed sickness had a strong nexus with the instant disease, suppression of material fact led to upholding the decision of the Respondent to repudiate the Claim with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0098
Mr. Paresh H. Desai
Vs
Oriental Insurance Co. Ltd.

Award Dated 18.4.2005

The Mediclaim is repudiated on the ground that the hospitalisation was for observation only. The IP had met with an accident on 5.8.03 and sustained injury at ankle and back region. The Claim was for Rs. 3,629/- In the certificate dated 2.2.04, the treating doctor has clearly stated that IP was admitted for observation and reassessment. As per Policy condition the consideration of Mediclaim benefit can arise when the hospitalisation takes place upon the advice of a qualified surgeon. It is clear from Doctor's certificate that hospitalisation was as per advice of the qualified doctor. So the repudiation was not justified. The Insurer brought out other procedural non-compliance during Hearing but the focus was justifiably restricted to the ground of repudiation rather than other procedural non-compliance. The Insurer was directed to make payment of Rs. 3,629/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.003.0228
Ms. Saroj B. Goel
Vs
National Insurance Co. Ltd.

Award Dated 25.4.2005

The Mediclaim of Rs. 9872/- was submitted by Ms. Saroja B. Goel for hospitalisation and allied expenses. The Insurer initially issued cheque of Rs. 7722/- and the Respondent had not bothered to justify deduction of Rs. 2150/-. The Respondent sent a cheque of Rs. 2150/- when they received notice of Hearing from the Office of Insurance Ombudsman. The Claim is settled for the amount it was lodged. As per Complainant's

contention during hearing, Insurer was insensitive and inefficient is settlement of this Claim. The papers on record also affirmed the same. Since amount of Claim was paid fully, an order of advisory aspect was passed in the matter of Claim Processing by the Respondent.

Ahmedabad Ombudsman Centre
Case No. 11.02.0095
Mr. Hetal R. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 25.4.2005

Repudiation of Mediclaim. The Complainant's dependant father was admitted to a hospital for treatment of Fissurectomy and Stricture of Urethra. The Respondent repudiated the Claim since the Policy Conditions excluded the disease Fistula in Ano in the first year of the Policy. The Respondent rightly argued that Fissurectomy was indeed Fistula in Ano and that the same is excluded. Again the Respondent pointed out that the treatment of Stricture of Urethra was excluded since the disease was pre-existing. However the Treating Surgeon opined that Stricture of Urethra developed as a result of trauma which happened due to an accidental fall and hence cannot be treated as pre-existing to deny the benefit of the policy. Since reimbursement of one disease was admissible the other was not, the rule of thump was applied and the Respondent was directed to pay 60 % of the amount claimed in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0227
Mr. Ramesh R. Padhiyar
Vs
United India Insurance Co. Ltd.

Award Dated 27.4.2005

Mr. R. S. Padhiyar, insured of mediclaim Policy since 31.12.2002 with the Respondent. He was operated for hernia between 7.2.04 to 12.2.04. There was dispute for admissibility of the Claim. As per respondent it was within 1st Policy year (Exclusion Clause 4.3). As per facts of the case, hospitalisation was during 2nd Policy year. The treating doctor had written that swelling in left lower abdomen since one year, i.e. around Feb. 2003. So as per expert opinion of the Insurer's doctor, the claim was repudiated. Clause 4.3 excludes benefit of treatment of Hernia during first policy year. It has nothing to do with the detection of the disease in the 1st Policy year. It was held that the repudiation under Clause 4.3 is not justified. Accordingly Award of Rs. 16,037/- was given in favour of Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.04.0287
Shri Suryakiant J. Goda
Vs
United India Insurance Co. Ltd.

Award Dated 28.4.2005

Under Mediclaim Policy, Complainant had lodged claim of Rs. 26787 to the Respondent for the head injury. The Respondent sent Discharge Voucher for Rs. 20864/- means claim was admissible without any infirmity except quantum. The Complainant returned

the Discharge Voucher with a protest letter challenging deduction of Rs. 5923/- to the higher authrities. During the Hearing, the Complainant informed that initially claim was admitted for Rs. 17606/-. On his direct representation it was increased to Rs. 20358/-. He refused to accept this amount. So finally Discharge Voucher for Rs. 20864/- was issued. These showed inconsistency in the approach of the Respondent. While scrutinizing disallowed items, it was observed that Rs. 852/- was spent for medicine not directly related to head injury. But the same were prescribed by Treating Doctor in the course of treatment. So it was admissible. The Complainant was disallowed Rs. 1700 for Ambulance charge, but Respondent Could not produce any terms / conditions on the Policy where it was mentioned as exclusion. The Complainant infomed that after the Accident, he was unconscious and other persons had arranged and paid for the Ambulance. So this was also allowed. For the remaining amount, the Respondent explained the same to the Complainant. The Complainant accepted the same. The Respondent was asked to pay Rs. 2552/- to the Complainant from the deducted amount of Rs. 5623/- The complaint partially succeeded.

Ahmedabad Ombudsman Centre
Case No. 11.003.0010
Mr. Promod K. Kastia
Vs
National Insurance Co. Ltd.

Award Dated 28.4.2005

Mediclaim Policy - The Complainant had submitted three claims for hospitalisation during 11.6.01 to 17.9.01 viz. (1) Chronic Renal Failure + Ischemic Nephropathy + NIDM (2) HBP + DM + Renal insufficiency (3) CNS Vasculitis + Left Cerebellar Infract + Aoroateritis + HBP + Seizure + DM + Renal Failure. As many as 8 Medical Professionals of both the parties had given their opinions/Certificates - whether HT/DM had any linkage with aforesaid disease. The only issue required to be decided was that whether the Complainant had HT 12 years and Diabetes for 3-4 years reckoned back from June 2001. All the doctors had confirmed the existence as above. The fist Policy commenced from 20.3.1999 and it was confirmed by the Complainant that in the Proposal Form he had not mentioned history of HT & DM in reply to specific questions. Insurance being a contract of Utmost Good Faith, the Complainant had failed to fulfill his obligation to disclose all material fact. Complainant is a matured person of 67 years of age and he understood the seriousness of HT & DM. Hence the repudiation of the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.005.0176
Mr. Bhikhabhai A. Prajapati
Vs
Oriental Insurance Co. Ltd.

Award Dated 6.5.2005

Repudiation of Mediclaim. The Complainant’s wife was operated for Ruptured Ectopic Pregnancy; which might have been fatal for her life, in case the surgery was not effected at the relevant point of time itself. The Respondent argued that the sickness was a complication of the previous surgery that took place prior to the inception of the policy. The Insured had while filling the Proposal replied that she had no Gynaecological disorders. Bur records showed that she had undergone Post TL Ectopic

Pregnancy prior to the date of Proposal. Hence the decision of the Respondent to Repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.003.0028
Dr. Yatin Mehta
Vs
National Insurance Co.

Award Dated 16.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised in May 2002 for Coronary Artery Bypass Surgery. The Respondent has repudiated the Claim since the Complainant had in on 18.7.2001 applied for increase in the Sum Insured for his Mediclaim Policy and in the proposal form, had suppressed the fact that he had been hospitalised for the treatment of Propstatecomy Operation on 10.7.2001. Now, the same servicing Branch of the Respondent had on one hand settled the Claim and on the other hand processed the renewal of the policy on an Increased Sum Insured. So the Respondent cannot take the plea that material fact was suppressed. Respondent was directed to pay to the Complainant the full value of the Claim Preferred.

Ahmedabad Ombudsman Centre
Case No. 11.004.0003
Shri Piyush B. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 16.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised for 9 days for the treatment of “Carcinoma of Left Buccal Mucosa”. The Respondent had repudiated the claim on the ground that the subject disease was pre-existing and hence attracted Exclusion Clause 4.1 This decision was inferred on the basis of the Clinical History Sheet of the Hospital which stated that the Complainant was regularly chewing tobacco and taking Gutkha for the last 7 years. In the absence of indisputable proof and given the limited facts and circumstances of the case, it is difficult to conclude that addiction of Gutkha for 7 years necessarily results in Buccal Mucosa prior to taking the policy. Repudiation was hence set aside and the Respondent was directed to pay to the Complainant the full value of the Claim preferred.

Ahmedabad Ombudsman Centre
Case No. 11.005.0016
Shri Mayank J. Chokshi
Vs
Oriental Insurance Co. Ltd.

Award Dated 19.5.2005

Repudiation of Mediclaim. The Complainant’s wife was hospitalised for 5 days for the treatment of Rt. MCA, tight stenosis. The Claim was repudiated by the Respondant since Hospital Discharge Summary quoted the patient to be suffering from Hypertension for the last 15 years. Since there was non-disclosure of hypertension in the Proposal Form, the Respondents decision to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.005.0136
Shri Bharatbhai U. Gopani
Vs
Oriental Insurance Co. Ltd.

Award Dated 19.5.2005

Repudiation of Mediclaim. The Complainant was admitted to the Hospital for "TIA - Lt upperlimb weakness" on the advice of a renowned Neuro Physician. The Respondent had repudiated the Claim based on the decision that the Complainant was suffering from Transient Weakness. On Perusal of records, it was seen that TIA in not Transient Weakness but Transient Ischaemic Attack described as a "Mini Stroke". The Respondent was directed to pay the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0094
Shri Kiritbhai R. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 19.5.2005

Partial repudiation of Mediclaim. The Complainant's daughter had undergone Dental Treatment following an Accident. The treatment of the Medical Expenses incurred beyond 60 days of hospitalisation was not allowed by the Respondent. The treating Dental Surgeon had certified that the Continuous Treatment (which is a step-by-step procedure wherein one has to wait for 3 to 4 months for the bone healing to be completed and the remaining treatment to be completed) lasted for over 8 months after the date of hospitalisation. An instant case in the Supreme Court viz B. V. Nagaraju vs. Oriental Insurance Co. Ltd. (II 1996 CPJ 18 SC) was referred to and it was decided that the basic purpose of the Cover was to help the Insured in the calamity in which she was subjected by the Accident. To deny the Claim just because the period exceeded 60 days will defeat the main purpose of the Contract. So the Respondent was directed to pay the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0006
Shri Pareshkumar K. Raval
Vs
The New India Assurance Co. Ltd.

Award Dated 23.5.2005

Repudiation of Mediclaim. The Complainant's 4 year old son was hospitalised for 2 days during which he underwent surgery for "Right Obstructed Inguinal Hernia" after having complained for 2-3 days. The Respondent repudiated the Claim on the ground that Hernia at this age is congenital in nature and is hence pre-existing. This view was opined by the Respondent's Specialist and supported by Text Books in Surgery. The complainant produced Cartificates of the Child Specialist who had affirmed that he had seen the child at birth and that he did not see/detect any swelling since birth. Since the views were contradicting; a refrence was made to Exclusion Clause 4.3 which states "If the insured is aware of the existence of the Congenital Internal disease / defects before inception of the Policy; it will be treated as pre-existing". Since there is no

specific evidence to this point except presumptions raised by the Specialist; the Respondent was directed to pay the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0048
Shri Ashok B. Pawar
Vs
The New India Assurance Co. Ltd.

Award Dated 23.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised for 1 day for the treatment of Congenital Heart Disease. A Consultant Cardioligist of repute has also based on the examination of the Case Papers Observed that the Complainant was suffering from Congenital Internal Heart Disease. Hence the same was treated as a pre-existing disease and the decision of the Respondent to Repudiate the Claim was upheld with no relief to the Complaint.

Ahmedabad Ombudsman Centre
Case No. 11.002.0054
Shri Jagdish A. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 23.5.2005

Repudiation of Mediclaim. The Complainant's wife was hospitalised for 7 days during which she underwent an operation of "Pregnancy followed by Atonic Post Partum Haemorrage Post Caesarean". The subject disease being post-caesarean; as per the Exclusion Clause 4.12 which excludes benefit for any treatment arising from or traceable to pregnancy, child birth including Caesarean Section. Hence as per documentary evidences; the decision of the Respondent to Repudiate the claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0020
Shri Biren R. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 26.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised for 1 day for Coronary Angiography on the advise of two Specialists and the Claim was repudiated on the ground that the Hospitalisation was solely for the purpose of investigations, hence no claim is admissible. The Respondent Company had long before instructed its Operating Offices to decide Angiography Claims on its merits on a case to case basis. Hence the Respondent was directed to pay the Claim in full.

Ahmedabad Ombudsman Centre
Case No. 11.002.0014
Shri Rameshbhai C. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 26.5.2005

Partial Repudiation of Mediclaim The Complainant's wife had undergone two operations - one for Hysterectomy and the other for Umbilical Hernia. The Claim for Operation of Umbilical Hernia was not accepted by the Respondent since as per the Policy conditions; no liability lies on the insurer for expenses incurred for a disease contracted within the first 30 days of commencement of the Policy. The record contains a certificate issued by RMO of the Hospital which states that Tubal Ligation was done 1 ½ years back. In the absence of any other documentary evidence to the contrary, the date of TL was computed as above which turned out to be within 30 days from the commencement of the Policy and since Umbilical Hernia has a direct connection with TL; the decision of the Respondent to settle the Claim only for Hysterectomy was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0034
Shri Vinodbhai U. Panchal
Vs
The New India Assurance Co. Ltd.

Award Dated 26.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised for 2 days for Sinus Surgery and the Claim was repudiated on the ground that the said disease existed prior to the inception of the policy and hence attracts Exclusion Clauses. It was observed that the Complainant had in vernacular under his own signature admitted to the investigating Doctor that the was indeed suffering from Cold and Allergy since his childhood and that Nasal obsturction and breathlessness prompted him to take treatment of the said disease since 2 years back. The policy was only 1 year old when the treatment took place. It gets established that the Complainant was suffering from the said ailment prior to the inception of the policy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0002
Shri Kodarlal H. Modi
Vs
The New India Assurance Co. Ltd.

Award Dated 27.5.2005

Repudiation of Mediclaim. The Complainant was hospitalised for 2 days for Coronary Angiography on the advise of a Cardiologist of repute and the Claim was repudiated on the ground that the Hospitalisation was solely for the purpose of invetigations, hence no claim is admissible. The Respondent Company had long before instructed its Operating Offices to decide Angiography Claims on its merits on a case to case basis. Hence the Respondent was directed to pay the Claim in full.

Ahmedabad Ombudsman Centre
Case No. 11.002.0091
Shri Amratlal H. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 31.5.2005

Mediclaim Repudiated - The Complainant had lodged Claim for Dialysis conducted for different dates. The factum of the said Dialysis was not in dispute. As per the Terms and conditions of the Mediclaim policy, Complainant was entitled for post-hospitalisation medical expenses incurred upto 60 days after Hospitalisation. The complainant having been repeatedly admitted to a Hospital for Dialysis will not be eligible for post-hospitalisation benefits. Since the policy was not renewed subsequently; the Respondent's decision to repudiate the Mediclaim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0278
Shri Laxman I. Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated 1.6.2005

Mediclaim Repudiated - The Complainant had lodged Claim for Hospitalisation for "Acute Chest Pain" on the advise of Cardiologist. The Respondent repudiated the Claim on the grounds that the hospitalisation had been to carry out investigations. However since severe chest pain prompted the Complainant to consult a qualified doctor under whose advice; he was admitted to a hospital. Hospitalisation was not done simply to take advantage of some Scheme / Package floated by Hospitals / Nursing Homes. The Complainant could not have any control over the same. Hence, the Respondent was directed to pay the complainant the full amount of Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0232
Shri Mukesh C. Nayak
Vs
The New India Assurance Co. Ltd.

Award Dated 1.6.2005

Mediclaim Repudiated - The Complainant had Claim for Hospitalisation for "Acute Chest Pain" on the advise of Cardiologist. The Respondent repudiated the Claim on the grounds that the hospitalisaiton was unjustified. However since severe chest pain prompted the Complainant to consult a Cardiologist under whose advise; he was admitted to a hospital. The Complainant could not have any control over the same. Hence, the Respondent was directed to pay the complainant the full amount of Claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0260
Shri Ashokbhai G. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 13.6.2005

Repudiation of Mediclaim : The Complainant was operated for "Septic Loosening of Left Total Knee Replacement". The Claim was repudiated on the grounds that it was a complication of the previous surgery done 5 years back, prior to the inception of the Policy. The complainant claimed that he had taken Mediclaim policies for the last 10 years. However, since fire in the Office of the Respondent destroyed all Old Records, they were unable to submit the records prior to 4 years. Taking into account the facts and circumstances of the case, the Respondent was directed to pay the full amount to the complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0295
Shri Kiritbhai D. Kothari
Vs
United India Insurance Co. Ltd.

Award Dated 14.6.2005

Repudiation of Mediclaim :The Complainant was admitted to Hospital for treatment of Cardio Vascular Stroke, Hyopertension, Intracerebral Haemorrhage, Heochromocytoma and Marfoid Feature etc. The Respondent repudiated the Claim since the complainant had undergone treatment for Mitral Valve Prolapse, Bilateral Paraureteric Diverticulum with Vesico Ureteric Reflux, bilateral prompt excretion, dilated lower Ureters etc. and had not disclosed the material fact while taking Mediclaim for the first time. The Complainant pleaded that the Surgeon had then certified “good post-operative recovery” and subsequently too had found him to be having normal kidney function. However, since it got establishe that the Complainant was suffering major ailments prior to the inception of the policy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.005.0357
Mr. Dineshchandra P. Gandhi
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.6.2005

Claim for interest for delay in payment of Mediclaim : The Complainant’s Mediclaim was initially repudiated by the Respondent. Subsequently, the same was reopened and payment was made on receipt of a Discharge voucher duly executed in an unqualified manner in full and final settlment of the Claim. Hence as per precedents in law the Complainant was estopped from reopening the issue and the complaint dismissed without any relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.002.0242
Mr. Navinchandra D. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 23.6.2005

Delay in settlement of Mediclaim. The Complainant was admitted in a Hospital for treatment of Chemotherapy. The payment was on receipt of a Discharge Voucher duly executed in an unqualified manner in full and final settlement of the Claim. Hence as per precedents in law the Complainant was estopped from reopening the issue and the Complaint dismissed without any relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0292
Mr. Vasantkumar P Nai
Vs
The New India Assurance Co. Ltd.

Award Dated 23.6.2005

Repudiation of Mediclaim. The Complainant was operated under General Anaesthesia for Excision of Right Cervical Node and drainage of Abscess. Pathological Reports shows HIV I & II as “Reactive”. Also Certificate of treating Hospital show that the Complainant was operated for “Koch’s (TB) Lymphadenitis” and also having HIV Positive. Since the Mediclaim policy excludes payment of expenses arising of any conditions caused by HIV virus, the Respondent’s decision to repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0198
Shri Jayantilal D. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 23.6.2005

Repudiation of Mediclaim. The Complainant was hospitalised for Eye surgery. The Claim was repudiated on the ground that the Complainant had diabetes before the inception of the Policy. However, it was observed that the Complainant had pointed out the fact that he had Diabetes at the time of Proposal itself. However since no restriction was made to exclude Diabetes, the Respondent had made an unqualified acceptance of the Risk. Hence denial of the claim on the ground of Pre-existing disease fails to sustain itself. As such the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0217
Mr. Haresh R. Lalwani
Vs
United India Insurance Co. Ltd.

Award Dated 23.6.2005

Repudiation of Mediclaim. The Complainant was hospitalised for treatment of Right Cerebellar Infarct with hypertension and Diabetes Mellitus. The Respondent repudiated the Claim on the grounds that the Complainant was suffering from Diabetes for the last 7 years and that Mediclaim Policy had been taken by the Complainant for the last 2 years only. The Complainant could show the fact that he was insured with Mediclaim for the last 8 years. Hence, the Respondent was directed to pay the full amount of Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0088
Mr. Ushir Bhanuchandra Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 27.6.2005

Repudiation of Mediclaim : The Complainant’s wife was admitted to a Hospital for Post TL Menorrhaegia. The Respondent had adequate proof that the Complainant was treated for Lump Removal of Breast 2 years back and that TL Surgery for Family Planning was done before 10 years and that the same was not mentioned in the Proposal Form. The nexus between the gynaecological surgery and the disease in the subject Claim also cannot be ignored. In view of this, the Respondent’s decision to Repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0279
Shri Hasmukhlal U. Vora
Vs
United India Insurance Co. Ltd.

Award Dated 30.6.2005

Repudiation of Mediclaim : The Complainant was admitted to Hospital for treatment of Myocardial Infarction. The Consulting Physician had noted history of Hypothyriodism and Gout. These diseases had been disclosed at the Proposal stage itself. However since the Respondent had not taken any cognisance of it while converting the Proposal into a Policy; they were estopped from taking the plea of pre-Existing disease at the time of Claim. As such the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0286
Mr. Rashmikant B. Jariwala
Vs
United India Insurance Co. Ltd.

Award Dated 30.6.2005

Partial Repudiation of Mediclaim. The Complainant's Claim was settled for an amount lower than what was claimed by him. An observation of the Claimed amounts showed arithmetical errors in the Tabulated Format submitted by the Complainant. Taking into account the facts and findings as above, the complaint was dismissed with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0355
Mr. P. K. Buch
Vs
National Insurance Co. Ltd.

Award Dated 7.7.2005

Cataract Claim under Mediclaim Policy was restricted to Rs. 10000/- The claim was for Rs. 26000/- for operation of two Eyes in two different spell within the same Policy period. The Respondent submitted that the amount of Claim for Cataract treatment was restricted to Rs. 10,000/- in that Policy and the same was made clear in the Proposal Form as well as in the Policy Document also. Policy Holder had enough opportunity to look at the Restrictive Clause as the Policy was with him before treatment was taken. This could be established through scrutiny of Proposal paper and Policy copy. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0026
S. S. Dalal
Vs
The New India Assurance Co. Ltd.

Award Dated 7.7.2005

Complainant's wife was hospitalised and treated for "Left Deauervain's Tenosynovitis". Claim repudiated on the ground that "hospitalisation is not required for the claimed disease" as opined by the Medical Referee of the Respondent although he inter alia confirmed that the procedure done for the diagnosed disease was justified and that the

bills are in accordance with necessary drugs for the claimed disease. The point took for determination of the case is whether in the facts and circumstances of the case, the Respondent is justified in repudiating the claim on the stated ground. Documents and submissions perused. It is observed from the Consultation - cum - Prescription of the Consultant Surgeon that the Complainant was advised “Admission and Surgery” by the said Doctor. Hence, it is established that hospitalisation was as per the advice of Specialist Doctor. Respondent to pay Rs. 2844/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0367
Shri S. S. Patel
Vs
National Insurance Co. Ltd.

Award Dated 8.7.2005

Claim for treatment of Hernia repudiated under first year Exclusion Clause 4.3. Party claimed that his Mediclaim Policy incepted on 2.5.2000. So the treatment taken on 11.11.03 to 14.11.03 did not attract first year Exclusion Clause. The Respondent could establish that the fresh Proposal submitted on 7.5.2003 did not mention the fact there were previous Mediclaim Policies and evidently it was the fresh policy. Therefore, the subject treatment for Hernia fell during the first year and they were right in invoking Clause 4.3 to repudiate the Claim. The complaint failed to suceed.

Ahmedabad Ombudsman Centre
Case No. 11.004.0259
Mr. S. B. Joshi
Vs
United India Insurance Co. Ltd.

Award Dated 8.7.2005

Mediclaim Partial settlement after deduction of Nursing Charges during 60 days of discharge from hospital. The visit fee of Cardiologist of Rs. 1000/- also was not allowed to be paid as the receipt was issued 61st day though the visit was done within 60 days. The Respondent submitted that Nursing charges for Rs. 27,970/- was unreasonable notionally compared with other claim cases. Also there was no advice of any Doctor for nursing attendance for 60 days. Claim for visit fee for Rs. 1,000/- was directed to be paid. But the nursing fees were not allowed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0297
Mr. J. G. Vaghela
Vs
The New India Assurance Co. Ltd.

Award Dated 11.7.2005

Complainant’s wife sustained accident injury. She was hospitalised and treated for “Fracture 2nd Lumber Vertebra without DNND”. Claim repudiated on the ground that treatment could be done on OPD basis without admission to the Hospital as opined by the Medical Referee of the Respondent. The case is examined with reference to the Operative Clause of Mediclaim Policy to determine whether the Respondent is justified in repudiating the claim on the above ground. It is observed that the hospitalisation and treatment was as per the advice of a qualified Medical Practitioner and the Treating Surgeon has mentioned in his Certificate that the hospitalisation of the Patient was

necessary atleast for 24 hours looking to the injury sustained and he concluded that “admission was absolutely necessary”. Held that the hospitalisation was as per advice of a qualified Medical Practitioner and the operative part of the Mediclaim Policy Clauses are complied with in the instant case. Repudiation is not sustained. Respondent to pay Rs. 2993.80 to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0320
Dr. K. C. Parmar
Vs
The New India Assurance Co. Ltd.

Award Dated 11.7.2005

Mediclaim for Cataract Operation under Householders policy was repudiated. The Respondent submitted that the Policy was taken at the age of 67 years, whereas their Underwriting Rule restricts admissibility of Claim for Cataract treatment taken any time if the age of the Insured Person is more than 50 years at the time of inception of Policy. The Complainant argued that he was never informed about this rule either before or after taking the Policy and the Policy Document mentioned on the Exclusion of Cataract Claim within first year of the Policy. As the treatment is taken after 1 year and 4 months since inception of the Cover claim should be paid. His contention was upheld and Respondent was directed to pay the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0339
B. G. Prajapati
Vs
The New India Assurance Co. Ltd.

Award Dated 18.7.2005

Mediclaim was repudiated on the ground of ‘hospitalisation not justified’. According to opinion of Mediclaim Referee Dr. Pranav Shah, M. S. (Ortho) the hospitalisation was not justified for the following reasons.

1. There is no history of Trauma, strain jerk etc precipitating Acute PID.
2. X-Ray did not show any sign of trauma except degenerative changes which may be age related.
3. First consultation paper stated B. K. Skin traction (non-adhesive) Inj. Dynapar and oral analgesics prescribed indicates treatment given on OPD basis.

It was observed that the Complainant was hospitalised only on advice of Dr. Pragnesh Shah M. S. (Ortho). The Operative Clause of the Mediclaim Policy inter alia provides that Mediclaim benefits are payable only on hospitalisation having taken place on the advice of a duly qualified Medical Practitioner. Once such hopspitalisation taken place what type of treatment is extended is a matter of Medical Management. The critical aspect is whether it is proved that payment had been made against such hospitalisation and the patient insured is validly covered under a Mediclaim Policy. If such conditions are met denial of the Claim on the ground that hospitalisation was not necessary is actually or commend against the medical management, while the denial inflicts loss on the Insured Patient who cannot be held responsible for it. Claim was repudiated on the basis of opinion. Hence repudiation is not upheld. Claim becomes payable for Rs. 4273/-.

Ahmedabad Ombudsman Centre

Case No. 11.002.0154
P. S. Pathak
Vs
The New India Assurance Co. Ltd.

Award Dated 25.7.2005

A Mediclaim was repudiated on the following ground.

1. Applilcation of Exclusion Clause No. 4.1 for pre-existing disease. There was no evidence of any pre-existing disease with the Respondent. So it was admitted by Respondent that this exclusion will not operative.
2. Hospitalisation was not justified. Here the Complainant first took treatment of his family physician for a week and then consulted Dr. Ashutosh Shah, M. D. and hospitalised on his advice.

It was observed that a Patient with health diorder is indicated in this case is expected to approach the expert Doctor and thereafter follow his advice. Such a hospitalisation cannot be regarded as not justified simply on the basis of Respondent's Referee finds hospitalisation unjustified on the basis of study of case papers. The treating Doctor's advice prevails over Referee's opinion. The Respondent was directed to pay the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0153
M. M. Kamkoriwalat
Vs
The New India Assurance Co. Ltd.

Award Dated 25.7.2005

Repudiation of Mediclaim for treatment of Heart Disease on the ground of pre-existing disease. The Family Physician issued two separate Certificates. The first dated 17.4.03 mentioned that he was family physician since last 3 years. The DLA was suffering from Hypertension since 2 years and was under Anti-hypertensive treatment. Against this the Insured Person had been hospitalised within 4 months of inception of this first Mediclaim Policy. He died also due to sever Heart Disease. The later Certificate dated 17.8.04 by the family physician was contrary to the first one. But it was held that the greater credibility and weightage should be given to the first Certificate. The claim repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0230
Dr. J. J. Kanani
Vs
The New India Assurance Co. Ltd.

Award Dated 27.7.2005

Mediclaim repudiated on the ground of :

1. The Claim is in respect of pre-existing disease attracting Exclusion Clause 4.1 of Mediclaim Policy.
2. Complaint had given incorrect information hiding material facts at the proposal stage rendering the contract voidable.

The first point was regarding episode of proximal palpitation in 1997. The Policy had incepted in 1997-98. The exact date of this episode could not be ascertained. Therefore it is not possible to decide whether the episode of illness preceded inception of the Mediclaim Policy. The second point was regarding giving incorrect information in proposal for the insurance. The Respondent could not produce the said proposal and

therefore their contention about mis-statement could not be proved. The complaint succeded. The respondent was directed to pay Rs. 70337/-.

Ahmedabad Ombudsman Centre
Case No. 11.003.0388
Mr. D.K. Bhavsar
Vs
National Insurance Co. Ltd.

Award Dated 27.7.2005

Mediclaim was repudiated on the ground of hospitalisation not required. The IP received RTA Head injury in scooter accident and was admitted to hospital for treatment. The Respondent contended that the treatment record suggested that Patient would have been treated in OPD basis and therefore 24 hours hospitalisation was not required. 1. It is unfair to decide about a case without proper appreciation of its facts and circumstances. When a person who suffered from a Road Traffic Accident and with “Head Injury” is brought to a Hospital considerably away from his residence in the late evening hours by passers by, he can only be expected to follow as the Hospital directs him to do. It is also noted that the Treating Doctor was an M.S. This aspect should be taken into account while appraising the position of the Complainant on 9.11.2003. Thus, when the Accident is not doubted, hospitalisation is not doubted and consequent medical expenses incurred by the Complainant is also not doubted, it will be unfair to penalise him by a decision not to pay the Claim simply by arguing that it could have been treated on OPD basis. This is more a comment on what Dr. Khemchandani did and should not have done rather than what the Insured suffered and spent vis-a-vis the Policy. The Complainant is having a Personal Accident Policy with the same Office of the Respondent Insurer. The said Accident prompted the COmplainant to submit Claim under the P.A. Policy also. The P.A. Claim originating from the same accident had been admitted and TTD paid, while it is repudiated under Mediclaim Policy.

In a holistic view of the facts and circumstance of the case, it is considered justified to set aside repudiation and admit the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.003.0196
Mr. M. G. Shah
Vs
National Insurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiation on the ground of hospitalisation not justified. The insured person was admitted in ICCU following severe chest pain and Ischemic Heart Disease. But no intravenous treatment was given. The Respondent pleaded that such treatment did not require hospitalisation whereas Complainant refuted it by stating that he was admitted on Medical Advice of qualified M. D. Doctor. It was held that nature of treatment given depends upon the treating doctor and hospitalisation advised by such a doctor should be considered justified. The Respondent was directed to pay the Claim for Rs. 4965/-.

Ahmedabad Ombudsman Centre
Case No. 11.004.0113
Mr. K. M. Sukhadia
Vs
United India Insurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiated on the ground of hospitalisation not required. Claim for surgical treatment of Corns in foot was repudiated as the surgical procedure was done under General Anesthesia. The Respondent pleaded that surgical treatment done under General Anesthesia is not major surgical procedure and could have been done on OPD basis This was the opinion of Medical Referee of the Respondent. The Complainant argued that their M. D. Doctor had advised for hospitalisation. It was taken into account that both the Doctors, Medical Referee and Treating Doctor were M.D., the treating doctor's opinion and advise holds more weightage than the Medical Referee who has depended on the case papers only. Repudiation was not upheld. Respondent was directed to pay Rs. 6008/-.

Ahmedabad Ombudsman Centre
Case No. 14.002.0015
D. M. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiated under Clause 2.3 at the hospitalisation was for less than 24 hours. This Clause 2.3 states "expenses on hospitalisation for minimum of 24 hours are not admissible". This clause also specifies the treatment which will not attract this time limit (like Dialysis, Chemotherapy etc.). In such listed exceptions the clause states that "even if the Insured is discharged on the same day the treatment will be considered to be taken under hospitalisation benefit". Here the treatment was for accidental Head injury in the nature of debridement and suturing which does not fall within the listed exceptions. So the Claim repudiation is just. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0124
R. P. Bhatt
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiated on the ground that hospitalisation for one day was not required and that treatment could have been given of OPD basis. The complainant suffered from "Traumatic Contusion of Left Knee joint with huge swelling of Left Knee joint - Haemarthrosis" due to Scooter accident. He was admitted in Orthocare on 13.3.2003 at 7.30 P.M. under the care of Dr. Atul G. Bhatt, M. S. (Ortho) and discharge on 14.3.03 at 9 P.M. followed by domiciliary treatment upto 18.4.03. The Respondent's Medical Referee opined that such cases are treated with General Anesthesia and patient are discharged within couple of hours. Based upon this opinion the Respondent repudiated the Claim. Following Rule was observed case. Operative Clause of Mediclaim Policy states that hospitalisation must be under Medical Advice. In this case the treating doctor had advised that hospitalisation was not only required but it was must. The Respondent argued that though hospitalisation had taken place it was not necessary for one full day. This was refuted by the treating doctor's advice not only for the said hospitalisation but one month's rest thereafter. So there is justification of said hospitalisation for more than one day and Claim become payable.

Ahmedabad Ombudsman Centre

Case No. 11.002.0123
R. P. Bhatt
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiated under clause 4.2 of the Mediclaim Policy. The Policy incepted on 11.9.2002. First consultantion was done on 10.10.2002. The ailment was Microcytic Hypochromic Anemia. According to Respondent's Medical referee who is Consulting Child Specialist, the Hemoglobin level of 4.6 G % in a 2 year old child due to above mentioned ailment takes long duration to develop. According to the Calause 4.2 of Mediclaim Policy any claim within first 30 days since the inception of the Policy is not payable. Therefore the claim was repudiated. This decision of Respondent was upheld. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 14.003.0144
Mr. M. K. Bhavsar
Vs
National Insurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim for treatment of Left RGP + Ureteric Dilation was repudiated on the ground of pre-existing disease. Though the Insured person had shown in the proposal form about his ailment of high Blood Pressure, Kidney Stone and Diabetes he had not mentioned details of his hospitalisation for treatment of problems related to Nephritis, track dilation and stone removal. This treatment was taken just 2 months before inception of the Mediclaim Policy. Thus, the pre-existing of the alleged ailment prior to the inception of the Policy is established by the Respondent. Claim repudiation is upheld. Complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.003.0114
Mr. R. T. Brahmbhatt
Vs
National Insurance Co. Ltd.

Award Dated 29.7.2005

Mediclaim repudiated on the ground that cover did not exist on the life of wife of the Insured person. The Complainant argued that he had given proposal for covering his wife in his Mediclaim Policy. But the Premium so paid for covering his wife under Mediclaim Policy was utilised by the Respondent to extend his cover to the tune of 1.5 lac from Rs. 1 lakh. The Complainant could not substantiate submission of proposal to Insurer. So the cover for wife did not exist and therefore the Mediclaim for her treatment also was rightfully repudiated.

Ahmedabad Ombudsman Centre
Case No. 11.002.0327
S. S. Prabhu Desai
Vs
The New India Assurance Co. Ltd.

Award Dated 5.8.2005

Mediclaim repudiated on the ground of pre-existing disease. Insured Person was a child who was admitted to the Hospital for treatment of Gastroenterological disease on 23.6.2002 and the Mediclaim cover also inception on this date. Medical Referee on the respondent had inquired from the Grand father of the patient that the child had been sick since 2 or 3 days earlier to 23.6.2002. Also it is noteworthy that hospitalisation generally takes place only after some domiciliary treatment in case of Gastro-enterological ailment. So it is quite reasonable to believe that prior to inception of Policy on 23.6.2002 the child was sick and therefore disease was pre-existing. The complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0301
D. N. Trivedi
Vs
The New India Assurance Co. Ltd.

Award Dated 5.8.2005

Mediclaim repudiated on the ground of hospitalisation being only for investigation purpose. The Complainant was hospitalised for treating of severe excruciating pain in left upper limbs tingling and number's rediating from neck to left hand which was indicative of possibility of pain due to cardiac origin. This belied the position taken by the Respondent that hospitalisation was only for investigation purpose. The Treating Neurologist also confirmed neurological deficit in upper limbs and stated that Insured Person was suffering from Cervical Spine Pain with Lt. Radiculopathy. The Respondent's reason for repudiation is refuted by the Treating Doctor's confirmation. The complaint Succeeds. Repudiation set aside.

Ahmedabad Ombudsman Centre
Case No. 11.002.0281
R. R. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 5.8.2005

Mediclaim was rejected on the ground that Accidental injuries sustained by Insured Person were not such requiring hospitalisation for 24 hours. The Certificate give by Treating Surgeon (M. S.) narrated the injuries suffered by the I. P. and traumatic experience of the accident depicted by the Complainant suggested that hospitalisation for little over 24 hours was necessary. Therefore, the Mediclaim for such hospitalisation became payable for Rs. 2,908/-.

Ahmedabad Ombudsman Centre
Case No. 11.001.0161
P. N. Pandya
Vs
The New India Assurance Co. Ltd.

Award Dated 11.8.2005

The complaint was regarding settlement of mediclaim after several deductions. The deductions made were as under :

1) Rs. 2530/- for Ambulance charges, not paid. Mediclaim Policies provides for “Room, treatment expenses etc. Treatment starts after hospitalization, does not provide for any ambulance charges.
2) Rs. 500/- for Lumber Support. Not paid as it is an outside support and not embedded in the body like Pace-maker or artificial limb.
3) Rs. 4100/- towards Nursing charges. Becomes payable under Clause 3.2 of the Mediclaim Policy which allows relevant medical expenses incurred during the period upto 60 years after hospitalization. Here relevant is interpreted as advised by treating doctor. In the present case, Insured Person had undergone a very major surgery on her Lumber Spine following which she required prolonged and complete bed rest and nursing care at her home. This was advised by treating doctor. Hence the Respondent was directed to pay Rs. 4100/- over and above the earlier amount paid under the claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0162
Shri S. K. Rastogi
Vs
The New India Assurance Co. Ltd.

Award Dated 11.8.2005

Mediclaim Repudiated - The Complainant had lodged Claim for Hospitalisation for “Paroxysmal Supraventricular Tachycardia”. The Respondent relying on the Discharge Summary of the Hospital repudiated the Claim on the grounds that the Disease was pre-existing. In the Discharge Summary, the Hospital Authorities had noted a history of Restlessness and Vomiting for the last 6 to 7 years. Since there was no arithmetical precision; the benefit of the doubt is supposed to go to the insured.The Policy too was covered without break for the last 6 years. In the absence of any definite proof of the date of pre-existing disease; the Respondent was directed to settle the full Claim amount to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0172
A. S. Parikh
Vs
The United India Insurance Co. Ltd.

Award Dated 11.8.2005

The Insured person had taken treatment in February, 2000 for Ischemic Heart Disease (IHD), Left Venticular Failure (LVF) with Urinary Tract Infection (UTI) Antihypertensive treatment also was taken by Insured Person at that time. The mediclaim Policy covering the Insured Person incepted since 8.5.1997 and had continuously run till 7.5.2001. It was renewed thereafter since 10.5.2001 i.e. with break of 3 days. Here because of this break the above cited treatment became pre-existing since the renewal dtd. 10.5.2001. So the present claim for the treatment taken during the Policy year 2002 - 03 becomes a claim for pre-existing disease and hence non-admissible. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.003.0387
Smt. Pankajben B. Bhatt
Vs
National Insurance Co. Ltd.

Award Dated 17.8.2005

Repudiation of Mediclaim : The Complainant aged 60 yrs old suffered from Chest Pain at 3.00 A. M. in the morning. The pain aggravated to such as extent that he had to be taken to a hospital. The Respondent repudiated the liability on the ground that hospitalisation took place for investigative purposes since the Chest pain diagnosed was not cardiac but was musculoskeletal and could have been managed on OPD basis. But looking into the age of the complainant and the time when he suffered the pain, the decision to repudiate was set aside and the Respondent was directed to pay the full claim amount.

Ahmedabad Ombudsman Centre
Case No. 11.002.0189
Mr. Arvind V. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 16.8.2005

Repudiation under Mediclaim Policy - Complaint was registered since the TPA had refused payment of hospitalisation for Angiography by Cashless facility. The terms and conditions of the Mediclaim Policy has no reference to the mode of payment of the Claim other than by way of reimbursement of the medical expenses for hospitalisation etc. Hence the decision to refuse payment by Cashless facility is beyond the jurisdiction of the Forum. As such no relief could be extended to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0345
Mr. Kanubhai S. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 17.8.2005

Repudiation of mediclaim. The Complainant wad admitted to a Hospital for Prostate Operation. The Respondent repudiated the Claim since Mediclaim Policy excludes Prostate Operation for 3 years from the Commencement. Since the exclusion clause is mentioned both in the Proposal Form and the Policy Document, the decision of the Respondent to treat the Claim as non-admissible was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.004.0397
Smt Alka C. Rao
Vs
United India Insurance Co. Ltd.

Award Dated 22.8.2005

Repudiation of Mediclaim. The Complainant was admitted to a Hospital for Left knee Pain on the advice of an Orthopaedist with qualifications of M. S. The Respondent repudiated the Claim since hospitalisation was not justified as per their Medical Referee. Since, the Insured was totally guided by an MS; to deny the benefit of claim will be denial of justice. Hence the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. 11.002.0349
Shri Rajiv N. Bhavsar
Vs
The New India Assurance Co. Ltd.

Award Dated 22.8.2005

Repudiation of Mediclaim : The Complainant's Claim for Hospitalisation due to Accident was repudiated since there were several infirmities as to the date of admission and discharge; the date of X-Ray and the date of admission; the Chemist's bills etc. The Complainant pleaded that he had signed blank forms. But since the contradictions and infirmities were so evident; the decision to repudiated the Claim was upheld without any relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0145
Shri Virendra R. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 22.8.2005

Repudiation of Mediclaim : The Complainant was admitted to a Hospital for treatment of Rt Ankle Insect Bite (Boil). He was diagnosed as a known case of Diabetes Mellitus and Hypertension presented with Diabetic Foot. Since Diabetes and Hypertension was excluded under his policy, the complications arising out of that pre-existing condition would also be excluded. Hence the Respondent's decision to repudiate the claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0149
Shri Jashvantlal A. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Repudiation of Mediclaim : The Complainant underwent surgery for Total Right Knee Replacement. The Respondent repudiated the Claim on the grounds that the sickness was pre-existing on the opinion of the Medical Referee who noted that on the study of the X-Ray reports etc, the Osteoarthritic changes took place 5 to 10 years back. The Complainant's Doctors had opined that the disease was existing for the past 6 months only. Since it is well known that management of Osteoarthritis concludes with Total Knee Replacment and that the degenerative processes take several years to conclude to such a condition; the Respondent's decision to repudiate the claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0157
B. B. Ruperelia
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

A mediclaim for excision of an infected Sebaceous Cyst was repudiated under Clause 2.3 on the ground that hospitalisation was for less than 24 hours and the said treatment was not within the list of exceptions given in Clause 2.3. The Complainant argued that because of latest technology used in the surgical procedure he had to stay in hospital for 8 hours only though he would have stayed there longer. He also gave to understand that Insurer's interest also was in his mind and that also was one of the reason for not being hospitalised for longer duration. The Respondent also was appreciative of the conduct of Complainant and affirmed that Claim was otherwise genuine. Respondent was directed to pay full amount of Claim. Respondent was directed to pay full amount of Claim for Rs. 2400/-.

Ahmedabad Ombudsman Centre
Case No. 11.003.0122
V. B. Badiani
Vs
National Insurance Co. Ltd.

Award Dated 29.8.2005

Repudiation of Mediclaim under Clause 4.3 which excludes treatment for certain listed diseases. Here during the first year of the Policy surgery for Fibroid Uterus Myomectomy was done. The said clause excluded treatment for Fibromyoma. Therefore, repudiation was justified. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0147
Haresh M. Jagani
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Smt. Bhavnaben Jagani's Mediclaim was repudiated on the ground that the hospitalization was only for investigation purpose. On going through the case papers of Dr. Kirit Shukla, it is stated that hospitalization was for evaluation and management of vertigo and headache. No treatment to cure any disease was given. In the result repudiation is upheld.

Ahmedabad Ombudsman Centre
Case No. 11.004.0304
Pratapbhai J. Desai
Vs
The United India Insurance Co. Ltd.

Award Dated 29.8.2005

Shri Pratapbhai Desai underwent total knee replacement left knee as a cure for Osteoarthritis. The claim was repudiated on the basis of Excl. Clause 4.1 i.e. pre-existing disease. The insured had first policy commencing from 30.6.2000 to 29.6.01. It was renewed for the period from 9.7.01 to 8.7.02, 24.9.02 to 23.9.03 and 24.9.03 to 23.9.04 i.e. there is no continuity in the renewal of Policy and NCB is also NIL for policy started from 24.9.02.

The case paper reveals that the Complainant had history of pain in both knees before 2 years on 16.3.2004. The complainant had not mentioned this problem in reply to relevant questions to the Proposal form. This amounts to suppression of material facts. The repudiation is upheld and complainant fails to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0156
Smt. Namrata R. Rathod
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

The claim of Rs. 2620/- was rejected by the Respondent on the ground that hospitalisation was not justified. The Respondent repudiated Claim as per opinion of their Medical Referee. The injury was due to vehicular accident and Insured was thrown away from his Scooter on the Road. He was brought rather unconscious state to the hospital. The Treading Ortho-Doctor has clearly stated in the Certificate that the Patient needed round - the - clock Parenteral Analgesic administration. The hospitalisation was under medical advice. Difference of opinion between medical referee and Treating Doctor should not become a ground of repudiation. The complaint succeds and Respondent is instructed to pay Rs. 2620/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0155
Ashok T. Surelia
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

The Complainant had preferred Claim for Rs. 46243/- for medical expenses. The Respondent had admitted claim for Rs. 35900/-. They allowed Rs. 3000/- only as per opinion of their Medical Referee for cost price of Disponsable Hernia stapler. The Respondent got verified purchase details of the Stapler from the Store through another Doctor. The operating Surgeon who is M. S. had also justified necessity of this instrument in his Certificate. The cost of the instrument was Rs. 12200/-. The Insured was only following instructions of a qualified Doctor and denial of full cost is an injustice to an innocent insured. The Respondent is instucted to pay Rs. 12200/- as cost of Stapler. Complaint succeeds.

Ahmedabad Ombudsman Centre
Case No. 11.002.0125
L. L. Loncha
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Mediclaim for surgical treatment of Nasal obstruction (Rhinosinusitis) was repudiated under Clause 4.1 on the ground of pre-existing disease. The treatment papers mentioned that the Patient / Insured Person had been suffering from recurrent common cold - Nasal obstruction since 12 - 15 years back. So the pre-existence could be established. Claim repudiation was found justified.

Ahmedabad Ombudsman Centre
Case No. 11.002.0373
J. B. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 30.8.2005

Claim for TTD for 12 weeks following fracture in Ankle was sought to be settled for 6 weeks. The Treating Doctor had advised for 13 weeks rest. Based upon various Medical Referees opinion taken one after other, the Respondent first offered 6 weeks TTD and then for 8 weeks and ultimately for 9 weeks. It was observed that the tenure for TTD was decided mere upon the opinion of the Medical Referees rather than on any objective evaluation. The Treating Doctor had advised for 13 weeks. Another aspect to consider before deciding quantum of TTD is that before a patient acquires full fitness partial fitness is surely required. So this period will not be eligible for getting TTD benefits is surely as it will be the period of Partial Disability. Here in this case as the Treating Doctor had advised 13 weeks rest for achieving full fitness 11 weeks were allowed for TTD benefits. The Respondent was directed to pay TTD for 11 weeks Rs. 33,000/-.

Ahmedabad Ombudsman Centre
Case No. 11.002.0365
S. A. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 31.8.2005

The Mediclaim for hospitalisation for treatment of condition called “major anxiety and depression disorder” was repudiated on the ground that hospitalisation was not justified. The operative Clause of the mediclaim Policy requires the hospitalisation to be under proper medical advice. Here in this case the Treating Doctor H. R. Patel is M. D. (Medicine) FRCP and a critical care physician high in experience. His hospital is also known for credibility of high order. His certificate mentioned “Patient is suffering from major anxiety and depression disorder. He tried suicide attempt twice. He had irrelevant talking, insomania. So the condition was very bad. So Patient was admitted in his hospital. In view of above facts and circumstances the Respondent’s plea of hospitalisation being unjustified is not tenable. Repudiation set aside. Respondent is directed to pay the claim for Rs. 6076/-.

Ahmedabad Ombudsman Centre
Case No. 11.005.0200
P. J. Kothari
Vs
Oriental Insurance Co. Ltd.

Award Dated 31.8.2005

Claim for hospitalisation for the purpose of investigation called Cystescopy was repudiated under Clause 4.1 of the Mediclaim Policy. The Complainant pleaded that hospitalisation was done under proper medical advice of Urologist Consultant and therefore it was justified. But the Respondent argued that the Consultant had advised admission for further investigation like Cystoscopy. So it is very clear that the very purpose was for investigation and Clause 4.1 needs no elaborate interpretation. It was held that the Respondent was right in repudiating the Claim. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 14.002.0366
P. A. Shirshikar
Vs
The New India Assurance Co. Ltd.

Award Dated 31.8.2005

Mediclaim was repudiated on the ground of "Hospitalisation not required". The Complainant was hospitalised on the advice of Treating Physician Dr. Sanjay Dubey, M. D. (Medicine). His Certificate confirms that the Complainant presented health disorder like Hypoprotienuria and massive Renal Protienuria. The first consultation took place on 26.2.2004 and thereafter as stated by Dr. Dubey the Complainant was admitted under his care for 3 days for control and stabilization of health disorder. The Complainant was also referred to Nephrologist for Renal Biopsy. Against this the Respondent's Medical Referee opined that hospitalisation was not required as no specific treatment was given. A view was held that hospitalisation done on proper Medical Advice of Consultant Treating Physician should be considered valid in contrast to the Medical Referee's comments. Repudiation was set aside. Respondent was directed to pay Rs. 6,862/-.

Ahmedabad Ombudsman Centre
Case No. 11.002.0193
K. B. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 31.8.2005

Mediclaim for treatment of disease (Fever) contracted within 30 days of inception of Mediclaim Policy was repudiated under Clause 4.2. The disease also was not falling under exceptions under Clause 4.3. So repudiation of the Claim under Clause 4.2 was right. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 14.002.0364
Mr. Viral C. Parekh
Vs
The New India Assurance Co. Ltd.

Award Dated 5.9.2005

Complainant's Mother was hospitalised due to certain Gynaecological problem. Claim was repudiated by the Respondent under Clause 4.1. According to the Respondent, the Intra Uterine Contraceptive Device (IUCD) inserted in the Insured in 1974 was not removed long after the Insured reached menopause and that the retained IUCD was the ultimate cause of Bleeding and complications thereof. Documents and submissions perused. It is observed that IUCD is neither a disease nor the insertion of Copper-T is a treatment for a disease and hence retention of IUCD itself cannot be called as a disease to invoke Exclusion Clause 4.1. Repudiation set aside. Respondent to pay Rs. 27500/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0061
Mr. Vinodkumar Agrawal
Vs
The New India Assurance Co. Ltd.

Award Dated 7.9.2005

Mediclaim repudiation. Complainant's wife was hospitalised due to Cardiac problems. As the Cardiac related diseases were excluded from the scope of the Policy, Respondent repudiated the Claim Documents and submissions perused. It is observed that the Insured had underwent Valve replacement in the past due to Rheumatic Heart disease and the Present sickness was Thromboembalic Complications. As all Cardiac problems were explicitly excluded in the Policy Schedule, repudiation decision of the Respondent upheld.

Ahmedabad Ombudsman Centre
Case No. 11.003.0316
Mr. M. M. Lunked
Vs
National Insurance Co. Ltd.

Award Dated 7.9.2005

Mediclaim - Complainant lodged Claim in connection with his treatment for Hepatitis - B. Respondent settled the Claim by Paying Rs. 57250/- and then Rs. 6000 as C. B. Complainant received the money after duly executing Discharge Voucher in unqualified manner. Complainant submitted that he short received the amount that what is claimed by him, which was the cause of his complaint. Respondent submitted that they had settled a Claim in 1999 - 2000 for the same Disease and hence, SI applicable for Hepatitis - B has got reduced. The point taken for determination is whether the Complainant is entitled to claim further amount, examined in the context of settled Law in this regard. It is observed that unless the Claimant could prove that the execution of Discharge Voucher was obtained by the Respondent through misrepresentation, coercion or fraud, the Recipient cannot reopen the case and ask for further amount. Cases referred are 2004 CCJ 325 and 1993 CCJ 543 NC. Settlement of Claim as decided by the Respondent upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0300
Mr. R. A. Pathan
Vs
The New India Assurance Co. Ltd.

Award Dated 7.9.2005

Complainant's wife covered under Mediclaim Policy was hospitalised. Based on MR's opinion, Respondent repudiated the Claim on the ground that there was no reason for hospitalisation. Documents examined and observed that the Treating Physician in his Certificate, has clearly indicated that the Insured consulted him for Nausea, pain in lower abdomen with restlessness and Vertigo and after investigation, it was diagnosed as Pelvic Inflammtory Disease and treated for the same. Held that the argument of the Respondent that the disease did not require hospitalisation is a comment on the Treating Doctor, and such sort of comment should not deprive the Insured from her legitimate benefit of the Policy, Repudiation set aside.

Ahmedabad Ombudsman Centre
Case No. 11.003.0336
Mr. D. S. Raol
Vs
National Insurance Co. Ltd.

Award Dated 7.9.2005

Mediclaim - Policy incepted on 20.2.2004. Complainant's Son was hospitalised due to Lower Abdominal Pain and the disease diagnosed was Rt. Renal Stone. Claim repudiated under Exclusion Clause 4.2. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0293
S. F. Bhavsar
Vs
The New India Assurance Co. Ltd.

Award Dated 26.9.2005

Claim for treatment of Painful Knee (Bil. Osteo - arthritis with Sumoritis effission) was partially settled for 10 days hospitalisation against Claim of 25 days hospitalisation. Based upon hospitalisation required for similar cases of treatment of several different hospitals. 10 days hospitalisation was considered reasonable. Respondent's Medical Referee (two opinions) also had opined for 10 days hospitalisation. The Respondent decision to settle Claim for 10 days hospitalisation was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0377
S. N. Banker
Vs
The New India Assurance Co. Ltd.

Award Dated 27.9.2005

Claim for Knee Replacement operation was offered to be settled considering Left Knee replacement and Right Knee replacement as one illness, whereas Complainant claimed it to be settled for each Knee replacement operation as two independent illness. Complaint succeeded. Respondent was directed to settle the Claim for Right Knee as separate illness.

Ahmedabad Ombudsman Centre
Case No. 11.002.0008
M. V. Prajapati
Vs
The New India Assurance Co. Ltd.

Award Dated 28.9.2005

Mediclaim repudiated on the ground of suppression of material fact regarding blood transfusions necessitated due to ailments like enteric fever, Malaria etc in past. Breach of Utmost Good Faith. Claim for treatment of Anaemia was repudiated. Complaint failed to succed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0369
M. S. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 28.9.2005

Claim for hospital treatment for chronic bleeding Duodenal ulcer was repudiated on the ground of pre-existing disease. The Policy incepted on 10.6.02 and treatment was taken 9 months after this date. The Respondent's Medical referee opined that ailment of Acid Peptic Disease would have been present quite some time before the onset of

bleeding disorder. pre-existence of the primary stage of the ailment treated for could be established and repudiation was upheld. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0120
H. A. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 28.9.2005

Mediclaim Repudiation under Clause No. 2.1 as Hospital did not comply with the indicators mentioned in the Policy. Clause 2.1 lays down that the Hospital / nursing Home should be registered as such with local authoritis and should be under the supervision of registered and qualified Medical Practitioners. Althernatively it is provided that it should have certain facilities including number of inpatient beds around 15. Respondent, when asked about the rationale of the above stipulations, stated that the underlying idea behind the stipulations was to guide the customers that there is high probability of good treatment to be available from Hospital / Nursing Home which satisfies the stipulations, while at the same time there are taken as indicators of credibility for the Service Provider as an Establishment. In the present case, the Patient belonged to the village and was treated in nearby Town Hospital by MS (ENT) Specialist. Amount of Claim and period or hospitalisation was not unjustified. So it was thought reasonble not to stick to the numerical norms laid down ultimately for the purpose of good treatment. The treatment being satisfatory, the Claim was directed to be paid for Rs. 10809/-.

Ahmedabad Ombudsman Centre
Case No. 11.003.0407
N. N. Shah
Vs
National Insurance Co. Ltd.

Award Dated 30.9.2005

Mediclaim for Cataract operation was repudiated on the ground of exclusion imposed at the time of inception of the Policy. In the Policy period 13.4.03 to 12.4.04, the exclusions were inadvertently not printed on the Policy Document. This mistake was however corrected before the treatment took place. The repudiation was upheld stating that no contractual benefit is to be derived as the exclusions were inadvertently not printed on the Policy document.

Ahmedabad Ombudsman Centre
Case No. 11.011.0107
S. C. Agrawal
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated 30.9.2005

Claim for medical treatment under Health Guard Policy was repudiated on the ground of pre-existing disease. Policy had first incepted on 28.7.03. But it was not duly renewed and therefore a new Policy was issued for the period 2.8.04 to 1.8.05 on the basis of fresh Proposal Form submitted on 30.7.04. So the Policy in question incepted

only on 2.8.04. Now Insured person had Renal Failure which was detected in February 2004. This was not mentioned in Proposal Form. So the Claim for hospitalisation for treatment of CRF due to CIN was repudiated on the ground of pre-existence. Repudiation was justified. Complaint failed to succed.

Ahmedabad Ombudsman Centre
Case No. 14.002.0321
D. L. Sheth
Vs
The New India Assurance Co. Ltd.

Award Dated 30.9.2005

Mediclaim for CABG treatment not settled for want of co-operation from Complainant in submitting past health report stating that such reports were never done. The Respondent's Investigation revealed that party had undergone Trade Mill Test in the past. The Claim had arisen only after six months from inception of the Policy. The Investigator's findings were taken to be true and Complainant's negation to having undergone any test in past was regarded as incredible in view of the Treating Doctors remarks regading past treatments. Repudiation was upheld. Compliant failed to succeed.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 11.002.0008
Shri Golak Chandra Jena
Vs
The New India Assurance Co. Ltd.

Award Dated 11.4.2005

Shri Golak Chandra Jena, the Insured-Complainant had taken a Mediclaim policy from The New India Assurance Co. Ltd., Bhadrak Branch covering himself and his spouse for sum insured of Rs. 200,000/- commencing from 25.5.2002 to 24.5.2003. Insured complainant felt chest pain on 1.4.2003 and consulted local physician immediately at Bhadrak and consulted Dr. S. S. Mishra, cardiologist at Cuttack. As per advice of Dr. Mishra the complainant admitted in Madras Medical; Mission Hospital on 8.4.2003. He underwent angioplasty for his Coronary Artery Disease and submitted a bill of Rs. 208069/-. Insurer repudiated the claim as the disease was pre existing as per the opinion of Dr. S. Banerjea.

Hon'ble Ombudsman directed the Insurer to Pay Rs. 184,996/- as Dr. Banerjea is not sure and definite as to how long the complainant was suffering from the disease. More over, Dr. Banerjea never examined the complainant. Neither Dr. Nayak, Dr. S. S. Mishra and Discharge Summary of Madras Medical Mission Hospital Stated about the existence of disease prior to 1.4.2003.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 14.005.0009
Shri Basanta Kumar Prusty
Vs
Oriental Insurance Co. Ltd.

Award Dated 25.4.2005

Insured Complainant obtained a overseas mediclaim policy from Oriental Insurer Co. Ltd., Bhubaneswar D. O. I. During his stay in U. S. A. insured complainant suffered from various illness and incurred medical expenses. Insured complainant lodged a claim with the over seas service provider M/s Mercury International Assistance and Claims Ltd. and submitted the necessary papers. That service provider did not settle the claim. In the mean time Insurer appointed M/s - Conis as their overseas service provider. Due to delay in settlement of the claim the complainant preferred this complainant. Hon'ble Ombudsman directed the Insurer to pay the claim within June, 2005 positively.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 11.002.0086
Miss Gayatri Samantaray
Vs
The New India Assurance Co. Ltd.

Award Dated 20.5.2005

Complainant had taken a mediclaim policy from New India Assurance Co. Ltd. for Rs. 200,000/- for the period 16.6.2003 to 15.6.2004. During the currency of policy insured complainant experienced occasional palpitation and dizziness in the month of March 2004. Complainant underwent surgery for the treatment of disease Atrial Septal Defects. Insurer repudiated the claim on the ground that ASD is a congenital heart disease which is excluded under the policy condition.

During Hearing complainant has shown the policy bond which has stated that policy is subject to exclusion none and she was supplied with the terms and conditions of the policy.

Hon'ble Ombudsman directed the Insurer to pay Rs. 111,564/- to the complainant as the policy has stated it was exclusion to none though congenital disease was excluded under the policy.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 11.004.0013
Smt. Annamma Philip
Vs
United India Insurance Co. Ltd.

Award Dated 11.7.2005

Complainant's husband Shri G. Philip, a retired employee of SAIL, Rourkela Steel Plant was covered under Group Mediclaim Scheme for the retired employees and their spouses. Complainant under went treatment as an out door patient at Amrita Institute of Medical Science and research centre, Kochi on 24.7.2002 and 12.11.2002. Complainant claimed for re imbursement of Rs. 125/- and 1870/- for both the treatment respectively. Insurer settled the claim for Rs. 125/- and repudiated the claim of Rs. 1870/- as complainant failed to submit the origional prescription and test reports.

Insurance Omudsman uphold the repudiation of insurer as per the policy condition 9 (B) (i) complainant should submit all doctor's presciption, all receipts for drugs/diagnostic tests, all diagnostic reports in origional if she is treated in out patient department. More over complainant preferred to remain absent without sending any written submission to substantiate her allegation.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 14.003.0025
Shri Nirmal Hans
Vs
National Insurance Co. Ltd.

Award Dated 12.7.2005

Complainant had taken a mediclaim policy from National Insurance Co. Ltd. for the period 14.10.2003 to 13.10.2004 for himself and his family members for Rs. 150,000/- each. During the currency of policy his wife Mrs Suman Hans was hospitalised for bleeding PV due to fibroid uterus at Vardaan Hospital, New Delhi on 20.11.2003. Complainant's wife underwent hysterectomy surgery for the treatment of disease. Insurer repudiated the claim on the ground that hysterectomy for fibroid during first year of policy is excluded under condition no. 4.3 of the policy.

During Hearing complainant has shown the policy bond which has stated that policy is subject to exclusion to none and he was supplied with the terms and conditions of the policy.

Hon'ble Ombudsman directed the Insurer to pay Rs. 59,000/- to the complainant as the policy has stated it was exclusion to none though hysterectomy for fibroid was excluded under first year of the Policy.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 11.005.0049
Shri Bimal Kishore Nanda
Vs
Oriental Insurance Co Ltd.

Award Dated 12.9.2005

Insured complainant is an employee of LIC of India covered under LIC Staff Group Mediclaim Policy of Oriental Insurance Co. Ltd. His wife Mrs. Jeeta Mohanty was also covered under the scheme. On 10.3.2003 Smt. Jeeta Mohanty delivered a baby in Nishamani Nursing Home. Attending Physician advised Mrs. Mohanty for rest up to 26.5.2003. Insured complainant lodged a claim for an amount of Rs. 16762.63 and deposited the bill and cash memo with his employer LIC, Nayagarh Branch on 2.6.2003. LIC Cuttack D. O. inadvertently sent the papers to Parmount Health services (TPA) on 25.7.2003 which has returned the papers to LIC on 25.9.2003. Then LIC of India sent the paper to Oriental Insurance who has rejected the claim on the ground of delay in submission of claim papers.

During hearing complainant stated that he has submitted the papers to his employer on 2.6.2003 and he has no control over for mistakes committed by LIC.

Insurance Ombudsman directed the insurer to pay Rs. 16,762/- as insured is no way responsible for delay and complainant in entitled for compensation.

Bhubaneswar Ombudsman Centre
Case No. I.O.O. / BBSR / 11.002.0045
Shri Himanshu Kumar Parija
Vs
The New India Assurance Co. Ltd.

Award Dated 14.9.2005

Insured complainant obtained a mediclaim insurance policy from New India Assurance Co. Ltd. which was commenced from 25.11.2003 Insured complainant alleged that on 28.11.2003 while on T. V. serial shooting at Bhubaneswar he sustained a injury in his scrotum for which he was admitted in Durga Nursing Home on 1.12.2003 for operation of bilateral hydrocele and spent Rs. 11,300/-. The claim has been repudiated by the insurer as per policy condition No. 4.3 as the expenses on operation of hydrocele is excluded during first year of policy.

In his letter dated 4.12.2003 insured complainant did not disclose that he sustained injury in his scrotum on 28.11.2003 necessitating surgical intervetion. Medical report do not disclose whether bilateral hydrocele was pre existing or caused by injury which was due to an accident.

Hon'ble Ombudsman uphold the repudiation as complainant failed to prove that bilateral hydrocele was not pre-existing, but caused due to injury sustained on 28.11.2003.

Chandigarh Ombudsman Centre
Case No. GIC / 28 / Royal Sund / 11 / 05
Shri M. C. Goel
Vs
Royal Sundaram Alliance Insurance Co.

Award Dated 13.4.2005

FACTS : The complainant had taken a mediclaim policy effective from 6.9.02 to 5.9.03. He was admitted at Gamma Centauri Health Care Centre, Kolkata on 26.11.02 in connection with a mild heart problem. His claim for treatment during hospitalization and post-hospitalization period was repudiated on the basis of medical record and the opinion of panel doctor that the ailment was the result of pre-existing HTN.

FINDINGS : The claimant was diagnosed for Inferior Wall Myocardial Infarction and was hospitalized from 26.11.02 to 30.11.02. He submitted claim for Rs. 13999/- towards hospitalization expenses along with discharge summary. The Echocardiography Report showed symptom of ischaemic heart disease and concentric LVH which was reportedly caused by pre-existing HTN. On the basis of opinion of panel doctor that inferior wall MI and its related symptoms could have existed before the policy period, the claim was repudiated. As the opinion was non-committal and inconclusive and could be interpreted either way, the insurer was advised to seek second opinion to establish the factum of pre-existing disease. Dr. C.R. Jain, Consultant Cardiologist confirmed after examining the claimant that he had progressive cardio vascular damage, but was unaware of the same. However, as per policy conditions, claims pertaining to sickness prior to the commencement of the policy were not payable, irrespective of the fact whether the insured was aware of the same or not.

DECISION : Held that the claim is not maintainable as per policy conditions though the complainant may have been unaware of the ailment, until his admission in the hospital on 26.11.02.

Chandigarh Ombudsman Centre
Case No. GIC / 130 / NIC / 14 / 05
Shri Vinod Bhushan Vashisth
Vs
National Insurance Co. Ltd.

Award Dated 16.5.2005

FACTS : Sh. Vinod Bhushan Vashisth has been having a mediclaim policy for self and family members since 7.4.99. The policy for the year 2003-04 was, however, renewed w.e.f. 21.4.03 with a gap of 15 days. He was given an understanding that the policy would be treated as continuous and he would be entitled to cumulative bonus on account of no claim for the past four years. His wife, Smt. Sunita Vashisth, developed acute abdominal pain in the first week of June, 2003. She had mild pain for 2-3 months, but no consultation was done. After treatment, claim for Rs. 39,736/- was lodged during August 2003. The complainant reportedly pursued the matter by visiting Branch Office and sending reminders, but failed to get any reply. Aggrieved by the delay, he filed a complaint in this office on 15.11.04, seeking intervention for early settlement. The insurer contended that the complainant did not seek condonation of gap from 7.4.03 to 20.4.03. Therefore, the policy was treated as a fresh policy and that being so, the disease was treated as a pre-existing disease. Hence the claim was not payable.

FINDINGS : Sh. Vashisht stated that during seven year period that he has been having the policy, no claim was lodged except the one in question. He further contended that the renewal was delayed because renewal notice was not received. When he approached the insurer, he was advised to give a request letter for condonation of delay to be forwarded to Regional Office for approval. He gave the same but was not aware if any decision for treating the policy as a continuous policy, as per understanding given to him, had been taken. The insurer admitted that the complainant had submitted a letter at the time of renewal of policy for 2003-04 for condonation of delay. The Divisional Office recommended it to the Regional Office on 22.4.03 and permitting cumulative bonus as there was no claim for the past five years. A reminder was also sent on 30.9.03, but no decision was taken.

DECISION : Held that the claim be settled by condoning delay. Further for delay in settlement, to be reckoned three months after submission of complete claim papers to the date of order, interest @ 7 percent be paid to the complainant.

Chandigarh Ombudsman Centre
Case No. GIC / 150 / OIC / 11 / 05
Shri R. N. Sharma
Vs
Oriental Insurance Co. Ltd.

Award Dated 25.5.2005

FACTS : Sh. R.N. Sharma took a mediclaim policy for the period from 20.8.03 to 19.8.04 for sum insured of Rs. one lac each for self and his wife. He had an attack of syncopal on 30.8.03. He was referred to Indraprasth Apollo Hospital. His claim amounting to Rs. 13,089 for treatment was repudiated on the ground that it pertained to treatment of a pre-existing disease, as he had undergone CABG in 1998.

FINDINGS : Sh. Sharma had disclosed in the proposal form that he had undergone CABG in 1998. He developed sudden weakness, giddiness and vomiting on 31.8.04. He was referred to Apollo Hospital, New Delhi where he was kept under observation. Investigations ruled out any cardiac cause of syncope. Finally he was discharged as no cardiac reason was established. Dr. Sanjay Kumar on the panel of TPA, expressed the view that an episode of syncope normally is not an indication for hospitalization. The proximate cause of hospitalization was to rule out Acute Myocardial Insufficiency, which was pre-existing. Hence the claim was not payable as per exclusion clause 4.1 of the policy. Another specialist Dr. V. K. Bhatia also concurred with the opinion

expressed by Dr. Sanjay Kumar. Hospitalization for syncope would not have been warranted, but for the past history of CAD.

DECISION : Held that the insurer's contention that hospitalization was not necessary and that the claim would not have arisen, but for the fact that the insured was a patient of CAD, was without any logic in the light of reported case history. The repudiation is based on the opinion given by the panel doctor that normally 'an episode of syncope is not a indication of hospitalization, but if there is past history of CAD then it is important to rule out Inferior Wall MI, in which feature remains the same". Repudiation may have been justified if it was established that syncopal attack had some connection with CAD. Repudiation on the ground that hospitalization was necessary because of a pre-existing disease and may not have been warranted otherwise, was not justified. Ordered that liability be admitted.

Chandigarh Ombudsman Centre
Case No. GIC / 190 / UII / 14 / 05
Shri Rajinder Parshad Gupta
Vs
United India Insurance Co. Ltd.

Award Dated 30.5.2005

FACTS : Sh. R.P. Gupta purchased a Mediclaim policy for self and his family for the period 9.2.04 to 8.2.05. He was admitted in N.C. Jindal Institute of Medical Care and Research on 23.4.04. He submitted a claim for Rs. 9,453, against which he was paid Rs. 8,763 only. Hospital admission fee of Rs. 40 and air-conditioning charges of Rs. 600 were disallowed. He objected to these deductions. He also claimed bank-clearing charges debited to his account, as UTI bank has no branch at Hissar. He was informed by TPA vide letter dated 20.11.04 that admission fee and charges for air-conditioning were not payable and bank collection charges could not be reimbursed.

FINDINGS : The insurer contended that as per the terms and condition of the policy, there is no provision for reimbursing charges for air-conditioning, but agreed to reimburse admission fee. As regards bank collection charges, it was stated that it was not possible for TPA to open account in all the cities and the miscellaneous expense on this account has to be borne by the insured.

DECISION : Held that the claim for room air-conditioning charges could not be denied solely on the technical ground that there was no head for reimbursement of such charges. These charges can be disallowed if there is a specific bar on getting an AC room. Since AC room charges have already been paid by the insurer, there is no basis for disallowing the same on the plea that head for such payment does not exist. Disallowing the same on the ground that these are shown separately and not as part of room charges is not rational. However, the plea of the insurer that it is not possible for TPA to open account in various cities to facilitate encashment of cheques at par has some force. Therefore, ordered reimbursement of Rs. 600 towards AC charges and Rs. 40 for admission fee.

Chandigarh Ombudsman Centre
Case No. GIC / 242 / OIC / 11 / 05
Shri Kulwant Singh
Vs
Oriental Insurance Co. Ltd.

Award Dated 14.7.2005

FACTS : Shri Kulwant Singh has been having medical policy from DO, Shimla for self and wife since 2001 for sum insured of Rs. one lakh each. His wife was admitted in Fortis Hospital, Noida on 18.10.04 for operation of her right knee after an accidental fall. After her discharge, the claim filed by her was repudiated by the office on 10.02.05 on the ground that treatment pertained to a pre-existing disease. It was admitted that she had got both knees replaced in 1995, and she was in good health. He, therefore, sought intervention of this office in getting the claim settled in his favour.

FINDINGS : The complainant stated that his wife had no problem after replacement of knees until 2004. She developed some pain in one knee and got it checked up from Fortis, Noida. It was diagnosed to have been damaged and was replaced. On behalf of insurer it was urged that replacement of knee by artificial means only provides some relief and does not result in complete cure. Besides, damage to knee was not on account of accident as contended by the complainant, as in the claim form it was stated that right knee had loosened.

DECISION : There is considerable weight in insurer's contention that claim pertained to treatment of a pre existing disease, as replacement by artificial means acts only as a palliative and the disease process continues. The replaced knee remains vulnerable to damage, as it is not a natural knee. Held that the claim was repudiated on valid grounds.

Chandigarh Ombudsman Centre
Case No. GIC / 246 / NIA / 14 / 05
Shri Ashwani Raheja
Vs
New India Assurance Co. Ltd.

Award Dated 10.8.2005

FACTS : Shri Ashwani Raheja had taken a mediclaim policy from BO Karnal for sum insured of Rs. 25000 each for self and other members of his family for the period 20.8.03 to 19.08.04. His mother was admitted in Mahesh Eye Hospital, Ambala from 24.11.03 to 25.11.03 for cataract operation. He filed the claim amounting to Rs. 9,960 on 12.12.03. The claim was repudiated by Raksha TPA vide letter dated 26.6.04 on the plea that in view of gap of three days the policy was treated as fresh policy and the claim was, therefore, not payable. He represented to the head office and the regional office, but did not receive any response. He felt harassed and suffered mental agony because of delay in settlement of claim. He also complained that he was denied cashless facility at Ganga Ram Hospital.

FINDINGS : The claim was repudiated as the policy was treated as a fresh policy and the claim was treated to have arisen during the first year of policy. The representative of insurer stated that claim was referred to TPA clarifying that the policy had been renewed. However, TPA detected a gap of three days and sought confirmation regarding condonation of gap. The TPA also advised the insured vide letter dated 9.9.04 that gap could be condoned by the insurer only and his request should be routed through the company. It was admitted that at the time of taking the policy the insured had submitted requisite health certificate. However representative of insurer could not explain why gap was not condoned for which health certificate was duly obtained and provision for condonation of gap upto seven days exists.

DECISION : Concluded that the insurer has not found any lacuna regarding admissibility of claim, except discrepancy with regard to gap of three days. The TPA also informed the insured that necessary action for condonation should be taken by the insurer. Held that there was no basis for not condoning the gap of three days, for which

the insured had submitted requisite health certificate. The claim was, therefore, payable. Ordered that the gap be condoned and claim admitted.

Chennai Ombudsman Centre
Case No. 11.3.1433 / 2004 - 05
Ms. Annia Thomas
Vs
National Insurance Co. Ltd.

Award Dated 8.4.2005

The complainant, Ms. Annie Thomas and her daugher Ms. Anju Anna Thomas were covered under mediclaim policy with National Insurance Company Ltd., Divisional Office 500600, Chennai from March 2004 onwards.

Ms. Anju Anna Thomas was hospitalised at Apollo hospital, Chennai from 8.11.2004 to 9.11.2004 for “Post Traumatic Scar and Contracture Hand”. The surgery done on her was “Tangenital excision of scar + Contracture Release + Instep Graft”. Her claim for cashless settlement, during the hospitalisation, was rejected by the TPA of the insurer, M/s Medicare Services on the ground that the present condition scar contracture was related to the injury earlier and since there was no claim reported for the earlier injury and the admissibility of the previous claim was not known, the present claim was not payable. The complainant contended that the question of the claim having been lodged the injury due to accident in June 2004 did not arise since the treatment was taken on OPD basis at that time and the injury was also supposed to heal. However, the injury did not heal and a big lump / scar developed for which the doctor had advised for the immediate grafting to be done, and hence, her daughter was hospitalised and an excision of scar and grafting was done.

During the hearing held before the Ombudsman, the representative of the TPA stated that the claim was payable and settlement would be done within 7 days. In view of this, admission, the representative of the TPA was directed to settle the admissible claim amount along with 8 % simple interest p.a. from 20.12.2004, i.e. the date of repudition of repudiation of the claim, within 7 days and revert to the Forum with payment particulars. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.4.1421 / 2004 - 05
Shri R. S. Somasundaram
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12.4.2005

The complainant, Shri R. S. Somasundaram was insured under mediclaim policy no 411700/2003/1557 with The Oriental Insurance Company Ltd., Divisional Office 7, Chennai for the period 13.3.2003 to 12.3.2004. Shri Somasundaram was hospitalised at Aysah Hospitals Pvt. Ltd., Chennai from 29.10.2003 to 31.10.2003 with complaints of convulsions. His claim for reimbursement of hospitalisation expenses was repudiated by the insurer, vide letter dated 25.2.2004, on the ground that as per the opinion of their panel doctor, all the investigations performed were within normal limits and it seems that he was admitted for investigations only. The complainant represented to the insurer’s Grievance Cell at their Regional Office, Chennai for reconsideration of the claim on the ground that he had sudden convulsion and was rushed to the hospital and based on scan report taken at that time, he was treated in the hospital and discharged. The insurer did not respond to the said representation of the complainant.

The documents submitted before the Forum were perused and from the discharge summary and other medical records before the Forum, it was noted that Shri Somasundaram was admitted follwing convulsions. From the remarks made in the "Course in the Hospital", Shri Somasundaram's was a case of Right Focal Seizure and he suffered from repreated complex partial seizures. The diagnosis, as per the discharge summary, was "Seizures". Therefore, it was clear that Shri Somasundaram suffered from "Seizure" and he had to be necessarily hospitalised following the convulsion. Convulsions are "a violent involuntary contraction or series of contractions of the voluntary muscles". An illness is "a condition marked by pronounced deviation from the normal healthy state". Having a convulsion is a deviation from a normal healthy state, which requires medical attention, and hence convulsions per se constitute the positive existence of an ailment/illness, as specified under clause 4.10. The investigations carried out in the hospital were for ascertaining the cause of convulsions. The CT Scan report also revealed Mild Atrophic Changes of Temporal Lobe on left side. The insured was treated with medication and discharged with the advice for review.

Hence, the case on hand did not fall within the ambit of exclusion clause 4.10 since the situation which the mediclaim policy envisages, namely reimbursement of hospitalisation expenses for the existence of an ailment/illness, has been met with in the present case. It was there concluded that the Insurers could not absolve themselves of liability in the said case and the complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.3.1428 / 2004 - 05
Shri C. Krishna Prasad
Vs
National Insurance Co. Ltd.

Award Dated 20.4.2005

The complainant, Shri Krishna Prasad and his wife and son were insured under mediclaim policy with National Insurance Company Ltd., Divisonal Office - 7, Chennai since 1st March 1997 onwards. The policy for the year 1997 - 98 was taken for a sum insured of Rs. 50,000/- and same was increased to Rs. 1,00,000/- for the period 1998 - 99. Subsequently, the sum insured under the policy was increased to Rs. 2,00,000/- from 7.3.2002 onwards.

Shri Krishna Prasad was hospitalised at Vijaya Heart Foundation, Vijaya Hospital, Chennai from 4.11.2004 to 13.11.2004 and a Bypass surgery was done on him. He preferred a claim with the insurer for Rs. 1,52,219/-. However, the claim was restricted by the insurer to Rs. 50,000/- on the ground that Shri Krishna Prasad had developed heart disease in the year 1997 at which point of time the sum insured under the policy was Rs. 50,000/-. Therefore, the subsequent increases in the sum insured in the year 1998 and 2002 respectively would not apply for any treatment of heart disease. Shri Krishna Prasad contended that nowhere in the policy document, the restriction in the sum insured for heart ailment was stated and therefore, he was led to believe that heart disease was not an exclusion under the policy for the revised sum insured. Hence, he contended that he was entitled for the balance amount of the claim of Rs. 1,02,219/-.

It was noted from the medical records produced before the Forum that Shri Krishna Prasad was diagnosed to have Coronary Artery disease for which a Coronary Artery Bypass Graft was done on him in November 2004. Shri Krishna Prasad had also undergone an Angioplasty earlier in the year 1997 and the medical expenses incurred

for the same was reimbursed by the insurer upto Rs. 50,000/- being the sum insured under the policy availed in 1997. During the next renewal for the year 1997 - 98, the sum insured was raised to Rs. 1,00,000/-. Subsequently in the year 2002 the sum insured was enhanced to Rs. 2,00,000/-. However, it was noted that in the column of the policy schedule pertaining to the disease excluded, no disease was specifically excluded and in fact, the policies issued from the year 2000 onwards, carried the word "Nil". The policy issued for the year 2004 - 05 carried the word "None" in the column meant to reflect the excluded diseases.

Any contract of insurance, to be enforced, has to necessarily be based on the principle of uberrimae fides, i.e. Utmost Good Faith, which makes it obligatory on the part of both the insured and the insurer to disclose the fullest possible information to each other. In an insurance contract, the intention of the parties must prevail and this intention is to be looked for in the policy itself. In the absence of any specific condition mentioned on the schedule of the policy limiting the sum insured to Rs. 50,000/- for the Coronary Artery Disease, the insured cannot be found fault with for having interpreted the terms of contract as those literally mentioned on the face of the policy, i.e. in the present case, the terms pertaining to "diseases excluded" as being "none", which the insurer's representative presented as an error of omission at the policy preparation stage. The insurer, by an act of omission, had placed the insured in a situation wherein the insured was led to nourish the hope of being eligible for the entire increased sum insured. Hence, in order to meet the ends of justice an ex-gratia payment of 50 % of the admissible balance claim amount was allowed by the Forum and the insurer was directed to pay the same to the complainant. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. 11.5.1398 / 2004 - 05
Shri A. N. Palaniappan
Vs
The Oriental Insurance Co. Ltd.

Award Dated 20.4.2005

The complainant, Shri A. N. Palaniappan and his son, Shri Arunachalam were covered under mediclaim policy initially from 24.10.1999 to 23.10.2000 with The Oriental Insurance Company Ltd., Divisional Office X, Chennai. The subsequent policy was taken from 26.2.2001, i.e. after a gap of 4 months and hence a fresh policy was issued on the basis of a new proposal form. Subsequently, in the year 2002, the policy was taken on 4.3.2002, i.e. after a break of 8 days. However, this renewal was done after getting a medical certificate, certifying the health of Arunachalam between 26.2.2002 and 4.3.2002.

Shri Arunachalam was hospitalised at Madras Institute of Urology from 5.11.2003 to 7.11.2003 and was diagnosed to have left lower Calyceal Calculus for which he underwent Extra Corporeal Shock Wave Lithotripsy treatment. His claim for reimbursement of the medical expenses was repudiated by insurer on the ground that the commencement of Urolithiasis was from June 2000 which was before the policy commencement on 26.2.2001 and hence the disease was pre-existing.

It was noted from the medical records produced before the Forum that Shri Arunachalam had calculi both in the left and right kidneys as early as June 2000. Treatment was administered for the calculi in the right UVJ and he was releved of the pain. During the hospitalisation in November 2003, Shri Arunachalam was treated for bilateral renal calculi by way of diruetic therapy for left lower ureteric calculus near VUJ and was also administred ESWL for left renal calculus. It was also noted from a

USG taken on 14.6.2000 revealed 2 calculus in the left kidney in addition to right VUJ and calculus in right kidney. Therefore, it bacame clear that left renal calculi was pre-existing. Further, the contention of the insured that he was treated for pain in the right kidney during June 2000, whereas the present treatment was for the left kidney and therefore, he was entitled for the Claim, did not have any relevance since the left renal culculus for which the present hospitalisation was done was pre-existing to the inception of the policy in February 2001. This Forum has referred the case to a Speciaist, Dr. Harinder Bir Singh, who opined that the November 2003 episode of hospitalisation was for the untread stones which were diagnosed in the year 2000.
It was, therefore, held that the ailment for which the claim was made was pre-exisitng and hence there were no valid grounds to interfere with the decision of the insurer in repudiating the claim on the ground of pre-existence. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.3.1412 / 2004 - 05
Shri Bijal K. Patel
Vs
National Insurance Co. Ltd.

Award Dated 22.4.2005

Smt. Jayaben K. Patel was insured under mediclaim policy since 1998 onwards. She was hospitalised in Apollo Hospitals, Chennai from 13.10.2003 to 18.10.2003. The diagnosis was “Chronic Interstitital Nehpritis, ESRD on Haemodialysis and Cystitis”.
The insured’s claim for rimbursement of the medical expenses was repudiated by M/s Medicare Services, the TPAs of the insurer on the ground that as per the opinion of their panel of doctors, the patient was a K/C/o CRF since 1996 i.e. prior to inception of policy and hence the disease was pre-existing and the claim not payable. The insured represented for reconsideration of the claim on the ground that the claim was for Cystitis.

From the was medical records, i.e. discharge summary, Certificate of consultant Nephrologist of Apollo Hospitals and the opinion of Chief Urologist produced before the Forum, it emerged that Smt. Jayaben Patel was suffering from End Stage Renal Disease since 1994 and was on Haemodialysis. She was hospitalised on 13.10.2003 for Haemodialysis following which she developed severe abdominal pain as well as low back pain along with haematuria. Suspecting Cystitis, she was put on medication and a cystoscopy was done on her. It also emerged that the Haematuria was due to cystitis which presented with bleeding from the urinary bladder mucosa. Further, the attending doctor, had also certified that the hospitalisation was not related to her chronic kidney disease. Hence, the cystitis for which Smt. Jayaben Patel received treatment during the hospitalisation of 13.10.03 to 18.10.2003, was an entity by itself. Though the insurer contended that the origin of the haematuria might have been due to CRF also, there was no medical evidence to that effect and therefore, it was held that the insurer was liable to reimburse medical expenses towards any treatment renderd for cystitis during the hospitalisation of 13.10.2003 to 18.10.2003. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. 11.5.1015 / 2005 / 06
Dr. V. V. Jayaraman
Vs
The Oriental Insurance Co. Ltd.

Award Dated 23.5.2005

The complainant, Dr. V. V. Jayaraman was insured under mediclaim policy from 29.5.1997 onwards. He was hospitalised initially from 8.11.2004 to 9.11.2004 for Coronary Angiogram (CAG) in Manipal Heart Foundation, Bangalore and subsequently from 8.12.2004 to 15.12.2004 for Coronary Artery Bypass Graft (CABG) in Wockhardt Hospital, Bangalore. His claim for reimbursement of medical expenses was repudiated by the Medicare Services, the TPA's of the insurer, on the ground that the patient was a known case of hypertension for the last 20 years and diabetes for the last 3 years and as both these were pre-existing diseases and as Coronary Artery Disease (CAD) is a known complication of diabetes and hypertension, the claim was not payable.

Dr. Jayaraman contended that Diabetes Mellitus (DM) was detected only in the year 2001 and hence was not pre-existing. He had already declared the existence of hypertension excluded under the policy. Further, medical literature stated that hypertension is at the time of proposal and subsequently, only hypertension was only a risk factor for CAD and if the hypertension was controlled and treated, it was not a risk factor at all.

It was observed from the medical documents submitted before the Forum that Dr. Jayaraman contracted hypertension in 1984 and diabetes in 2001. The proposal form submitted by Dr. Jayaraman at the time of availing the mediclaim policy in May 1997 revealed the existence of hypertension. It was, therefore, clear that hypertension was pre-existing as early as 1984 whereas diabetes having been detected only in the year 2001 could not be classified as a pre-existing disease in Dr. Jayaraman. The contention of the Insurer that Diabetes was pre-existing therefore stood disproved. Regarding Hypertension and CAD being a complication of hypertension, it was noted that Dr. Jayaraman stood covered under mediclaim policy from May 1997 onwards and the policy specifically excluded the disease of Hypertension. As per the medical documents, namely the discharge summaries of Manipal Heart Foundation and Wockhardt Hospital, the hospitalisation had been for Coronary Artery Disease which necessitated Angiogram and CABG respectively. There was no medical record evidencing the existence of CAD prior to May 1997. The Insurer has repudiated the claim on the ground that the disease of CAD was a complication of the pre-existing Hypertension. As per the tenets of Insurance the aspect of proximate cause cannot be ignored. From the classic definition of proximate cause, it followed that for a medical complaint to qualify as a proximate cause for a disease, it has to be sole, direct and efficient cause of the disease It is a Medically ackonwledged fact that Hypertension is a strong risk factor for CAD. So also Diabetes, Cholesterol, Obesity are pre-disposing factors for CAD. Dr. Jayaraman was also afflicted by Cholesterol and Diabetes in 1999 and 2001 respectively, i.e. prior to his contracting CAD. It therefore followed that in the medical history of Dr. Jayaraman there was more than one pre-disposing factor for CAD afflicting him of which only Hypertension was pre-existing. Further the actual extent to which Hypertension **alone** had facilitated and contributed to CAD was unfathomable and was not established. Under the circumstances, to conclude that Hypertension alone was the **sole, active, efficient** cause of CAD or that CAD was a complication of Hypertension was medically unjustifiable. At best Hypertension could be perceived as one of the facilitating factors for CAD in Dr. Jayaraman. Under the circumstances the Insurer's conclusion that CAD was a complication of Hypertension was found not tenable.

The insurer is directed to pay the admissible medical expenses subject to policy terms and conditions. The complaint is allowed subject to sum insured.

Chennai Ombudsman Centre
Case No. 11.5.1074 / 2005 - 06
Shri M. Sethumadhavan
Vs
The Oriental Insurance Co. Ltd.

Award Dated 23.5.2005

The complainant, Shri M. Sethumadhavan, an employee of LIC of India, was covered under LIC Group Mediclaim Policy. He was hospitalised in Christian Medical College, Vellore from 22.7.2003 to 26.7.2003 for "Portal Hypertension ? Childs A Cirrhosis". His claim was reimbursement of hospitalisation expenses was repudiated by M/s Paramount Health Services, the TPA of the insurer on the ground "admission for investigation - liver biopsy and there was no need for hospitalisation".

It emerged from the medical records produced before the Forum that Shri Sethumadhavan had a history of GI Bleed, Parenchymal Liver disease, Portal Hypertension and fundal varices. He was admitted in Apollo Hospital in 1999 and 2003 and had undergone treatment for the same. Further, he was advised by Apollo Hospitals for removal of spleen. The discharge summary of Christian Medical College, Vellore, pertaining to the present hospitalisation, stated the diagnosis as "Portal Hypertension and ? Childs A Cirrhosis". The liver biopsy showed incomplete Septal Cirrhosis. Further, the opinion of the doctors at CMC, Vellore was that there was no need for spleenectomy, contrary to the advice of doctors at Apollo Hospital. However, it followed that Shri Sethumadhavan was already afflicted with ailments like Paranchymal Liver disease, Portal Hypertension and fundal varices and had GI Bleed for which he availed treatment before being admitted in CMC, Vellore. The admission in CMC Vellore, was only in countinuation of the treatment for various ailments availed by the insured earlier in Apollo Hospitals. The discharge summary of CMC also stated that he was admitted for a Transjugular liver biopsy and that he "tolerated the biopsy well and there was no procedure-related complications". It was, therefore, apparent that the procedure Transjugular liver biopsy, being an invasive procedure administered under general anaesthesia, naturally warranted hospitalisation. In view of the ailments with which Shri Sethumadhavan was already afflicted and had also taken treatment earlier and as also diagnosed at CMC Vellore, the contention of the insurer that the admission was only for investigation was found to be incorrect. The admission in the hospital was preceded by illness, which was eventually diagnosed as "Portal Hypertension, Incomplete septal Cirrhosis, Dilated Portal veins with an Intraluminal Bland Thrombus" in the medical report of CMC Vellore. Subsequent to the liver biopsy and diagnosis, Shri Sethumadhavan was advised "further treatment plan" as mentioned in the discharge summary. The positive existence of the disease, therefore, stood established and test/investigations done at CMC were also consistent to the diagnosis and treatment of the disease. Further, the insured was covered under mediclaim policy prior to 1999 and the ailments were existing from 1999 only.

It was, therefore, held that the repudiation of the claim by the insurer was not sustainable. The insurer was directed to reimburse the admissible medical expenses for the complainant's hospitalisation at CMC, Vellore. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.2.1006 / 2005 - 06
Shri Meethalal Manormal
Vs
The New India Assurance Co. Ltd.

Award Dated 2.6.2005

The complainant, Mr. Meethalal Manormal was covered under Good Health Policy continuously from 1.12.2000 onwards. He was hospitalised in Narayana Hridayalaya, Bangalore from 10.7.02 to 11.7.02 for Coronary Angiogram (CAG). Subsequently, he was again hospitalised in the same hospital from 29.7.02 to 10.8.02 for Coronary Artery Bypass Graft (CABG). The complainant's claim for reimbursement of medical expenses was repudiated by the insurer on the grounds that it was observed from the medical documents that the insured person had Old Inferior Wall MI prior to inception of the policy and hence, the present ailment being pre-existing was not payable as per exclusion clause 4.1. Subsequently, the insured represented for reconsideration of the claim and submitted a certificate issued by the attending doctor Sanjay Mehrota clarifying the aspect of pre-existence. However, the insurers insisted on the insured producing ECG and other diagnostic reports taken prior to 1.12.2001 and since the same were not produced, the insurers expressed their inability to settle the claim.

In his representation to this Forum, Shri Manormal reiterated that with regard to a reference to an old Inferior Wall MI in the discharge summary, he had furnished a medical opinion of his doctor to the insurer. However, the insurers continued to insist on further ECG and other diagnostic reports which he was not able to produce since none has been taken.

From the documents produced before the Forum, it was noted that Shri Manormal was first hospitalised in July 2002 for Coronary Artery disease and it was this Discharge Summary that mentioned about 'Old Inferior Wall MI'. To render CAD as a pre-existing disease, there had to be medical evidence of the disease existing prior to 1.12.2000, i.e. the date of inception of the first policy. The term Old Inferior Wall MI only indicated that Shri Manormal was afflicted by a Myocardial Infarction (MI) prior to July 2002. In other words, the MI could even have occurred between December 2000 and July 2002 and there were no medical records available to prove to the contrary and hence the disease cannot be reckoned as a pre-existing one. The attending doctor, Dr. Sanjay Mehrotra had also clarified that the old Myocardial Infarction could even be 15 days old and only an ECG done at the time of policy decides whether it was present at that time or not.

Since there was no ECG taken at the time of commencement of cover, i.e. as on 1.12.2000 and there were no other medical records available to substantiate the pre-existence of the disease, it was held that pre-existence of the disease was not conclusively proved. The insurer was directed to reimburse the admissible medical expenses subject to policy terms and conditions. There was no order as interest an other compensation claimed. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.3.1396 / 2004 - 05
Shri K. P. Devarajan
Vs
National Insurance Co. Ltd.

Award Dated 14.6.2005

The complainant, Shri K. P. Devarajan and his Smt. S. V. Chandra were insured under mediclaim policy with the National Insurance Company Ltd., Mylapore Branch, Chennai from 25.1.2002 onwards. Smt. Chandra was hospitalised from 28.1.2003 to 3.2.2003 for Coronary Angiogram at Cardiac Care Centre, Ramachandra Hospital and subsequently from 3.2.2003 to 8.2.2003, she was hospitalised at Vijaya Heart Centre

for Post Transluminal Coronary Angioplasty (PTCA). The insured's claim for reimbursement of medical expenses was repudiated by the TPAs of the insurer, M/s Medicare Services, on the ground that it was the opinion of their panel doctor that the coronary artery disease was pre-existing since 90% CAD Stenosis and 50 % OMM Stenosis could not have developed over just one year from policy inception and indicated long standing coronary artery disease. Further in July 2003, the insured was having severe hypertension and long standing hypertension could also give rise to heart ailment.

It was observed from the discharge summary of Shri Ramachandra Hospital that the insured had no H/o of DOE / AOE / Orthopnea / PND / TIA / Palpitation / Dysphagia. The discharge sumary also revealed that the insured was recently detected to have hypertesion, found to be IGT and Dyslipidemic in the present admission and was admitted with complaints of rest angina since 25.1.2003. The discharge summary of Vijaya Hospital, where she underwent PTCA, stated that the Smt. Chandra was a hypertensive with CAD, anterior well no. STEMI (25.1.2003). No significant personal of family history". There was also a certificate from the family doctor of the insured stating that she was detected to have hypertension for the first time on 25.1.2003 and was referred to a cardiologist subsequently. There was also a letter from the doctor to whom Smt. Chandra was referred by the family doctor which also did not establish pre-existence of HTN / CAD.

The insurer has gone by the opinion of their panel doctor that high blood pressure cannot occur all of a sudden and therefore the history of hypertension had been either supressed or not recorded earlier and that only long stating hypertension can give rise to CAD. The Forum observed that the opinion of the insurer's panel doctor was based only on the general nature of the disease and therefore, was an assumption. It was noted that there were no medical evidences of the pre-existence of hypertension and treatment taken for hypertension and its bearing on CAD or the awarencess that Smt. Chandra had of the existence of hypertension in her prior to 25.1.2003 if any. Assumption, however strong cannot take the place of proof. The insurer also could not produce any evidence of the pre-existence of CAD. It was, therefore, held that the insurer had failed to conclusively prove their contention of pre-existence of the disease. The insurer was directed to reimburse the admissible medical expenses and the complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.4.1436 / 2004 - 05
Shri A. Ravi
Vs
The Oriental Insurance Co. Ltd.

Award Dated 17.6.2005

The complainant, Shri A. Ravi, insured under mediclaim policy, was hospitalised in Apollo Hospital, Madurai with complaints of chest pain from 18.12.03 to 20.12.03. Certain investigative tests were done on him and he was discharge on 20.12.03. His claim for reimbursement of the medical expenses was repudiated by the Insurer on the ground that as per the Discharge Summary and the investigations, there was no positive existence of any disease and hence the claim was not payable.

From the perusal of the records submitted before the Ombudsman, it emerged that Shri Ravi was admitted with complaints of chest pain and sweating and these symptoms proved to be non-specific and not related to any cardiac problem. It also emerged that the illness of asymptomatic renal calculi was diagnosed as a result of investigations

conducted. Asymptomatic renal calculi was an incidental finding and since Shri Ravi did not have any acute symptoms connected with the same, there was no medical intervention done for the same during the hospitalisation. The ECG, Echo and TMT done gave normal readings and ruled out cardiac cause of chest pain. It was also noted that on hospitalisation, Shri Ravi was not administered any treatment for his chest pain. The only treatment given to him was by way of medication of Tab Loripam and Polybion, apart from Investigative tests like ECG, ECHO and X-Ray. It, therefore, emerged that all the investigative tests done, except USG of Abdomen, were normal, including the ECG and ECHO done for the complaint of chest pain for which he was admitted. The USG Abdomen revealed Renal Calculi which again, did not warrant treatment as per the advice of Urologist. Exclusion clause 4.10 of the mediclaim policy excludes reimbursement of hospitalisation expenses, wherein investigative tests alone are done and ultimately there is no positive existence of any disease. In the said given case, the only ailment diagnosed to be existing was Renal Calculi and the same had not been treated in the hospital. Therefore, there being no positive existence of a disease established as a result of the investigations done and which necessitated the hospitalisation, the applicability of exclusion clause 4.10 in the case on hand cannot be disputed and hence it was held that the insurer cannot be faulted in repudiating liability. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.4.1060 / 2005 - 06
Smt. T. Sujatha
Vs
United India Insurance Co. Ltd.

Award Dated 23.6.2005

The complainant, Smt. T. Sujatha was insured under mediclaim policy from 25.8.2001 to 24.8.2002. The policy was renewed for a period of one year from 25.8.2002 to 24.8.2003. Smt. T. Sujatha was hospitalised from 25.8.2002 to 29.8.2002 for fibroid uterus for which a hysterectomy was done on her. Her claim for reimbursement of the medical expenses was initially repudiated by the insurer on the ground of “pre-existing illness”. Subsequently, when the insured represented for reconsideration of the claim, the insurer again rejected the claim on the ground that the claim was preferred in the second year policy though the diagnosis for surgery has been done during the first year policy, and since hysterectomy for fibromyoma was an exclusion under the first year policy, the claim was not payable as per exclusion clause 4.3 of the policy.

It was noted that as per exclusion clause 4.0 of the policy, the Company was not liable to make any payment under the policy in respect of any expenses whatsoever, incurred by any insured person in connection with or in respect of **expenses on treatment** of disease such as cataract .... hysterectomy for mennorhagia or fibromyoma ... during the first year of the operation of the policy.

The first mediclaim policy covering Smt. T. Sujatha commenced on 25.8.2001 and expired on 24.8.2002 and the policy was renewed for the second year w.e.f. 25.8.2002 for a further period of one year. The hospitalisation for which Smt. Sujatha had claimed had been from 25.8.2002 to 29.8.2002. It, was, therefore, clear that the **treatment** for which Smt. Sujatha had claimed reimbursement took place during the second year of the mediclaim policy. Exclusion clause 4.3, as narrated above, excluded only expenses incurred during the first year of the policy. Hence, it was held that the clause 4.3 clause did not apply in the case on hand. The insurer was directed to entertain the

claim and reimburse the admissible medical expenses to the insured. The Complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.2.1011 / 2005 - 06
Shri J. Krishnan
Vs
The New India Assurance Co. Ltd.

Award Dated 12.7.2005

The complainant, Shri J. Krishnan was insured under mediclaim policy for the period 28.3.2003 to 27.3.2004. Shri J. Krishnan, following a fall at home on 13.12.2003 and resultant injury to his left knee, was admitted in Bone & Joint Research Centre on 13.12.2003 and the injury was diagnosed as "# Left Patella with Communion". He was discharged on 25.12.2003 after undergoing the procedure "Tension band wiring left patella".

Shri J. Krishnan lodged a claim with the insurer on 12.4.2004, i.e. after a lapse of 4 months. The claim was repudiated by the insurer, invoking policy condition 5.4 of the policy on the ground that the claim was not submitted within 30 days stipulated in the said condition.

It was observed from the documents submitted before the Forum that Shri Krishnan submitted the claim for reimbursement of medical expenses only on 12.4.2004 which was after a delay of nearly three months. The insurer repudiated the claim on the ground of late submission of claim, which, according to condition 5.4 of the policy, should have been within 30 days of the date of discharge from the hospitalisation. The Insured contented that he was not moving around after the discharge and was not aware that the claim was to be submitted within 30 days as stipulated in the policy. No doubt once the insurance contract is entered into and the same evidenced by the policy document, both the parties under the contract, i.e. the insurer and the insured are bound by the terms and conditions of the policy. The insured cannot seek remedy on the grounds of ignorance of the terms and conditions of the policy. However in any breach of a condition in a contract, the impact of the same is to be viewed to determine the magnitude and materiality of the particular breach of condition on the liability of the insurer, and it is the same that should determine the condition on the liability of the insurer, and it is the same that should determine the avoidance of the contract in the present case, the delay of nearly three months in submission of the claim papers did not appear to have changed the characteristics of the claim or in any way aggravated the claim. Therefore, delay in submission of the claim had not, in any way, been material to the claim and this delay did not assume such significance as to have a bearing on the liability of the insurer so as to impel him to repudiate liability under the claim. Hence, it was held that the claim warranted consideration.

The insurer was directed to entertain the claim subject to the claim meeting with the remaining stipulations of the policy and convery their decision to the Forum within 20 days. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.5.1056 / 2005 - 06
Smt. S. Kalavani
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12.7.2005

The complainant, Smt. S. Kalavani was insured under Mediclaim Policy from the year 2001 onwards. Smt. S. Kalavani was hospitalised from 8.12.2004 to 9.12.2004 for Bracheal Neuralgia in Ashwini Soundra Hospital and Research Centre. Her claim for reimbursement of medical expenses was repudiated by Medicare Services, the TPA of the insurer on the ground that the patient was admitted for mere investigations and so the claim was not payable.

It was observed from the discharge summary that the condition of Smt. Kalavani, on admission, was that of “Bracheal Neuralgia”. The investigations done in the hospital, namely MRI and ENMG, were negative for any disease. The only treatment administered on the insured in the hospital was medication with Proxyvon and Renerve which are only analgesic and nerve regenerators respectively. On discharge, the insured was advised for Thyroid Function test and it was only from this test that her Thyroid problem was detected. It, therefore, emerged that the investigative tests done during the hospitalisation did not prove positive existence of an ailment. Further, neither the diagnostic tests done in the hospital nor the treatment administered to the insured in the hospital were of the nature that warranted hospitalisation - the same could have been done on an out-patient basis. Further, from the records submitted, it was noted that Smt. Kalavani had been having complaints of pain and undergoing treatment right from July 2004 onwards and at the time of the present hospitalisation, the presenting complaints did not indicate any drastic changes in her condition or any emergency that necessitated immediate hospitalisation. Under the circumstances, it was held that the claim did not fall within the purview of the mediclaim policy and the insurer cannot be faulted for repudiating liability. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.5.1051 / 2005 - 06
Shri R. Shankar
Vs
The Oriental Insurance Co. Ltd.

Award Dated 18.7.2005

The complainant, Shri R. Shanker was insured under mediclaim policy from 1997 onwards. Shri Shanker was hospitalised in Apollo Hospitals, Chennai from 12.11.2002 to 25.11.2002 for myocardial Infarction and underwent Rescue PTCA to LAD. His claim for reimbursement of medical expenses was repudiated by the insurer on the grouunds of Non-disclosure of elevated blood pressure in the proposal form and pre-existence of Hypertension from 1993 onwards.

From the discharge summary submitted before the Forum by the complainant, it was noted that the history of hypertension had been mentioned places as “3 months”, “2002 July” and “Found to have elevated blood pressure and on irregular treatment since 2002”. The insurer also produced another copy of discharge summary attested by the hospital authorities, which contained the following noting in addition to the above mentioned notings - “Seen by cardiologist in 1993 for burning sensation in chest, found to have elevated BP and on irregular treatment”.

It emerged that there were discrepancies regarding the history of Hypertension in the notings in both the discharge summaries. There were also two letters from the attending doctor, Dr. K. P. Misra, in which he stated that Shri Sankar was not Hypertensive nor had any treatment for hypertension prior to his admission in 2002. On the other hand, the medical superintendent of the hospital has stated in her letter that the history taken by the Junior doctor in the emergency had carried the information that he was hypertensive from 1993.

In the light of the discrepancies in the various records submitted regarding the history of hypertension, it would have been appropriate for the insurer to verify with the attending doctor as to the factual position. However the discrepancies were not verified with the attending doctor. It was also noted from the investigation report of the Insurer that the doctor had affirmed that he was not aware of the episode in 1993 and that it was a combination of heavy smoking, family history and Stress that would have contributed to the present incident. In the light of the above, the noting of “seen by cardiologist in 1993 for burning sensation”, alone could not be taken as conclusive proof of pre-existence of hypertension. Since the existence of hypertension at the time of proposing for insurance, i.e. in 1997, had not been established, the contention of the Insurer that there had been suppression of facts at the time of proposing for insurance was not tenable. It was, therefore, held that the Insurer cannot absolve themselves of liability and the Insurer was directed to entertain the claim and reimburse the admissible amount. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.2.1062 / 2005 - 06
Shri S. Sreenivasan
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

The Complainant Shri S. Sreenivasan was covered under the Good Health Policy for Citibank Card Holders for the period 1.11.04 to 31.10.05. Shri Sreenivasan took Ayurvedic treatment as an inpatient in Arya Vaidya Chikitsalayam and Research Instutute, Coimbatore for Cervical Spondylosis and low back pain. His claim with the Insurers for an amount of Rs. 47,575/- was restricted by the insurer to Rs. 25,000/-, by invoking clause 1.1.f of the policy. The Insured represented that condition 1.1.f was applicable only to diseases mentioned under clause 4.3 and the disease namely Cervical Spondylosis, for which he underwent treatment, did not come under clause 4.3 of the policy.

On perusing the terms and conditions attached to and forming part of the Good Health Mediclaim Policy issued to the Master Policyholder, it was obsered that Condition 1.1.f commences with the words “in respect of the following specified ailments” and then gave a table which stated the limit per claim for

a) “All disease which are excluded under clause 4.3 other than Total Knee Replacement
b) Total Knee replacement
c) Non-Allopathic Treatment (Rs. 25,000/-)

In view of the opening words of the condition, viz “In respect of following speficified ailments”, followed by the specific mentioning of “All disease which are excluded under condition 4.3” it was logical to coclude that the clause 1.1.f in particular applied to only ailments speficied in condition 4.3. In other words, the limit set out in condition 1.1.f would apply only to diseases specified in condition 4.3, Further, since the table also mentioned the limit per claim for non-allopathic treatment, it was understandable that a reading of the same could lead to an inference that non-allopathic treatment pertained to the disease specified in condition 4.3. It is to be acknowledged that normally, a sub-clause, if provided, will refer to items of a particular category and hence in the said case since the sub-clause opened with the words, “in respect of the following specified ailments” it was understandable that the insured had interpreted it to mean that the clause was applicable only to the diseases specified under condition 4.3. Hence, this

Forum was constrained to hold that there was an obvious ambiguity in the clause which allowed for the same to be interpreted in the manner in which it had been interpreted by the insured. When the Insurer's intention had been to specify a limit for Non-allopathic treatement availed for any disease, the same should have been mentioned under a separate sub-clause leaving no room for an misinterpretion.

In the case on hand, since the treatment was for Cervical Spondylosis and the same did not figure among the diseases specified under condition 4.3, it was concluded that the insured could not be faulted for interpreting the condition in the aforesaid manner and thereby staking his claim for reimbursement of the entire medical expenses. Since the benefit of doubt had to be given to the insured keeping in view the fact the policy had been drafted by the insurer, it was held that the claim of the complainant warranted consideration and the insurer was directed to entertain the insured's claim and pay the balance of the claimed amount subject to the sum insured under the policy.

Delhi Ombudsman Centre
Case No. GI / 530 / OIC / 04
Smt. Ekta Suri
Vs
Oriental Insurance Co. Ltd.

Award Dated 18.5.2005

FACTS OF THE CASE

The Claim of the complainant is under an Overseas Mediclaim Policy taken by her. The claim is in respect of Ectopic Pregnancy. The claim has been disallowed by M/s. Heritage Health Services Pvt. Ltd. on the ground that "the policy excludes pregnancy and its complications". The agency is relying on the following condition in the policy :-

"8. The Insurance will not cover pregnancy of the Insured Person including resulting childbirth, miscarriage, abortion or complication of any of these."

Observations of Hon'ble Insurance Ombudsman :

In the course of the hearing, Hon'ble Insurance Ombudsman drew the attention of the representative of the Insurance Company to a circular dated 17th April, 2001 which has been issued by his own company and which clearly says that medical expenses incurred in respect of termination of Ectopic Pregnancy will be payable under the individual Mediclaim policy, in view of the fact that such pregnancy is abnormal and poses a serious danger to the life of the mother.

In the light of the above - mentioned circular Insurance Company can not deny the claim of the complainant. The Insurnace Company cannot take the stand that the circular dated 17th April, 2001 will apply only within India and will not apply outside India. The circular itself does not make any distinction between policy taken within India and Overseas Mediclaim Policy.

If the Insurance Company tries to draw a distinction between a Mediclaim policy within India and an Overseas Mediclaim Policy then it would amount to discrimination. The logic of the decision must apply equally in this case.

Hon'ble Insurance Ombudsman, therefore, recommended that the claim of the complainant be allowed and the admissible claim amount paid to her after due scrutiny of bills. The Insurance Company should issue appropriate instructions to M/s. Heritage Health Services Pvt. Ltd. This is not a matter to be left to the agency. The contract it with the Insurance Company. The Insurance Company

should, therefore, issue appropriate instructions to the agency and ask the agency to pay the claim.

Delhi Ombudsman Centre
Case No. GI / 393 / NIC / 04
Shri M. S. Lamba
Vs
National Insurance Co. Ltd.

Award Dated 19.5.2005

FACTS OF THE CASE

The claim of the complainant is in respect of the total abdominal hysterectomy undergone by his wife (Smt. Prakash Kaur) in Sita Ram Bhartia Institute of Science & Research, on 11.11.2003. The claim has arisen during the second year of the policy period.

The claim has been repudiated by the Insurance Company on several grounds which are detailed in their letter dated 15th September, 2004 addressed to the complainant.

Observations of Hon'ble Insurance Ombudsman :

Hon'ble Insurance Ombudsman is of the view that these grounds are entirely misconceived. Exclusion No. 4.2 of the contract has no applicability at all in this case. This was admitted by the representative of the Insurance Company at the hearing today.

Menorrhagia occurs during the reproductive years of most women's lives. For women, it is in the nature of an ordeal decreed by God Almighty. It does not become chronic in every case. It is merely a passing phase. In itself, it does not point to a Fibroid Uterus. Fibroid Uterus is quite a different thing.

In this particular case, hysterectomy was necessitated because of the existence of a Fibroid Uterus. That Smt. Prakash Kaur was having a Fibroid Uterus was diagnosed only on 10.9.2003 on the basis of an ultra-sound test. There is no evidence to show that there was any diagnosis prior to that date or that she knew about it prior to that date.

In the circumstances, Hon'ble Insurance Ombudsman is of the view that the Insurance Company is clearly liable to pay the claim of the complainant. Accordingly, Hon'ble Insurance Ombudsman passed the Award that National Insurance Company Limited shall pay to Shri M. S. Lamba the admissible claim amount, after due scrutiny of bills, in respect of the hospitalization of his wife, Smt. Prakash Kaur, in Sita Ram Bhartia Institute of Science & Research from 10.11.2003 to 15.11.2003 for undergoing total Abdominal Hysterectomy.

The Award shall be implemented immediately. The exact claim amount paid to the complainant shall be intimated to my office for information and record.

Delhi Ombudsman Centre
Case No. GI / 532 / UII / 04
Shri Rajeev Kumar Saxena
Vs
United India Insurance Co. Ltd.

Award Dated 25.5.2005

FACTS OF THE CASE

The claim of the complainant is in respect of the hospitalization of his wife, Smt. Amita Saxena, from 27.1.2001 to 14.3.2001. Smt. Amita Saxena died in the hospital on 14.3.2001. She had been admitted to the hospital with complaint of "Stevens-Johnson Syndrome & fever and cough & breathlessness". This is a serious and sometimes fatal inflammatory disease. It is characterized by the acute onset of fever. Pneumonia, pain in the joints and prostration are common. This disease is either due to allergy to drugs or due to some infection. Probably, Smt. Amita Saxena was prone to infection because she had a kidney transplant a few years ago. In the course of her hospitalization in January - March, 2001, she developed acute renal failure also.

The hospitalization occurred during the policy period from 11.1.2001 to 10.1.2002. According to the representativies of the Insurance Company, the policy for this period carried a condition that liability in respect of treatment of kidney related diseases would be restricted to Rs. 1,00,000/-. The representatives of the Insurance Company showed to Hon'ble Insurance Ombudsman a copy of the relevant policy schedule which carrries this condition. At the time of the hearing, Hon'ble Insurance Ombudsman asked the complainant's representatives to show the complainant's copy of the policy schedule. They were unable to do so; they said that they had not brought the copy. They promised to send the copy to my office on the next working day. Inspite of a reminder, the complainant's copy of the policy schedule has not been produced.

Observations of Hon'ble Insurance Ombudsman :

After hearing both the parties and after careful consideration of the facts of the case, Hon'ble Insurance Ombudsman is of the view that the Insurance Company is not right in assuming that Smt. Amita Saxena was treated entirely for kidney related diseases. They are ignoring the fact that she was also treated for Stevens-Johnson Syndrome which is not kidney related disease at all.

In so far as treatment of kidney related ailments is concerned, the Insurance Company would be justified in restricting their liability Rs. 1,00,000. This is because of the aforsaid condition stipulated in the policy schedule. However, the Insurance Company is also liable to pay compensation for the management of Stevens-Johnson Syndrome.

It is evident, therefore, that a bifurcation of the expenses incurred by the complainant is necessary. As a matter of fact, the complainant himself has, according to the Insurance Company, made a bifurcation of the expenses. The Insurance Company is, however, not satisfied with the bifurcation. They are questioning bifurcation because the complainant has tried to make it appear that the bulk of the expenditure was on Stevens-Johnson Syndrome, and relatively only a small portion of the expenditure was on kidney related ailments.

In the circumstances, Hon'ble Insurance Ombudsman recommended that -

1) The Insurance Company shall ask a doctor than Dr. Vinod Gandotra to make a fresh bifurcation of the expenses; and
2) The fresh bifurcation shall be done in the presence of the complainant so that the bifurcation is transparent and the complainant will have an opportunity to say what he wishes to say; the Insurance Company shall call the complainant or his authorized represntative for this purpose at a date and time convenient to both the parties.

The Insurance Company shall discharge its liability on the basis of the fresh bifurcation agreed upon by both the parties and as per the terms of the insurance contract.

The complaint is disposed of accordingly.

Hyderabad Ombudsman Centre

Case No. IO (HYD) / G / 11.002.0411
Shri Varadaraju
Vs
New India Assurance Co. Ltd.

Award Dated 30.5.2005

The complainant is a close friend of the insured. The insured purchased a mediclaim policy for the period 30.9.2003 to 29.9.2004 and was allowed 50 % cumulative bonus. This policy was renewed for the period 2004 - 05.

The insured was hospitalized in August 2004 for the treatment of stroke and an amount of Rs. 150000/- (amount inclusive of culmulative bonus) was paid to the hospital. Further amounts were not allowed by the company on the ground that the entire sum insured was exhausted and the insured was not entitled to further benefit as per the Clause 3.0 the mediclaim policy which deals with Any One illness.

Held : Insurers are bound by their policy terms and conditions and cannot be faulted for their decision to repudiate the claim. However, insured is one of their old customers enjoing 50 % bonus and he was terminally ill needing constant medical attention. It is absurd to expect such a patient to get discharged from the hospital to avail himself the benefit of claiming reimbursement. Further, insurer accepted premium for the year 2004 - 05 aware of the fact that the insured continued to be treated in the hospital. Hence this is a fit case for payment on ex-gratia. The insurers are directed to pay Rs. 1,00,000/- as ex-gratia to mitigate the financial hardship of the complainant.

Complaint Admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.002.0431
Shri N. Venu
Vs
New India Assurance Co. Ltd.

Award Dated 1.6.2005

The complainant's mediclaim policy for 10.3.2000 to 9.3.2001 excluded reimbursement of expenses towards heart related diseases. However, later renewals did not contain this exclusion. He preferred a claim for Rs. 50,598/- towards heart disease. The claim was rejected the TPA under exclusion No. 4.1 - pre-existing disease.

The insurer contended that the earlier policy lapsed on 30.6.1999 and was renewed with effect from 10.3.2000 after a gap of 7 months. Policies for years after 2001 did not contain the exclusion owing to clerical error. Moreover, the proposal form clearly states that he was a heart patient and thus was never construed to be included in the policy.

Held that the insurer cannot be faulted for their decision to consider the policy as a fresh one. However, printing of "None" in the exclusion column of the policy for 2 to 3 successive years was understood by the complainant as a favourable response to his request for non-exclusion. Hence, insurers are directed to make a 'one-time' payment only on account of their indifferent attitude. However, his prayer for continuity of insurance cover and benefits for heart disease is not allowed.

Complaint Admitted on exgratia.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.013.0417
Smt. Tara S. Prabhakar

Vs

National Insurance Co. Ltd.

Award Dated 1.6.2005

The daughter of the complainant. Ms. Smita S. Prabhakar, purchased HDFC Bank Health Plus Credit Card which provides for medical insurance coverage for Rs. 50,000/- effective from 1.3.2004. Under the same card, she pruchased additional mediclaim coverage for her father Shri Swarna Prabhakar for a sum insured of Rs. 4,00,000/- which was also effective from 1.3.2004.

The complainant's husband, was admitted at St. Isabel's Hospital, Chennai on 15.5.2004 with complaints of having vomited large quantities of coffee ground vomitus.

The TPA repudiated her claim on the ground that the present hospitalization was for the management of an ailment which was related to a pre-existing condition clause 4.1."

Passing of bloody urine occurred for the first time on 3.5.2004. He was rushed to Chennai for treatment where it was diagnosed as Urinary Bladder Cancer on 15.5.2004.

The treating doctors revealed that both the illness could remain asymptomatic and present as an emergency. Hence to state the disease was pre-existing was not jutified.

Their decision to repudiate the claim was based on the TPA panel doctor's opinion. The disease had developed more than 3 months prior to the date of admission in the hospital and more than one month before the inception of the policy. Hence, the claim falls under exclusion no. 4.1 of the policy and merits repudiation.

The discharge summary of St. Isabel's, Chennai, mentions that the patient had "painless hematuria about 3 months back". Working backwards, it would mean that the symptom first surfaced in February, while the policy was taken with effect from 1.3.2004.

The doctor in his report has categorically stated that this condition does not develop in few months but develops over a period of time.

On perusal of the doctor's opinion, I have reason to believe that the disease would not have assumed fatal proportion within a week or two as contended by the complainant and definitely would have developed over a considerable period of time. Further the fact that additional sum insured was opted for to cover the deceased alone makes me believe that it was to take advantage of the scheme.

Complaint dismissed.

Hyderabad Ombudsman Centre

Case No. IO (HYD) / G / 11.005.0405

Shri K. V. V. Narayana

Vs

Oriental Insurance Co. Ltd.

Award Dated 15.6.2005

Complainant purchased Mediclaim Policy with the Respondent Company for the period 10.3.2003 to 9.3.2004. Policy renewed with a gap of 6 days. Wife of the complainant underwent kidney Transplantation on 25.8.2003. TPA rejected the claim on 30.12.2004 on the ground that the patient was a Diabetic since 22 years and the final diagnosis was Diabetic Nephropathy reaching end stage. The complainant contended that

although she was a diabetic the same was controlled through medication. Symptoms of Nephropathy diagnosed only after January 2002.

Held : The treating Doctor stated that the patient was a known diabetic since 23 years and was insulin dependent for the last 4 years and Renal failure was diagnosed in 2001. Hence, patient was suffering from diabetes even before the inception of the policy and material facts about her health was not mentioned in the proposal form. The consultant Nephrologist also opined that the Diabetic Hephropathy is a combination of pre-existing diabetes Nellitus. The complainant wife was suffering from the disease even before the cover commemced.

Complaint dismissed.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.005.017
Shri Karamchandani Mahesh Kumar
Vs
M/s. Oriental Insurance Co. Ltd.

Award Dated 1.7.2005

The complainant purchased a mediclaim policy from the above insurer to cover himself, spouse and child for the period 2003 - 04. The policy for the period 2003 - 04 was issued to him with a loading of premium by 100 % and an endorsement on the policy excluding 'Cardiac Related Diseases'. The complainant preferred a claim on account of by-pass surgery and the same was settled by the insurer under the policy for the period 2002 - 03. He was hospitalised once again on 16.1.2004 for the treatment of Ischaemic Heart Disease. He preferred a claim with the insurer for reimbursement of expenses incurred. The insurer vide letter dated 20.5.2004 rejected the claim on the ground that the policy excluded Cardiac Related Diseases and as such, the disease was Considered pre-existing.

Held : It is observed that the insured was a regular mediclaim policy holder with the insurer and his policies were renewed without a break since 2001. The policy was initially offered to him on the basis of the declaration made by him in the proposal form. Apparently, the insurers were convinced about the good health while offering the first policy. They also honoured a claim from the complainant related to cardiac disease.

The insurer stated during the hearing that he was allowed to "load" premia as and when the case demanded basing on the claims experience of the insured customers. In this case, I understand, the insurer loaded premium by 100 % as a penalty for preferring a claim.

The complainant's contention that he was not informed about the intended exclusion remains unchallenged as the insurer could not produce any evidence in the form of letter addressed to the insured to the contrary. It appears that the insurer sought for a fresh proposal form the insured / complainant. They did not give convincing reply why this was done as the policy was renewed in chain. They have been whimsical in their action of mentioning Cardiac Related Diseases as pre-existing diseases in the 10th column in the policy schedule when they themselves have paid the earlier claim for the same disease. I hold that they are not justified in their repudiation of claim. The insurers are hereby directed to process and pay the claim as per the terms and conditions of the policy. Relief towards interest and expenses are not considered.

Complaint Admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.003.032
Shri Narsingdas Soni
Vs
M/s. National Insurance Co. Ltd.

Award Dated 1.8.2005

The complainant was covered under mediclaim policy for the period 1.12.2003 to 30.11.2004 for a sum insured of Rs. 50,000/-. He was admitted on 19.6.2004 with the complaints of shortness of breath since three days. He was diagnosed as suffering from severe MR, and was advised Mitral Valve Replacement. He incurred an expenditure of Rs. 1,95,223/-. The TPA, rejected the claim on the grounds that the treatment was for a pre-existing disease. The complainant contended that he was regularly renewing his policies since 1998 without any break. He never suffered from hypertension or diabetics. His claim with the company is restricted to only the sum insured along with bonus although he incurred more than Rs. 2 lakhs.

Held : The insurer accepted the policy with New India Assurance Co. Ltd., for the period 2003-04 fully aware that the earlier policy with New India Assurance Co. Ltd., expired on 25.11.2003 and allowed cumulative bonus and higher sum insured of Rs. 50,000/- which only reveals that they were convinced about the genral health of the insured. All the diagnostic reports and discharge summary reveal that the patient was suffering from shortness of breath since one month prior to hospitalisation. He would not have waited or postponed the surgery for six years to avail the benefit of insurance. Having accepted the premium they cannot shirk away from the responsiblity while honouring a genuine claim.

Complaint Admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 1.004.001
Shri Khaja Azeez Ahmed
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 1.8.2005

The Complainant is an account holder with Andhra Bank purchased mediclaim policy to cover himself and his family for a floater sum insured of Rs. 50,000/- for the period 31.8.2004 to 30.8.2005. His son was admitted to Pramila Hospital on 1.10.2004 and was diagnosed to suffer from Bilateral Grade IV Vesico - Ureteral Reflux. He underwent an Ureteral Reimplantation and was discharged on 11.10.2004. The TPA rejected the claim on the grounds that the disease was pre-existing and claim under exclusion 4.1 of the policy.

The complainant contended that the disease was first detected on 10.9.2004 and confirmed on 27.9.2004. His son, never took treatment earlier for either this disease or any other disease. Therefore, as on the date of commencement of the policy, the disease was not detected. The insurer contended that first consultation was made on 4.9.2004, five days after the policy was issued. Doctor diagnosed the problem as contracted right kidney on 7.9.2004 in the Grade - IV Reflux indicates the the disease was in an advanced stage.

Held : First prescription dated 4.9.2004 and confimation of diagnosis on 7.9.2004 were observed. The panel doctors contention that the disease is categorised into five stages and Grade - IV is considered to be advaced stage warranting surgery was noted. No

arguments were provided by the complainant to refute the insurer's contention. As such, the complaint is dismissed.

Complaint Dismissed.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.004.014
Shri G. Nageswara Rao
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 1.8.2005

The complainant purchased mediclaim policy for Rs. 1,50,000/- sum insured for the period 16.10.2003 to 15.10.2004 and he underwent Right Upper Lobectomy and incurred an expense of Rs. 75,314/-. The claim was rejected on the grounds that the disease was pre-existing as on the date of issue of policy. The complainant contended that the problem was first diagnosed in May, 2004 when he underwent health check-up, treating doctor confirmed the same and also certified that the ailment was not pre-existing. The insurers contended that cancer of the lungs takes about six months to one year to develop and hence was pre-existing.

Held : The treating doctor clearly clarified that the disease was not pre-existing at the time of surgery and also was willing to clarify the insurers in case of doubt. Both the discharge summary as well as the case sheet stated that the patient was asymtomatic. The insurers could have obtianed further clarifications from the treating doctor which they did not do.

Complaint Admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.008.061
Shri Gollen Amrutha Rao
Vs
M/s. Royal Sundaram Allianze Insurance Co. Ltd.

Award Dated 1.8.2005

The complainant purchased health shield insurance policy for the period 24.4.2004 to 23.4.2005. He took treatment as out-patient for cancer of Oesophagus. He submitted bill to the insurer for Rs. 50,000/-. The claim was rejected under exclusion no. 17 of the policy where company was not liable to pay expenses incurred with out-patient treatment. The insured contended that he opted for out-patient treatment as he could not afford getting admitted in the hospital. Insurer contended that sum insured under the policy along with bonus was Rs. 1,15,000/- and could not easily availed this facility.

Held : Since policy specifically excludes out-patient treatment from the scope of cover and also speficies minimum period of hospitalisation is 48 hours. There is no merit in the complaint.

Complaint Dismissed.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.003.0103
Smt. N. Hiram Raju
Vs

M/s. National Insurance Co. Ltd.

Award Dated 30.8.2005

Complainant was covered under mediclaim policy for the period 12.3.2004 to 11.3.2005 for a sum insured of Rs. 40,000/- He was hospitalised on 19.11.2004 and was diagnosed to suffer from cirrhosis of the liver. The TPA rejected their claim on the ground that the disease was pre-existing at the time of hospitalisation. The complainant contended that he was a regular mediclaim policy holder since 1995. However, there was a break in insurance for the period 2003-04 which was purely unintentional. The onset of the disease was sudden and needed immediate treatment.

Held : Insurers are not wrong in considering the policy for 2004 - 05 as a fresh one. The discharge summary of the hospital clearly states that the disease was in its advanced stage. As such the insurers are justified in rejecting the claim.

Complaint Dismissed.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.002.085
Mrs. C. Rajagopala Naidu
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 6.9.2005

The complainant purchased mediclaim policy for a sum insured of Rs. 2,00,000/- for the period 4.11.2003 to 3.11.2004. He was admitted to hospital on 3.9.2004 and was diagnosed to suffer from Hepatitis C, Hyper Spleenism. He preferred a claim on the Insurance Co. for Rs. 40,000/-. The claim was rejected by the TPA on the grounds that the disease was pre-existing. The complainant contended that he was absolutely in good health as on the date of purchasing the policy. He had a few bouts of blood vomiting on 2.9.2004 and he consulted his family doctor who advised him to consult gastroenteroligist. Accordingly, he got himself treated at Global Hospital. the insurer contended that he complainant had blood transfusion six months prior to admission to the hospital and Hepatitis C and Hyper Spleenism are chronic which did not manifest within a short time.

Held : The discharge summary of the hospital, where the complainant underwent transfusion was examined. He sustained lacerated injury to his left ankle with blood loss necessitating blood trasfusion. There is a certificate from the treating hospital which confirms that the symptoms were present only a day prior to admission. In view of the evidence that pre-existence is not established and that the disease of asymtomatic almost till the insured was admitted on 3.9.2004, I direct the insurer to admit the claim.

Complaint Admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.004.433
Shri G. Satyanarayana
Vs
M/s. United New India Insurance Co. Ltd.

Award Dated 13.9.2005

Shri G. Satyanarayana covered his wife, Smt. G. Narimani, under mediclaim policy No. 050601 / 48 / 37 / 296 / 97 for the period 17.10.1997 to 16.10.1998. The complainant

claimed reimbursement of medical expenses from the insurers for by-pass surgery conducted on his wife on 7.1.1998.

As per the instructions, the claim was processed and repudiated on 8.4.2004 under Exclusion No. 4.1 of the policy wherein pre-existing diseases are not covered under the policy. There was no cardiac problem prior to this hospitalisation. The patient did suffer from Hypertension and Chest pain. Since there was no cardiac problem, it was wrong to allege that the disease was pre-existing.

The insurer's agent requested his wife to affix her signature on the proposal form, which she did. She was not aware that all past ailments / diseases have to be disclosed. Since there was no heart disease prior to the inception of policy, the same was not pre-existing. As such the claim was genuine and merited settlement.

The policy was issued for the first time for the period 1997-98. The insured was hospitalised on 7.1.1998, within three months of issual of policy.

Their panel investigator obtained case sheet copies from the hospital. The same clearly revealed that insured was a 'known case of chronic unstable Angina. She had episode of chest pain six months back. Swelling of the left lower limbs three months back and was hypertensive since two years'. None of this adverse medical history was disclosed in the proposal, thereby deliberately suppressing material facts affecting under-writing considerations.

Held : None of the facts pertaining to patient's medical history were disclosed in the proposal form. On the contrary, the insured declared that she was in good health and free from medical complaints. Non disclosure of details of patient health adversely affected the under-writing considerations. Hence the insurer's decision is upheld.

Complaint Dismitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.002.107
Shri P. Srinivasa Rao
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 30.9.2005

The complainant's daughter was covered unde a mediclaim policy for the period 19.5.2003 to 18.5.2004. This policy was renewed upto 19.5.2004. His daughter was admitted on 8.9.2003 and was diagnosed to have Cancer of the Blood. The Third Party administrator settled the claim for Rs. 15,000/- in October 2003. She under went continuous treatment upto 4.6.2004 where she died in the hospital. The balance of Rs. 15,000/- was not honoured by the TPA on the ground that the sum Insured was exhausted The complainant contended that the policy was renewed without break and was he entitled to Rs. 15,000/- being S.I. under the policy. The insurer contended that the claim fell under clause 3.0 'Any one Illness' and merited is repudiation.

Held : The insurer, based his decision under any one illness clause which is as per the policy. However, this condition is very harsh as it is absurd to expect the deceased who was terminally ill patient to be discharged from the hospital to avail the benefit of claiming reimbursement. This is a fit case for awarding an ex-gratia to mitigate the financial hardship of the complainant.

The Complaint is admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.005.0135

Shri B. Magal Chand Bohra
Vs
M/s. Oriental Insurance Co. Ltd.

Award Dated 30.9.2005

The complainant insured his father under Mediclaim Policy for the period 29.11.2004 to 28.11.2005. He was admitted to a hospital on 18.4.2005 and was diagnosed to suffer from Progressive Cerebellar Ataxia. The claim was rejected under clause 4.1 pre-existing disease. The complainant contended that they had stated in the proposal form that he suffered from Diabetes and B.P. which were also excluded in the policy.

Held : The current ailment is resultant of BP and Diabetes and this disease existed before inception of the policy. As such insurers are justified in repudiating the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.005.091
Shri M. Mukunda Rao
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 30.9.2005

Complainant and his wife were covered by Andhra Bank Aarogyadaan Mediclaim Policy from 17.7.2005 to 8.6.2005. The complainant preferred two claims :

i) Severe pain and heavy bleeding from anus on 24.2.2005. Amount claim were Rs. 20,681/-.

ii) His wife was admitted on 21.1.2005 for abnormal backache and numbness of toes. An amount claimed Rs. 8,288/-. Both claims rejected by the insurer. The insured contended that his wife was having backache for the last nine months. But numbness was not there at any time. The insurer stated that the policy was a fresh one and piles falls under the first year exclusion clause of the policy. As regards his wife claim, the policy was only six months old while the complaints are nine months old.

Held : As regards the complainant's claim for piles surgery it is observed that the same is a first year exclusion under the policy. Therefore, insurers are justified in rejecting the claim.

As regards his wife's claim, the connection between earlier symptoms and present diagnosis is reasonably established. Hence, insurers are justified in rejecting both the claims. Complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.002.069
Shri S. Balaraman
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 30.9.2005

The complainant purchased overseas mediclaim policy for the period 17.8.2004 to 10.1.2005. He has two claims under the policy :

i) The hospitalisation claim for the period 5.9.2004 to 27.9.2004, settlement for which was delayed during the hearing. The insurer informed that the claim was being settled. Hence this complaint is closed.

ii) He covered his baggage under the policy and when he landed at Detroit Airport on 17.8.2004, he found one baggage containing personal clothes were not delivered by the Airlines. This baggage was delivered to him on 18.8.2004 at 11.30. P.M. He preferred a claim for $ 100 for cost of clothes and mental agony. On 21.9.2004, he was adviser by Coris International orally to purchase a set of clothes and submit the bill. Accordigly, he submitted bill for $ 97.58 being the cost of the new set of clothes. The insurer contended that the claimant's contention that Coris International, telephonically advised him to purchase clothes after retrieval of baggege is not acceptable to them as there is no proof of the same. They also opined that the claimant, a senior officer the Insurance co., cannot plead ignorance of the policy conditions.

Held : Though repudiation of the claim is technically correct, as purchase was done after baggage was restored, the insurer failed to appreciate that he had to either purchase clothes or borrow from somebody. In this case, he borrowed from his son-in-law and having done so, was obliged to return in the form of substitute. The expenditure incurred on clothes is not disputed either by the insurer or by the TPA. Therefore, ex-gratia payment towards cost of clothes is admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 14.004.060
Smt. Padma Shamal Iyengar
Vs
M/s. Oriental Insurance Co. Ltd.

Award Dated 30.9.2005

The complainant purchased an overseas mediclaim policy for the period 8.7.2004 to 11.8.2004 which was extended to 4.11.2004. She was hospitalised on 7.8.2004 in USA and discharged on 9.8.2004. She was again admitted with complaints of diabetis and hypertension and discharged on 16.8.2004. She was again admitted on 23.8.2004 with severe bleeding in her stools and discharged on 25.8.2004. She submitted her claim to the third party servicing agents. M/s. Coris International who did not respond to her claim. The insurer contended that the first two hospitalisations were on account of diabetic mellitus, hypertension and for cardiac related problems which were past history, not disclosed in the proposal form.

Held : The short - stay forms filled up for hospitalisation on 8.8.2004 and 25.8.2004 recorded diabetic mellitus, hypertension and four year old angioplasty as past history and the same were not found mentioned in the proposal or in the certifying doctor's report. The insurers are justified in rejecting these two claims. However, I observe that third claim though allowed is yet to be paid. We should understand the amount of pressure the complainant and her family members should be receiving from the treating hospitals for early settlement of their bills. The insurers are directed to pay the claim for GI Bleeding within a month from this day with interest as per IRDA guidelines.

Complaint admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.004.0101
Shri Vishwanath Manjunath Pai
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 30.9.2005

The complainant purchased a mediclaim policy and covered his mother also. She was admitted to hospital with diagnosis of 'Metastasis from unknown primary, left lower limb DVT & right sided malignant pleural effusion'. He claimed for an expenditure from the above hospital with M/s. Medsava Healthcare Pvt. Ltd. He received no reply for his claim. The insurer contended that they reminded the insured on many occasions to submit all the documents.

Held : This is a case of negligence of the TPA and helplessness on the part of the insurer. Despite various reminders, the insurer could not ensure the disposal of the claim. This case is one among the many cases ineptly handled by the TPA who do not appear to be under control of anyone. The insurer is directed to settle the claim as claimed by the claimant along with interest as the IRDA norms.

Complaint admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G / 11.002.0154
Shri N. Rajaraman
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 30.9.2005

Complainant purchased a mediclaim policy for the first time in 2000. In the year 2005 he claimed for reimbursement of health check-up as per policy terms and conditions. The claim was rejected because four years had not been completed. The insured contended that he has been renewing these policies only since 2000. The insured contended that the first policy was dated 6.6.2000 while the second policy was with effect from 9.7.2001 leading to a break of 32 days. The policy for a period 2001 - 02 was considered a fresh one and four continuous years were not completed as on the date of the claim.

Held : The insurer was right in concluding that as on the date of check up the insured had not completed four years.

The policy condition clearly speaks after completion of four Continuous claim free insurance. Since there is no ambiguity in the conditions enumerated in the policy. There is no complaint with this office.

Complaint Dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.004.261 / 2004 - 05
Smt. Sarojini Asokan
Vs
United India Insurance Co. Ltd.

Award Dated 5.4.2005

The complaint under rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose of repudiation of a mediclaim by the insurer. The complainant had taken a mediclaim policy from the respondent insurer (fresh policy) for the period 27.9.2001 to 26.9.2002. The complainant had undergone two spells of hospitalization for Osteo Arthritis in May 2002 and July 2002 and she had both the knees replaced. The medical history had shown that the complainant had the disease for the past three years. Since all pre-existing diseases are excluded under Cl.4.1 of the mediclaim policy, both the claims were successively repudiated. The facts of the case were clear to the point that the

disease in question was pre-existing and the insurer had rightly repudiated the claims. There being no merits in the complaint, the action of the insurer in repudiating the claim was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.253 / 2004 - 05
Shri U. P. Rajan
Vs
Oriental Insurance Co. Ltd.

Award Dated 6.4.2005

The Complaint under rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 resulted out of partial repudiation of a mediclaim by the insurer. The complainant, who is a known heart patient, had sustained an accidental fall in the bathroom on 25.8.04 and was hospitalized. When he submitted the claim for a total amount of Rs. 8101/-, the insurer had disallowed the Cardiac medicines from the bills for the reason that the cardiac medicines included in the bills formed part of his regular treatment, which was not directly due to the accident. The pre and post-hospitalization should necessarily be related to the main course of treatment and medicines taken for the already existing diseases did not come under the purview of the policy. The stand of the insurer being on justifiable grounds, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 14.03.251 / 2004 - 05
Shri M. M. Parthan
Vs
National Insurance Co. Ltd.

Award Dated 13.4.2005

The Complaint under rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a mediclaim by the respondent insurer. The complainant's wife was hospitalized for treatment of fibroid uterus and endometrial endocervicitis during the period 9.11.03 to 20.11.2003 and a claim for Rs. 24,071/- was preferred before the insurer. Although the medical report indicated the disease as 8 to 10 months old, since it was mentioned as a case of chronic cervicitis, the insurer had got the claim investigated. During the investigation, it came to light that the complainant's wife had these problems for 5-6 years. It was however possible that the party had not taken the symptoms very seriously and the treatment was continued which might have prompted him to disclose the details in the proposal form. However, as the case was proved beyond doubt to be existing much before the commencement of the medical insurance, the insurer was right in rejecting the claim as pre-existing disease as per Exclusion clause No. 4.1 of the Mediclaim policy. The complaint was therefore dismissed and the the action of the insurer in repudiating the claim was upheld by the Hon. Insurance Ombudsman.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.004.296 / 2005 - 06
Shri Jose Kappen
Vs
United Insurance Co. Ltd.

Award Dated 26.4.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a mediclaim by the respondent insurer. The complainant was for long insured with the National Insurance Co. Ltd. and his policy expired in September 2003 after which he took a fresh policy from the respondent insurer only from 8.1.2004. During the first year of the fresh policy, the complainant had undergone treatment at Lakeshore Hospital for vomiting, loose motion, hemorrhoids, increased gastro colic reflux, insomnia etc. and applying the first year exclusion for such diseases under cl. 4.3 of the mediclaim policy, the insurer had rejected the claim. On verification of the records it was found true that the policy with the respondent insurer was a fresh one and the first year exclusions under cl. 4.3 of the policy applied to the complainant. The insurer had rightly rejected the claim and the claimant having been found not eligible for any relief whatsoever under the policy cited, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.004.297 / 2005 - 06
Dr. S. Jeevanand
Vs
United India Insurance Co. Ltd.

Award Dated 26.4.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a mediclaim by the insurer. The complainant's father Shri Sarvothama Shenoi was admitted in Sudheendra Medical Mission Hospital in May - June 2004 for Ulcer lateral dorsal (R) foot and he was diagnosed as Diabetic. The original certificate stated that the patient was Diabetic for about 4 years. The mediclaim policy was in existence right from 1999 and renewed continuously. On an investigation, the Doctor had issued a certificate that the patient was a Diabetic for about 10 years and therefore the insurer repudiated the claim, as the disease was considered pre-existing. However, the first certificate issued at the time of treatment had primacy over a subsequent one obtained at the instance of the insurer and since the insurer was not able to prove hospitalization/treatment of the complainant's father before May-June 2004 and in the absence of any medical evidence to show that the beneficiary was a Diabetic for 10 years, the contention of the insurer could not stand the scrutiny of law and logic. In the circumstances, the claim of Rs. 9530/- was allowed subject to proper verification of bills and compulsory deductions, if any.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.201 / 2005 - 06
Shri P. V. Michael
Vs
Oriental Insurance Co. Ltd.

Award Dated 26.4.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a mediclaim by the insurer. The complainant, an LIC employee was a member of the Group mediclaim policy issued by the insurer covering LIC employees dependents. The complainant's wife was treated in a famous hospital for Glaucoma and his representation to the insurer against the basic rejection of the claim by the TPA remained unanswered. However, on fixing up a date of hearing this Forum, the insurer had faxed a message saying that the claim for Rs. 2,510.02 was being processed for settlement within a week's time from 25.4.2005. In view of the undertaking by the insurer, the complaint was disposed of by asking the insurer to

settle the claim as promised within a week's time from 25.4.2005 for an amount of Rs. 2510.02 (amount not disputed by the insurer).

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.175 / 2005 - 06
Shri K. R. Xavier
Vs
Oriental Insurance Co. Ltd.

Award Dated 27.4.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arises out of the inordinate delay by the respondent insurer in settling a mediclaim. The complainant, an LIC employee, was covered for medical insurance and the hospitalization bills for chemotherapy of the complainant himself were submitted to the TPA, M/s. Paramount Health services Pvt. Ltd., through the insurer within the prescribed time - frame, but there was no response for a long period and hence the complaint before this Forum. Even as the hearing of the case was fixed for 27.4.2005, the complainant had orally informed the office of this Forum that the matter was already settled between them and hence the complaint was dismissed without any fetter on the settlement, if any, arrived at between the parties.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.178 / 2005 - 06
Shri P. N. Gopalakrishna
Vs
Oriental Insurance Co. Ltd.

Award Dated 27.4.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arises out of the inordinate delay by the respondent insurer in settling a mediclaim. The complainant, an LIC employee, was covered along with his family for medical insurance and the hospitalization bills for surgery in Dhanya Hospital, Chalakudy of the complainant's wife were submitted to the insurer within the prescribed time-frame, but there was no response and hence the complaint before this Forum. Even as the hearing of the case was fixed for 28.4.2005, the office of this Forum received a fax message from the insurer on 25.4.2005 that the claim for Rs. 2607/- would be settled in a week's time. In view of the assurance by the insurer; the complaint was disposed of by directing the insurer to settle the claim in a week's time as promised.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.144 / 2005 - 06
Shri C. O. Mathew
Vs
Oriental Insurance Co. Ltd.

Award Dated 28.4.2005

THe Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 stems out of the inordinate delay by the respondent insurer in setting a mediclaim. The complainant, an LIC employee, was covered alongwith his family for medical Insurance and the hospitalization bills pertaining to the medical treatment of the complainant's wife in November 2003 were submitted to the insurer within the prescribed time-frame,

but there was no response and hence the complaint before this Forum. Even as the hearing of the case was fixed for 28.4.2005, the office of this Forum received a fax message from the insurer on 25.4.2005 that the claim for Rs. 3499.30 would be settled in a week's time. In view of the assurance by the insurer; the complaint was disposed of by directing the insurer to settle the claim in a week's time as promised. However, this Forum recorded its displeasure on the inordinate delay caused by the respondent insurer in settling the claim within a reasonable time.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.003.286 / 2005 - 06
P. Nandakumar
Vs
National Insurance Co. Ltd.

Award Dated 4.5.2005

The Complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Mediclaim by the insurer. The complainant's mother Smt. Pankajakshy Amma was administered treatment for rheumatic complaint KMK Hospital, North Paravur. His claim for Rs. 3,316/- was turned down by the respondent by virtue of the decision by M/s. TTK Health Care Services denying the Cashless treatment for the complainant's mother. The insurer's contention is that the disease of Smt. Pankajakshy Amma existed 5 years preceding the hospitalization, while the insured's plea is that the disease had surfaced only about 2 ½ years prior to hospitalization. On verification of the certificate issued by Dr. Saju Abraham of the said hospital, it is clear that the age of the disease of Smt. Pankajakshy Amma was 2 ½ years before the hospitalization and the Insurer had no material evidence. to prove that the disease of Smt. Pankajakshy Amma existed 5 years preceding the hospitalization. In the above circumstances, this Forum directed the insuer to pay the claim of Rs. 3316/- to the complainant within 15 days subject to verification of bills and compulsory deductions, if any.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.187 / 2004 - 05
Shri V. K. Sunny
Vs
Oriental Insurance Co. Ltd.

Award Dated 17.5.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 was a fall out from the repudiation of a mediclaim by the Respondent insurer. The complainant - an employee of M/s. Apollo Tyres was covered under the Group Personal Accident Policy issued by the insurer in favour of the employees of M/s. Apollo Tyres. The complainant had met with a motor-bike accident on 13.9.03. While he was driving the Motor bike on the public road in the evening, the bike skidded and the complainant had sustained dislocation of the (L) clavicular joint. However, the hospital records showed that the complainant was under the influence of alcohol at the time of accident. During the personal hearing, the complainant himself had admitted that he had consumed 1 ½ pegs of liquor at noon on the date of accident and he could not say whether the intoxication had caused the accident. In any case, Exclusion clause No. 5 of the policy clearly excluded compensation for any injury caused to an insured person while he was

under intoxication and hence there being no merit in the case, the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.137 / 2005 - 06
Shri Dixon Alias
Vs
Oriental Insurance Co. Ltd.

Award Dated 24.5.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of a mediclaim by the insurer. The complainant, his wife and children were covered under an individual mediclaim policy during the relevant period. The complainant's son, aged 10 years, had a history of fall and some two months thereafter, the boy developed pain all over his head, ears and eyes. Although he was initially taken to local doctors, the pain did not subside and fearing some internal disorders consequent to the history of fall, he was taken to a super speciality Hospital and even after thorough examination including scanning the ENT and Ophthalmologists could not find anything wrong. The child was once again referred to a paediatrician and it was found out that the boy had dental caries, which caused the head-ache. The TPA of the insurer had rejected the claim stating that all examinations were for diagnostic purposes which did not come under the policy and further that the dental treatment which was ultimately done did not need hospitalisation. But, in the peculiar circumstances of this case, the hospitalisation was due to the fact that the boy was suffering from severe head - ache etc. and all tests carried out by the doctors on him were not at the option of the patient or his parents. In the process of finding out the cause for head ache various tests became necessary and therefore it was untenable to contend that the treatment was for dental caries and therefore the hospital bills were not payable. The admission of the boy into the hospital being for other genuine reasons and all tests were only incidental to the main problems, it was not a case of dental treatment or investigation diagnostics. There being no merits in the arguments of the insurer, the repudiation was set aside and the complaint was allowed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.004.05 / 2005 - 06
Smt Jemma Loy
Vs
United India Insurance Co. Ltd.

Award Dated 25.5.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arises out of repudiation of a mediclaim by the insurer. The complainant was insured with the Respondent Company since 31.10.2000. On 31.7.2004, the complainant was hospitalized at Medical Trust Hospital and discharged on 1.8.2004 after certain diagnostic tests for Menorrhagia. The mediclaim policy specifically excluded investigative tests only if the hospitalization was not for treatment of any disease. In this case only investigative tests were conducted and neither there was any additional medication prescribed nor the patient was advised rest. Besides, the records also revealed that the complainant had problems of Menorrhagia for a few years earlier although it could not be conclusively said that the problem existed on the date of taking the insurance. However, the insurance policy covered only the complainant and therefore an element of doubt was entertained on selection of risk. In any case, going

by the records on file, it was clear that the tests conducted on the complainant at the Medical Trust Hospital on 31.7.2004 and 1.8.2004 were only diagnostic tests any they came under the exclusion clauses of the policy. In the cicumstances, the order of repudiation by the insurer was upheld and the complaint dismissed consequently.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.002.09 / 2005 - 06
Shri K. K. Alikunji
Vs
New India Assurance Co. Ltd.

Award Dated 25.5.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 relates to repudiations of a mediclaim by the insurer under the Pravasi Suraksha Kudumba Arogya Scheme. The complainant's son Shri Abdul Samad, who is now in Saudi Arabia, had taken the disputed policy tenable for the period 8.2.2000 to 7.2.2005. The complainant was one of the beneficiaries under the policy. The complainant had a myo cardial infarction in 1984 and was treated at Samaritan Hospital, Aluva and thereafter he was continuing medications. He was detected to have diabetes 1997 and problems of High blood pressure in 1999. He had chest pain in September 2004 and after an angiogram at Lissie Hospital, Kochi, he underwent By-pass surgery at MIOT Hospital Chennai. The expenses came to be around 1.72 lakhs, which was disallowed by the insurer citing that the complainant's coronary problems were in existence even from 1984. Besides, in the proposal form itself submitted in 2000, the complainant's son had mentioned the coronary problems / Diabetes / Hypertension of his father. The policy had excluded pre-existing diseases under Sec. VII of the policy, which, the complainant or his son had not reportedly noticed or understood properly. Both are educated persons. In short, the complaint was baselss in as much as that the insured himself had disclosed the pre-existing nature of the diseases of his father and the policy had excluded the pre-existing diseases for coverage. In the above circumstances, the repudiation of the claim was found just and proper and the complainant was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.005.031 / 2005 - 06
Capt. (Retd) S. Radhakrishna Pillai
Vs
Oriental Insurance Co. Ltd.

Award Dated 23.6.2005

THe complaint under Rule No. 12 (1)(b) read with Rule 13 of the RPG Rules 1998 arises out of repudiation of madiclaim by the insurer. The complainant's wife Smt. Chandrakumari had undergone Ayurvedic treatment for correction of vision at Sreedhareeyam Ayurvedic Hospital, Koothattukulam in August - September 2004 and the medical expenses to the extent of Rs. 14,420/- was claimed for by the complainant from the respondent company. The company repudiated the claim stating that Ayurvedic treatment was excluded from the purview of the policy by virtue of a Rubber stamp affixed on the policy and also as additionally printed on the proposal forms. It is the version of the insurer that there were certain spurious claims coming in under the nomenclature of Ayurvedic treatment like "Rejuvenation treatment" etc. and hence they had excluded it. However, strangely enough the T.P.A. of the insurer had in February 2004 allowed an Ayurvedic treatment claim of the same beneficiary. According to the insurer, it was mistake in as much as that perhaps the Rubber Stamp describing the

exclusion concerned was not incorporated in the policy copy forwarded to the TPA. Be that as it may, even assuming that an earlier mistake was committed and the insured was benefited out of it, there was no meaning in arguing that it sets a precedent. The exclusion in the policy being very expicit and as the complainant was also aware of it, there was no force in the complaint and the same was dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.004.051 / 2005 - 06
Shri N. Ramchandran Kartha
Vs
United India Insurance Co. Ltd.

Award Dated 20.7.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a mediclaim by the respondent under Pol. No. 101181 / 48 / 04 / 00154. The policy in dispute was taken from the insurer effective from 15.9.2004. Earlier,the insured had a mediclaim policy with M/s Oriental Insurance Co. Ltd. in the year 2000 which was not renewed. therefore, the policy taken from the respondent was a fresh one. the complainant's wife Smt. Radhamani Kunjamma had gall bladder problems prior to commencement of the disputed policy and she had undergone surgery at AIMS Kochi on 14.8.2004. In the proposal for medical insurance before the insurer in sept. 2004, the existing gall bladder problems were not mentioned and as the policy, commenced only from 15.9.2004, that too, as a fresh policy, the disease was obviously pre-existing. The insurance availed of earlier from M/s. Oriental was not renewed and therefore there was no continuity of medical insurance. In the circumstances of the case, the pre-existing nature of the disease was very clear and the insurer was found correct in repudiating the claim under Exclusion Cl. 4.1 of the mediclaim policy. The complaint was therefore dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.002.058 / 2005 - 06
Shri Serin Antony
Vs
The New India Assurance Co. Ltd.

Award Dated 26.7.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of partial repudiation of a claim under RAK Policy No. 760701 / 48 / 04 / 00404 by the insurer. The complainant had met with a serious road accident on 21.11.2004 and was hospitalized at Medical Trust Hospital, Ernakulam from 21.11.2004 to 1.12.2004. He was discharged with an advice for follow - up treatment with the dentist after 8 weeks. The insurer honoured the inpatient treatment claim and refused to pay for the dental OP treatment saying that OP treatment was not covered under the policy. The jaw - bones of the complainant were fractured in the accident and he had also lost tow teeth which were all duly mentioned in the wound certificate and discharge summary removing all doubts that the dental treatment was necessitated solely and directly due to the accident on 21.11.2004 and, as per the policy Condition No. 4, all bodily injuries arising out of the same accident were to be treated as on claim. the insurer had erroneously segregated the outpatient dental treatment, which in any case could not have been done simultaneously with the inpatient treatment as the jaw - bones were not set properly and the gum had not become firm. Going by the facts of the case, the

insurer's decision was grossly out of tangent and hence set aside. The complaint was allowed for the full claim subject to compulsory deductions if any.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.002.105 / 2005 - 06
Shri P. T. Thomas
Vs
New India Assurance Co. Ltd.

Award Dated 27.9.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a mediclaim by the insurer under Pol. No. 760500 / 48 / 03 / 0091 for the period 13.1.2004 to 12.1.2005. On 14.3.2004, the wife of the complainant was admitted at KNS Hospital, Kottarakkara for Hysterectomy and allied problems. The claim had arisen within the two months from the issuance of the policy. As per Exclusion Clause 4.3 of the policy, the licensed TPA of the insurer repudiated the claim for the reason that, during the first year of the policy, expenses on treatment of diseases, such as Cataract, Benign Prostate Hypertrophy Hysterectomy for Menorrhagia or Fibromyoma are excluded. The facts of the case being unambiguous, the action of the insurer in repudiating the claim was on justifiable grounds. The complaint was found devoid of merits and therefore dismissed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI / 11.014.124 / 2005 - 06
Shri K. Srinivasan
Vs
Cholamandalam MS Gen. Ins. Co. Ltd.

Award Dated 29.9.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a claim by the insurer under Mediclaim policy AH100005061 - 000 - 000 covering the complainant and his wife for the period 23.6.2004 to 22.6.2005 The complainants' wife was admitted at Ernakulam Medical Centre for hysterectomy due to Fibroid Uterus, DUB with ovarian cyst. The TPA of the insurer rejected the claim for the reason that the treatment came under the First year exclusions of the policy. The treatment was in fact hit by Exclusion Clause No. 3 of the policy. The second allegation of the complainant was against non-extension of cashless facility for treatment. It was found from the records, the insurer had acted swiftly and declined the cashless facility as they did not have the full information of the case. It was upto the complainant to furnish the necessary information when he had sought for permission from the insurer for cashless facility. On the whole, there was no merit in the case and the operation and further treatment having been clearly hit by general exclusion clause 3 of the policy, the complaint was dismissed.

Mumbai Ombudsman Centre
Case No. GI - 292 of 2004 - 2005
Shri Vijay H. Thacker
Vs
The Oriental Insurance Co. Ltd.

Award Dated 4.4.2005

The Oriental Insurance Company Ltd., Mumbai D. O. 8 had covered Smt. Sona Vijay Thacker under a Mediclaim Policy with her husband. Smt. Thacker was admitted in

Bombay Hospital following complaints of chest pain, breathlessness and radiating pain from shoulder while walking. The doctors felt that complete evalution would be necessary for which she had to undergo ECG, Stres Test and CAG to diagnose the exact problem. When the claim was put up to the Company, they rejected the same on the ground that hospital admission was only for evalution purpose and that she was discharged the same day without complying with the provision of 24 hrs stay in hospital. They mainly invoked clause 4.10 of the mediclaim policy to repudiate the claim.

It would be evident after analysis of the case that Smt. Thacker had a problem which was chest pain, breathlessness and shoulder pain radiating in the hands for which she was hospitalised hence hospitalisation was necessary. It is a fact that she had to be diagnosed as to what was the reason for the ailments. Her Stress test proved positive for which Coronary Angiography (CAG) was a must. CAG study of course proved prominently that she had normal coronaries. The issue before us is whether hospitalisation was absolutely necessary and whether hospitalisation was utilised solely for diagnostic purposes. The answer to these questions would be that she did not have a criticality necessitating emergency hospitalisation. It was pain off and on while walking and such complaints normally person do have which are investigated without getting hospitalized. In the present case, ECG and Stess Test may have shown some complications for which CAG had to be done but these are all done as outpatient. During hospitalisation, except for the said test no specific treatment was administered. Significantly, no treatment was mentioned as having been administered to the patient in the Hospital and the patient was discharged on the same day with advice of two medicines to be taken for adverse lipid profile. Considering the facts of the case read in line with the hospital papers which were clear in noting the circumstances for which the tests were done as there was no positive illness following investigations and that the discharge card did not give any diagnosis but mentioned that admission was for CAG, the decision of the Company to repudiated the claim cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 485 of 2004 - 2005
Shri Vinayak S. Khandekar
Vs
New India Assurance Co. Ltd.

Award Dated 11.4.2005

The Complainant Shri Vinayak S. Khandekar along with his wife Smt. Sudha Khandekar was covered under a Mediclaim Policy No. 142000 / 48 / 03 / 09015 for the period 30.03.2004 to 29.03.2005 with New India Assurance Company Ltd., Vile Parle D. O. for a sum insured of Rs. 1,00,000/- each. The Complainant preferred a mediclaim for his wife's hospitalization at Conwest Jain Clinic Group of Hospitals from 27.05.2004 to 15.06.2004 for her Renal Failure and Hyperuricemia. She was again hospitalized in the same hospital from 30.08.2004 to 15.09.2004 for Hyponatremia with metabolic encephalopathy. As the business was serviced through Third Party Administrator M/s. Paramount Health Services Pvt. Ltd., the Insurance Company referred the matter to the TPA who after processing the same informed the Complainant that his claims were rejected under exclusion caluse 4.1 of the Policy as the disease of Hypertension which induced chronic renal failure was not disclosed prior to taking the policy. Not satisfied with the decision of the Company the Complainant, Shri Khandekar approached Insurance Ombudsman for his intervention in the matter. After perusal of the records both the parties to the dispute were called for hearing.

On a further scrutiny of the records submitted to this Forum it is observed that the hospital record was very specific in mentioning in 15 years hypertension. It was later corrected by Dr. Sanjay Godbole in his own capacity to certify that it was for 8 years which was again rectified to make it as 5 years with his initial. Again there was an effort to rectify 15 years duration of hypertension by approaching Medical Suprintendent of Conwest Jain Clinic Group of Hospitals and the Medical Superintendent Dr. Devan K. Sanghvi stating the story of hypertension for a period of 2 months only before admission. Elsewhere it has been mentioned that the history was narrated by someone at the time of first hospitalization which seems rather unusual as the hospital only records the history either stated by the patient. Clearly, there has been an attempt to tamper with the duration of hypertension because the claim was rejected by the Company on that ground and there was desperate attempt to revive the case only through revision of the earlier statement. Unfortunately, this is crux of the dispute on which the claim rested and only on this ground the entire claim could be repudiated. However, considering the fact that the patient was of advanced age and had been insured since 1991 and did not claim under the policy before this claim which earned her maximum cumulative bonus of 50 %, I sympathetically view the lapse as an overenthusiasm to get the claim at any cost and decide that 15 years hypertension should be taken to be within the policy period thus making the claim admissible but only 50 % of payment shall be made to meet the ends of justice.

Mumbai Ombudsman Centre
Case No. GI - 580 of 2004 - 2005
Shri Ghanashyam Girdharlal Mehta
Vs
National Insurance Co. Ltd.

Award Dated 18.4.2005

Shri G. G. Mehta was initially covered under a Mediclaim policy of the New India Assurance Company Limited since March, 1990 which was being renewed till March, 2001 without any exclusions being noted under the policy. New India's policy 130600 / 48 / 00 / 094 issued from 26.3.2001 to 25.3.2002 was however endorsed to note-diabetes, hypertension and cardiac and pace marker related ailments from August 14,2001 as per Endorsement No. 130600 / 48 / 00 / 30323. In March, 2002 he renewed the policy with National Insurance Company Limited, Unit 250601 as a member under a scheme floated by Varishield Healthcare Ltd which has some special conditions like coverage of pre-existing illness after one year, cashless hospitalization and Bank credit facilities to the Insured. He and his wife availed this policy from National Insurance from 31.3.2002 to 30.3.2003 which was renwed subsequently. The dispute for which the complaint has come to this Forum is that New India wrongly put exclusions under the policy as diabetes, hypertension and cardiac ailments alongwith pacemaker related problems. Based on this perhaps National put the same exclusions on the policy from March, 2002 and finally they (National) issued renewal policy with Pacemaker exclusion totally which was wrong and should be withdrawn since inception.

The analysis of this case reveals that New India had paid 3 claims under their policies in November, 1993, September, 1995 and June, 2001. Pacemaker was implanted in 1995 and presumably the other two claims were cardiac with Hypertension and diabetes recorded. After paying the claims why they issued the endor esement to exclude the diseases is not intelligible nor it is in necessary for this Forum to establish, firstly the policy has expired and that the complaint is not against them and the expired policy in any case would be beyond the jurisdiction of this Forum. The next issue is Varishield cover was granted by 'National' from March, 2002. As an argument

Varishield has accepted that pacemaker is always due to arrhythmic heart and this is a condition which continues with recurring problems. Exclusion of this on a policy which would now be issued by National would be a fresh cover and therefore, National could take underwriting safeguard to reduce their most certain liability.

In the facts and circumstances, the decision of National Insurance Company Limited to exclude diabetes, hypertension and cardiac ailments alongwith pacemaker related problems does not need to be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 575 of 2004 - 2005
Smt. Sheila Kishor Kanungo
Vs
The New India Assurance Co. Ltd.

Award Dated 20.4.2005

Smt Sheila K. Kanungo was holding a mediclaim policy with New India since 1998. In the year 2003 when New India made an offer of Good Health Policy at concessional rates to all Diners Club Card Holders of Citibank, Smt. Kanungo opted to go for the said policy and she was issued a Good Health Policy No. 712500480400002 in May, 2003 by the New India Assurance Company Limited, Chennai through Citibank. Smt. Sheila K. Kanungo was hospitalized at Breach Candy Hospital from 3.7.2004 to 6.7.2004 for Piles & Fistula in Ano. When a claim was preferred by Smt. Kanungo for 1,52,640/- to The New India Assurance Company Limited for the said hospitalisation the Company's Third Party Administrator sent a Discharge Voucher on 9.8.2004 for 25,000.

Not satisfied with the decision of the Company, Smt. Kanungo represented to the Grievance Cell of the Company but the Company reiterated the decision taken by their T. P. A. Aggrieved by the decision of the Company, Smt. Kanungo approached this Forum for redressal of her grievances.

On going through the records submitted to this Forum it is observed that the Insurance Company decided to fix maximum limit under Good Health Policy for certain specific ailments like Cataract, Hernia and Fistula in Anus and piles etc and such fixation of a cap was with effect from October, 2003. It is also noted that being a Group Mediclaim Policy, the Company had resrtored to certain modification in the terms and conditions of the policy and the proposed changes have been duly communicated to Citibank Credit Card holders through Renewal Notice incorporating information on fixation of a cap for certain ailments and through renewal intimation letter of M/s Citibank. Under the above circumstances this Forum does not find any merit to interfere with the decision of the New India Asssurance Company to limit their liability as per the policy conditions framed by the Insurance Company.

Mumbai Ombudsman Centre
Case No. GI - 244 of 2004 - 2005
Shri Jayant S. Shetty
Vs
The New India Assurance Co. Ltd.

Award Dated 21.4.2005

Shri Jayant S. Shetty was covered under mediclaim policy issued by New India Assurance Co. Ltd. He lodged a claim for undergoing Angioplasty at Bombay Hospital and Bypass Surgery at Asian Heart Institute and claimed reimbursement from the Company. The Company, New India Assurance rejected the claim through Raksha TPA

on the ground that the Insured had Hypertension for 7 years i.e. before the policy was taken and therefore the claim comes under Exclusion Clause 4.1 On an analysis of the case based on the various records produced before this Forum it appears that the Insured was First admitted at P.D. Hinduja Hospital for Coronary Angiography done on him as the CAG had come positive with Double Vessel Occlusion. Two options were given to the Insured (a) CABG (b) Double Vessel PTCA. The Insured opted for second one and got admitted at Bombay Hospital and for a repeat Angiography and attempted Angioplasty which was not successful. The Insured was then shifted to Asian heart Institute where Coronary Artery Bypass graph (CABG) was done to remove the blockages The dispute is centering around the duration of Hypertension which was recorded in P.D. Hinduja Hospital as the patient was hypertensive since 7 years and was on medicine. This statement has been contested by the Insured that he never said 7 years, he only told 7 months which was wrongly noted by the doctor either because he overheard or he was extermely busy because of his pre-occupations. As regards past history against Hypertension, it was mentioned on regular treatment and the previous operation which was done was mentioned as Tonsillectomy. The Insured contended that history of illness was recorded for 5 months only and not for 7 years. It is however noted that as regards first hospitalisation there was a clear noting that he was on regular treatment for Hypertension and that he was k/c/o of HT. How the duration has been shortened to 5 months or 6 months as claimed by the Insured is not known. The Insured's habits strongly suggest that he has basically sedentary job which is conducive to atherosclerosis with other importnat health factors like lipid profie, food habits and general life style also to be known to infer vulnerability. Hypertension is one of the most important risk factor for Coronary Artery Disease.

The Insured is having the policy since 12.6.1998 and he was admitted to P. D. Hinduja Hospital for CAG in January, 2004 and the Angioplasty which failed and the CABG were also done in the month of January, 2004 itself. With the 7 years history the Insured became a borderline case of Hypertension before the policy was taken. New India's contention was that the Hypertension was varying between 5 months to 7 years is not correct as the duration of 5 months Hypertension was not recorded in Asian Heart Institute. It only recorded the present problem of breathlessness and chest pain on exertion and hence the charge that the Insured wanted to tamper with the duration of Hypertension cannot be levelled as he has given a verbal statement that his Hypertension should have been recorded as 7 months and not 7 years and the doctor has made a mistake in noting down the actual duration. The 7 years Hypertension would be straightway before the policy was taken while at the same time it would be just a borderline case as the policy was taken from 12.6.1998 and the hospitalisation was in January, 2004 approximating 6 years. Granting the benefit of doubt in favour of the Insured I deside that his claim should be considered for 50 % on the basis of Sum Insured.

Mumbai Ombudsman Centre
Case No. GI - 029 of 2004 - 2005
Shri K. Pradeep Kumar
Vs
The New India Assurance Co. Ltd.

Award Dated 21.4.2005

Shri K. Pradeep Kumar alongwith his family members was insured under a Mediclaim Policy for which he lodged a claim with the company for reimbursement of expenses incurred in connection with hospitalisation of his wife, Smt. Rekha Pradeep at Wockhardt Hospital, Mulund from 4.9.2003 to 5.9.2003 for Chronic Cholecystitis with

Laproscopic Cholecystectomy. The TPA of the Company, M/s Raksha TPA, rejected the claim vide their letter dated 13.11.2003 on the ground that the disease was pre-existing (Exclusion Clause 4.1) since she had Jaundice in 1995 which was not disclosed at the time of taking the policy.

The repudiation letter dated 13.11.2003 issued by M/s Raksha TPA was further reviewed by New India and they decided to uphold the decision of the TPA. They also took the defence under Policy Condition 5.7 by implicating tampering of some documents which was produced in support of the treatment received by Smt. Rekha Pradeep Being aggrieved by the decision, Shri K. Pradeep Kumar approached the Ombudsman vide his letter dated 5th April, 2004.

The etiology of Cholecystectomy reveals the fact that there would be pain off and on and the patient would have repeated bouts of jaundice due to obstruction which were the symptoms prompting to investigate further to find out the real reason. In most cases, it reveals presence of calculi in the gall bladder. Obviously it develops over a period of time and manifests with the symptoms mentioned above and until such time the patient remins asymptomatic. This exactly happened in the present case as the doctor hs mentioned that repreated bouts of pain was treated with analgesics for temporary relief.

The complaint's contention is that the previous Hepatitis (Jaundice) was viral and had no connection with the Cholecystitis for which Laparoscopic Surgery was done. The point at issue is different. It seems the patient had Caesarian section which is a surgical intervention and Laparoscopy for infertility was done which again was a surgical intervention followed by Hepatitis / Jaundice which is also an important intervention in the health status. All these were required to be disclosed at the time of taking the policy for proper evaluation from the acceptance point of view. In that context removing gall bladder stones for which Laparoscopic Cholecystectomy was done would be related to the symptoms which were persisting for sometime and therefore, the patient's having contracted Hepatitis / Jaundice would be relevant for consideration. It is also seen from the Wockhardt Hospital papers dated 24.7.2003 that the duration of one year has been corrected as 6 months without any initial or authentication Similarly, the discharge summary has also a correction without authentication and all this points to some kind of tampering at whatever levels learning the insurance company free to refer to Clause 5.7 being applicable.

Since the diagnosis made at the wockhardt Hospital is Chronic Colecystitis it would appear that the symptoms and the disease were existing for quite sometime and not suddely occurred to become acute and therefore, the decision of the company on grounds of pre-existing of illness is in order.

Mumbai Ombudsman Centre
Case No. GI - 480 of 2004 - 2005
Smt. Bhavika Raju Paleja
Vs
The New India Assurance Co. Ltd.

Award Dated 25.4.2005

Smt. Bhavika R. Paleja was insured with the New India Assurance Company Limited since August, 2001. When she lodged a claim under the policy No. 110900 / 48 / 02 / 06756 to the New India Assurance Company Limited for her hospitalisation at Bharatiya Arogya Nidhi Sheth Kantilal C. Parikh General hospital from 10.12.2002 to 13.12.2002 for Migraine and Neuralgia. The Company based on the opinion of their panel doctor

repudiated the claim vide their letter dated. 12.5.2003 invoking clause 4.10 of the policy. Not satisfied with the decision of the Company, Smt. Paleja represented to the Grievance cell of the Company but the Company turned down her representation. Aggrieved by the decision of the Company, Smt. Bhavika R. Paleja approached the Insurance Ombudsman. Records have been perused and the parties to the dispute were heard on 11.1.2005.

The analysis of the file reveals that the Insured smt. Bhavika R. Paleja was having complaint of giddiness and black out without vomiting or any fever for a few days. The diagnosis was migraine and neuralgia. Migraine is due to a spasm of the arteries of the brain associated with throbbing pain and is quite common. Neuralgia is pain in the nerves and when it refers to migraine it would be migrainous neuralgia with headache and facila pain lasting for some time.

The point would be it would not require a strict management with a controlled environment in a place like hospital but it would certainly require thorough probe to rule out deeper and serious complications. Such investigations are commonly done as an outpatient but no doubt these cannot be claimed as per policy condition. The findines as per reports were normal and there was no criticality. She was given oral medicines which are quite commonly used. The hospitalisation was therefore, utilized to claim the benefits of the treatment Considering all these, that the rejection of the claim by New India on the ground of exclusion clause 4.10 as per Mediclaim Policy is in order and need not be questioned.

Mumbai Ombudsman Centre
Case No. GI - 473 of 2004 - 2005
Shri Jeetendra P. Shirodkar
Vs
The New India Assurance Co. Ltd.

Award Dated 25.4.2005

Shri Jeetendra P. Shirodkar alongwith his parents and other family members were covered under a Good Health Mediclaim Policy issued by the New India Assurance Company Limited, D. O. 712500 from April, 2000 for Card Holders of Citibank. Smt. Vijaya P. Shirodkar, mother of Shri Jeetendra Shirodkar was hospitalized at Dr. Pradhan's Samarth Maternity and Nursing Home, Mumbai from 16.3.2004 to 20.03.2004 for (R) Thyroid cyst c multinodular goitre. When a claim was preferred by Shri Shirodkar under Policy Certificate No. 712500 / 02976 / GH March, 2004 to the New India Assurance Company Limited for the said hospitalisation, the Compnay's Third Party Administrator (TPA), repudiated the claim stating that the diseases was pre-existing and invoked clause 4.1 of the Mediclaim policy. Not satisfied with the decision of the Company, Shri Shirodkar represnted to the Company but the company reiterated the decision. Aggrieved by the decision of the Company, Shri Shirodkar approached the Office of the Insurance Ombudsman.

The analysis of this claim reveals some interesting factors. Apparently the patient gave history and mentioned that she was having problem since 7-8 years. Considering the fact that the patient's disease was at an advanced stage as it appeared from the hormonal tests done in February, 2004 and the fact that earlier the symptoms were not manifest, it would seem that she had four years of continuous policy since April, 2000. Some trouble was breawing up well before the policy was taken no doubt, but the Insured being asymptomatic throughout would go well with Dr. A. M. Samuel's opinion given in his certificate in which he said that the patient had an idea that she was having some problem following thyroid tests in June 2000 and probably wrongly

estimated the time to mention 7-8 years. As per medical theory Thyroid problems are difficult to be assessed if it is often applicable to some other diseases. Since confirmation of thyroid problem came in June 2000 with some kind of unspecified problems before the policy was taken, the case deserves some consideration and 50 % of the admissible expenses should be reimbursed to Smt. Shirodkar to meet the ends of Justice.

Mumbai Ombudsman Centre
Case No. GI - 509 of 2004 - 2005
Shri Pradip Madhukar Jadhav
Vs
The New India Assurance Co. Ltd.

Award Dated 26.4.2005

The New India Assurance Co. Ltd., Chennai had issued a Group mediclaim policy covering all members of the Diner's Club. He preferred a claim to the Company after his hospitalisation at Lilavati Hospital and was diagnosed as having Ischeamic Heart Disease (IHD) + CAD Post PTCA. He claimed reimbursement of his hospitalisation expenses from the Company. The claim was processed by M/s Paramount Health Services Pvt. Ltd. and they informed the Insured that the claim was not payable due to break of 12 days in policy period from 1.2.2001 to 31.1.2002 which was renewed from 12.2.2002 to 11.2.2003. The policy period 12.2.2002 to 11.2.2003 has been taken as the first year of the policy, for which cardiac complaints were considered to be pre-existing as per exclusion clause 4.1. Some documents including all policy documents since February, 1992 have been produced by Shri Pradip Jadhav which New India failed to confirm. The first thing which strikes that the Insured was covered right from February, 1992 under Club Solace Protection Plan Group Mediclaim Policy. The only breack which came was due to bounceing of a cheque for which the New India was obliged to withdraw the cover already granted as a renewal which resulted into a break of 12 days following receipt of cash money. It may be called an unfortunate lapse and totally unintended as the Insured has already established his credentials reposing his faith in Insurance system. He also issued a cheque for the premium which for whatever reason including lack of funds may have bounced. In the business parlance this happens but in Insurance this cannto be pardoned because it is guided by a statutory provision of section 64 VB of Insurance Act which enjoins on the Insured to pay the consideration money i.e. premium before hand to enable the Company to go on risk. The points for consideration would be that the Insured's Angioplasty claim in 1999 done from Breach Candy Hospital was settled by Chennai Office of New India and therefore it would be taken to be within the knowledge of the Insurance Company even if it was not intimated to the Company's Mumbai Office on transfer of the policy. It was the duty of the Chennai Office to note on the policy the existing claims under previous years and similarly it would be the duty of receiving Office i.e. Mumbai to call for past claim experience when the policy was transferred. Consequently, no issue can be raised on this score by the Company that they did not know whether in the year 2000 when he transferred the policy he had declared Angioplasty done in December, 1999 or nor. Having settled the claim due to IHD / CAD and consequently PTCA, the Company cannot go back and look upon subsequent claim as pre-existing illness even if there is a technical gap of 12 days. New India also admitted that upto 7 days delay they could consider and reckon the policy as continuous and in fact this is given in the policy as a note of warning Effectively therefore although the gap has exceeded more than 7 days there could always be a consideration that the claim lodged has many redeeming features and favourable factors which would merit consideration. On the basis of

records of PTCA in 1999 received from Breach Candy Hospital and the policies taken right from 1992, I consider that treatment of policy from 12.2.2002 as a first year policy is unfounded as the disease was not contracted during the gap period as it was already on a 13 year old policy. Accordingly, the repudiation of claim by New India would be unjust and unethical.

Mumbai Ombudsman Centre
Case No. GI - 155 of 2004 - 2005
Smt. M. C. Doshi
Vs
The New India Assurance Co. Ltd.

Award Dated 27.4.2005

Shri Ketan Doshi, was covered under a Mediclaim Policy issued by New India Assurance Company Ltd., for a sum insured of Rs. 1 lac. He was insured with New India since 13.7.2001. He was admitted to Bombay Hospital from 4.9.2002 to 14.9.2002 and was diagnosed to have Squamous Cell Carcinoma Grade III of the tongue for which he was operated and Left Hemiglossectomy was done. After surgery it was followed up with Radiation treatment and finally the insured was admitted to Nanavati Hospital from 7.11.2002 to 12.11.2002 when his health condition worsened.

When the claim was put up, New India rejected the claim on the ground of Exclusion Clause 4.8 having got the history of 10 years tobacco chewing as per Bombay Hospital case papers. The complainant, Smt. M. C. Doshi mother of the Insured appealed to the Insurance Company which was not considered and finally she preferred the claim before the Ombudsman's Office for redressal of her grievance.

The case has been thoroughly examined at this Forum and it seems that New India has based their repudiation on the ground that the Insured had several treatments earlier from Dr. Ashok Mehta, BSES M. G. Hospital, Parvish Nursing Home, Tata Memorial Hospital for the treatment of Carcinoma of tongue and that he was also a tobacco chewer for past 10 years. They linked tobacco chewing with Carcinoma of tongue and repudiated the claim as this was not disclosed and it fell under Exclusion Clause 4.8.

The fact remains that the first operation was done on 5th September, 2002 and thereafter the Insured was subjected to Radiation Therapy. The total claim amount in Bombay Hospital was around Rs. 1 lac which has been made the subject of dispute. The other claim from Nanavati Hospital has not been made a point of contention in New India's letter dated 1.7.2004 and not also raised in complainant's letter.

Tobacco Chewing for 10 years is no doubt a feature which can cause cancer. The hospital records provide no other information about the past history of illness to Shri Doshi, a young man of 32 years and therefore no issue of non-disclosure can be held against the Insured. One cannot convincingly made a point that he took the policy in his 31st years in July 2001 only after he had an inkling of the ailments somewhat deep in his mind which must have provoked him to take the cover to meet the expenses should the emergency arise. The nexus between tobacco and carcinoma may be there but cannot be definitely held as a relevnt point not disclosed to the Insurance Company. The arguments based on the explaination given by the Medico - legal Consultant that it would acquire an extended meaning of intoxicating drugs being synonymous with poisonous drugs would be a little far - featched. Considering this aspect and the fact that there has not been any conclusive proof of the Insured being on treatment before the policy was taken, but circumstantially and through preponderance of probability proved. I decide that the claim should be settled at least

for 50 % of the admissible expenses incurred at Bombay Hospital for the treatment received, to resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI - 413 of 2004 - 2005
Shri Sadruddin Nazarali Jivani
Vs
United India Insurance Co. Ltd.

Award Dated 27.4.2005

Shri Sadruddin Nazarali Jivani approached Insurance Ombudsman with his grievance that the claim for reimbursement of hospitalisation expenses incurred for his wife's hospitalisation was rejected by the Company and prayed to settle his genuine claim. Shri Sadruddin N. Jivani alongwith his family members covered under Family Floater Policy issued by United India Insurance Co. Ltd. for Lifeline EMS India Ltd. She was hospitalised degenerative cervical spine and sacralisation of lumber spine. The Company repudiated the claim under Exclusion Clause 3.3 of the mediclaim Policy.

The analysis of the claim reveals that Smt. Shahina Jivani took low level therapy for which the hospital charged fees apart from consultation, bed charges etc. for 30 days. The Company rejected the claim on the ground that in resepect of such illness there was no necessity for getting admitted in a hospital and get a prolonged treatment of 30 days which could always be done as an outpatient without devolving any liability on the part of the Insurance Company as provided under the basic terms and conditions of mediclaim policy. The whole dispute is centering around this issue and we have to examine and resolve the particular point in relation to the complications involved and the treatment received. Effectively, this is the on set of the disease and numerous such cases are being treated through domicillary treatment not involving any hospitalization as there is no criticality or emergency for this type of illness. There is need for bed rest and if anybody is unable to provide the same at his own house perhaps hospitalisation would be the best answer. Admitedly, therefore, it is a combination of medicine, physiotherapy and complete bed rest that cures it fast. Considering the fact that the mediclaim policy is guided by the basic principle of "expenses necessarily and reasonably incurred" and that it is purely a hospitalisation policy where confinement to a hospital should be of such a critical nature that keeping the patient at house would be dangerous to his or her survival Again it should be such a condition that the patient has to be monitored medically and managed through an environment which is provided by the hospital only. Since these conditions were not fulfilled, the Company's contnetion alongwith their medical opinion would justify that continuous 30 days hospitalisation for availing treatment which otherwise would have been availed of keeping indoors, cannot be justified under the terms of the policy. Therefore essentially upholding the decision of the United India to reject the claim, a lenient view is being taken by me to grant 50 % of the cost of laser therapy, clinic medicine and consultation charges which make the total cost Rs. 16,100 as per Indian Institute of Laser Medicine's bill.

Mumbai Ombudsman Centre
Case No. GI - 568 of 2004 - 2005
Dr. (Ms) Vidya Vencatesan
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 29.4.2005

Smt. Jayam Vencatesan, mother of Dr. (Ms) Vidya Vencatesan was covered under Health Shield Gold Insurance Policy No. HJ00001049000100 issued by Royal Sundaram Alliance Insurance Company Limited for the period from 23.2.2004 to 22.2.2005. Smt. Jayam Vencatesan was hospitalized from 17.8.2004 to 20.8.2004 at Hinduja Hospital and was then later shifted to Bombay hospital from 20.8.2004 to 7.9.2004 for treatment of Guillian Barrie Syndrome and Rheumatoid Arthritis respectively. When Dr. (Ms) Vencatesan preferred a claim for the said hospitalisations to the Company. The Company repudiated the claim on the ground of non-disclosure of material facts. Aggrieved by the decision, Dr. (Ms) Vidya Vencatesan represented to the Company and not receiving any response approached this forum for redressal of her grievance.

The case has been thoroughly examined at this Forum. It appears from Bombay Hospital case papers dated 20.8.2004 “H/o patient is old case of rheumatoid arthritis since childhood she used to get on and off pain in all the joints”. In 1996 Patient started developing deformities in all the distal joints of hands and legs. The issue is beyond dispute that Smt. Jayam V had longstanding complications which have been evident from all the records forwarded to this Forum. The Company’s rejection was on the ground of non-disclosure of material facts.

It is abundartly clear that from the host of diseases Smt. V. Jayam suffered, the disclosure was not made leading to the contract being void ab initio. The declaration signed as a proposer by Smt. Jayam V. formed the basis of contract and the revelations of the diseases through the hospital records of a number of ailments / diseases and that too since childhood made it a total mis - representation as per Condition 6 of the Health Shield Gold Insurance Policy issued by Royal Sundaram Alliance. I therefore, do not find any valid reason to interfere with the decision of Royal Sundaram Alliance Insurance Company Limited to repudiate the claim.

Mumbai Ombudsman Centre
Case No. GI - 537 of 2004 - 2005
Shri Brijmohan L. Sarda
Vs
New India Assurance Co. Ltd.

Award Dated 29.4.2005

Shri Brijmohan L. Sarda took mediclaim policy from New India Assurnace Co. Ltd. in the year 1993 and the present claim arose after his hospitalization at Bombay hospital for Coronary Artery Disease and Coronary Angiography was done. He preferred a claim to the Comany for reimbursement of medical expenses incurred. The claim was processed by M/s TTK Healthcare Services Pvt. Ltd. (TPA) and they informed the Insured that the claim was repudiated under Exclusion Clause 4.1 of the mediclaim policy. Shri Sarda represented to TPA alongwith a certificate from his family doctor, Dr. Kiran J. Desai. The Company i.e. New India referred the matter to its panel doctor, Dr. Fardum Dastur and the Company intimated the Insured that they are concurring with the decision of M/s TTK Healthcare Services.

The analysis of the claim with all documents reveals that the rejection of the claim was made only on the ground of the past history of hypertension since 1989. New India confirmed that the policy was issued by them since 1993 while the Insured claimed it was from 1990 - 91 and produced an Income Tax record of payment of Rs. 2340/- as mediclaim premium claimed under 80D Section of IT Act. He also produced corresponding noting of policy being taken from 1990 - 91 financial year. However, New India not only confirmed the policy from 1993 but also made a point that the entire period of policy operation has been without any claim to enable the Insured earn

maximum Cumulative Bonus for claim free years. The next issue is the duration of hypertension, its effect on the Insured and his vulnerability to be a patient of Coronary Artery Disease. The Insured's hypertension has been termed as 'mild' by noted consultants and his BP readings prove the same, he would be called just a borderline case. He had little chest pain, some uneasiness occasional breathlessness and he got these examined and for full evaluation was advised by his doctor to be hospitalised. It was decided that although he had complications in one artery is should be managed medically and after consulting. Dr. Desai one or two medicines were changed / added.

The fact that New India has not been able to contradict the contention of the Insured that he had policy from 1990-91, nor able to reject it, would go in favour of the Insured. The record point is that the on-set of a "mild" hypertension even in 1989 would always remain as a self - management and being on 'borderline' it could be even ignored and not a big point to establish. Arguing further it may be said that having taken the policy from 1990-91 and being claim free for 14 years the Insured has amply demonstrated that he had faith in the system of Insurance and enjoyed a sound health to earn maximum Cumulative Bonus under the policy. Another issue is relevant viz, the risk factors of DM, adverse lipid profile etc. did not go alongwith his hypertension since 1989 and he was non-diabetic even in December, 2003 when he was hospitalised. Hence treatment was there but may not be surgery which is not the point for contention. The whole issue being only a borderline case with uncofirmed medication for Hypertension in 1989 with actual policy coverage since 1990-91 and the immediate linkage of Coronary Artery Disease with Hypertension being not there as Dr. Goel termed it "no CAD", I decide that the claim should be paid as an invasive CAG was done with all signs of illness and that it was better managed only in a hospital enviornment.

Mumbai Ombudsman Centre
Case No. GI - 035 of 2004 - 2005
Smt. Irani Freny Khodadad
Vs
The Oriental Insurance Co. Ltd.

Award Dated 3.5.2005

Smt. Irani Freny Khodadad was continuously insured with the Oriental Insurance Company Limited since 14.10.1993. During the renewal of the policy in the year 1999 as there was a break in the policy, the Company issued a fresh policy with effect from 8.11.1999. Smt. Irani was hospitalized for total Left Knee Replacement at P. D. Hinduja Hospital from 16.4.2002 to 26.4.2002 and when the claim was preferred by her for the said hospitalisation the Company based on the panel doctor's opinion repudiated the claim invoking clause 4.1 of the mediclaim policy. Her representations were also turned down and hence being aggrieved Smt. Khodadad approached this Forum for justice. Records have been perused and parties to the dispute were called for hearing. On examination of the claim file it appears that the basic issues are four fold viz, Since When the policy was in Operation, when was there a break, how the break came and whether it could be condoned.

The Insured claimed that the policy was in operation since 1993 and all the conclusions would be drawn as she had continous insurance since 1993. The next point is that there was a break in 1999 for 26 days allegedly due to switching of the cheque between Freny Irani and Shirin Irani. At the hearing Shri K. Y. Pandit who deposed on behalf of Smt. Freny Irani produced the records and also Bank pass books to show that there was no shortage of funds but lack of attention by the Company who had tagged the renewal cheque with the wrong renewal notice which was therefore, dishonoured.

Obviously rectification took a little time and the policy was issued considering them as fresh ones but without any medical examination. This was a genuine mistake but more on the part of the Insurer and since the cheque came for the right amount with the names switched due consideration should be given and accordingly I decide that the claim which is lodged for total knee replacement (Left) should be payable However, since there has been delay of actually getting the policy renewed some amount of penalty should be levied on the policyholder to meet the ends of justice. Hence The Oriental Insurance Company Limited is directed to entertain the claim in question of Smt. Irani Freny Khodadad in connection with her hospitalisation at P. D. Hinduja Hospital from 16.4.2002 to 26.4.2002 for total Left Knee Replacement and pay only 80 % of the admissible amount of expenses. There is no order for any other relief.

Mumbai Ombudsman Centre
Case No. GI - 247 of 2004 - 2005
Shri Omprakash Shahi
Vs
The Oriental Insurance Co. Ltd.

Award Dated 3.5.2005

Shri Omprakash Shahi was insured with National Insurance Co. Ltd. in the year 1999-2000 and in the years 2001-02, he shifted to the Oriental Insurance Company Ltd. and insured himself and his family members. Shri Shahi's daughter Kum. Sweeta Shahi met with a road accident by two wheeler and she was admitted to Pranjali Maternity Surgical & General Hospital on 17.9.2003 and she was examined by Dr. Kirankumar P. Bhavani, Consulting Orthopaedic Surgeon. Shri Shahi preferred a claim to the Company for Rs. 2168/-. M/s Raksha TPA informed Shri Omprakash Shahi on 31.5.2004 about the non-adminissibility of the claim.

The basis point on which the dispute rested is lack of understanding of the Mediclaim Policy which is purely a Hospitalisation Policy where the need for hospitalisation or confinement is due a criticality and emergency which cannot be treated from home or even an outpatient availing hospital treatment. This is the issue which should be appreciated in entirety. The other provision of the policy. "reasonably and necessarily incurred" expenses are to be reimbursed following hospitalisation. The certificate issued by the doctor of Pranjali Hospital who did the cast amply explains the point. We quote : "On 17.9.2003 she had significant soft tissue injury to the Right Knee / (R) lower 1/3rd thigh. She was given a plaster cast alongwith medication. The Plaster would be maintained about 7-10 days".

Moreover, the doctor himself advised hospitalisation was not required and maximum 2 days bed rest was required. It is mentioned by the complainant at the hearing that as he was sick, keeping the daughter in hospital was not a workable proposition He felt that domiciliary hospitalisation should have been considered. Unfortunately, the nature of injury and the gravity was such that it neither warranted hospitalisation and nor "Domiciliary hospitalisation" which has different norms and conditions. With no fracture, there was no case for seriousness in the health status for constant management. Accordingly, based on the facts and circumstances, the repudiation of the claim by the Oriental Insurance Company Ltd. is in order and need not be interfered with.

The claim of Shri Omprakash Shahi for reimbursement of hospitalisation expenses incurred at Pranjali Maternity Surgical & General on 17.9.2003 for his daughter Kum Sweeta Shahi is not sustainable.

Case No. GI - 552 of 2004 - 2005
Shri Prem G. Vaswani
Vs
National Insurance Co. Ltd.

Award Dated 3.5.2005

Shri Prem G. Vaswani alongwith his wife was covered under Mediclaim Policy No. 270106 / 48 / 03 / 8501285 for the period 11.2.2004 to 10.2.2005 issued by National Insurance Company Limited, Pune D. O. I for Sum Insured of Rs. 3 lacs each with Cumulative Bonus of Rs. 59,250/-. Shri Vaswani was initially insured with National Insurance Company Limited, Chennai from 1993 for Rs. 50,000. When he got transferred from Chennai to Mumbai in 1995 he transferred his policy from Chenai to Pune D.O. I and also increased the Sum Insured from 1998 in piecemeal at the time of renewals. When Shri Prem Vaswani felt some uneasiness, he consulted his family physician who advised him to undergo stress tests which was carried out and the results were positive. The doctor advised Shri Vaswani for angiography and accordingly he was admitted to Wadia Institute of Cardiology on 25.11.2004 for Angiography. When he preferred the claim the Company rejected the claim stating that the ailment was pre-existing. Not satisfied with the decision, Shri Vaswani represented to the Company and not receiving any reply approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim amount. After perusal of the records parties to the dispute were heard at Ombudsman's Camp at Pune. The claim file has been scrutinized with whatever documents made available to this Forum Regarding condition 4.10 which is the revised thinking of the Company / TPA based on which they felt the claim was not payable, CAG is an important invasive investigation which must be considered in right perspective and that if there was a blockage in the heart it required investigation and monitoring and strictly on that ground reimbursement for CAG even without surgery can be considered. The issue of pre-existence of illness (4.1 exclusion clause) under which the claim was denied would be relevant to scrutinise since the diseases (Hypertension and Diabetes Mellitus) were first detected in 1994 and the policy was taken from 1993 and it was left to National Insurance Company to prove otherwise that the policy was not continuous which they failed to do. In absence of any evidence provided by the company to this effect it would not be taken as pre-existing while reckoning the fact the policy was from 1993 Hence the National Insurance Company Limited is directed to settle the claim of Shri Prem G. Vaswani for reimbursement of expenses only towards Coronary and Renal Angiography done at Wadia Institute of Cardiology on 25.11.2004.

Mumbai Ombudsman Centre
Case No. GI - 68 of 2005 - 2006
Shri Mangalath Karunkaran Nair
Vs
National Insurance Co. Ltd.

Award Dated 4.5.2005

Shri M. Karunakarn Nair was holding the Mediclaim policy since 1993 with National Insurance Company Limited and he was renewing his policy regularly. His current mediclaim policy No. 260300 / 48 / 04 / 8500097 was for the period from 22.4.2004 to 21.4.2005 for a Sum Insured of Rs. 1,00,000. In the meantime Shri Nair took an Overseas Mediclaim Policy (B & H) No. 260100 / 48 / 04 / 0580079 and Policy No. 260100 / 48 / 04 / 0580080 covering self and his wife for the period from 24.12.2004 to

22.4.2005. The policy covered travel worldwide including USA and Canada. It seems he reminded United India to pay for hospital expenses towards cataract operation and also requested the Company for extension of his mediclaim policy which was available as per practice. Inspite of several reminders when he did not receive any reply he approached this Forum for redressal of his grievance. On examination of the file it reveals that initially the complaint was lodged on account of non settlement of his claim for cataract operation and also non-extension of mediclaim policy (domestic) following corresponding Overseas Mediclaim Policy taken by Shri Nair. The matter was suitably taken up with National Insurance Company who has confirmed under their letter dated that cataract claim was settled by their TPA. As regards non extension of the mediclaim policy in India, It seems that the request came after expiry of the policy. Taking a cue from the provisions, it appears National Insurance Company's contention that the request came long after expiry of the policy and that it cannot be complied with because of new administrative instructions issued by the Mumbai R. O. would be the important point to consider. It is evident that the circular was issued on 11.1.2005 when Shri Nair was staying abroad and was not informed of the revised guidelines. Primarily therefore, he cannot be faulted for not advising the Company beforehand. At the same time the Company's revised guidelines came because of problem in the software packages of mediclaim and Overseas Mediclaim Policy and strictly speaking this had nothing to do with the fundamental insturction that whenever the Overseas Mediclaim Poliy is taken the domestic policy would be under suspension and which was Shri Nair's understanding. At the same time Regional Office having issued the revised underwriting insutrictions, the Division Office of the Company is duty bound to follow the instruction. Technically the Company was handicapped by the absence of any information till one month after expiry of the Mediclaim Policy and it may be held that even if the Insured was not available in India, his Agents should have been forthright in communicating the advice for extension to the Company well before expiry of the policy. The result would have been that atleast at that time the Agents would have been informed by the Company about the revised instructions and they would have acted accordingly which was not done. In consequence, the Company's total rejection to renew the policy on the basis of a technical snag merits special reconsideration. National Insurnace Company Limited is advised to reexamine its decision to reject the renewal of the mediclaim policy to Shri M. Karunakaran Nair on the ground that the issue of revised administrative instructions had been done during the course of the earlier policy. It is further suggested that in view of the bonafides of claim experience even if technically renewal cannot be granted, a special despensation is given to the Insured on the fresh policy by taking suitable underwriting safeguards.

Mumbai Ombudsman Centre
Case No. GI - 68 of 2004 - 2005
Shri Kishor Meswani
Vs
United India Insurance Co. Ltd.

Award Dated 4.5.2005

Shri Kishor Meswani who insured with United India Insurance Compnay Limited, Bassein Branch Office since 1991, had approached the Office of the Insurance Ombudsman with a grievance against United India Insurance Company Limited for non settlement of his claim under Policy No. 121201 / 48 / 02 / 00751 for the period 10.8.2002 to 9.8.2003. Shri Meswani at the time of taking the policy had disclosed that

he was polio stricken since childhood and accordingly the Compnay had excluded polio and related disease under the Policy.

Shri Kishor Meswani was hospitalized at Breach Candy Hospital and had undergone Haemorrhoidectomy + Polypectomy for internal piles. When Shri Meswani preferred the claim for Rs. 1,42,478,75, the Company sent a discharge voucher for Rs. 93,858 which was not duly discharged by Shri Meswani as he was not satisfied with the amount of settlement. The analysis of the complainant and the claim would reveal that the dispute about partial settlement is composed of two components (a) higher charges of Surgeon's fees and (b) non-payment of some chemists' bill and nursing charges. On the first count, Mediclaim Policy is guided by the basic principles of Insurance viz., reimbursement of medical expneses "reasonable and necessarily incurred". The rationale for deduction of some surgical fees based on (a) standard comparable charges as per scale of fees obtained from hospitals and (b) duly escalated being done from Breach Candy hospital, a top hospital in the City, answers the point no doubt. As per the principles and practices any high cost need not be paid by the Insurer and after making some adjustments they may offer an amount and call upon the Insured to bear the balance in order to rule out any imbalance in total cost structure to maintain premium parity. Indeed it is difficult to appreciate and accept this logic as really the Insured may be out of pocket even after taking a mediclaim policy which is unacceptable to him.

The other issue of non-settlement is fairly simple. If the bills and prescriptions do not tally or not duly substantiated payment cannot be made and at the hearing itself the Company offered to settle another Rs. 1994 with supporting papers. It is seen about Rs. 5000 was held up on this account. The other deductions were made of Nurses' Bills for Rs. 14275 as it was due to already excluded "Polio and related ailments".

Further, the Insured has renewed the policy all along and has not claimed since inception and thus demonstrated his faith in the system of insurance to earn maximum Cumulative Bonus. He should be rewarded for this. As regards Nursing charges may be the "polio related ailments" have been excluded but it is a fact that the main ailment was something else and the fall out could be prolonged and cost intensive with requisite Nursing charges and the Company should not grudge the same. In consequence, both under the surgical fees and Nursing charges some relaxation should be shown. However, since Shri Meswani did not accept the offer of Rs. 93858 by United India, this Forum would not grant any interest on that account. In view of the foregoing analysis I, feel a further Rs. 25,000 subdivided as Rs. 12,000 cost of surgery and Rs. 13,000 as Nursing charges and of medicines (including Rs. 1994 as per documents) be paid to Shri Meswani to resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI - 048 of 2004 - 2005
Shri Rajnikant Ramanlal Gunderia
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated 6.5.2005

Shri Rajnikant Ramanlal Gunderia took a Critical Illness Policy from Bajaj Allianz General Insurance Co. Ltd. for the first time on 18.10.2002 for himself for a Sum Insured of Rs. 2,00,000/-. He was first admitted in Riddhi Vinayak Critical Care and Cardic Centre and was diagnosed as Unstable Angina and he was admitted to Wockhardt Hospital and was diagnosed as severe Triple Vessel Disease with moderate L. V. Function and Coronary Artery Bypass Graft (CABG) was done by Dr. Kaushal Pandey and he was discharged on 4.1.2004. He preferred a claim to the Company for

reimbursement of the expenses incurred at both the hospitals. The Company repudiated the claim on grounds of non-disclosure of material facts and consequently due to pre-existing diseases.

The Insured Vehemently objected to this and pointed out alleged irregularities by the Riddhi Vinayak Hospital which acording to him did manipulation in the hospital records only to teach Shri Gunderia, the Insured, a lesson of not helping them. As an evidence he cited the hospital case papers of Wockhardt Hospital which had no notings of past ailments whatsoever. The Company held the view that the Insured did not give any past history to the hospital as a deliberate ploy. The discharge summary duly typed has given with narration history of past ailments exactly as per Indoor Papers for which the Company concluded that the Critical Illness Policy taken by Shri Gunderia for the first time was taken without disclusing past ailments with an obvious intention to benefit out of this insurance. The course of events at Riddhi Vinayak Hospital with necessary investigation reports suggest that ailments were there for quite sometime and there were definite reasons for severe occlusion in the arteries so much so that it was diagnosed as Triple Vessel Disease for which 3 grafts were given. We should also not have any valid reason to doubt that as per history given, the Insured had Coronary Angiography and was diagnosed having Coronary Artery Disease (CAD). However, as the Insured has challenged this contention and alleged that the history was not given by by him but the hospital authirities made a foul play, this Forum would not like to adduce further to counter his contention, that such a severe blockage would not occur even in months time and that it would require quite sometime to develop The Insurance Company produced two different Discharge Summary from Riddhi Vinayak Hospital of which one was forwarded to them by the hospital and the other by the Insured. The Company alleged tempering of his record on which this Forum would not be able to comment except that the two differed only in respect of past illness recording and therefore, become suspect. The entire matter, therefore, depends on appropriate investigations to look into the basis of charges and examine if those were founded on merits.

In the facts and circumstances, the complaints of Shri Rajnikant R. Gunderia render themselves as partly non-entertainable and totally non-actionable with inconclusive documents mainly because those are challenged.

Mumbai Ombudsman Centre
Case No. GI - 222 of 2004 - 2005
Shri Pravin D. Gala
Vs
The Oriental Insurance Co. Ltd.

Award Dated 6.5.2005

Shri Pravin D. Gala alongwith his wife and daughter was covered under Policy No. 2002 / 3801 issued by the Oriental Insurance Company Limited, Divisional Office - 5 for the period 27.1.2002 to 26.1.2003 for the Sum Insured of Rs. 1,00,000/-. They were covered under mediclaim policy since 1997. Smt. Pushpa Gala wife of Shri Pravin D. Gala was hospitalized at Dr. Trivedi's National Institute of Laser & Endoscopic Surgery (NILES), Aakar IVF - ICSI Centre, Mumbai from 23.8.2002 to 26.8.2002 for Laparoscopic Hysterectomy. When a claim was preferred by Shri Gala for the said hospitalisation the Company repudiated the claim vide their letter 28.7.2003 invoking clause 4.1 of the mediclaim policy. Dissatisfied with the deision of the Company, Shri Gala represented to the Grievance Cell of the Company which was also turned down Aggrieved by the decision he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs.

48,900/-. His contention was that the reason of pre-existing of the disease given by the Company was not correct and that the surgery done for his wife in 1991 for ovarian cystectomy and 1995 laparoscopy for infertility had no relation with the present operation. After perusal of the records parties to the dispute were called fo hearing. The dispute is regarding the past treatment and surgery the Insured had respectively in 1991 and 1995 for Ovarian cystectomy and laparoscopy for infertility was taken to be a pre-existing condition of the Insured for which claim for hysterectomy removal of uterus done in 2002 for fibroids was repudiated. The Complainant felt and so also the Doctor that the repudiation has been uncalled for as there is no linkage between the two operations. The issue is perhaps of respective viewpoint for which a pre-existing condition is evaluated. First of all, there were two operations one in 1991 and the other in 1995 for which there was no disclosure. Surgical intervention is an important health intervention and at the stage of proposal it should have been mentioned. The relevant records of respective hospitalisation in 1991 and 1995 have been studied at this Forum very carefully and it is observed that in 1991 the USG of the Pelvis showed “large cystic mass of the left ovary” which was operated and the histopathology Report gave the diagnosis “Ovary serous cyst and follicular cysts”.

In the facts and circumstances and based on the documents and submissions, it is proved that there was non-disclosure of past ailments and also the ailments were pre-existing of which the Insured had knowledge out of the treatment he received and the claim of Shri Pravin D. Gala for reimbursement of expeses for his wife’s hospitalisation at Dr. Trivedi’s National Institute of Laser & Endoscopic surgery is not tenable.

Mumbai Ombudsman Centre
Case No. GI - 013 of 2004 - 2005
Shri Shabbir T. Kapadia
Vs
The New India Assurance Co. Ltd.

Award Dated 9.5.2005

Shri Shabbir T. Kapadia alongwith his son and daughter was covered under Mediclaim policy No. 111300 / 48 / 02 / 07200 issued by the New India Assurance Company Limited, Divisional Office 111300 for a Sum Insured of Rs. 2 lacs for self and Rs. 1 lac each for his children. Master Taizoon S. Kapadia son of Shri Shabbir Kapadia was hospitalized at Prince Aly Khan Hospital from 3.12.2003 to 5.12.2003 for Bilateral Gynaecomastia. When Shri Kapadia preferred a claim for the said hospitalisation the Company repudiated the claim stating that the surgery done for liposection of bilateral gynaecomastia was for cosmetic purpose and invoked clause 4.5 of the mediclaim policy. Not satisfied with the decision of the Company Shri Kapadia represented to the Company and also to the Grievance Cell but the Company upheld the decision of repudiation. Aggrieved by the decision of the Company, Shri Shabbir T. Kapadia approached the Insurance Ombudsman. His contention was that it was a painful enlargement of male breast which had to be clinically and medically treated and the surgery was advised by the senior physician after unsuccessful oral treatment and it cannot be termed as cosmetic.

Records have been perused and the parties to the dispute were called for hearing. The issue is of technical, medical inportance and the dispute is only the same. The TPA’s medical Consultant advised the Company that it is not a disease but a health condition due to hormone changes. This is absolutely a correct statement. The classical theory is that rarely it is caused by a disease or even a tumour and in most of the cases it goes on its own in 3 years. The Insured has written about his pain for which he was

hospitalized. The medical advisor of TPA, however, has written that there was no pain and that is developed over a period of 1 ½ years. There was no further invasive findings done by the hospital which proved there was no problems or complications for which Doctors has written once that it was done to avoid social embarrassment. Taking note of these issues this Forum finds substantial agreement of its views with those of the Company's TPA or their Consultant for which it was taken as a cosmetic surgery. However, it may be argued that any swelling needs to be checked and studied. If surgery would have been containdicated Doctors would not have resorted to it and therefore, to charge that the Insured did it only to avoid social embarrassment and therefore, it was cosmetic would be wrong. The TPA pointed out that antibiotic coverage was not given, which cannot be taken as surgery would have been done through IV coverage of antibiotics etc and not orally. Taking a balanced view, therefore, I decide that some consideration in the form of payment of 50 % of hospitalisation expenses may be given as the policy of medical insurance has to meet its principal objective.

Mumbai Ombudsman Centre
Case No. GI 130 of 2004 - 2005
Smt. Sarla Bhupendra Kanji Dholakia
Vs
United India Insurance Co. Ltd.

Award Dated 10.5.2005

Smt. Sarla B. Kanji Dholakia was insured under a Group Mediclaim Insurance Policy No. 120400 / 48 / 02 / 00118 issued by United India Insurance Company Limited, D. O. 13 through the General Practitioners Association, Greater Mumbai. When Smt. Dholakia preferred a claim of Rs. 34,982.80 to the Company for her hospitalisation at Cumballa Hill hospital for a left eye cataract surgery, the company settled the claim for Rs. 26,457/- Not satisfied with the decision of the Company, Smt. Dholakia represented to the Company and aggrieved for not knowing the reason for deduction of Rs. 8525/- from her claim amount of Rs. 34,982.80/- she approached this Forum for full settlement of her claim. After perusal of the records parties to the dispute were called for hearing. The scrutiny of the claim reveals that the claim was admissible and paid by United India Insurance Company and the dispute is for short payment. As regards Rs. 1695 there cannot be any dispute as the pre-expenses incurred prior to this period cannot be claimed and reimbursed. As the surgery was on 22.2.2003, there was no question of this amount. The other point of exorbitant fees for surgery paying (Phaeco with IOL) for Rs. 19,000, as against the market rates even in class I hospitals in the City, the point would be that there cannot be any convincing ruling from this Forum. Admittedly there is a provision for reimbursement of expenses "necessarily and reasonably incurred" and the Company could apply the same to reduce their liablity and issue the treatment was taken in a hospital as an OPD, the charges should have been as per standard rates of the good hospitals. However, as there is reason in the argument that the payment has been made to the Surgeon, I decide that amount of Rs. 3,000/- i.e. 15,000 cost of surgery may be allowed to resolve the dispute.

In the facts and circumstances United India Insurance Company Limited is directed to pay further a sum of Rs. 3,000 over and above Rs. 12,000/- (which was already paid) i.e. total Rs. 15,000/- towards the cost of surgery for the hospialization expenses of Smt. Sarla B. K. Dholakia at Cumballa Hill hospital for a left eye cataract surgery.

Mumbai Ombudsman Centre
Case No. GI - 159 of 2004 - 2005

Shri Sanjeev Vashist
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated 10.5.2005

Shri Sanjeev Vashist and his wife Smt. Monika Vashist were covered under Health Guard Policy issued by Allianz General Insurance Company Limited for the period from 29.11.2002 to 28.11.2003 under policy No. OG-03-2006-8401-00000061. It is reported by Shri Vashist that he was having the policy since 1999 but there is nothing on record with this Forum to establish the same. It is however noted that Shri Vashist and his wife was covered under Family mediclaim Insurance issued by United India Insurance Company Limited for the period from 29.11.2001 to 28.11.2002. Shri Vashist was hospitalized at Shri Ganapati Netralaya from 30.12.2002 to. 1.1.2003 for bleb repair of his left eye and from 21.4.2003 to. 30.4.2003 for Pyoderma Gangrinosum at Jehangir hospital. When Shri Vashist preferred claim for these hospitalizations the Bajaj Allianz Company repudiated the claim vide their letter dated 18.6.2003 stating that the claim was not payable as the disease was pre-existing and also invoked non-disclosure of pre-existing ailments. They also cancelled the policy. Not satisfied with the decision of the Company, he represented to the Company and not receiving any reply he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim. After perusal of the records parties to the dispute were heard. The scrutiny of the claim reveals that the Insured took the policy with Bajaj Allianz only on 29.11.2002 and got admitted to Shri Ganapati Netralaya, Jalna for large Cystic Belb repair / surgery of the left eye on 30.12.2002 and again on 3.3.2003 at Raj clinic, Karnal for Post Allergic skin gangrene for which surgery and debridement was done. It clearly indicates that Shri Vashist was having some problems of non-healing woulds well before the policy was taken which was not disclosed. The first hospitalisation remarks of Dr. Vyas also clearly says he had a post trabeculectomy status with large cystic bleb with hypotensive maculopathy in the left eye. The very expression post trabeculectomy confirms tabeculectomy done neither claimed nor intimated. Based on these confirmed health status which was before the policy was taken by Shri Vashist from Bajaj Allianz the pre-exsting condition is established.

Under the circumstances the decision of the Company to reject the claim as per clause C-1 of the policy is in order.

Mumbai Ombudsman Centre
Case No. GI - 09 of 2004 - 2005
Shri Subhash J. Sharma
Vs
National Insurance Co. Ltd.

Award Dated 11.5.2005

Shri Subhash J. Sharma alongwith his wife Smt. Aruna Sharma was insured with National Insurance Company Limited under policy No. 250601 / 48 / 02 / 8501967 for the period 7.7.2002 to 6.7.2003 issued through Varishield Health Care Limited. This policy was the renewal of the policy taken for the first time on 7.7.2001. Smt. Aruna Sharma was hospitalized at Bombay Hospital and Medical Research Centre from 5.5.03 to. 13.5.03 for vaginal hysterectomy with AP repair. The total hospitalisation expenses were Rs. 1,19,257 out of which 30,000 was paid by Shri Sharma to the hospital and the balance amount of Rs. 89,257 was paid by M/s Varishield Health Care. After the hospitalisation when the claim was preferred by Shri Sharma for Rs. 30,000/-, the Company, based on their panel doctor’s opinion repudiated the claim and asked Shri

Sharma to refund the amount of Rs. 89,257 as he was not entitled for the same. Shri Sharma managed to refund Rs. 40,000/-.

Not satisfied with the decision of the Company, Shri Sharma represented to the Company but the Company turned down his representation and aggrieved by the decision of the Company, Shri Subhash Sharma approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. Records have been perused and hearing of the parties to the dispute was held. The analysis of the case reveals that essentially the Insured disputed her own statement of past complaints and symptoms of something coming out per viginnum (SCOPV) which is the classical symptom of prolapse of uterus. One should be truthful to oneself and before the doctor, there cannot be any question of suppession of the complications as that would be harming the patient himself or herself with possibility of wrong diagnosis and treatment. Let us examine the other history which the hospital papers have noted down. Smt. Sharma was having depression since 1981 and on medicine, difficulty while passing motion and SCOPV 3 ½ years, Menopause 7 years, history of hernia 15 years, Rt. lymphadenectomy (TB) and taken anti Koch's treatment. If one goes through the proposal form of Varishield dated 5.7.2001 it would be seen that TB of abdomen and Angioplasty were only mentioned as past ailments and to that extent it was not a fair or full disclosure of health status which was material to the Contact. This was a case of vaginal hysterectomy where the symptoms narrated were exactly the same as the text book would recommend. Viewed from this angle the correction of the ailment with a period of 6-7 months is circumstantially an after thought and medically unfounded and in view of the fact that the policy was taken from 7.7.2001 for the fist time the Company's rejection on the ground of pre-existing illness / condition need not be questioned.

Mumbai Ombudsman Centre
Case No. GI - 508 of 2004 - 2005
Shri Anil M. Bhatkal
Vs
The New India Assurance Co. Ltd.

Award Dated 13.5.2005

Shri Anil M. Bhatkal was insured under a good Health Policy No. 712500 / 02966 / 480200003 for the period 1.6.2002 to 31.5.2003 issued by the New India Assurance Company Limited, Chennai D. O. 712500 to Citibank Card holders. Shri Anil Bhatkal was hospitalised at P. D. Hinduja hospital from 5.8.2002 to 10.8.2002 for Chronic Obstructive Pulmonary Disorder (COPD) and infective exacerbation for which he preferred a bill for Rs. 68,692 to New India. New India rejected the claim on the ground that the basic condition of submitting originals of the bills received from the hospital to support the treatment received by him was not fulfilled by him and therefore the claim was not sustainable. The Insured submitted all duplicate bills to the Company stating that it was genuine case and he misplaced the original bills for which he should be excused and the claim should be settled.

New India did not consider his representation for which he preferred a complaint against the Company before the Insurance Ombudsman.

After perusing the records it appears that New India did not go into the merit of the claim as good health policy is reimbursement policy and therefore, reimbursement can be justified only by submissions of the origional records, cash memos, bills etc. This is a basic requirement and cannot be tampered with. This Forum does not have any authority to ask Insurance Company to disregard this provision and allow the claim to

be settled on the basis of duplicate bills. There is a detailed claim procedure forming part of the good health in terms of which this is a fundamental requirement. This position was explained to Shri Mohan Ponkshe at the hearing itself.

Considering basic violation of the terms of Contract, I do not find any valid reason to interfere with the decision of the company and therefore, sustain their repudiation.

Mumbai Ombudsman Centre
Case No. GI - 556 of 2004 - 2005
Shri Rajkumar S. Anand
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated 16.5.2005

Shri Rajkumar S. Anand and his son Shri Nishank R. Anand were covered under a Health Guard Policy issued by Bajaj Allianz General Insurance Company Ltd., Mumbai from 10.2.2003 to 9.2.2004 which was renewed for the next term 10.2.2004 to 9.2.2005 under which a claim was reported. In June, 2004 Shri Rajkumar S. Anand, complainant, became ill and was admitted to Breach Candy Hospital with a complaint of abdominal pain which was detected as Gastric Ulcer and perforation of the stomach for which he was operated upon and was confined from 3.6.2004 to 7.6.2004. When he forwarded the Bill for expenses to the Company for reimbursement, the Company's TPA, M/s Paramount Health care repudiated the claim vide their letter dated 28.7.2004 on the ground that the policy did not cover the disease as per Exclusion Clause C2. The analysis of the claim file together with the documents made available to this Forum reveals that the dispute is only relating to the scope of cover and applicabilty of the exclusions under the policy in the particular case. The ground of repudiation is Exclusion Clause C2 which is quoted below :

C "What we will not pay

We will not pay for claim arising out of or howsoever connected to the following :

2) Without derogation from C1 above, any Medical Expenses incurred during the first two consecutive annual periods during which you have the benefit of a Health Guard Policy with us in connection with cataracts, benign prostatic hypertrophy, hystrectomy, menorrhagia fibromyoma endometriosis, hernia of all types, hydrocele, fistulae, haemorrhoids, fissure in ano, stones in the urinary and biliary systems, surgery on tonsils, adenoids, sinuses, ears, skin and all internal tumours / cysts / nodules / polyps of any kind including breast lumbs, gastric or duodenal ulcer. This Exclusion period shall apply for a continuous period of a full 4 years from the date of your first Health Guard Policy with Us if the above referred illness were present at the time of commencement of the policy and if you had declared such illness at the time of proposing the policy for the first time."

It is quite clear from the scope of this exclusion that the Company has highlighted under C captioned "what we will not pay". In terms of this, gastric or duodenal ulcer comes prominently as an exclusion for a continuous period of four (4) years from first policy taken. As this was in the second year of operation of the policy, it directly fell under the clause and therefore has been rightly rejected. The point raised by the Complainant and his representative that the brouchers did not contain the full terms of exclusions and therefore, misguided him would not hold good simply for the fact that the policy is a legally enforceable document in evidence of the contract and the Insured was supposed to go through the terms fully and even if at a later date he felt some

conditions were not suitable to him, he could have cancelled the contract at his option as per terms of the policy. It was stated further that he was misguided by ther terms of the brochure, but the final provision in the brochure mentioned “The details furnished above do not constitute the entire list. Please visit our office for the details terms and conditions” which was to guide him to refer to this Office and also to the policy for details of coverage. Moreover, this claim being lodged in the second year and the Insured renewing the contract with all terms intact, the charge would not be sustainable. However, this Forum would not adjudicate on the extraneous issue like wrong prospectus or misleading advertisement etc. which is clearly outside its jurisdiction and could be taken up separately. Nevertheless to the extent its applicability to the claim lodged is concerned this Award is specific and focussed to the point of rejection by the Company.

Mumbai Ombudsman Centre
Case No. GI - 015 of 2004 - 2005
Shri Mahendra K. Vira
Vs
The New India Assurance Co. Ltd.

Award Dated 17.5.2005

Shri Mahendra K. Vira alongwith his wife and children were covered under Mediclaim Policy No. 140702 / 48 / 02 / 01100 for the period 29.6.2002 to 28.6.2003 issued by the New India Assurance Company Limited, Unit 140702 for a Sum Insured of Rs. 2 lacs for self and his wife and Sum Insured of Rs. 25,000 each for his sons. He had earned Cumulative Bonus under the said policy. It is reported that Shri Vira was covered under mediclaim policy since 1992 and had increased the Sum Insured for himself and his wife in piecemeal. Smt. Bhanu M. Vira was hospitalized at Breach Candy Hospital from 9.10.2002 to 19.10.2002 for By - pass surgery and when a claim was preferred for the said hospitalisation the Company referred the file to their panel doctor and under the advice of the panel doctor asked Shri Vira to submit certain documents. The company later on repudiated the claim on the ground of non submission of documents. Not satisfied with the decision of the Company he represented to the Grievance Cell and not receiving any reply from the Company he approached the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. After perusal of the records parties of the dispute were heard.

The analysis of the complaint and rejection of the claim by New India reveals that the claim was not actually repudiated but first withheld and later refused on grounds of non-substantiation as to why Smt. Vira required to be advised for Angiography, who gave the advice and where is the documentation based on which she was admitted to Jaslok Hospital. The Complainant had submitted to New India that only the first consultation paper was misplaced but subsequent progress of the case was fully documented. The New India did not obtain the full clinical records from Jaslok hospital through their efforts and investigation. The effect of getting the initial advice is no doubt significant. However the end result of CAG dated 18.9.02 rom Jaslok and subsequent reference to one of the top most surgeons in the City even by his name can be taken as most logical outcome and cannot be questioned. As Dr. S. Bhattacharyya, the attending physician and surgeon who did the CABG surgery has signed the claim form with relevant date about the past history and detailed account of the surgery done by him in his letter dated 11.10.2002 there is no reason to doubt about the genuineness of this claim lodged by Smt. B. Vira. Nevertheless it is also a fact that

Shri M. Vira could not produce any confirmatory certificate from Dr. Munshi and therefore, hospitalisation expenses of Jaslok should not be settled. Since there was a separate CAG done at Breach Candy Hospital where she was finally admitted for CABG, the admissible expenses should be reimbursed subject to deduction of 15 % being the penalty for non submission of initial records and non compliance with the Company's requirements.

The New India Assurance Company Limited is directed to settle the claim of Shri Mahendra K. Vira in respect of his wife Smt. Bhanu M. Vira's hospitalisation at Breach Candy Hospital from 9.10.2002 to 19.10.2002 for By-pass surgery and pay the admissible expenses subject to deduction of 15 % from the total admissble expenses.

Mumbai Ombudsman Centre
Case No. GI - 67 of 2004 - 2005
Shri Shashikant J. Kamdar
Vs
National Insurance Co. Ltd.

Award Dated 17.5.2005

Shri Shashikant J. Kamdar was covered under Policy No. 250700 / 48 / 02 / 8500799 for the period 3.5.2002 to 2.5.2003 issued by National Insurance Company Limited, D. O. VII which was after 18 days gap. Earlier to this policy, Shri Kamdar was holding the policy No. 250700 / 48 / 2001 / 8500341 for the period 15.4.2001 to 14.4.2002 wherein he had earned Cumulative Bonus of 50 % under this policy. Shri Shashikant J. Kamdar was hospitalized at Shroff (Eye) clinic from 13.12.2002 to 14.12.2002 for Left Eye Cataract extraction and when a claim was preferred by Shri Kamdar to National Insurance Company Limited the Company repudiated the claim invoking clause 4.3 of the policy. Not satisfied with the decision of the Company, Shri Kamdar represented to the Company as well as the Grievance Cell and not receiving any favourable response from the Company approached this Forum. The facts under this claim are fairly straight forward. The insured has actually produced documents since 1988 - 89 and the Company also confirmed the policy earned Cumulative Bonus of 50 % maximum under the policy from 15.4.2001 to 14.4.2002. The Insured and Complainant claimed that every year the Agent used to collect the cheque and deposit the same to the Insurance Company. The renewal cheque was reportedly collected on time dated 7.4.2002 as per the counterfoil of cheque issued noting sheet produced by the Complainant. He alleged that the Company delayed the submission to Bank till 16.4.2002. The Company could not confirm this nor could it be confirmed as to when the Insured gave the cheque to the Agent, whether Agent gave the same to the Insurance Company promptly and the Company only delayed. Even granting a total lapse on the part of the Insured, a policy which has run for 14 years as on the date of claims and enjoyed maximum 50 % bonus on it, cannot be called "a policy in its first year of operation" by any means. His claim free record and meticulous renewal of policy established his bonafides. In such a situation I am of the view that invoking this clause to reduce a 14 year policy to first year policy would be utterly impractical. The logic of 1st year exclusion is different and easily understood that the policy should earn minimum supporting bottomline price to exclude some of the surgeries which can be delayed easily. In that context the outright rejection being a "first year" policy due to technical reason is unethical and therefore, unacceptable.

Mumbai Ombudsman Centre
Case No. GI - 08 of 2004 - 2005

Shri Ashok Shanker Achrekar
Vs
The New India Assurance Co. Ltd.

Award Dated 18.5.2005

Shri Ashok Achrekar alongwith his wife Smt. Ashwini A Achrekar was insured with the New India Assurance Company Limited, D. O. 111900 under Policy No. 111900 / 48 / 00 / 05567 for the period 26.12.2000 to 25.12.2001 for the Sum Insured of Rs. 1 lac each. He had also earned Cumulative Bonus @ 20 % under the said policy. Shri Ashok Achrekar was hospitalized at P. D. Hinduja National Hospital and Medical Research Centre form 20.2.2001 to 24.2.2001 for Left side indirect Inguinal hernia. When a claim was preferred by Shri Achrekar for the said hospitalisation, the Divisional Office of the New India Infromed Shri Achrekar that based on the opinion of the panel doctor taken by their Regional Office, claim was not payable under clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Achrekar represented to the Company and also to the Grievance cell several times but the Company reitereted their stand of repudiation. Aggrieved by the decision Shri Achrekar approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. Records have been perused and hearing of the parties to the dispute was held.

The analysis of the case reveals that Shri Achrekar was operated for left side herniotomy with omentectomy with hernioplasty with prolene plug as the final diagnosis was left sided indirect inguinal hernia. It would appear that the surgery was comprehensive for the patient to get cured and going by the nature of complications the hernia was quite old. The Insured has claimed in to be of ¾ years duration while the hospital records suggest as per statement made by the Insured that left side swelling was there for 30 years. Later there was strenuous effort to deny this statement by means of a clarification by Shri Achrekar that he had a scrotal injury 30 years back and that was mistakenly written as inguinal swelling which in fact he had for last ¾ years. The Company asked M/s Three Escorts to investigate into the matter and the investigators checked with the records of P. D. Hinduja National Hospital, Mahim, M - 16 and have forund out that there are no changes made regarding the duration of the disease, in the case papers as it is still mentioned as 30 years.

In the facts and circumstances this Forum is not convinced about the submission of the Insured in the face of hospital records of past history and deep complications of indirect irreducible hernia which required so many correction / repairs through surgery. Consequently, New India's repudiation of the claim is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 144 of 2004 - 2005
Shri Dhruv Jha
Vs
Cholamandalam MS General Insurance Co. Ltd.

Award Dated 19.5.2005

Shri Dhruv Jha took Health Insurance for himself and his family members from Cholamandalam MS General Insurance Co. Ltd. He preferred a claim to the Company for his hospitalisation at Bombay Hospital for Hepatitis C, fever, body aches and skin rashes. The claim was processed by M/s Paramaount Healthcare Services (TPA) and informed the Insured that the claim fell under General Exclusion No. 1 of the Policy.

The analysis of the claim file together with the relevant documents would reveal that the Insured Shri Dhruv Jha was hospitalised only for a day primarily to get treated for rashes and itching as an after effect of Hepatitis C injection duly recommended by the

doctor for treatment of Hepatitis C which was already diagnosed. The point to be noted here is the fact of hospitalisation which was not warranted but desired and there was nothing spectacular done at hospital as the authorities were frank to note down in Discharge Summary and indoor papers. The next issue is how was the treatment taken. It is a known fact again that it was a specialised treatment requiring an injection to be given which is to be imported from some important dealers.

"Thoracotomy" done at Vellore was very vital and the blood transfusion would be a factor reckon. Going however by the treatment of Tuberculosis for 2 years would have certainly impacted a vital organ like 'liver' and in absence of the complete past record of treatment which is only in possession of the Insured and will never come to be known to the Forum, the trend analysis, etiology of the disease and behaviour pattern of manifestation of Hepatitis C would reveal that circumstantially the disease would be pre-existing even if the diagnosis was on 5.4.2003 just after the policy was taken by Shri Jha on his 47th year for Rs. 3 lakhs. As per the analysis made above the certificate of Dr. (Mrs.) Banerjee dated 23.3.2004 has been accepted as the first privileged document which is duly established by the report of M/s V. B. Associates. Considering aforementioned analysis and preponderance of probabilities, the decision of the Company to reject the claim is in order.

Mumbai Ombudsman Centre
Case No. GI - 569 of 2004 - 2005
Dr. P. B. Bhagat
Vs
Cholamandam MS General Insurance Co. Ltd.

Award Dated 20.5.2005

Dr. P. B. Bhagat approached the Insurance Ombudsman with grievance that his claim for reimbursement of his hospitalisation expenses were not settled by Cholamandalam MS General Insurance Co. Ltd. for 2 years. Dr. Bhagat took a Health Insurance Policy from Cholamandalam Insurance Co. covering himself and his wife. Dr. Bhagat was admitted to Bombay hospital for breathlessness and chest pain and accordingly, Angiography was carried out. The claim was repudiated by M/s Paramaount Health Services Pvt. Ltd. (TPA) They informed the Insured about their inability to settle the claim as it fell under General Exclusion Clause 4.1 of the policy condition. The analysis of the case reveals that Dr. Bhagat was admitted to the hospital basically for "chest pain for evaluation" as noted in the discharge summary. It is also noted from papers that there was no specific diagnosis but a combination off gastric ailments with chest pain resembling cardiac problems were suspected by the patient himself for which he got himself admitted for full evaluation. This was done in two stages of hospitalisation. The gastric biopsy revealed Atrophic Gastritis with intestinal Mataplasia for which he was hospitalised. The entire treatment was taken on OPD basis for which the Insured did not claim the amount and it is not the subject of the complaint either, hence out of our consideration.

The scrutiny of the hospitals records indeed points out that there was no diagnosis but it was clearly mentioned that hospitalisation was for evaluation only. Secondly, the Insured was already having Hypertension for 2 years and was on regular medicine like Aten and Amlodopine. He was also taking medicines for Hypothyroidism. Hypertension is known to be a great risk factor for Coronary Artery diseases. Hypertension is caused by atherosclerosis of the arteries throughout the body. It is very likely that if a person has atherosalerosis in the general circulation, the coronary arteries will also be

affected. Hypertension may cause damage to artery walls. The Insured came for suspected problems for which CAG was done only to rule out Ishaemic Heart Disease. Hence both on the ground of pre-existing illness and only investigations were done, the claim has been rejected which is in order.

Mumbai Ombudsman Centre
Case No. GI - 615 of 2004 - 2005
Shri Kishore Sharma
Vs
The New India Assurance Co. Ltd.

Award Dated 24.5.2005

Shri Kishore Sharma and his wife were insured under a Mediclaim Policy issued by the New India Assurance Company Limited reportedly since 15 years. As per Shri Sharma's statement he was renewed till 1998 and then he opted for Diners' Club Group Policy with New India, Chennai D. O. 712500 as a member of the Club. The claim which has given rise to the complaint is under the policy issued from 1.10.2003 to 30.9.2004 known as Good Health Policy for a Sum Insured of Rs. 3 lakhs. Shri Sharma's wife Smt Hansa Sharma was operated for Total Knee Replacement in Breach Candy Hospital, Mumbai following her hospitalisation from 20.7.04 to30.7.04 and he incurred a cost of Rs. 2,28,942 out of which the Company New India settled only on Rs. 1,00,000 leaving a balance amount of Rs. 1,28,942 unpaid for which he represented to the Company which was not considered by their TPA M/s TTK Health Care and New India as well. He therefore, approached the Insurance Ombudsman for his intervention in the matter. The records of the case have been perused and the parties to the dispute were called for hearing. The analysis of the case appears simple to the extent that the claim has been admitted and paid by the TPA of New India as per their policy provision and terms, while the Complainant felt he was short paid as per his policy coverage. The records submitted by New India show that the subject policy had Rs. 3 lakhs Sum Insured but as per the salient terms and conditions of Good Health Policy offer from The New India Assurance Company, for the, mediclaim (Plan 5 to 12) given to the members there are in-limits or cap of claims payable for specific ailments. The Good Health Policy is a different product marketed by the Company for Citibank Cardholders and the revised terms and conditions were intimated to Citibank being uniformly applicable to all members. In fact the Insured was coverd under the policy as per the policy terms and conditions issued to all Cardholders but restriction of the limit of payment of claims to some specified illnesses is an underwriting policy of the Company and cannot be questioned. Under this it is found that Total Knee / hip surgery is pegged at maximum Rs. 1,00,000 per claim.

Based on this clause the Company's settlement is justified. As regards non-issue of the policy the Company confirmed issue of certificate with exact terms and conditions to all members. The company's rejection therefore is in order.

Mumbai Ombudsman Centre
Case No. GI - 020 of 2004 - 2005
Shri Harnam Singh Khani
Vs
The New India Assurance Co. Ltd.

Award Dated 26.5.2005

Shri Harnam Singh Khani alongwith his wife was insured under Mediclaim policy No. 111200 / 48 / 02 / 06345 issued by The New India Assurance Company Limited, D. O. 111200 or the period from 3.9.2002 to 2.9.2003. The said policy was taken for the first time from 3.9.2001 for a sum insured of Rs. 1,00,000 with exclusion of Heart ailments and Circulatory Disorders for Shri Harnam Singh Khani. Shri Khani was admitted to P. D. Hinduja National Hospital from 29.7.2003 to 14.8.2003 for Paralytic Stroke. When Shri Khani preferred a claim for the said hospitalisation the Company based on the opinion of their panel doctor repudiated the claim vide their letter dated 6.11.2003 invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision, Shri Khani represented to the Grievance Cell of the Company stating that as he had undergone bypass surgery only heart ailments should have been excluded and not the circulatory discorders. But the Grievance Cell upheld the decision taken by their Divisional Office. Aggrieved by their decision Shri Khani approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim The records have been perused and the parties to the dispute were called for hearing The analysis reveals that the policy excluded the risk of “heart ailments and circulatory disorders”. The intention and the purpose of this exclusion was quite clear to exclude liabilities on account of not only direct heart ailments following circulation disorder but also covering other organs which normally get affected by circulation problems. The discharge card has mentioned diagnosis as Stroke and within bracket in was written (? TIA) which is Transient Ischaemic Attack which was deleted. It is an acknowledged medical fact that brain stroke may be named as such but is a problem of circulation and therefore, by excluding all circulatory disorders the claim arising out of stroke or brain hemorrhage or Cerebro Vascular Attack (CVA) or Transient Ischaemic Attack (TIA) have all been excluded.

In the facts and circumstances the decision of the Company to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 105 of 2004 - 2005
Shri Suryaji Jayram Kadam
Vs
Oriental Insurance Co. Ltd.

Award Dated 26.5.2005

Shri Suryaji Jayram Kadam and his family was covered under LIC Group Mediclaim Policy. His wife Smt. Sonali S. Kadam was taking treatment from their family physician Dr. Pushpa Sanap for Vertigo. As there was no improvement in the condition, as per the advice of the family physician, she approached Dr. Siddharth Shah of Bhatia Hospital for further treatment and she was admitted in the hospital for fever and Vertigo. After hospitalisation, Shri Kadam preferred a claim to M/s Paramount Health Services Ltd. TPA, for reimbursement of the hospital expenses. The TPA repudiated the claim stating that the hospitalisation was primarily for investigation purpose and evaluation of the complications so the claim was not payable. The claim was repudiated under Exclusion Clause 4.10 of the mediclaim policy. The analysis of the case reveals that the Discharge Summary issued by Bhatia General Hospital recorded the diagnosis as only “Vertigo”. The hospitalisation was also used to have some other investigations which can always be rationalised by the Doctors as necessary but viewed in the context of the principles of insurance. It would be seen from the hospital records and treatment received by Smt. Sonali S. Kadam was usual therepy after getting examined by ENT Specialist and nothing much was done at the hospital to

warrant confinement. It should be also noted that Dr. Siddharth Shah's certificate was issued after the claim was repudiated by the Company and therefore, one would expect him to establish the case through his reasonings. However, as the policy is based on the principles of insurance and the concept of reimbursement of expenses "reasonably and necessarily incurred" the repudiation of the claim by the Company need not be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 030 of 2004 - 2005
Shri Narendra R. Gupta
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27.5.2005

Shri Narendra R. Gupta was covered under a mediclaim policy issued by the Oriental Insurance Company Ltd., Borivali D. O. since 12.11.2001. He preferred a claim with Oriental Insurance for treatement of Hernia and Hydrocele for his son Mast. Kaustubh N. Gupta for his hospitalisation at Cumballa Hill Hospital from 3.11.03 to 4.11.03. However, the claim was repudiated by Oriental Insurance vide their letter dated 29.1.2004 on the ground that it was a case of congenital external disease which was excluded under the policy condition 4.8 of the mediclaim policy. The Complainant made a further representation to the Company with the certificate of Dr. Vivek M. Rege under whose case the child was treated but yet the case was not considered by the Company.

The analysis of the case would reval that the diagnosis made on Cumballa Hill Hospital was (L) Hernia with Hydrocele and the age of the child, Kaustubh N. Gupta was 2 ½ years at the time of admission on 3.11.2003. He was put under the care of Dr. Vivek M. Rege who preformed Herniotomy. The presenting symptoms as mentioned in the case resume refers "2 ½ yrs / male child admitted with the C/o - swelling (L) testis since 3 - 4 wks. No - fever / Nausea / Vomiting / no Constipation. Birth / H - Full Term Normal Birth (FTNB). Fully Immunized for age - Mile Stones (N)". The above history has been written after questioning mother and it has been specifically mentioned that the swelling was in (L) testis and in right testis there was no abnormality. Against this background, the Company has rejected the claim on the ground that Hernia and Hydrocele in infants are most certainly congenital. Their panel doctor has drawn from the text books a disease which is known as Hernialis which is a condition in which Hernia accompanies infantile or congenital Hydrocele and peritoneal fluid accoumulates in a hernial sac. It is true that at the birth there may be swelling in the testis which accumulates the fluid but there is no treatment as it subsides on its own However, if it does not subsides till age 5 surgery is done to correct the defect / ailment. The diagnosis being Hernia with Hydrocele for a small child of 2 ½ years, the Company came to this conclusion, in absence of any specific history being recorded in the hospital, that it would be congenital i.e. since birth and as an external disease / defect was not payable.

Against the rejection of the Company, Dr. Vivek Rege who is a noted Pediatric & Neonatal Surgeon issued a letter dated 11.3.2004 giving his technical views on the subject as particularly he seemed to have examined Mast. Kaustubh Gupta. His point was that the deformity obvious at birth could not be covered but this was detected after birth and therefore should be covered. What was effectively meant that detection of deformities after birth should be covered which does not rule out that the deformities

were there at birth but remained undetected. Secondly the case of Hernia and Hydrocele as an infant clearly suggesst that it should be congenital as mentioned under Hernialis. There is another expression called Infantile Hernia which can occur both in male and female child and which refers to accumulation of serious fluid in a saclike cavity esp. in the tunica vaginalis testis. Dr. Vivek Rege's certificate was put upto the panel doctor who remarked that "A Consultant who operates on a child cannot know the details of the ailment, except from 'history' as told to him. To that extent, it is impopssible for him to comment on the origin of the disease. More importantly, he does not deny that such hernia / hydrocele is congenital, which it clearly is". Here the important point would be Dr. Vivek Rege was not the Consulting Neonatal surgeon at birth and therfore whether the deformities were present or not, he would not be able to confirm. In most cases, the parents become unmindful The swelling normally goes on its own without causing any pain as such and therefore the most likely chance is their getting unnoticed. However, as the mother gave the history before the hospital authority which should be faithful and to the minutest detail, it is felt that some consideration should be made to grant an ex-gratia to the extent of 50 % of the admissible expenses incurred at Cumballa Hospital.

Mumbai Ombudsman Centre
Case No. GI - 18 of 2005 - 2006
Shri Virendra Gupta
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27.5.2005

Shri Virendra Gupta had a Mediclaim Policy with United India Insurance Co. Ltd. in the year 1995 and he renewed the same with the Oriental Insurance Company Ltd. in the year 1996. Shri Virendra Gupta was admitted to Ashirwad Nrusing Home on 19.5.2003 for breathlessness and chest pain and diagnosed as unstable angina. He was admitted to Lilavati Hospital for Angiography and Coronary Artery Bypass Graft (CABG) surgery was done by Dr. Kaushal Pandey. Shri Gupta submitted all his claim papers to the Company for reimbursement of the hospital expenses incurred by him at Lilavati Hospital. The Company referred the file to Dr. M. S. Kamath, Medicolegal Consultant for his expert opinion and accordingly repudiated the claim under Exclusion 4.1 of the Mediclaim Policy.

The exact sequence of events leading to By-pass surgery in Lilavati Hospital would lead to the facts of the case. In the instant case, Shri Gupta was first admitted to Ashirwad CAG in Lilavati which was recorded in Lilavati Hospital history sheet dated 26.5.2003 as "known case of IHD for CAG" The issues which important to note would be the case history recordings at two hospitals for 3 times. Ashirwad Nursing Home mentioned clearly that he had breathlessness since 15 years and he was uncomfortable on exertion. The CAG admission recorded history of retrostunal discomfort and heaviness accompanied by breathlessness even on normal walking. As past history it was recorded Myocardial Infarction 5/6 years back which was treated. The next hospitalization for CABG recorded the history of breathlessness virtually since 15 years although the wordings and sentence construction was wrong by the writer. As regards other history there was no noting of Diabetes Mellitus / Hypertension etc. The Company has based their repudiation on the ground of 15 years breathlessness and maintained that even if they had settled the earlier Myocardial

claim based on the record available at that time, it did not bar them from examining again out of the records made available for the subsequent claim and act accordingly.

The contention of the Company is essentially correct but it required strong and clinching evidence of actual record of illness and the treatment he had taken in the past to establish their view point. The hospital record did not note any disease that the patient was having nor any high risk factors, to be considered vulnerable. The past claim records of the Insured regarding Myocardial Infarction paid by the Company have not been forwarded to this Forum. However, the Company admitted that there was no cause to suspect pre-existing illness to make him non-eligible to get the claim The Company has therefore only a lone evidence of Insured marking a statement that there was complaint of breathlessness since 15 years. There was no cardiac evaluation report or the Company did not put any restrictions on the policy to indicate their underwriting intention. The Company admitted that the policy was with United India in 1995 and no claim was reported in 1995 / 96 period for which Oriental took the policy from 1996 / 97 period by granting 5 % Cummulative Bonus. Therefore, they have settled a claim for heart problem as well. Although no policy particulars or other details could be produced, this document would be of some value as it gives a history of continuous insurance since 1992 i.e. 10 years as on the date of admission to Ashirwad Nursing Home in May, 2003. As this is the only available medical record and the Company has already settled a claim accordingly, this Forum is not convinced that the Company's contention that the Insured's having the symptoms of breathlessness alone since 15 years should be treated as pre-existing heart disease and therefore the claim should be rejected. On the Contrary, the Company has failed to provide clinching evidence of known cardiac ailments or even the risk factors for which their repudiation should be set aside.

Mumbai Ombudsman Centre
Case No. GI - 223 of 2004 - 2005
Smt. Sulbha S. Rege
Vs
The New India Assurance Co. Ltd.

Award Dated 3.5.2005

Smt. Sulbha S. Rege, an Ex-employee of Life Insurance Corporation of India was covered under a Group Mediclaim Insurance Policy No. 120700 / 48 / 04 / 00050 issued to LIC by The New India Assurance Company Limited, D. O. 120700 for the period 1.4.2004 to 31.3.2005. When Smt. Rege preferred a claim of Rs. 14,369.50 to the Company for her hospitalisation at Irla Nursing Home & Polyclinic for the period from 21.4.04 to 22.4.04 for Haematemesis, the Company based on the opinion of their panel doctor repudiated the claim by stating that hospitalisation was for less than 24 hours period and also stated that the test done for haematemesis was on 17.4.2004 whereas she was admitted to the hospital only on 21.4.2004 for investigation through gastroscopy which could have been done on OPD basis. Not satisfied with the decision of the Company, Smt. Rege represented to the Company which was also turned down. Aggrieved by the said decision, Smt. Rege approached this Forum for justice and full settlement of her claim. It is observed from the relevant documents that Smt. Sulbha S. Rege was under treatment and there were repeat consultations. Gastroscopy was done and there was clear evidence of positive existence of illness. As per the findings of the investigation reports she had lower oesophagitis oesophageal moniliasis and inflammatory antritis. The hospital admission was at 10.30 a.m. on 21st April, 2004 and discharge was at 10.00 a.m. on 22nd April, 2004, effectively therefore, as per

calculation it was 30 minutes short of full 24 hours although the Insured claimed that she was actually discharged well after payment of bills and only at 11.30 a.m.

The Company rejected the claim under their letter of June 25,2004 on two grounds (a) hospitalisation was for less than 24 hours and (b) Insured patient was admitted to hospital only for investigation and further evaluation. The in-depth scrutiny of the claim reveals that the whole treatment was basically done on domicilliary basis except for gastroscopy (endoscopy) done by Dr. Banka on a clear reference from Dr. Gosavi. It was therefore a clear case of evaluation through investigation and such tests of course are being done on outpatient basis daily. The point would be that after containing the disease through thereapy the patient was sent to hospital for endoscopy only when after the critical emergency situation was already handled and a positive advice for endoscopy at the clinic as an outpatient was not accepted. Obviously this type of investigation only for the purpose of diagnosis would not justify the utter urgency to hospitalize and therefore, as per 4.10 exclusion clause of the mediclaim policy the claim has been rejected which is in order. The issue of 24 hours confinement is not that material which could have been condoned as well and therefore, its merit is not being evaluated in the present case.

Mumbai Ombudsman Centre
Case No. GI - 043of 2004 - 2005
Shri Champalal Purohit
Vs
United India Insurance Co. Ltd.

Award Dated 31.5.2005

Shri Champalal Purohit and his wife Smt. Kamala Purohit were insured with United India Insurance Company Limited, D.O. Malad since 31.8.2001. Smt. Kamala Purohit underwent hospitalisation for Cirrhosis of liver, portal hypertension Ascitis and P. V. bleeding at Aakashdeep hospital, New Bombay, MGM hospital Vashi and Dr. Das hospital in Chembur between January and February, 2003. He preferred the hospital bills against United India for reimbursement of expenses but the Company rejected the claim on the ground that the disease was pre-existing and that the Complainant also did not cooperate with the Company in providing previous history of surgery for which the Company asked for hospital papers specifically. There was representation from his side which was not considered based on the opinion of the Company's medico - legal Consultant. The Complainant therefore approached the Insurance Ombudsman for redressal of his grievances. The case papers were studied and both parties were called for hearing.

The analysis of the the case reveals that the most important issue raised by the Company was about the Insured Smt. Purohit's disease due to kidney stone which was removed through surgery in 1993 called pylolithotomy. The Company felt this was an important intervention in health status and first of all it should have been disclosed at the time of taking the policy and secondly when their Medico-legal Consultant asked for the details, the Complainant should have furnished the same without any hesitation. This was not done. The full medical file not being available, one would be forced to draw conclusions and if those are based on scientific, medical and logical assumptions, should be acceptable as well. There was a remark about Duodenitis and B. A. not on medication, varices bleeding and P. V. Bleeding (diathesis) All these combination of multiorgan failure substanitiates the conclusion. Moreover the conclusion reached by the Company that hepatitis was pre-existing with all complications was evidently a

dominant probability as per analysis made above. Hepatitis and then Cirrhosis of the liver howsoever caused whether by blood transfusion or as an auto immune disease or through anaemia or even drug induced by anti-koch's drugs which are known to cause liver damage or by other drugs after the kidney stone surgery was no doubt fully established. It is a fact that Smt. Purohit was critically ill and most certainly had symtoms of past health complications. The cause of disease is immaterial but the effect of the disease is important to mention as presenting symptoms before the policy was taken Considering all these the Company's rejection on grounds of non-disclosure, pre-existing illness (4.1), non-cooperation (5.5) can be held sustainable.

Mumbai Ombudsman Centre
Case No. GI 051 - of 2004 - 2005
Shri Dharmendra Hari Pendhari
Vs
United India Insurance Co. Ltd.

Award Dated 3.6.2005

Shri Dharmendra H. Pendhari was insured with United India Insurance Company Limited, D. O. 18 through Unique Mercantile Services Pvt. Ltd. from January, 2001 for a Sum Insured of Rs. 3 lacs. Shri Pendhari was hospitalized at P. D. Hinduja Hospital, on 10.11.2002 to 27.11.2002 for End Stage Renal Disease (ESRD) and operated for live donor Kidney transplantation. When a claim was preferred by Shri Pendhari for the said hospitalisation, under Policy No. 21800 / 000 / 43 / 6024 / 2001 for the period from 11.1.2002 to 10.1.2003 the Company repudiated the claim stating that the patient was on maintenance hemodialysis since last 2 years which goes beyond the policy date hence the claim was repudiated under clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Pendhari represented to the Company and not receiving any favourable response approached this Forum for redressal of his grievance. The records of the case have been perused and the parties to the dispute were called for hearing. The analysis of this complaint reveals an important fact quite clearly that the Insured Shri D. H. Pendhari was straightway admitted to P. D. Hinduja Hospital with diagnosis of End Stage Renal Disease (ESRD) and was posted for operation for kidney transplant. The admission was on 10th November, 2002 and surgery on 12th November, 2002. There was no fuss, no consultations, straightway surgery as a last resort. There was nothing of that sort which was presented to the Insurance Company and to this Forum No doctor would take a decision to transplant a kidney just at the presentation of a patient within a couple of days. Even going by the Insured's admission at the hospital that the problems started $^{4}/_{5}$ months back, no treatment record was furnished. There is complete wash out of earlier treatment in this case and the policy was taken only in January, 2001. The policy was taken from 10.1.01 as a member of Unique Mercantile Services Pvt. Ltd. to Shri Dharmendra H. Pendhari and family consisting of self, parents and a brother. Most significantly while the other members had a meager Rs. 25,000 Sum Insured cover which had aged parents and brother of 29 years of age, the policy for Shri Dharmendra Pendhari, the Insured claimant aged 24 years had a Sum Insured of Rs. 3,00,000 straightway. There was no query from United India at that time which has also been noted.

It is evident that kidney transplant as a last resort was thought of in Augest 2001 i.e. after 7 months of the policy but prior to that a fair degree of knowledge about the disease and making heart, liver and kidney infact the whole body system, stable to carry on must have gone through therapy as conclusively proved by facts and

circumstances and hospital indoor case papers. The decision of the company to reject the claim being pre-existing and not disclosed is in order.

Mumbai Ombudsman Centre
Case No. GI - 066 of 2004 - 2005
Shri K. Satheesan
Vs
The New India Assurance Co. Ltd.

Award Dated 6.6.2005

Shri K. Satheesan alongwith his wife Smt. Suma Satheesan was covered under a mediclaim policy issued by the New India Assurance Company Limited, Kalyan D. O. 141800 since 1995 with exclusion of Diabetes, Hypertension and Cataract. As there was gap of more than 7 days in the policy renewal in 1997, a fresh policy was issued for the period 1997 - 98 without putting the exclusions on the new policy. Shri Satheesan was first admitted to Wockhardt hospital on 24.5.03 for unstable angina and CAG was done. Later he was hospitalized on 3rd June, 2003 at Wockhardt Hospital for Coronary Artery BY-pass Graft (CABG) which was done on 7th June, 2003 and he was discharged on 11.6.03. However, the claim put up by him to New India was examined by their panel doctor and the Expert Medicolegal Consultancy and based on their opinions the claim was repudiated on 10.12.2003 on the ground that the disease was pre-existing. Shri Satheesan contested the decision by arguing that he never had heart problems before the policy was taken, hence the claim. The facts of the case had been gone through at this Forum and both parties to the dispute were called for personal hearing.

New India's rejection has come on the basis of the hospital records and clear noting of past ailments in the discharge summary and indoor case papers. The diseases Hypertension / Diabetes once contracted requires life long treatment and therefore it cannot be denied that he was suffering from these ailments beforehand. The Insured's contention was that he did not have any heart ailment, which is true However, what is exactly heart ailment per se' ? There could be some congenital defect or other rhythmic problems of heart or pericarditis etc to constitute purely heart diseases otherwise it would be only problems of circulation and vascular in nature. The type of problem for which CABG is done is due to atherosclerosis and stenosis in the arteries for which he had Double Vessel Disease (DVD) as CAG and Echo D clearly bore evidence that there was severe stenosis in two arteries. All these are due to long suffering from Diabetes. Mellitus and Hypertension which are great risk factors for heart ailments. Therefore linkage of Coronary Artery disease with longsanding DM/HTN is well established. There is a clear nothing of diabetes being there for 20 years and the insured being Oral hypoglycemic medicine which must had a deep effect on the arteries and consequent heart ailments.

In the facts and circumstances the decision of the New India Assurance Company Limited to repudiated the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 070 of 2004 - 2005
Smt. Neeta M. Butala
Vs
The New India Assurance Co. Ltd.

Award Dated 9.6.2005

Smt. Neeta Butala took a mediclaim insurance policy for the first time in 2000 from the New India Assurance Company Limited, D. O. 111400 covering herself and her son Master P. M. Butala for a Sum Insured of Rs. 2,00,000/- and Rs. 30,000/- respectively. When the said policy came for renewal in the 2001, Smt. Neeta Butala increased the Sum Insured of her son from Rs. 30,000/- to Rs. 50,000/- and also included her husband Shri Mukund C. Butala's name for a mediclaim insurance cover of Rs. 1,00,000/-. At that time Smt. Butala gave a statement that they were all enjoying good health and based on which New India issued the policy. Shri Mukund Butala, husband of Smt. Neeta Butala was hospitalized at Lilavati Hospital and Research Centre from 23.1.03 to 29.1.03 for lumbar laminectomy and when his wife Smt. Neeta Butala preferred a claim for Rs. 90,000/- the Company repudiated the claim vide their letter dated 19.12.2003 invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision, Smt. Butala represented to the Company which was also not considered. Hence being aggrieved she approached the Insurance Ombudsman for intervention in the matter and settlement of her claim. The records of the case have been perused and the parties to the dispute were called for hearing. The entire records produced to this Forum have been scrutinized. And an analysis of the above records throws light on the fact that the insured was suffering from backpain for several years, associated with Hypertension for which he was on medication. It is supplemented by the fact that the insured was advised for surgery due to prolapsed disc L4 - L5 and Disc removal was done on 25.1.03, which would have been due to the chronic stage of degeneration progress gradually. Another point to be considered is that Shri Mukund C. Butala was covered under mediclaim policy only at the time of renewal of the policy and not not since inception which is rather unusual and looks selective insurance to cover only Smt. Neeta Butala and his son Master P. M. Butala. From the medical records of May, 2002, i.e. MRI Scan it would be quite justifiable to conclude that the back pain was there for quite some time which is circumstantially established and probably the need to take a policy to get Shri Butala included was felt because of this complication.

Considering the above the decision taken by the Insurance Company to repudiate the claim on the ground of pre-existing disease as per policy exclusion clause 4.1 is in order which also takes care of non-disclosure of material facts.

Mumbai Ombudsman Centre
Case No. GI - 65 of 2004 - 2005
Smt. Rekha Dilip Muni
Vs
The New India Assurance Co. Ltd.

Award Dated 10.6.2005

Smt. Rekha D. Muni approached the Insurance Ombudsman with grievance that her genuine claim was repudiated by the Company and made a prayer that the Company should settle her claim.

Smt. Rekha D. Muni took first mediclaim policy for herself and her husband Shri Dilip Mukundraj Muni in the year 1999 from the New India Assurance Co. Ltd., Divisional Office 111400. She was admitted to Belle Vue Nursing Home on 18.9.2003 and diagnosed as Grade I Hypertension She was discharged on 19.9.2003. She preferred a claim to the Company for reimbursement of hospitalisation expenses. The claim was precessed by M/s TTK Healthcare Services Pvt. Ltd. and they informed her that the claim fell under Exclusion Clause 4.1 of the mediclaim policy so the claim is not payable. Smt. Rekha represented to the Grievance Cell of the Company. The Company

took Expert Medical Opinion and after getting the same, the Company upheld the decision taken by the M/s TTK Health Services Pvt. Ltd.

The hospital records reveal that Smt. Rekha Muni was admitted with chief complaints of headache with giddiness with chest discomfort and uneasiness and she was diagnosed as suffering from Grade I Hypertention. Usually hypertension which is a symptom and manifestation of a disease is treated with common medicines. However, the type of Hypertension and the severity would determine hospital admission. Here the case was quite severe even going by the B. P. readings and the hospital records show that she was suffering from Hypertension since last 5 years. Apart from hospital records, Dr. Tushar Shah, MD and clinical cardiologist in his certificate dated 29.9.2003 has written “Ref. y Dr. C. V. Kothari BP 230/130 (throbbing headache 10-12 days back. Headache persists. High BP first detected 5 years back”. He has further written that some medicines were stopped which were again administered and that she had non-toxic (euthyroid) goitre treatment for which thyroidectomy was done in 1980 and presently she was on medicine. It also appears she had hysterectomy in 1990 and she had feeling of something coming out of vagina (SCOPV) which is a quite common disease following hysterectomy.

A deeper scrutiny of the entire records reveal that Smt. Muni was referred by her medical attendant to P. H. Medical Centre and the case history noting by them dated 4.8.1998 had made the following remarks “Occasional dizzy spells, very anxious, nervous personality, occasional swelling over entire body”. About past history - Partial Thyroidectomy and Hysterectomy were noted. Drug history noting was “Eltroxine”. All these clearly prove that she had the ailments since several years and after the surgery also she was checked in 1998 with all these ailments. In fact there would be a causative relationship with hyperthyroidism with thyrotoxicosis which could be the primary cause for hypertension. As she took the policy fom 1999 these ailments would be pre-existing and as per Doctor’s confirmation the hypertension was existing well before the policy was taken. In the facts and circumstances, the claim of Smt. Rekha Dilip Muni in respect of reimbursement of expenses towards her hospitalisation at Belle Vue Nursing Home from 18.9.2003 to 19.9.2003 for Grade I Hypertension is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 102 of 2004 - 2005
Smt. Neeta Karnani
Vs
The New India Assurance Co. Ltd.

Award Dated 15.6.2005

Shri Arjun Karnani was insured under a Mediclaim policy alongwith his wife since 26.2.2001 with New India Assurance Co. Ltd. Shri Arjun Karnani was admitted to Lilavati Hospital on 23.9.2003 for Cerebrovascular Stroke due to Thrombosis in Vertebrobasilar region (Brain Infarction) and he went into coma and passed away on 2.10.2003. Smt. Neeta Karnani, his wife & complainant put up the claim to New India which was rejected on grounds of policy exclusion of heart ailment and related diseases arising out of CABG Cardiac Surgery which Shri Karnani had undergone before the policy was taken. Smt. Karnani contested this contention of the company and the company after considering her representation maintained their earlier stand of repudiation on the strength of their medical opinion vide New India’s letter dated

31.3.2004. Smt. Karnani then approached Ombudsman for redressal of her grievances vide her letter dated 11.5.2004.

The analysis of the case reveals that Shri Arjun Karnani had a history of drowsiness and fall while waking which resulted into unconsciouness and he was admitted to Lilavati Hosptial with the diagnosis of vertebrobasillar thrombsis with Midbrain haemorrage with cerebellar infarct. He went into coma and never recovered. The hospital records noted a known case of Cardiac Ischaemia and CABG done 3 years back. The Insured while taking the policy in 2001 made a disclosure of the CABG surgery for which the policy excluded heart diseases and related ailments. The company rejected the claim on the ground that heart ailment and consequent CABG was a disease which was basically a circulatory disease due to atheroclerosis in the arteries. The Vertebrobasilar infarct is also caused by blockage in the supply of blood to the brain stem which would be excluded by the exclusion clause given under the policy and hence not payable. However, this requires proper examination in the light of the actual circumstances of the present ailment.

The complainant pitched her claim for settlment on the basis of hospital case noting that it was an acute onset COMA with brain stem seizure, massive brain stem infarct or cerebellum infarct with brain stem compression. She supplemented this by providing a certificate from Dr. Mohinish G. Bhatjiwale, Neuro Surgeon.

The strength of the argument on which the Company repudiated the claim was the fact of atherosclerosis which is the principal reason for causing stenosis / thickening of the arteries thus blocking the way of circulation. While this is not doubt an acceptable position and in fact the effect of this blockage could be disastrous in many organs other than heart, the pointed reference to the brain damage by the instant case merits some special consideration. Here specially the arteries of the brain were affected as mentioned above. It cannot perhaps be likened the same way to blockage in heart arteries although the basic reason would be problems in circulation. However, pinpointing the cause of brain stroke solely to the exclusion of heart ailment incorporated in the policy would be in the realm of brain stroke solely to the exclusion of heart ailment incorporated in the policy would be in the realm of doubt as far as formation of ‘clots’ claim to be an independent single cause to effect posterior ischaemia. Strictly viewing from this angle that it was a cerebellar infarct due to vertebro basilar insufficiency and also the fact that the company’s exclusion was specific to heart disease and related ailments, there is a case for reconsideration of the case by allowing 50 % of the admissible expenses on ex-gratia basis and I decide in favour of the complainant to receive the claim amount on that basis. New India Assurance Company Ltd., is directed to settle 50 % of the admissible expenses on ex-gratia basis of Shri Arjun Karnani in respect his Hospitalisation expenses at Lilavati Hospital.

Mumbai Ombudsman Centre
Case No. GI - 95 of 2004 - 2005
Shri Mahendra Dedhia
Vs
The New India Assurance Co. Ltd.

Award Dated 15.6.2005

Shri Mahendra Dedhia and his wife Smt. Kalpana Mahendra Dedhia were covered under a Mediclaim Policy issued by the New India Assurance Co. Ltd., for Rs. 50,000/- Sum Insured each. Shri Mahendra Dedhia fell sick in May 2003 for which twice he was

hospitalised at Chetna Critical Care Unit from 2.5.2003 to 9.5.2003 and at Shraddha Polyclinic & Nursing Home from 22.5.2003 to 3.6.2003. for Ischaemic heart disease. However, when he preferred the bill against the Insurance Company, New India, they rejected the claim as per their letter dated 18.9.2003 on the ground that the disease was pre-existing. Shri Dedhia made an appeal for reconsideration which was also rejected on 2.1.2004 on the same ground. He then approached the Insurance Ombudsman for his intervention in the matter through his letter dated 20.5.2004.

The analysis of the case reveals the following features. First of all, it must be noted the claim was lodged in the 1st year itself of the policy operation and also that Shri Mahendra Dedhia took the Mediclaim Policy in his 51st year only without any policy coverage before this insurance. The next feature is that following chest pain and discomfort, he was admitted to Chetna Critical Care Unit on 2.5.2003 and was straightaway diagnosed as having Myocardial Infarction. His health status was not favourable at all for which Smt. Dedhia had to submit a high risk consent on admission on the advice of the doctors attending on him. He was discharged on 9.5.2003 apparently after management of the ailments and with proper diagnosis. Yet he had to be hospitalised again on 22.5.2003 at Shraddha Polyclinic and Nursing Home. During the first hospitalisation, he was taken to Dr. Choukar's Cardiac Clinic for Echo D which gave the findings as "ischaemic heart disease. LV dysfunction EF 35 %. Septum open show hypokensia". It would be apparent from this observation that even a non-invasive examination gave a clear verdict about the disease of ischaemic heart disease with a poor EF and decreased motor reaction to stimulus. The further notings were "Pericardial effusion mild. Thrombus at LV apex" which indeed confirmed that the onset of the disease was most certainly earlier that the policy was taken as this was a first year policy. The second hospitalisation was as a result of fall for which external injury was suffered. During this period of hospitalisation from 22.5.2003 to 3.6.2003, he had haemoptysis which is vomiting of blood and 15 to 20 cc quantity of blood was ejected on 25.5.2003. There is a further noting on the hospital case papers that Shri Dedhia was a chronic smoker and final diagnosis was ASMI thrombolysed. He was only medically managed and a group of medicines was tried.

The records as produced before this Forum clearly point out evidence of earlier complications from the progress of the disease. The diagnosis was based on objective facts and relevant documents and being a policy taken out the same financial year the decision of the company to reject the claim on grounds of pre-existing illness cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 90 of 2004 - 2005
Shri Devesh Pramodray Mehta
Vs
National Insurance Co. Ltd.

Award Dated 16.6.2005

Lifeline EMS India Ltd. is an organisation having many members whom they offer various medical facilities which includes coverage of hospitalisation expenses. A Group Mediclaim policy No. 250800 / 46 / 2001 / 8500108 was issued to the cardholders of Lifeline EMS India Ltd. by National Insurance Co. Ltd. on 2001. On 28.12.2001 there was a request from Lifeline for inclusion of its members by payment of Rs. 5,00,000/- in respect of additional premium. Endorsement was passed and certificates were issued on 28.12.2001 after receipt of premium cheque. But the cheque was dishonoured by Bank so the Company cancelled all the endorsements and intimated to

Lifeline and only after getting the payment on 11.1.2002 the Company again included the members for medical facilities. Shri Devesh Pramodray Mehta was covered under membership no. A - 300 - 00019 on 11.1.2002. His father, Shri Pramodray H. Mehta was operated for cataract on both the eyes in the month of January & February, 2003. Shri Devesh Mehta preferred a claim to the Company for reimbursement of expenses incurred for cataract operation of his father. The Divisional Office had repudiated the claim under exclusion no. 1.3 of the certificate issued to the policyholders.

The strength of National's rejection was based on the fact that Cataract could not have matured within a year (although have referred it to be 10 days). On that basis it should be presumed that Cataract was 'mature' and the Insured took advantage of the Exclusion Clause 1.3 to claim only in the second year. Having said that the issue would be how could the policy wording be disregarded. It says during the first year it would not consider some specified diseases in which Cataract is included. However, how could one come to the conclusion that Cataract could mature for surgery even in one year. The point is that the rejection of first year Cataract or for that matter other specified diseases, is of a different logic in the sense that the policy wants to clearly stay away from surgeries which can be delayed with some medicines in the first year policy itself primarily to be a viable underwriter of risks for acceptance. One needs to address what could be done if an Insured delays the surgical process to take advantage of the respective clause. The only point comes whether the Insured's diagnosis of Cataract formation was over before the policy was taken which would be a deliberate move to delay to take advantage under the policy. This is not clearly proved although it would be a safe conclusion to say that cataract does take time to develop and mature only when normally surgery is undertaken. As the Insured lodged the claim immediately after the 1st policy year, there is an element of doubt that the Insured had consciously delayed the procedure. On this grond the Company's contention is acceptable but since the Exclusion Clause is specific to operate only in the second year, some consideration for only a part settlement can be given and therefore, I decide that only 50 % of the admissible expenses may be paid.

National Insurance Company Ltd. is directed to settle the claim of Shri Devesh Pramaodray Mehta for hospitalisation of his father Shri Pramodray H. Mehta at Eye Hospital for Cataract operation of both the eyes in the month of January and February, 2003 on ex-gratia basis at 50 % of the admissible expenses only.

Mumbai Ombudsman Centre
Case No. GI - 52 of 2004 - 2005
Shri Harakchand N. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 20.6.2005

Shri Harakchand N. Shah who was insured with the New India Assurance Company Limited had approached the Office of the Insurance Ombusman with a complaint against the New India Assurance Company Limited for non settlement of his claim. Shri Harakchand Shah was hospitalised from 19.11.2001 to 25.11.2001 at Suchak Maternity and General Hospital for Acute Coronary Syndrome with uncontrolled HT with dyslipidemia c cervical lumbar Spondylolysis c Bilateral Osteoarthritis of knee joint. In the meantime Shri H. N. Shah was admitted to Indo American Centre on 24.12.2001 for Coronary Angiography. When the claim was preferred by Shri Harakchand Shah, for the expenses incurred at Suchak Maternity and General Hospital, the Company sent the file to their panel doctor and based on the opinion of their panel doctor repudiated the

claim vide their letter dated 23.4.2003 on the ground of pre-existing illness and invoked clause 4.1 of the mediclaim policy.

On going through the various medical records produced to this Forum, it is observed that the Insured was admitted on 19.11.2001 in Suchak Maternity and General hospital and diagnosed to be a case of Acute Coronary Syndrome with uncontrolled Diabetes Mellitus with Hypertension with Dyslipidemia and Lumber Spondylolysis with bilateral osteoarthritis of knee joint. He was discharged on 25.4.2001. In the case papers there is a mention of the Insured's past history as known case of Hypertension since 5 years on medication and Borderline diabetes. While going through the past medical records of the Insured, the consultation paper dated 17.6.83 from Dr. K. D. Shah, Consulting Orthopedic surgeon mentions that the insured was overweight and some treatment was given for 'plantar fascilities (L) heel. Usually this is a localized tenderness. It is further observed that the insured was referred by Dr. H. S. Vakharia on 27.2.96 to Dr. Vimal K. Kabra, Cardialogist and Diabetes specialist and the doctor has mentioned that the insured was found 'ECG-S Tachy c ST-T Changes' and diagnosed to have Neuralgia. The earlier ailment in 1996 - Neuralgia which is caused by pressure on nerve trunks has valid reason to cause cervical lumber Spondylolysis The earlier records of 1983 show that he was overweight and in 1996 the insured was referred to a Cardiologist. Thus the Insured was long time would be found acceptable. Longstanding Hypertension with overweight medically known to cause precipitate and aggravate IHD and the Company's rejection was based on the same. However, it is not proved for certain that he was hypertensive since last 15 years and if it is for 10 years it is a borderline case. In any case the Insured had kept his Hypertension under control by some medication which the Company could not mention. Since he controlled it well and some manifestation took place well after a decade goes to show that he became fully conditioned with appropriate medicines. Hypertension is regarded as a great risk factor for Coronary Artery diseases and therefore, it would be a lapse and non-disclosure on his part. His parents had a history of IHD and death due to same disease. He had obesity and hypertension, and he admitted the same but claimed that the duration would be 5 years only. All these do not speak well that he made full disclosure before the Insurance Company at the time of taking the policy. On the other hand he tried to establish Suchak's notings of 5 years history as correct and with proven longer duration of Hypertension it would be a malafide intention. Since there was an attempt to nullify the history recorded at Indo-American Centre against a clear noting of HT for 10-15 years and HT as uncontrolled and even when the Sum Insured was increased in the year 2000 he did not make any disclosure of Hypertension which he himself admitted he had at least for 5 years, the company's rejection of the claim on the ground that it pre-existed the first policy cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI - 86 of 2004 - 2005
Ms. Purnima Sadashiv Parkhi
Vs
National Insurance Co. Ltd.

Award Dated 22.6.2005

Ms. Purnima Sadashiv Parkhi alongwith her parents was insured under a mediclaim policy of the National Insurance Company Ltd. since 2001. Her father, Shri Sadashiv Parkhi consulted Dr. Amit M. Vora on 8.4.2003 for angina and echocardiography was done and as per his advice Shri Parkhi was admitted at Smt. Sushilaben R. Mehta & Sir Kikabhai Premchand Cardiac Institute for Coronary Angiography. Shri Parkhi was re-admitted on 22.4.2003 for PTCA (Percutaneous Trasluminal Coronary Angioplasty).

Ms. Purnima S. Parkhi preferred a claim to the Company for reimbursement of the expenses incurred at Hospital for her father's treatment. The claim was processed by M/s. Medicare Services and they informed to the Company that Shri Sadashiv was suffering from hypertension and it was pre-existing illness. Accrodingly, the Company informed the same to the Insured.

The analysis of the case reveals certain features which require proper examination to arrive at a decision. First of all, Shri Parkhi was covered under a Mediclaim Policy in his 65th year which straightway makes it a high selection against the Insurance Company and puts a question mark whether or not the move to cover her parents by Ms. Parkhi had a design in it. In respect of such a decision - making by the Insured one must go by circumstantial evidence to read the move and draw appropriate conclusions. Shri parkhi's admission was with chief complaints of "retrosternal chest pain" which was "not radiating, not also with sweating / giddiness" and his BP reading was quite high 170 / 100. The advice was to go for CAG and the insured utilised the stay to have investigations followed by a second hospitalisation to have Angioplasty as diagnosis was Acute AWMI. The analysis made by the TPA, M/s Medicare Services by Dr. Majumdar is a well reasoned one as the conclusion was drawn on the basis of concentric LVH. One cannot find fault with the analysis that the ventricular hypertrophy would be a sign of long standing hypertensions. As a doctor and in absence of any medical records, he has used the expression that it is unlikely that the Concentric LVH with associated complaints would have developed within a year and therefore, he felt he had probably Hypertension since long and well before the policy was taken. This was an internal correspondence between the Insurance Company and the TPA, however the letter of repudiation was issued by the Company clearly mentioning that the claim was inadmissible because of a pre-existing illness. All the three certificates appear to be focussed on the issue of establishing the duration of Hypertension and that the onset was recent and not as back as before the policy. For example, Dr. N. G. Bihani writes that he is the house physician for 20 yrs and that as per his records, Shri Parkhi was never observed to be hypertensive or having heart disease. But he concedes that after 1998 he did not examine him for any ailment although what was the ailment in 1998 he did not mention The complainant has submitted as ECG taken on 27.11.2001 but what was the reason for taking ECG was it a periodical check up or only for BP problems for which ECG was taken, was not mentioned. As the policy is from 2001 and the claim was lodged immediately under the second year operation of the policy, the claim is suspect. The progress of the disease would bear substantial evidence that the complications were there for quite sometime to cause severe Myocardial Infarction and complete arterial blockage for which PTCA was done and thefore to be taken as pre-existing. Moreover, the history recorded has mentioned it to be a 'known case of Hypertension' and the expression 'known case' would always indicate some duration as also that both the patient and the treating doctor know the disease to be existing. Hence the Company's contention based on TPA's specialist Dr. Majumdar's observation that the disease, Hypertension was pre-existing cannot be faulted and thus upheld be me.

Mumbai Ombudsman Centre
Case No. GI - 133 of 2004 - 2005
Shri Lalji Kanji Gala
Vs
National Insurance Co. Ltd.

Award Dated 23.6.2005

Shri Lalji Kanji Gala alongwith his family members were covered under Group Mediclaim Policy since 29.7.2000. The said policy was issued by National Insurance Company Limited, D. O. 9 to Shri K. V. O. Seva Samaj, Sanjivani Swastha Yogana Group under Medicare Services for covering their members, Shri Lalji K. Gala was hospitalized at Sir Hurkishondas Nurrotumdas Hospital and Research Centre, Mumbai from 22.5.2003 to 2.6.2003 for Exp. Lap for Internal Obstruction due to band and adhesion in RIF. When a claim was preferred by Shri Gala for the said hospitalisation the Company based on the panel doctor, repudiated the claim invoking clause 4.1 of the mediclaim policy. Dissatisfied with the decision of the Company, Shri Gala represented to the Company and aggrieved by the said decision Shri Gala approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. After perusal of the records parties to the dispute were called for hearing. The analysis of this case reveals that it was a case of emergency laparatomy for intestinal obstruction due to band and adhesion in ileum The distension was in Jejunal and ileal loops and there was “a tight band constrion ileum 2 cm with pleaty of ascitis fluid of 400 cc. The band was released and liagated”. Unfortunately the Company felt that the “Old pelvic colon infection” is referring to some previous illness caused by scar marks of appendectomy and hernioplasty. Medically this view does not stand any scrutiny as there was no reference about the scar marks of hernioplasty or appendectomy or complications arising therefrom in the operating Surgeon’s notes. These may have been externally visible but have caused no internal intestinal obstruction which has a totally different etiology. Intestinal obstruction is a complication of the intestines which produces symptoms of vomiting, distension and abdominal pain, failure to pass flatus or feaces and complete constipation is usual. Untreated hernia may cause this or chronic tumors or through some other obstruction, which has happened in this case i.e. due to band adhesion. This commonly occurs in abdominal cavity and usually involve intestines. The operative notes are clear enough to suggest that the problem was in intestines only and ‘old pelvic colon infection’ was inferred to be the cause leading to sudden intestinal obstruction and an emergency laparatomy was done to release the adhesion which should not be related to earlier appeandicitis or bilateral hernia. It can be an independent occurrence.

Based on these facts it would be necessary for the Company to revise their decision and settle the claim in full.

Mumbai Ombudsman Centre
Case No. GI - 299 of 2004 - 2005
Shri Arvind T. Raval
Vs
National Insurance Co. Ltd.

Award Dated 23.6.2005

Shri Arvind T. Raval, alongwith his family members was insured through Winner Capital with National Insurance Co. Ltd. under a Mediclaim Policy. He lodged a claim with the company for reimbursement of expenses incurred in connection with his hospitalisation at Ameya Orthopaedic Centre, Borivali (W) for (L) Total Hip Replacement. The Company, rejected the claim vide their letter on the ground that the disease was pre-existing as deformity and shortening of the limb of a person to the extent in his case, takes at least 5 years to occur. Aggrieved with the decision of the company, Shri

Arvind T. Raval, represented to National Insurance, however, receiving no reply, he approached the Ombudsman.

If we look at the nature of disease and the advancement of the disease, it would be seen that Shri Arvind T. Raval had difficulty in squatting / sitting cross legged. He had no fall or trauma and the x-ray reveals stage IV AVN Left Hip with with Arthritic changes. His normal flexion was only 10 % and the IR / ER was quite painful The MRI shows “that there was a large, punched out destructive focus along the superior portion of the left femoral head”. The necrosis is very significant. It means death of the cell and by all indication which were clearly readable, the disease was in an advanced stage and must have been long and certainly not in the first year or second year of the policy. The Insured was hospitalised in Ameya Orthopaedic Centre from 21st July to 31st July, 2003 which was on the second year of operation of the policy and therefore, clearly could be categorised as pre-existing illness as it led to deformity and shortening of the limb which must have occurred over period of time. In the facts and circumstances of the case, there is no cause for this Forum to intervene in the matter and, therefore, the decision of the company to repudiate the claim is hereby upheld.

Mumbai Ombudsman Centre
Case No. GI - 073 of 2004 - 2005
Dr. Jawahar C. Bijlani
Vs
United India Insurance Co. Ltd.

Award Dated 23.6.2005

The General Practitioners’ Association covered all its members to Group Health Insurance Scheme of United India Insurance Co. Ltd. Dr. Jawahar C. Bijlani and his family members were also covered under the same policy. The claim arose in the year 2003 when Dr. Bijlani admitted to Jaslok Hospital from 20.3.2003 to 1.4.2003 under the care of Dr. S. C. Munsi, Cons. Cardiologist and diagnosed as Ischeamic Heart Disease (IHD) c TVD c Hypertension c Diabetes Mellitus c Coronary Artery Bypass Graft (CABG). After hospitalization, Dr. Bijlani claimed for reimbursement of treatment expenses to the Company. He submitted all the necessary documents to the General Practitioners’ Association on 14.5.2003 and the same was submitted by GPA to the Company on 7.6.2003. After scrutiny of the claim, the Company repudiated the claim under Exclusion Clause 5.4 of the policy condition.

If we look at the area of dispute for which this complaint has come to this Forum, we will see that the claim has not been considered only on account of delay in submission of the entire claim papers to United India Insurance Co. Ltd. as per clause 5.4 of the mediclaim policy. It has been submitted to this Forum that General Practitioners’ Association as a body had covered their members with United India Insurance Co. Ltd. under a Group Mediclaim Policy and right at the entry point they were advised that the policy would be subject to the terms and conditions of the usual mediclaim policy issued to the entire insuring public. If we look at the facts of the case, Dr. Bijlani was discharged from the hospital on 1.4.2003 and effectively the claim should have been lodged within 30.4.2003 or latest 1.5.2003 while it was received by the Company actually on 7.6.2003. The complainant submitted that as per their internal arrangement, they were forwarding the papers to GPA who processed the same and submitted to the Insurance CO. and this practice was going on without any problem and the Company was accommodating in the past claims received within 60 days period from the date of discharge. Why suddenly they applied this condition so rigidly was not known to them. The Company, on the other hand, mentioned that first of all delays in submitting the

claim papers cannot be encouraged and in this regard past practice need not be mentioned. Secondly they felt that there has to be some discipline regarding submission of claims and therefore they quoted the policy condition. Finally, they mentioned that the Company wanted to withdraw from the policy issued to GPA from 2003 - 2004 and for this purpose a notice was sent to the GPA as back as December, 2002. Moreover, as the GPA has got suficient notice of cancellation of the policy they should have been more careful of not committing any delay to ensure settlement of the claims. It would be appreciated that the above dispute is not really a matter of judgement on which this Forum is supposed to pass an Award but a matter of fact based on the relevant policy condition. Strictly speaking if there is a violation in the terms of the policy, the claim is vitiated and cannot be entertained. The arguments that have been given by the Company are primarily acceptable and they are within their rights to go by a stipulation of acceptance of claims. If some borderline cases were considered in the past it would be perhaps appropriate to accept a maximum procedural delay of 2 / 3 days to constitute reasonableness. In this case, the delay is well beyond 2/3 days. In the facts and circumstances as explained above, this Forum does not find any special merit to ask United India to violate the terms of the policy and accept this claim which has been delayed.

Mumbai Ombudsman Centre
Case No. GI - 128 of 2004 - 2005
Shri Jiwat Bhawandas Amarnani
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27.6.2005

Shri Jiwat Bhawandas Amarnani was insured himself and his family under Mediclaim policy of the Oriental Insurance Company Ltd. Shri J. B. Amarnani was under the treatmnt of Dr. Ashok Sirsat, MD (Neurology) for Left Facial Nerve Twitching and as per his advice Shri Amarnani got admitted to Abhijit Hospital. Shri Amarnani preferred a claim to the Company after his hospitalisation. M/s Raksha TPA processed the claim and informed to the Insured, Shri Amarnani that the claim fell under Exclusion Clause 4.10 of the mediclaim policy.

It would be necessary to examine all the hospital records in this case and come to an appropriate conclusion. It is no doubt evident that the hospitalisation was to evaluate the status of illness and whether any deep rooted complication was involved in the apparently unremarkable health condition like ‘nerve twiching’. The doctors indeed did so and the Insured also had the benefit of entire set of investigations related or unrelated or remotely related. In the event of conclusive evidence through MRI, some of the invetigations would be remotely related no doubt. Let us now examine the hospital discharge card and records of treatment. It was written as a disease “left facial nerve twitching ? He was kept under observation to conduct all tests for 2 days and was discharged with the comment “no abnormality detected” with a medicine package and advice to follow up after 4 days. The admission to hospital had no emergency, no criticality and no life threatening risks were exhibited to justify the hospitalisation except the need to find out the cause which could have been done as outpatient. In fact day in and out a large number of cases are being done so and obviously the advantage of having the policy was utilised for reimbursement. In the facts and circumstances, the decision of the Company to repudiate the claim on grounds of Exclusion Clause 4.10, cannot be faulted and the complaint of Shri Jiwat Bhawandas Amarnani is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 154 of 2004 - 2005
Dr. Raghuvir Tulsidas Kapadia
Vs
United India Insurance Co. Ltd.

Award Dated 27.6.2005

The General Practitioners' Association covered all its members to Group Health Insurance Scheme of United India Insurance Co. Ltd. Dr. Raghuvir Tulsidas Kapadia and his family members were also covered under the same policy. The claim arose in the year 2003 when Dr. Kapadia was admitted to Asian Heart Institute and was diagnosed as Triple Vessel Disease with NIDDM and Coronary Artery Bypass Graft (CABG) was done. After hospitalization, Dr. Kapadia claimed for reimbursement of treatment expenses to the Company. He submitted all the necessary documents to the General Practitioners' Association on 1.4.2003 and the same was submitted by GPA to the Company on 5.5.2003. After scrutiny of the claim, the Company repudiated the claim under Exclusion Clause 5.4 of the policy condition i.e. delayed submission.

If we look at the area of dispute for which this complaint has come to this Forum, we will see that the claim has not been considered only on account of delay in submission of the entire claim papers to United India Insurance Co. Ltd. as per clause 5.4 of the mediclaim policy. It has been submitted to this Forum that General Practitioners' Association as a body had covered their members with United India Insurance Co. Ltd. under a Group Mediclaim Policy and right at the entry point they were advised that the policy would be subject to the terms and conditions of the usual mediclaim policy issued to the entire insuring public. If we look at the facts of the case, Dr. Kapadia was discharged from the hospital on 10.3.2004 and effectively the claim should have been lodged within 10.4.2003 while it was received by the Company actually on 5.5.2003. The complainant submitted that as per their internal arrangement, they were forwarding the papers to GPA who processed the same and submitted to the Insurance Company and this practice was going on without any problem and the Company was accommodating in the past claims received within 60 days period from the date of discharge. Why suddenly they applied this condition so rigidly was not known to them and therefore they felt that the Company was unreasonable. The Company, on the other hand, mentioned that first of all delays in submitting the claim papers cannot be encouraged and in this regard past practice need not be mentioned. Secondly, they felt that there has to be some discipline regarding submission of claims. Finally, they mentioned that the Company wanted to withdraw from the policy issued to GPA from 2003 - 2004 and for this purpose a notice was sent to the GPA as back as Dec'2002. The Company suspected that the spate of claims which they received between January - March were quite large because of the withdrawal notice and therefore they had to enforce the clause of 5.4 rigidly. Moreover, as the GPA has got sufficient notice of cancellation of the policy they should have been more careful of not committing any delay to ensure settlement of the claims. The Co. also mentioned that if there was delay in GPA's submission the respective claimants cannot hold Co. responsible in not accepting such dealyed claims. It would be appriciated that the above dispute is not really a matter of judgement on which this Forum is supposed to pass an Award but a matter of fact based on the relevant policy condition. Strictly speaking if there is a violation in the terms of the policy, the claim is vitiated and cannot be entertained. The arguments that have been given by the Company are primarily acceptable and they are within their rights to go by a stipulation of acceptance of claims. However, there is no discretion allowed in this case which must be appreciated. In the facts and circumstances as explained above, this Forum does not find any special merit to ask

United India to violate the terms of the policy and accept this claim which has been delayed.

Mumbai Ombudsman Centre
Case No. GI - 050 of 2004 - 2005
Shri Kirtibhai T. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 28.6.2005

Shri Kirtibhai T. Shah alongwith his wife was covered under mediclaim policy issued by the United India Insurance Company Limited, D. O. 8 since 2001 for a Sum Insured of Rs. 1 lac each. Shri Kirtibhai Shah was hospitalised at Breach Candy Hospital on 20.11.2003 for CAD, Aneurysmal aorta, Bilateral Renal artery stenosis and again from 8.1.2004 to 9.1.2004 for CAD, Renal Artery Diseases and Renal Angioplasty. When Shri Shah preferred a claim the Company repudiated under exclusion clause 4.1. Their contention was that as Shri Shah was suffering from Hypertension since 1982 as per the hospital record the present claim was not payable as the ailment was related to Hypertension. His representation to the Company was also turned down and hence being aggrieved Shri Kirti Shah approached this Forum for justice. Records have been perused and parties to the dispute were called for hearing. Relevant records produced to this Forum have been scrutinized. It was obseved that Shri K. T. Shah, was a known case of Hypertension since 1982 and he stopped smoking since 2 months and alcohol since one year and also the insured was obese. It is noticed that the Insured was diagnosed to have atherosclerotic Coronary Artery disease. As per the Discharge card of Breach Candy Hospital the insured was admitted on 20.11.03 and discharged on the same day. The diagnosis was aneurysmal aorta and Bilateral renal artery stenosis. From the above records it is observed that the insured had some long standing problems. He was alcoholic and also a smoker reportedly having stopped respectively a year and couple of months before he took the treatment in October, 2003.

The main contention of the Insured was to establish that the Hypertension was not from 1982 which was wrongly recorded in the hospital case papers which should be from 2002, However, the Doctor under whose care he was treated, i.e. has written in his certificate that he was an old hypertensive patient since 1982 and that he had chest pain and breathlessness from 2 months only. Longstanding Hypertension has an adverse impact on kidney any renal arteries. The length of the disease is substantiated by the treating Doctor’s certificate for which the decision of the Company to repudiate the claim is in order.

Mumbai Ombudsman Centre
Case No. GI - 77 of 2004 - 2005
Shri Vikas C. Jagtap
Vs
United India Insurance Co. Ltd.

Award Dated 28.6.2005

Shri Vikas C. Jagtap is a member of Lifeline EMS Ltd. and he took a mediclaim policy of United India Insurance Co. Ltd. from 2001. Shri Jagtap preferred a claim to the Company after his hospitalisation at Poona Hospital from 1.6.2003 to 4.6.2003 under the care of Dr. A. V. Bhaulikar and diagnosed as Acute Coronary Syndrome + Diabetes Mellitus + Hypertension. The Company repudiated the claim under Exclusion Clause

4.1 of the mediclaim policy. The analysis of the file in the light of what has been mentioned above and records made available to this Forum reveals the following.

In view of the declaration of Hypertension in the proposal, the coverage for Hypertension was excluded from the policy. The Insured was hospitalised from 1.6.2003 to 4.6.2003 in Poona Hospital and Research Centre and diagnosis was Acute Coronary Syndrome with Diabetes Mellitus and Hypertension. In the Discharge Summary there is a mention of past history of Diabetes Mellitus since one year and history of hypertension since 6 years. It is evident that Hypertension existed prior to commencement of Insurance and the Insured's declaration to this effect made the policy restrictive. The nexus between Hypertension and Coronary Artery diseases cannot be denied, as Hypertension is a high risk factor. Coupled with Diabetes it would only aggravate heart ailments through stenosis and blockages in the arteries thereby affecting circulation. Dr. A. V. Bhaulikar, the treating doctor has also admitted the fact that hypertension may be one of the causes of heart ailment but not the "sole" cause. This certificate has been produced by the Insured only after the claim was rejected and obviously it would be expected that the doctor would be weighing all options to conclusively write anything in a focussed manner. Moreover, the doctor has written further "I feel Mr. Jagtap should be given benefit and his claim for hospitalisation be sanctioned" Evidently, the doctor acted at the behest of the Insured and exceeded his authority to ask for sanctioning the claim by giving benefit of the doubt. This indicates that the doubt was genuine. There would be another point which the Insured would have in his mind that hypertension was excluded but not the heart disease. However, it indicates that all related diseases of circulation which has one of the reflections in hypertension, was excluded. Hence, the effects of Hypertention get excluded. In view of disclosure of Hypertension in the proposal form, it is quite clear that hypertension was a pre-existing disease and therefore the effects of the same to cause heart ailments would also be excluded. Accordingly, this Forum has no good ground to interfere with the decision of the Company on the basis of the available medical records.

Mumbai Ombudsman Centre
Case No. GI - 84 of 2004 - 2005
Shri Oan A.Thingna
Vs
The New India Assurance Co. Ltd.

Award Dated 28.6.2005

Shri Oan A. Thingna alongwith his wife and daughter was covered under Mediclaim Policy issued by The New India Assurance Company Limited, D. O. 111700 from February, 2000 had approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. Records have been perused and the parties to the dispute were called for hearing. It is evident from the nature of dispute that while the Company feels that hospitalisation was unnecessary as it was intended for investigation, the Insured felt that he needed to get a fair evaluation of his ailments which included Gidddiness apart from Hypertension. The hospital case papers clearly mentioned that Shri Oan Thingna was admitted with diagnosis as "Hypertension with giddiness for investigation". The admission was done without any criticality and emergency situation and in a designed manner to get the appropriate investigations done. In fact the hospital and clinical notes of the Nanavati hospital states that there

were no other signs causing alarm to suspect Ischaemic Heart disease (IHD) or Myocardial Infarction (MI) or Cerebro Vascular Accident (CVA).

In the facts and circumstances the governing principle would be the need and necessity to get admitted to a hospital following which there would be a process of evaluation through investigations which would lead to a diagnosis to indicate positive existence of an illness followed by actual treatment. Here the diagnosis was already made and the treatment was going on as is evident from the remark to “continue” some of the medicines except possibly stemetil and nothing special happened at the hospital which could not have been done otherwise.

Mumbai Ombudsman Centre
Case No. GI - 99 of 2004 - 2005
Shri Premji Nishar
Vs
The Oriental Insurance Co. Ltd.

Award Dated 30.6.2005

Shri Premji Nishar alongwith his wife was covered under Mediclaim Policy issued by The Oriental Insurance Company Limited, Borivali D. O. under Policy No. 124300 / 48 / 04 / 2015. Smt. Shantaben Nishar, wife of Shri Premji Nishar was hospitalized at Smt. Motiben B. Dalvi Hospital from 17.10.2003 to 18.10.2003 for chronic pain in abdomen and when Shri Nishar preferred a claim to The Oriental Insurance Company Limited for the said hospitalisation, the Company’s Third Party Administrator i.e. Raksha TPA vide their letter dated 2.2.2004 rejected the claim invoking clause 4.10 of the policy. Aggrieved by the decision of the Company, Shri Premji Nishar approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim.

Records have been perused and the parties to the dispute were called for hearing. The analysis of the reveals that the dispute is resting on (a) Whether hospitalisation was necessary and (b) exact type of treatment given in the hospital did not reflect any seriousness in the health status of Smt. Shantaben P. Nishar. Further details mentioned that the patient was well nourished and had no oedema and no cyanosis. Her B. P. reading and general condition was normal. She was not put under any drip to be fully hydrated and subsequent investigations did not reveal any abnormality. In fact the patient was taken out of the hospital on personal bond of carrying out some investigations, facility for which was not available at Smt. Motiben B. Dalvi Hospital. In fact one would be surprised at the range of investigation done at the hospital or outside at N. M. Medical centre which included spiral CT Scan of abdomen to rule out almost all areas of infection and diseases except finding out Hepatic cyst in the right lobe of liver which was obviously not the cause for hospitalisation.

Based on the above provisions and in line with the treatment given to Smt. Shantaben Nishar there is no valid reason for this Forum to intervene with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI - 141 of 2004 - 2005
Shri Shabir Jaffer Contractor
Vs
The New India Assurance Co. Ltd.

Award Dated 30.6.2005

Shri Shabir Jaffer Contractor insured his family with The New India Assurace Company Limited, for the first time w.e.f. 28.3.2002 under policy No. 111100 / 48 / 02 / 09455. He lodged a claim for Rs. 25078 for hospitalisation expenses in connection with surgery of uterine fibroma Myomectomy and hysterectomy under the renewal of the policy, hospitalisation being from 9.2.04 to 10.2.04 at Jaslok Hospital. However, M/s Raksha TPA, the TPA of New India rejected the claim on the ground of non-disclosure and pre-existing illness. Shri Contractor contested the decision and appealed to the Company for reconsideration which was rejected both on the ground of pre-exsitence of illness and being primary infertility treatment under clause 4.8 of the Mediclaim policy. Being aggrieved at this decision Shri Contractor approached the Insurance Ombudsman. After perusing the records both the parties to the dispute were called for personal hearing. It would be seen from the nature of rejection that two important issues were raised and examination of those would resolve the dispute. First of all Smt. Femina Contractor was operated in 1994 for the same ailment Myomectomy and when the policy was taken in March, 2002, it was not disclosed to the Company which constitutes non-disclosure and the disease being there earlier, also pre-existent. This is an important point and surgical intervention in ones health is always a must for declaration. This non-disclosure involved serious flaw in the insurance contract as the Insurance Company was deprived of assessing the risk properly. As repeated occurrence was there doctors must have decided on the basis of hysteroscopy to get hysterectomy done.

In the facts and circumstances, as all the past treatment records have been corroborated by the case papers is Jaslok hospital, the decision of the Company to reject the claim on grounds on non-disclosure and pre-existence of illness coupled with infertility treatment as per clause 4.1 and 4.8. are in order.

Mumbai Ombudsman Centre
Case No. GI - 152 of 2004 - 2005
Shri Paresh P. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 30.6.2005

Shri Paresh P. Shah alongwith his wife, sons and parents were insured under mediclaim policy under policy No. 111900 / 48 / 01 / 01147 for the period 26.5.2001 to 25.5.2002. Master Karan, son of Shri Paresh Shah was hospitalised from 18.8.2001 to 25.8.2001 at Anandpara Surgical and General Hospital for Viral Hepatitis. When the claim for Rs. 11725 was preferred by Shri Paresh Shah to the Insurance Company for the expenses incurred at the said hospital, the Company repudiated the claim vide their letter dated 23.6.2003 stating that bills of the Chemist were not signed by the Pharmacist and there was a discrepancy in the date mentioned in the certificate and the discharge card. Not satisfied with the decision of the Company Shri Paresh Shah represented to the Grievance Cell of the Insurance Company and not receiving any favourable reply he approached this Forum. Records were perused and the parties to the dispute were called for hearing. As regards chemists' bills, it is noted that bills have not been signed but medicines were supplied as per treatment records / prescriptions. At the end of it, the investigation done on master Karan and the chemists' bills prepared all correctly recorded the name of the patient when supplied. It is also possible that Shreeji Medical used to supply medicines to Anandpara Surgical hospital. Finally, the Registration of the hospital was also proved by a document. Taking therefore, a moderate and lenient view, I feel that such a small claim for the treatment of a child who needed the care at that moment should be considered in a

proper spirit as the effort of New India to prove the claim irregular has not been fully established. With the doubts lingering and finality not reached the benefit of the doubt should go to the Insured. Hence total rejection by New India would not be proper. However, as discrepancies were there and all the bills were unsigned by the chemists, a penalty of 50 % may be levied and balance 50 % of admissible expenses may be settled by New India.

Mumbai Ombudsman Centre
Case No. GI - 75 of 2004 - 2005
Dr. (Mrs) Roshan R. Rau
Vs
United India Insurance Co. Ltd.

Award Dated 30.6.2005

The General Practitioners' Association covered all its members under Group Health Insurance Scheme of United India Insurance Co. Ltd. Dr. (Mrs) Roshan R. Rau and her husband Shri Rammohan Damodar Rau were also covered under the same policy. The claim arose in the year 2003 when Shri Rau was admitted to Lilavati Hospital from 21.3.2003 to 27.3.2003 and diagnosed as Massive Jejunal Bleeding. After hospitalization, Dr. (Mrs) Roshan Rau preferred a claim to the Company for reimburesement of the hospital expeses. She submitted all the necessary documents to the General Practitioners' Association on 14.4.2003 and the same was submitted by GPA to the Company on 5.5.2003. After scrutiny of the claim, the Company repudiated the claim under Exclusion Clause 5.4. of the policy condition. If we look at the area of dispute for which this complaint has come to this Forum, we will see that the claim has not been considered only on account of delay in submission of the entire claim papers to UII Co. Ltd. as per clause 5.4 of the mediclaim policy. It has been submitted to this Forum that General Practitioners' Association as a body had covered their members with United India Insurance Co. Ltd. under a Group Mediclaim Policy and right at the entry point they were advised that the policy would be subject to the terms and conditions of the usual mediclaim policy issued to the entire insuring public. It has been mentioned under the relevant clause 5.4 that the waiver of the condition may be considered in extreme cases of hardship where the Company is satisfied that under circumstances beyond the control of the insured the delay has taken place. The Company also has mentioned that they have not gone into the merit of the claim as to what would be the admissible amount of expenses that would be allowed or whether the claim was at all admissible or not since it was felt that the submission itself was delayed and therefore not acceptable under the terms of the policy.

The complainant submitted that as per their internal arrangement, they were forwarding the papers to GPA who processed the same and submitted to the Insurance Company and this practice was going on without and problem and the Company was accommodating in the past claims received within 60 days period from the date of discharge. Why suddenly they applied this condition so rigidly was not known to them and therefore they felt that the Company was unreasonable. The Company, on the other hand, mentioned that first of all dealys in submitting the claim papers cannot be encouraged and in this regard past practice need not be mentioned. Secondly, they felt that there has to be some discipline regarding submission of claims and therefore they were proper in quoting the policy condition Finally, they mentioned that the Company wanted to withdraw from the policy issued to GPA from 2003 - 2004 and for this purpose a notice was sent to the GPA as back as December, 2002. The Company suspected that the spate of claims which they received between January - March were quite large because of the withdrawal notice, and therefore they had to enforce the

clause 5.4 rigidly. It would be evident that United India has gone by only the norms of entertainment of claims without going into any merit of the claim lodged in so far as admissibility or actual amount payable etc. is concerned. Accordingly this Forum, also will not go into that area at all but ask the Company to preceed with the processing as per norms and if there are some issues for which the claim cannot be considered, it would be upto the concerned parties to resolve without referring it back to this Forum on that Ground.

Mumbai Ombudsman Centre
Case No. GI - 161 of 2004 - 2005
Dr. Pinakin K. Dave
Vs
United India Insurance Co. Ltd.

Award Dated 30.6.2005

The General Practitioners' Association (GPA) covered all its members under Group Health Insurance Scheme of United India Insurance Co. Ltd. Dr. Pinakin K. Dave and his family members were also covered under the same policy. The claim arose in the year 2003 when his wife Dr. (Mrs) Prabhavati Dave admitted to Ashirwad Heart Hospital from 27.1.2003 to 6.2.2003 and was diagnosed as Acute LVF c Infarction. He submitted all the necessary documents to the Genral Practitioners' Association in the first week of April, 2003 and the same was submitted by GPA to the Company on 5.5.2003. After scrutiny of the claim, the Company repudiated the claim under Exclusion Clauses 5.4 of the policy condition.

If we look at the area of dispute for which this complaint has come to this Forum, we will see that the claim has not been considered only on account of delay in submission of the entire claim papers to United India Insurance Co. Ltd. as per clause 5.4 of the mediclaim policy. It has been submitted to this Forum that General practitioners' Association as a body had covered their members with United India Insurance CO. Ltd. under a Group Mediclaim Policy and right at the entry point they were advised that the policy would be subject to the terms and conditions of the usual mediclaim policy issued to the entire insuring public. It has also been mentioned under the relevant clause 5.4 that the waiver of the condition may be considered in extreme cases of hardship where the Company is satisfied that under circumstances beyond the control of the insured the delay has taken place. The Company also has mentioned that they have not gone into the merit of the claim as to what would be the admissible amount of expenses that would be allowed or whether the claim was at all admissible or not since it was felt that the submission itself was delayed and therefore not acceptable under the terms of the policy. If we look at the facts of the case, Dr. Prabhavati Dave was discharged from the hospital on 06.02.2003 and effectively the claim should have been lodged within 6.3.2003 while it was received by the Company actually on 5.5.2003. The complainant submitted that as per their internal arrangement, they were forwarding the papers to GPA who processed the same and submitted to the Insurance Company and this practice was going on without any problem and the Company was accommodating in the past claims received within 60 day period from the date of discharge. The Company, on the other hand, mentioned that first of all delays in submitting the claim papers cannot be encouraged and in this regard past practice need not be mentioned. Secondly, they felt that there has to be some discipline regarding submission of claims and therefore they were proper in quoting the policy condition. Finally, they mentioned that the Company wanted to withdraw from the policy issued to GPA from 2003 - 2004 and for this purpose a notice was sent to the GPA as back as December, 2002. The Company suspected that the spate of claims which they received between January -

March were quite large because of the withdrawal notice, and therefore they had to enforce the clause of 5.4 rigidly. Moreover, as the GPA has got sufficient notice of cancellation of the Policy they should have been more careful of not committing any delay to ensure settlement of the claims. The United India Insurance Co. Ltd. also mentioned that if there was delay in GPA's submission the respective claimants cannot hold United India Insurance Co. Ltd. responsible in not accepting such delayed claims. It would be evident that United India has gone by only the norms of entertainment of claims without going into any merit of the claim lodged in so far as admissibility or actual amount payable etc. is concerned. In the facts and circumstances as explained above, this Forum does not find any special merit to ask United India to violate the terms of the policy and accept this claim which has been delayed.

Mumbai Ombudsman Centre
Case No. GI - 148 of 2004 - 2005
Shri Vinod P. Gada
Vs
The Oriental Insurance Co. Ltd.

Award Dated 8.7.2005

Shri Vinod P. Gada alongwith his wife and son was covered under a Mediclaim policy with The Oriental Insurance Company Limited, D. O. 8 since 9.1.2001. Shri Vinod Gada got chest pain on 9.9.2002 for which he was initially to Shivam Nursing Home and after undergoing some tests he was shifted to P. D. Hinduja Hospital on 9.9.2002 and was admitted till 13.9.2002 where the diagnosis was Anterior Wall Myocardial Infarction with LAD (100 %). He was then later hospitalized at Nanavati hospital from 19.9.2002 to 20.9.2002 for IHD Post AWMI PTCA to LAD with stenting. When Shri Vinod Gada put up a claim to The Oriental Insurance Company Limited for reimbursement of the expenses for the said hospitalizations the Company repudiated the claim on the ground that Shri Gada was suffering from Hypertension since last 8 years and the claim fell under exclusion clause 4.1 of the Mediclaim Policy. Not satisfied with the decision of the Company, Shri Gada represented to the Company for reconsideration and simultaneously approached the Office of the Insurance Ombudsman requesting intervention of the Ombudsman in the matter for settlement of his claim. After perusal of the papers, parties to the dispute were called for hearing. The examination of the relevant records reveal that the Insured Shri Gada was diagnosed as having Coronary Artery disease. The whole record of status was noted by a working Nurse and her name was mentioned at the box earmarked for the purpose. The same hospital recorded it in fair at a different sheet where the history of 8 years HTN was tampered with which was clearly done afterwards as it failed to get synchronized with the hospital record. As the Insured later disputed the duration of the disease, there would be a suspicion that the tampering was done with his knowledge. He had Hypertension and he was not on regular medicine. He was a chronic smoker and was obese, all these were favourable factors to accelerate the progress of the disease. As the Insured took the policy only from January, 2001 and was hospitalized in September, 2002, the Company held the view that the Insured suppressed his illness and therefore, the contract suffered from non-disclosure as also the disease became pre-existent.

It is also evident that the Insured wanted the hospital people to change the duration of the disease and there was some attempt to alter the duration to 1 year only perhaps to coincide with the policy period for which this Forum feels that the intention was not congenial and therefore, on grounds of non-disclosure and pre-existence of the disease the denial of the claim by the Company need not be intervened.

Mumbai Ombudsman Centre
Case No. GI - 110 of 2004 - 2005
Shri Harish Chandra Chaurasia
Vs
United India Insurance Co. Ltd.

Award Dated 11.7.2005

Shri Harish Chandra Chaurasia was covered under the mediclaim policy no. 020900 / 48 / 02 / 01126 issued by United India Insurance Co. Ltd., Divisional Office 9, since 2000 alongwith his family members. Shri Chaurasia was admitted to Charu Nursing Home on 8.5.2003 and was diagnosed as having Acute PID c (Lt) radiculopathy. The Company referred it to its panel doctor, Dr. (Mrs) G. J. Sunavala who opined that the claim should be referred to an Investigator. Accordingly, the Company appointed M/s Swastika International Investigators to investigate the matter. After getting the investigation report, the Company repudiated the claim vide their letter dated 4.2.2004.

An analysis of the case reveals that the nature of illness, the need for hospitalisation, the treatment given and the repeat follow-up by the attending physician, the medicines supplied by the chemist, all came under scrutiny and rightly so. The hospital charges listed out in a statement dated 23.5.2003 sums up the entire methodology and leaving many things to be desired. The comfinement of 12 days for essentially back pain is unintelligible as the type of treatment such disease requires is long term and not by keeping a patient for 10 / 12 days in a hospital. The repeat visits by the doctor for 15 times could not have done any special thing to improve the patient's condition particularly in a case like this. It was not a case of critical health emergency which required heavy monitoring everyday, every six hours or so. The IV fluids continuance is not intelligible. The bill has given an account of 12 days traction charges while as per New India's consultant's noting the patient has admitted somewhere there was no traction given to him at all. In the facts and circumstances, based on the Investigation Report and circumstances of the case backed up by the certificates issued by concerned Agencies, the decision of the backed up by the certificates issued by concerned Agencies, the decision of the Company to repudiate the claim as not fully substantiated, is in order.

Mumbai Ombudsman Centre
GI - 143 / 2004 - 05
Smt. Pavan R. Siroya
Vs
The Oriental Insurance Co. Ltd.

Award Dated 11.7.2005

Smt. Pavan Siroya alongwith her husband and son was coved under mediclaim policy issued by The Oriental Insurance Company under Policy No. 121300 / 48 / 03 / 4201 for the period 29.3.2003 to 28.3.2004 with Cumulative Bonus. It is reported that they were having the policy since 1993. Smt. Pavan Siroya was hospitalized at Bombay Hospital and Research Centre from 24.9.03 to 28.9.03 for Obsessive Compulsive Disorder (OCD) with Anafranil induced Extra Pyramidal Syndrome with Iron deficiency causing anemia. When a claim was preferred for the said hospitalisation by Shri Ramesh M. Siroya, husband of Smt. Pavan Siroya, the claim was repudiated by Raksha TPA who is the TPA of the Company invoking clause 4.10 of the policy. Not satisfied with the decision Smt. Siroya represented to the Company and not hearing any favourable response approached this Forum for redressal of her grievance. The records of the case have been perused and the parties to the dispute were called for hearing. Records submitted to this Forum have been scrutinized and an analysis of the

entire records would reveal the following. From the documents it is noticed that the Insured was having the problem in May'03 and after consulting various doctors and finally Dr. S. Jayaram she was hospitalized only on 24th September, 2003 for investigating the exact cause. The Company's TPA has rejected the claim on grounds of clause 4.10 of the Mediclaim policy, i.e. hospitalisation was not necessary, there was no positive existence of illness and that only investigations were done which could have been done on OPD basis. Unfortunately there was lack of application of mind by the TPA and the Company in analyzing the entire case papers. The analysis reveals that on the physical discomfort symptoms, she had dysmenorrohea, severe palpitation, general debility due to anemia, coupled with neurological problems of drug induced degenerative nervous disorders of Central Nervous system throwing symptoms akin to Parkinson's disease but known as Extra Pyramidal Syndrome. This must have led to mental disorder, lack of comprehension, failure to respond to commands etc leading to confusion. Hence it was an amalgamation of psycho-somatic disorders which acted simultaneously. The need for hospitalisation could be justified by the fact that she had similar symptoms of myocardial Infarction and therefore, to brush aside the entire episode as frivolous is not correct.

Considering the long association and the history recorded in the hospital papers for various symptoms involving physiological, neurological and psychological problems, since 2 years, 50 % of the admissible expenses can be made instead of total rejection of the claim made by The Oriental Insurance Company.

Mumbai Ombudsman Centre
Case No. GI - 150 of 2004 - 2005
Shri Vasudev Kashinath Thakurdesai
Vs
The New India Assurance Co. Ltd.

Award Dated 11.7.2005

Shri Vasudev Kashinath Thakurdesai was covered under Individual Mediclaim Policy of The New India Assrance Co. Ltd. covering himself and his wife for a sum of Rs. 1,50,000/- each under the policy no. 111200 / 48 / 02 / 02061. Shri Vasudev was admitted to Nityanand I.C.C.U. & Nursing Home on 26.10.2002 Ischeamic Heart disease and on same day he was discharged and transferred to Lilavati Hospital under the care of Dr. Pavan Kumar. Coronary Angiography was done on 28.10.2002 by Dr. Jhala and he was discharged on 31.10.2002. After hospitalisation, he preferred a claim to the Company, the Company referred the case file to Expert Medicolegal Consultancy and after getting their report, the Company repudiated the claim under Exclusion Clause 4.1 of the mediclaim policy and the same was intimated to the Insured vide their letter dated 17.11.2003.

The basic point on which the Company rejected the claim to be hospital noting that Shri Thakurdesai had chest discomfort 1 ½ years back and going by the duration it was taken that he had this ailment / complication even before the policy was taken although it was not conclusively proved as to what happened following the complaint. No treatment record has been produced or found out by the Insurance Company. On the other hand, the hospital papers recorded further that he did not have any medicines. Shri Thakurdesai did not have any hypertension or diabetes recorded as per the hospital record, hence no past illness was proved to be existing. On this basis, the symptom of breathlessness as a complaint is not normally disclosed at the time of taking the policy. It is possible, of course, that when the symptom of chest discomfort took place 1 ½ years back, the Insured, Shri Thakurdesai must have had some consultation which he did not refer or disclose. Moreover, he was 67 years old when he was hospitalised and thus he took the policy only in his 66 years which is a very high

selection against the Insurer. Again, immediately after taking the policy, he lodged the claim on the second year. Interestingly, when earlier episode took place he did not go to hospital and as per record was not even on medicine but why ? It is not unreasonable to conclude that he did not have a Mediclaim Policy at that time for which he chose not to go for hospital treatment and instead be on medicine. His CAG reveals some problems but not so serious occlusions and with a good LVEF of 55 %, the doctors might have decided to keep him on medication and not go for angioplasty or by - pass surgery, age being in his favour. However, the entire investigation was completed and diagnosis was clear following hospitalisation which recorded the ailment of breathlessness for 1 ½ years as on 26.10.2002 and since the Policy was taken from 31.5.2001, it makes a borderline case with the symptom occurring only just before the policy was taken, which is circumstantially correct. It is also circumstantially possible that he was on some kind of treatment or conservative management before taking the policy but the Company having got the medical examination done before acceptance and having accepted the insurance without any exclusions have indirectly pre-empted the charge of non-disclosure to be levelled against him.

Considering all these and recognising the fact that although there was no declared illness / diseases, the existence of some discomfort / Symptoms / complications remain proved evenas per hospital record, the total rejection of claim by New India Assurance Co. Ltd. is incorrect and the Insured is given the benefit of the doubt for 50 % of the claim as a penalty leavied on him for not referring to some recurring age related problems for appropriate underwriting of the policy.

Mumbai Ombudsman Centre
Case No. GI - 312 of 2004 - 2005
Smt. Tara R. Vasa
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12.7.2005

Smt. Tara R. Vasa alongwith her husband was covered under Mediclaim Policy No. 122300 / 48 / 04 / 0911 for a Sum Insured of Rs 3,00,000 with Cumulative Bonus issued by The Oriental Insurance Company Limited, Ghatkopar Divisional Office. It is reported that they were having the policy since 1986 and Sum Insured was increased to Rs. 3 lacs from 2003. Smt. Tara R. Vasa was hospitalized at P. D. Hinduja hospital & Medical Research Centre on 2.12.2003 to 5.12.2003 for NIDDM (Peripheral neuropathy, Retinopathy), Ischaemic dilated Cardiomyopathy Bilateral degenerative OA knee, obesity, Vit B12 deficiency, Atherogenic dyslipidemia. When Smt. Vasa preferred a claim to the Company, the claim was rejected invoking clause 4.10 of the policy. Aggrieved by the decision of the Company, Smt. Vasa represented to the Company and not receiving any reply approached the Insurance Ombudsman for settlement of her full claim alongwith interest. Records have been perused and the parties to the dispute were called for hearing. The dispute is concerning the need for hospitalisation for a package of treatment covering number of diseases which were managed after admission to the hospital. The Company's T. P. A. gave a reasoning that she was a known case of Diabetes Mellitus since 10 years, hypertension since 3 years, Cardiomyopathy with poor L. V. Function since 5 years, Oestoarthritis Bilateral knee joint pain since 5 years, obesity with atherogenic dyslipedemia with Vit. B deficiency and all these did not require any hospitalisation but sustained treatment. The record shows that she was admitted with complaints of breathlessness on exertion off and on, pain in legs since 1 month and pedal oedema. On admission she was referred to many doctors. All these suggest that she had a number of complaints to be referred to various physicians of diferent disciplines and indeed hospitalisation was availed of

getting requisite investigation. In the present case the investigations were relevant and consistent but what was meant was the provision of the operative clause of Mediclaim policy which says that hospitalisation expenses should be “necessarily and reasonably incurred”.

In the facts and circumstances it is felt that the treatment concerning heart ailments being of emergency nature the related expenditure would get considered as allied expenditure and to that extent maximum 30 % of the total admissible expenses may be allowed as a special case, while all other treatment like dyslipidemia, Osteoarthritis, maculopathy etc are long drawn treatment and could be carried on at home with appropriate therapy as per medical advice. The Insured being a known patient, of all these diseases for sometime, must have been used to such treatment without being admitted to hospital every time.

Mumbai Ombudsman Centre
Case No. GI - 94 of 2004 - 2005
Shri Rupesh Gupta
Vs
The New India Assurance Co. Ltd.

Award Dated 13.7.2005

Shri Rupesh Gupta alongwith his wife and parents were covered under the mediclaim policy issued by The New India Assurance Company Limited, D. O. 110900 since 1999. Shri Harishchandra Gupta, father of Shri Rupesh Gupta had some breathing problem on 12.4.2003 and was taken to Ashoka General Hospital I.C.C.U. and Maternity Home where he was admitted till 18.4.2003. Later on he was shifted to Asian Heart Institute and Research Centre on 18.4.2003 for angioplasty. Shri Rupesh Gupta preferred a claim under Policy No. 110900 / 48 / 02 / 9442 for the said hospitalisation. Inspite of several reminders and personal visits when he did not receive any reply from the Company he approached this Forum for settlement of his claim of Rs. 1,15,000/-. After perusal of the records parties to the dispute were called for hearing. The analysis of the above case reveals that the dispute is only recording duration of diabetes which was recorded in the Asian Heart Institute history sheet as “h/o DM 3-4 years”. Later on the Insured claimed that there was communnication error for which wrong recording was done and that the disease should have been recorded as 3-4 months and not years. The whole issue starts from the noting in the Discharge Card vis-a-vis the Investigation reports which showed high blood suger level for which the Company became suspicious and wanted to probe further in the matter. The very fact that the Ashoka hospital has given 3-4 months proves the point that the Insured wanted to suppress actual duration of the illness and the truth came out only when the matter was probed further through investigation. But at the same time the Investigations conducted by them could not prove that there was any actual treatment taken prior to 1999. The entire claim was made to depend on this declaration which was no doubt vital but could not be convincingly made to suggest the duration of the disease with conflicting claims made by the Insured that he did not make the statement. However, taking into consideration the whole episode, an important point comes to the fore, that there has been an attept to conceal the duration of diabetes and the treatment being taken by the Insured. Shri Gupta was 66 years old and had a single vessal stenosis for which Angioplasty had been done. The on-set of diabetes even with 3-4 years duration at that age would be somewhat commonly found. It was for New India to accept or reject the Insurance when offered to them after taking the medical report. Having not done that the charge cannot be squarely leveled that he has misled the Company by a wrong statement. In fact 3-4 years diabetes would make it just coincide with the taking

of the policy and thus a borderline case. In the facts and circumstances, it is felt that the best course would be to penalize the Insured for 50 % of the claim while balance 50 % be borne by New India thus setting aside their total rejection.

Mumbai Ombudsman Centre
Case No. GI - 149 of 2004 - 2005
Shri Baldev Raj Kalia
Vs
The Oriental Insurance Co. Ltd.

Award Dated 18.7.2005

Shri Baldev Raj Kalia alongwith his wife Smt. Snehlata Kalia was covered under mediclaim policy No. 112200 / 48 / 04 / 00134 issued by The Oriental Insurance Company Limited, D. O. 21. It is reported that Smt. Snehalata Kalia had a fall from the bed on 27.8.2003 and sustained injuries on her knees and her four upper teeth, which got uprooted. As Smt. Kalia was bleeding profusely her family Doctor, Dr. Mahesh Jhaveri was called immediately and after the first aid given by Dr. Mahesh Jhaveri when Smt. Kalia's bleeding did not stop, Dr. Anil Arora, Dentist was called at her residence and on the advice of Dr. Anil Arora, Smt. Kalia was admitted to his "Day Care" Centre at his dental clinic. Thereafter the dental treatment continued for about 3 months. When Shri Baldev Raj Kalia preferred a claim for the said dental treatment, the Company repudiated the claim invoking clause 4.7 of the policy It would be noticed from the above clause that the most crucial point for coverage of dental treatment is the need for hospitalisation, the status and condition of the illness comes later. It is in this context that the hospitalisation of Smt. Kalia is to be seen and what we see is the issue of a certificate by the house physician well after the incident was over, which would make the certificate as a document always suspect. Secondly the Complainant admitted that Smt. Kalia had denture in lower teeth which came out after fall. Hence primarily the denture which was already a fixture came out and must have hurt to cause bleeding. The incident of fall following afternoon "nap" is not quite intelligible as the impact would not be so serious by itself to cause injury and this is particularly commented upon as there was no treatment specifically for the wounds in other parts of the body or specially in face, forehead, chin, cheek Was the fall so selective as to affect only the teeth, the question remains. The accident being the proximate cause is not well established with all certainties and confirmation leaving the hospitalisation itself suspect as a must following accident to teeth and denture. We should also note that the policy does not cover the 'denture' and Smt Kalia was already having one such. The follow up treatment for 3 months indicates deeper complications and not merely due to an accident which should be a "one-off" situation. Similarly a consolidated bill for all costs without any treatment for actual injury like stitching etc, would make the clause 4.7 applicable and therefore, the Company's rejection would be in order.

Mumbai Ombudsman Centre
Case No. GI - 160 of 2004 - 2005
Smt. Rekha V. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 18.7.2005

Smt. Rekha V. Shah alongwith her husband and daughters were covered under mediclaim policy issued by United India Insurance Company Limited, D. O. 120400

since September, 2001. Shri Virendra Shah, husband of Smt. Rekha V. Shah was hospitalised at Bhatia General Hospital from 3.7.2003 to 5.7.2003 for Lt side Irreducible Inguinal Hernia. When Smt. Rekha Shah preferred a claim for the said hospitalisation under Policy No. 120400 / 48 / 02 / 01448, the Company based on their panel doctor's opinion repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision, Smt. Rekha Shah represented to the Company and also approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of her claim. The records have been perused and the parties to the dispute were heard.

The analysis of the case reveals that Shri Virendra Shah was admitted in the Bhatia General Hospital and the presenting Symptoms mentioned in the discharge card of the hospital were "Patient admitted with left sided irreducible hernia was taken up for emergency hernia Surgery". The Indoor case papers of the Bhatia hospital states that "c/o swelling in the left groin since 3-4 years which became irreducible since 1 day". Irreducible hernia refers to a hernia that cannot be returned to its original position out of its sac by manual methods. It is clear from the hospital record that Shri Virendra Shah was suffering from hernia since 3-4 years and he had disputed his own statement of swelling in left groin since 3-4 years given in the hospital to say that he did not have any swelling in left groin at the hearing.

It is noted that the policy was taken by Smt. Rekha Shah in September, 2001 and therefore, as per the provisions of the policy conditions rejection of United India Insurance Company Limited is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 151 of 2004 - 2005
Shri Dharam Chand Jain
Vs
United India Insurance Co. Ltd.

Award Dated 18.7.2005

Shri Dharam Chand Jain alongwith his wife was covered under Mediclaim Policy No. 020100 / 48 / 02 / 05894 for the period 23.10.2002 to 22.10.2003 issued by The United India Insurance Company Limited, D. O. I for a Sum Insured of Rs. 2 lacs. Shri Jain had the policy prior to 1991 but as there was a break in the policy he had taken this policy afresh from 2001 which was hospitalized at Cumballa Hill hospital and Heart Institute for Coronary Angiography where the diagnosis was Triple Vessel disease. He was then admitted as Breach Candy Hospital where he had undergone By-pass Surgery on 7.6.2003. When a claim was preferred by Shri Jain for the said hospitalisations the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied by the decision Shri Jain represented to the Company which was also turned down. Hence aggrieved, Shri Jain approached this Forum seeking intervention of the Ombudsman in the matter of settlement of his claim. After perusal of the records parties to the dispute were called for hearing. The repudiation of the claim done by the TPA, M/s Medicare Services Ltd and approved by United India was merely on the assumption that the progress of the disease leading to Triple Vessel blockages coud not have taken place in a span of a year and half after taking the policy and therefore, must be pre-existing. The TPA and the Company failed to produce any strong evidence of Insured's having any ailment with a direct linkage and nexus with the Ischaemic Heart Disease (IHD) leading to CABG. It appears that there was no mention of past history in the Breach Candy Hospital discharge card. Usually it is recorded in the

Indoor case papers which was not produced before this Forum and presumably the TPA got those records and came to the conclusion that the Insured was having some complications associated with IHD. The TPA has a medical team and the analysis done by them is based on a critical look at the circumstances plus the CAG Report giving enough clues to suggest some duration of the symptoms / illness. It must be admitted that the Insured Shri Jain's policy was fresh from 2001 and that the caim was lodged on the second year. It is also noted that the Cumballa Hill papers recorded no illness and symptoms while the Breach Candy Hospital discharge card was silent which neither proves nor disproves the status, leaving circumstantial conclsion as the logical outcome. Based on this conclusion it is difficult to ignore the contention of the TPA that a disease with such an invasive progress could not have taken place without throwing off absolutely any signals.

In the facts and circumstances, I decide that while setting aside the total rejection of the claim by United India Insurance Company, I should allow 50 % of the claim as being a case not conclusively proved nor could be denied strongly as per medical science even granting that it was without palpable symptoms.

Mumbai Ombudsman Centre
Case No. GI - 158 of 2004 - 2005
Shri Chandrakant Patel
Vs
National Insurance Co. Ltd.

Award Dated 18.7.2005

Shri Chandrakant Patel was insured under mediclaim policy of National Insurance Co. Ltd. since 1993. Shri Patel preferred a claim to the Company for Rs. 2,53,085/- after his hospitalisation at Sir Hurkisondas Nurrotumdas Hospital from 3.8.2003 to 12.8.2003 for treatment of Diabetic Foot with toxic hepatitis with septicemia. The Company forwarded the claim file to its TPA M/s Medicare sercives (I) Ltd. for further processing the claim. They repudiated the claim by stating that the Insured was suffering from Diabetes Mellitus for the last 22-25 years and the current illness i.e. Diabetic foot with toxic hepatitis septicemia was direct result of diabetes.

Shri Chandrakant Patel was hospitalised in Sir Hurkisondas Hospital during the period from 3.8.2003 to 12.8.2003. The diagnosis arrived was Diabetic foot c toxic hepatitis c septicemia c abnormal heart beats. It was noted that a permanent pacemaker was placed. There was restriction of cover for heart disease and circulary disorders for sum insured of Rs. 1 lakh in the policy. There is a mention in the Discharge Card that the insured was a known case of Diabetes Mellitus since 7 years had history of CABG 6 years ago an history of varicose veins on (L) 7 years ago. From the Histopathology Report dated 6.8.2003 it is observed that this insured was diagnosed to have 'Acute necrotising Cellutitis, right foot'. The finding as per the Haemogram Report dated 18.8.2003 was 'Hypochromia + Anisocylosis + Microcybosis'. On going through the case papers of the hospital it is observed that there is mention of history of diabetes since 1985 on insulin 3 times a day.

The main dispute is regarding the duration of past history diabetes. On a close analysis of the entire medical records it is found that the insured had a history of CABG done 6 years before hospitalisation, later he developed diabetic foot c toxic hepatitis c septicemia. This illness directly progresses with diabetes for long duration. No doubt the Discharge Sumonary dated 12.8.2003 which was prepared at the time of discharge

mentioned the duration of diabetes as 7 years but the Indoor case papers of the hospital mentions the duration as since 1985. This discrepancy between the hospital case papers and discharge card has to be set aside for the reason that the treating doctor, Dr. Atul Adaniya while seeking opinion from Dr. Siddharth Shah has mentioned clearly that the insured was a known case of diabetes for 22-23 years. Again the reference as well as Indoor case papers would always mention correct history of the patient for proper diagnosis and correct treatment for the ailment.

Taking into account the notings as per the information given by the patient, in the treatment records during the hospitalisation and the chronicity of the disease developing into diabetic foot c Toxic hepatitis c septicemia, it can be concluded that Insured, Shri Chadrakant Patel was suffering from diabetes for pretty long duration as per the hospital case papers, for which he was even taking daily insulin injections. Diabetic foot is the outcome of long sufferance of diabetes which causes circulation disorder throughout and causes deep occlusion. The recording of the duration of diabetes must have been made on the basis of the statement made by the patient or his relative and the Insured's attempt to prove it wrong was after the rejection of the claim by the Company. Evidently this makes the document as "called for" or "requested" by the Insured and which cannot alter the hospital notings merely by virtue of a certificate issued post event, and thus making it non-enforceable. In consideration of this and based on facts, the Company's decision to repudiate the claim for the reason of pre-existing disease is held in order.

Mumbai Ombudsman Centre
Case No. GI - 176 of 2004 - 2005
Shri Mahendra Gheewala
Vs
The Oriental Insurance Co. Ltd.

Award Dated 19.7.2005

Shri Mahendra Gheewala alongwith his wife was covered under Mediclaim Policy No. 124300 / 48 / 03 / 2981 for the period 4.1.2003 to 3.1.2004 issued by The Oriental Insurance Company Limited, Borivali Divisional Office for a Sum Insured of Rs. 1,00,000 with Cumulative Bonus of Rs. 20,000. Smt. Uma M. Gheewala, wife of Shri Mahendra Gheewala was hospitalized at Suchak Maternity and General Hospital on 31.12.2003 to 2.1.2004 for Accelerated HT with Dyslipidemia. When Shri Gheewala preferred a claim to the Company, they rejected the claim invoking clause 4.10 of the policy. Aggrieved by the decision of the Company, Shri Mahendra Gheewala represented to the Company alongwith a certificate dated 11.5.2005 by Dr. Ketan Mehta. Not receiving any reply from them he approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. His plea was that the condition of his wife at the time of hospitalisation was very critical and her B. P. was 200 / 100 for which she was admitted in an emergency. Records have been perused and the parties to the dispute were called for hearing. An examination of the entire records submitted to this Forum revealed that Smt. Gheewala was already on Hypertension drugs like Enam and Hipres. It is possible that she may not have been very regular in taking these medicines and she must have missed some in between or she must have been having some psychological or family problems for which there was Accelerated Hypertension. The likely cause further appears to be from the blood chemistry with adverse lipid profile as per blood report produced before this Forum. The need was to contain the B. P. and the LDL / HDL, triglyceride low through medicines. It is noted that while retaining the two medicines which were being taken by

Smt. Gheewala, the doctor at Suchak added Atten and Amlosafe with Trika for good sleep at night and relaxation of nerves. The other advice was complete salt free diet. There was no abnormality in Central Nervous System, Cardio - Vascular System nor there were any Cardiac related problems. All these could have been done with the patient being at home through therapy and hence need for hospitalisation was not established.

In the fact and circumstances the decision of the Company to repudiate the claim as per clause 4.10 of the policy is in order.

Mumbai Ombudsman Centre
Case No. GI - 177 of 2004 - 2005
Shri Anant T. Pandya
Vs
The Oriental Insurance Co. Ltd.

Award Dated 19.7.2005

Shri Anant T. Pandya alongwith his wife and children were covered under Mediclaim Policy 121400 / 48 / 02 / 4526 for the period 7.3.2002 to 6.3.2003 issued by The Oriental Insurance Company Limited, D. O. 121400 for a Sum Insured of Rs. 1 lac for self, Rs. 75,000 for his wife and Rs. 60,000 for his children. Shri Anant Pandya had the policy continuous from 1991. Shri Anant T. Pandya was hospitalized at Bhargava Nursing Home from 2.8.02 to 8.8.02 for pericolic retrocolic retroperitoneal Abscess. When the claim for the said hospitalisation was preferred by Shri Pandya to the Company, the Company as per their procedure forwarded the file for their panel doctor's opinion. Based on the opinion of their panel doctor, the Company repudiated the claim on the basis of clause 4.1 of the mediclaim policy and also non-disclosure. Not satisfied with the decision of the Company, Shri Pandya represented to the Company and aggrieved for not receiving any favourable reply from the Company Shri Pandya approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. After perusal of the records parties to the dispute were called for joint hearing. The Company's handling of this case is based on the notings of the hospital papers to the extent that diabetes was pre-existing. The noting of 10 years in a history noting cannot be taken so seriously to constitute non-disclosure as the Insured had no particular illness all these years. The Insured was having the policy since 1991 which has been proved and duly acknowldeged by Oriental Insurance earlier and the issue before the Company was to point out diabetes from the case papers of Brihanmumbai hospital. In respect of such a long lasting association of more than a decade with the Insured Shri Pandya, the reference to ailment like diabetes which appears to have been well under control and management, may not have been that dominant to cause subsequent complications like lower back pain and retroperitoneal abscess. In fact cause of this disease / development has not been mentioned. The Insured enjoyed Cumulative Bonus at varying percentage from which it could be possibble that he lodged some claims and it was for the company to come forward with complete record some claims and it was for the company to come forwar with complete record of such claims together with past history of illnesses if at all. Shri Pandya has demonstrated abiding faith in insurance since 1991 and has rendered himself as an eligible case for consideration and having regard to this aspect, I decide that a settlement of 70 % of the claim should be made by The Oriental Insurance Company as admissible expenses within the sum Insured available, and balance 30 % may be deducted as expenses directly / indirectly related to diabetes.

Mumbai Ombudsman Centre
Case No. GI - 315 of 2004 - 2005
Shri Kishore P. Thakurlal
Vs
The New India Assurance Co. Ltd.

Award Dated 21.7.2005

Shri Kishore P. Thakurlal was hospitalised at P. D. Hinduja Hospital Mumbai on 7th June, 1996 for Sleep Disorder which was treated and he was advised to regularly use a machine called continuous Positive Air Pressure (CPAP). He preferred his claim against New India which was settled by the company at that time. Under the present claim bearing No. PHS ID No. 5001431 of TPA, M/s Paramount Health Service under Policy No. 140100 / 48 / 02 / 07048 issued by New India, he claimed a further amount of Rs. 73,792/- for purchase of a CPAP machine as the old machine was completely worn out because of use and this claim was not paid by the TPA / New India.

His point was that as the earlier claim was settled by New India and it was identified to be a Sleep Disorder which was life threatening, his claim to replace the old CPAP machine with a new one should be considered for settlement. Since the company did not relent on this ground, he appealed to the Insurance Ombudsman for redressal of his grievances.

The point New India has made in their note is that purchase of CPAP machine cannot be considered under the Mediclaim Policy as per the relevant clause which is specific to allowing certain apparatus like cost of pacemaker, artificial limbs and cost of organs and similar expenses. Their point is that unlike pacemaker or artificial limbs, CPAP is a drug delivery device and is used intermittently and does not form an integral part of the human body.

While sustantially agreeing with the contention of the TPA in terms of Mediclaim Policy Condition 1(d), this Forum is of the opinion that the claim does not fall under the terms of the policy particularly because it is hospitalisation policy and the Insured has merely ordered a replacement of the old machine without availing any treatment or hospitalisation. Granting that the circumstances under which the first one was purchased could be the same yet, there was need for evaluation by a medical person through admission in hospital and appropriate check up of the other vital parameters of functioning of health. The Insured has taken upon himself the task of replacing worn our machine which is not particularly covered under the policy. As this was the sole reason for which the claim was repudiated by the TPA it is held sustainable, without going into the merit whether apparatus like CPAP is payable or not.

The claim of Shri Kishore P. Thakurlal for reimbursement of cost of purchase of CPAP machine is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 208 of 2004 - 2005
Shri Shantilal Ramdas Patel
Vs
The Oriental Insurance Co. Ltd.

Award Dated 22.7.2005

Shri Shantilal Ramdas Patel took mediclaim policy from. The Oriental Insurance Company Ltd., in the year 2001 covering himself and his wife which was being renewed regularly. At the time of taking the first policy, the insured declared that he was suffering from Diabtes. Accordingly, all the diseases arising out of or relating to

Diabetes were excluded from the cover. The claim arose in the month of August, 2003 when he was admitted to Sir Hurkisondas Hospital for treatment of Ischeamic Heart Disease and Coronary Angiography was done on 29.8.2003 by Dr. Dalal. Subsequetly, he was re-admitted to Asian Heart Institute on 4.9.2003 for Coronary Bypass Surgery and discharged on 12.9.2003. Shri Patel preferred a claim for Rs. 4,40,854/- for both the hospitalisation. The claim was processed by TPA M/s Raksha TPA and they informed the insured about its inability to settle the claim as long standing Diabetes Mellitus caused Triple Vessel Disease and Diabetes Mellitus is in exclusion in policy.

The analysis of the case reveals that the Insured, Shri Patel declared his diabetes while taking the policy and he felt that the treatment relating to diabetes would not be reimbursable to him. The Insurance Company has an underwriting norm for which they exclude not only treatment for diabetes but all related ailment s consequent to being a diabetic. The nexus between diabetes and cardiac problems is established in the medical science and it depends on the other adverse features of health like lipid profile hypertension, and of course, the habits, life style and family history of the concerned person. A detailed scrutiny reveals that Shri Patel was diabetic and on medicine (Oral Hypoglycemic Agents OHA). He denied having any other illness but against family history 'hypertension' was noted in the hospital papers. As regards the progress of the disease, Shri Patel had LVEF 40 % which was poor coupled with diastolic dysfunction plus mild MR. and mild AR. The other parameters like status of stenosis the RICA hypoecoiec plaque was reduced to the extent of 20 % to 30 % and LAD, RCA, Cx was varying between 70 % to 80 % for which he was diagnosed as Tripple Vessel Disease and a fit case for CABG.

The Insured declared himself as diabetic and was recorded as a knownn case of diabetes in the hospital records. Since when he was diabetic was not disclosed but he took the policy only from February, 2001 and opted for CABG in 2003 which means he took the first policy only in his 58th year with some known complaints. The Company took underwriting safeguard by denying the treatment relating to diabetes. The fact that the Company has not clearly spelt out the whole clause of non-allowance of diabetes and ailments relating to diabetes cannot be held too strongly against them as the exclusion will always take the usual reference and connotation even without them as the specific mention. However, no doubt it would have been better to explicitly mention the entire clause wordings in the policy. Based on the analysis and the facts and circumstances, it is held that the decision of Oriental Insurance Co. Ltd. to repudiate the claim is in order.

Mumbai Ombudsman Centre
Case No. GI - 209 of 2004 - 2005
Shri Tapan Biswas
Vs
The Oriental Insurance Co. Ltd.

Award Dated 26.7.2005

Shri Tapan Biswas alongwith his wife and daughter was covered under Mediclaim policy NO. 123105 / 48 / 04 / 1417 for the period 21.12.2003 to 20.12.2004 issued by The Oriental Insurance Company Limited, Thane Branch Office for a Sum Insured of Rs. 1,50,000 for self and his wife and Rs. 1,00,000 for his daughter. He had taken the policy for the first time in the year 2001. Kumari Aparajita Biswas, daughter of Shri Tapan Biswas was hospitalized for Renal Stones with UTI. When Shri Biswas preferred a claim for the said hospitalizations, the Company repudiated the claim stating that as the disease was pre-existing t he claim was not payable as per clause 4.1 of the mediclaim policy.

Shri Tapan Biswas approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim Records have been perused and the parties to the dispute were held. The complainant, Shri Tapan Biswas, father of Kum. Aparajita raised two issues, First of all he pointed out that there was a mistake in writing the history of past ailments viz. h/o kidney stones at the age of 5 years, he mentioned it would be only abdominal pain. If a proper analysis is made for the present hospitalisation it would be seen that the discharge summary is a neatly typed narration of diferent procedures adopted at the hospital together with investigations, present and past history, diagnosis made, treatment given and treatment advised. However, the hospital record which is neatly narrated and typed, very legibly mentions the past record which must have been written as described to them cannot be rejected later. The history sheet was forwarded alongwith the claim folder by the Complainant to the TPA which he believed to be true and genuine and based on which the conclusions were drawn. Even otherwise the fact is established that Kumari Aparajita experienced severe pain in the abdominal region at her age of 5 years which fact would have been important for the Insurance Company to consider from the underwriting point of view.

In the facts and circumstances the decision of the Company to reject the claim on the ground of pre-existing illness is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 234 of 2004 - 2005
Shri Tapan Biswas
Vs
The Oriental Insurance Co. Ltd.

Award Dated 26.7.2005

Shri Tapan Biswas alongwith his wife and daughter was covered under Mediclaim policy No. 123105 / 48 / 04 / 1417 for the period 21.12.2003 to 20.12.2004 issued by The Oriental Insurance Company Limited, Thane Branch Office for a Sum Insured of Rs. 1,50,000 for self and his wife and Rs. 1,00,000 for his daughter. He had taken the policy for the first time in the year 2001. Smt. Sharda biswas, wife of Shri Tapan Biswas was hospitalized for Acute renal colic with UTI When Shri Biswas preferred a claim for the said hospitalisation, the UTI. When Shri Biswas preferred a claim for the said hospitalisation, the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Their contention was that as per hospital records Smt. Sharda was a known case of renal calculus disease since past 5 years and so the disease for which the claim was preferred was pre-existing. Not satisfied with the decision of the Company, Shri Tapan Biswas represented and approached the Office of the Insurance Ombudsman for redressal of his grievance. The analysis of the case reveals that Smt. Sharda Biswas had chronic renal colic pain with Urinary Tract Infection It appeared further that she did not have any surgery like lithotripsy which is crushing of stones in the bladder or in the Urethra through production of shockwaves. Necessary investigation like USG of Abdomen and Pelvis and further invasive investigations like Intravenous Pylograpohy (IVP) was also done alongwith other pathological tests. In the process it has rather confirmed that renal stone disease would have a behaviour pattern to repeat itself if the body system is vulnerable and similar cases of repeat renal calculi are proving the point. The USG which was submitted to this Forum was dated 5th January, 2001 and the Insured took the policy in December, 2001 while history noting of renal calculi inthe hospital dates back to 1999 and therefore, circumstantially the case is strongly suggesting that most probable cause would be history of past illness arising out of lower abdominal pain as per earlier narration

suspected or diagnosed as renal calculi and therefore, pre-existing. On this basis the rejection of the Company on the ground of past illness is sustainable.

In the facts and circumstances, the decision of the Company to repudiate the claim based on the hospital records is in order.

Mumbai Ombudsman Centre
Case No. GI - 402 of 2004 - 2005
Shri Harish K. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 26.7.2005

Shri Harish K. Shah who alongwith his wife and son was covered under Mediclaim Policy No. 112500 / 48 / 02 / 09891. It is reported that Shri Harish K. Shah was holding mediclaim policy for the last 15 years and had earned 50 % Cumulative Bonus under the policy. Master Siddharth Shah, son of Shri Harish K. Shah was hospitalised at Bhatia General Hospital from 28.3.2003 to 29.3.2003 for Saebecous cyst on lip. When the claim was preferred by Shri Shah the Company repudiated the claim invoking clause 4.10 of the policy. Aggrieved by the decision of the Company, Shri Harish Shah approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs. 30,000 He said this operation was necessary as his son was not able to eat his food properly. He had also given a detailed account as to what led to his opting for surgery as the cyst was subsiding and recurring over and over again and Doctor advised that surgery would be the remedy. An analysis of the claim reveals that the TPA and the Company based their arguments only on there being no need for hospitalisation and over and above, the specialist consultant felt that the discharge from hospital was in less than 24 hours time for which the provision was not met. It is felt both these counts were not properly reasoned out and evaluated. The cyst was reappearing and the cyst was inside the lip and month. Apart from causing problem for swallwing and munching, it is never advisable to keep a cyst / swelling inside and part of the body without proper examination. Some of these could be in a pre-cancerous state even and the excised material was indeed sent for histolopathologica report for clearance.

It appears that proper application of mind was not done by the TPA, the Co's Medical Consultant and also by the Company themselves, to examine the claim. Considering all aspects of the claim and the need for surgery which was done in the hospital under care and medical management, I hereby set aside the repudiation of the Company but ask the Company to deduct 10 % of the admissible expneses being spent in excess in room charges and also for some investigations not exactly relevant.

Mumbai Ombudsman Centre
Case No. GI - 211 of 2004 - 2005
Smt. Sangeeta Singh
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Smt. Sangeeta Singh took a mediclaim policy from The New India Assurance Co. Ltd., Direct Agent Branch 140104 since 2001 covering herself and her family members for Rs. 50,000/- each. The claim arose in the year 2002 under policy no. 142000 / 48 / 01 / 07519 when she was admitted to Ashirvad Nursing Home under the care of Dr. Rajeev H. Pathak, Consultant orthopadic Surgeon for slip disc from 23.5.2002 to 1.6.2002. Not

agreeing with the decision, she had made representation to the Company alongwith a certificate from Dr. Rajeev H. Pathak dated 23.12.2002. The Company again investigated the matter by appointing an Investigator, Shri Suryakant Kambli. Not getting any favourable reply from the Company, Smt. Singh approached the Insurance Ombudsman by letter dated 23.7.2004 with her grievance that the ground on which the Company repudiated the claim is not correct.

The analysis of the case reveals that the cause of accident or cause for hospitalization is the most important issue to be resolved first and the other issues would get automatically sorted out. As per Insured's narration at the hearing she had a fall in the bathroom and she had to be hospitalized later due to pain. The hospital papers however, although recroded history of fall did not record that the episode occurred a day before as per the medical certificates produced by her. In a different version it was stated that while standing at the balcony she felt severe pain and it was difficult for her to stand. The indoor case papers stated that "c/o pain in LS (Lumbar spine) due to stretching of traction". This is an important observations and reveals a serious discrepancies in the statement of the Insured vis a vis what was stated in the hospital. Let us examine the statement circumstantially. The first point which should strike anyone is the direct impact of the fall, if in the bathroom or any other place. There direct was non, no impact and hit on face, hand or any other parts of the body was noted in the hospital case paper. In any fall there should be some fresh injury which was not there. Secondly the impact of the fall cannot be such to cause severe chronic slip disc or cervical spondylosis or lumber spine as happened in this case to warrant immediately six kg weight tractions. The investigator Dr. Jayesh Shah and later Shri Suryakant Kamble have confirmed that Smt. Sangeeta Singh was admitted as a patient under Dr. R. H. Pathak with acute PID with bilateral roots pressure LYR with spasm. It was though written that she had fall in the house the diagnosis of PID confirms it was a case of previous injury which must have been aggravated by the fall. Next important issue is the treatment given. It was all regular treatment of cases of cervical spondylosis and pain in the pelvic region with traction and regular physiotherapy. The day she was admitted it was recorded as "Pain in LS (Lumber Spine) due to stretching of traction" which thus indicates that traction was going on.

Based on these facts and circumstances it is considered that the repudiation of New India on the ground of pre-existing illness is upheld with further observations that the claim is unsubstantiated.

Mumbai Ombudsman Centre
Case No. GI - 301 of 2004 - 2005
Shri Gaurishankar Sonthalia
Vs
The Oriental Insurance Co. Ltd.

Award Dated 29.7.2005

Shri Gaurishnakar Sonthalia and his wife Smt. Snehlata Gaurishankar was covered under an Individual Mediclaim Insurance Policy No. 121700 / 48 / 04 / 2084 issued by The Oriental Insurance Company Limited, MCDO - 8 for a Sum Insured of Rs. 90,000 alongwith Cumulative Bonus of Rs. 21,000. He has been holding this Insurance cover since 1997. Smt. Snehlata Gaurishankar was hospitalized at Jaslok Hospital from 16.2.2004 to 17.2.2004 for Lumber Canal stenosis with facet joint Arthnopathy. When a claim was preferred by Shri Gaurishankar for the said hospitalisation the Company's TPA, M/s Raksha TPA repudiated the claim by stating that hospitalisation was for less than 24 hours and hence the claim was not payable as per clause 2.3 of the mediclaim

policy. Not satisfied with the decision of the Company, Shri Sonthalia represented to the Company which was also turned down. Hence aggrieved by the said decision, Shri Sonthalia approached this Forum for justice and full settlement of his claim.

Records have been perused and the parties to the dispute were called for hearing. An analysis of the entire records produced to this Forum would reveal that the Insured suffering from the ailment viz off and on back pain radiating to (L) Lower Limb and after having tests like X-ray, MRI of Spine on 30.8.2003 underwent various pathological tests on 6.2.2004 as per advice of Dr. N. H. Wadia and Dr. Preeti Doshib subseqnetly got admitted in Jaslok hospital on 16.2.2004 for having Epidural injection. It is felt strongly that there was no emergency situation requiring hospitalisation. Again it is noticed from the Discharge Card that apart from giving injection, no treatment followed except advice for continuing physiotherepy and taking medicines for 3 days. Thus the above findings lead us to the conclusion that there was no need for hospitalisation. Let us look at the repudiation by the Company from the angle of hospitalisation being for less that 24 hours which is indeed a basic requirement. In any case, this claim is conditioned by the need for hospitalisation and therefore, as per the analysis made above, the fundamental issue of need for hospitalisation remain unsubstantiated.

On the basis of the above analysis I find that the decision for repudiation of claim by the Company is in order this Forum has no valid reason for interfering in the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI - 210 of 2004 - 2005
Shri Alex S. Cardoz
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Shri Alex S. Cardoz alongwith his wife and daughter was covered under a Mediclaim policy No. 140300 / 48 / 03 / 07666 since 1997 and he had been increasing the Sum Insured from Rs. 50,000 for himself in piecemeal during renewals at different intervals. Shri Cardoz had also earned Cumulative Bonus under the policy.

Shri Alex Cardoz was hospitalized at P. D. Hinduja National Hospital and Medical Research Centre for Calloid Cyst of third ventricle with blocked (Rt) VA Stunt and when Shri Cardoz put up a claim to The New India Assurance Company Limited for reimbursement of the expenses for the said hospitalization, the TPA of the Company, repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Cardoz represented for reconsideration of his claim which was also turned down and hence aggrieved, Shri Alex Cardoz approached this Forum requesting intervention of the Ombudsman in the matter settlement of his claim.

After perusal of the papers, parties to the dispute were called for hearing. The analysis of the case reveals that Shri Cardoz was admitted to Bombay Hospital from 22.7.85 to 28.7.85 and had undergone colloid cyst in third ventricle with hydrocephalus and hence the Company had repudiated the claim on the ground of pre-existing disease. Shri Cardoz does not deny he had undergone the said surgery in 1985. But his contention was that he had disclosed about the surgery while taking the mediclaim policy in 1997 and also when he increased the Sum Insured but the Company had not excluded the same from the policy. He also informed that he was not aware that the surgery which was done in 1985 would cause further complications and would required another

surgery after 19 years. It is important to note that irrespective of any exclusions on the face of policy, any disease pre-existing prior to the policy is automatically excluded as per exclusion clause 4.1 of the mediclaim policy. Under the present case the 1985 surgery could successfully drain out the fluid but over a period the shunt created got blocked for which fresh surgery was required. The surgery of cyst and the drainage of fluid due to hydrocephalus is a very important surgical intervention in one's health status that has to be disclosed. Secondly, the second surgery is positively linked with the earlier surgery as was explained by the medical opinion received by the Company.

In view of this the decision of The New India Assurance Company Limited to repudiate the claim cannot be faulted with.

Mumbai Ombudsman Centre
Case No. GI - 581 of 2004 - 2005
Shri Subodh Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Shri Subodh Shah alongwith his wife and daughters were covered under a Mediclaim policy issued by The New India Assurance Company Limited, D. O. 112000 under policy No. 112000 / 48 / 02 / 08736 for the period 24.2.2003 to 23.2.2004. Smt. Falguni Shah wife of Shri Subodh Shah was hospitalized at Sarla Nursing Home from 26.3.2003 to 27.3.2003 for D & C with laparoscopic tubal ligation When a claim of Rs. 15,545.09 was preferred by Shri Subodh Shah for the said hospitalisation, the Company's Third party administrator after scrutiny of the case papers sent a discharge voucher dated Nil for Rs. 4,000/-. The same was received by Smt. Falguni Shah who signed the discharge voucher and sent it to the Company under protest. Not receiving any reply from the Company nor the claim amount of Rs. 4,000/- as allowed by the Company, Shri Subodh Shah approached the Office of The Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his full claim amount. After perusal of the records parties to the dispute were called for hearing The analysis of the case reveals that the Insured Smt. Falguni Shah was hospitalized with complaints of irregular bleeding and later excessive bleeding through PV and severe lower abdominal pain. She had a history of 2 caesarian sections for two children. She had a difficult and painful menstrual period. The obvious course followed by the Doctor was D & C to prevent the progress and in the process laparatomy for tubal ligation was done. The Company's medical consultant examined the case thoroughly and opined that while the D & C was considered, tubal ligation was done to pretent future conception. If we go through the discharge Summary and the other hospital papers we would see that the whole problem came from irregular bleeding and consequent recurring complications for which the decision was to get D & C done.

In the facts and circumstances the decision of the New India Assurance Company Limited to repudiate the claim is hereby set aside and they are directed to settle the claim in full the admissible amount In case they have already paid an amount of Rs. 4,000 as per the discharge given by the Insured, they should settle only the balance admissible amount and resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI - 482 of 2004 - 2005
Shri Raveen Kumar Tangri

Vs

National Insurance Co. Ltd.

Award Dated 29.7.2005

Shri Raveen K. Tangri was insured with his family under a Mediclaim policy issued by National Insurance Company, Panji D. O. I since 3.10.2000 under Policy No. 270907 / 48 / 2000 / 8500524. Under the proposal submitted by him there was no mention of any past illness for which policy was issued without any exclusion. During this period the Insured Shri R. K. Tangri was admitted to Goa Medical College, P. D. Hinduja hospital and Asian Heart Institute, Mumbai respectively on 29.11.2003, 24.12.2003 and 6.1.2004 for heart disease and was operated for Coronary Artery By-pass Graft. When he submitted the claim the Company repudiated the same on the ground that he had past ailments of Hypertension and diabetes and also bronchial asthma which were not disclosed for which exclusion clause 4.1 was invoked. He made an appeal to the Company which was also not considered by the Company. Accordingly he approahced the Insurance Ombudsman for redressal. On examination of the file it appears that as per the Insured's statement under the policy taken in October, 2000, he made a declaration about his having B. P. and Asthma and accordingly these two diseases were reportedly excluded by National but no policy copy was made available to confirm the same. On examination of the hospital records It was written in past history k/c/o HTN since 12 years and on antihypertensive medicines, for Diabetes Mellitus remark was NIDDM on OHA (Oral Hypoglycemic Agents) since January, 2003. Over and above it was remarked that he was a known case of Bronchial Asthma - COPD (Chronic Obstructive Pulmonary Disease). Hence it is a clear case of non disclosure and as the Insured was on medication all along for Hypertension and later for diabetes such disclosure would have been vital for acceptance of risk by the insurance Company. Non disclosure has deprived them of this knowledge which in turn was responsible to form a nexus to cause Coronary Artery Disease.

On this ground the contention of the Company that the claim should be rejected on the ground of policy exclusion clause 4.1 which also includes obvious non-disclosure of vital information in the health status, cannot be questioned.

Mumbai Ombudsman Centre

Case No. GI - 202 of 2004 - 2005

Shri Jai Prakash Saxena

Vs

The New India Assurance Co. Ltd.

Award Dated 29.7.2005

Shri Jai Prakash Saxena had approached the Office of the Insurance Ombudsman seeking intervetion of the Ombudsman for settlement of his wife Smt. Meenu Prakash Saxena's claim which was rejected by The New India Assurance Company Limited. Smt. Meenu Prakash Saxena was covered under the Mediclaim Insurance Policy No. 111900 / 48 / 02 / 03279. Smt. Meenu Prakash Saxena was hospitalized at S. L. Raheja Hospital on 27.5.03 to 28.5.03 for DM with HT with Osteoarthritis Rt. Knee joints with degenerative L-S spondylosis. When a claim was preferred by Smt. Saxena to the Company, the Company repudiated the claim invoking clause 4.10 of the policy. After perusal of the records parties to the dispute were called for hearing. The Company rejected the claim on the ground that hospitalisation was not necessary and it was used for investigations only as per clause 4.10 of the Mediclaim Policy. In fact the documents submitted to us point out that the Insured Smt. Meena Saxena was a

known case of Diabetes type 2, Hypertension with Oestoarthritis Rt knee joint with degenerative Lumber Spine (LS) Spondylolysis. The very diagnosis and the expression “degenerative LS” by itself suggests the chronicity and duration of the disease. The issues were squarely reasolved. It was a case of chronic Oestoarthritis with painful knee compounded by severe diabetes which is known to cause stenosis in the arteries for which there would be occasional terrible state of health and in one such instance, she was admitted while, in effect, it was a case of prolonged treatment with palliatives and conservative management to contain the virulence of the disease.

Nothing special indeed was done in the hospital nor was it possible to do except perhaps doing surgery which was not done for good reasons and therefore, I find the ground of repudiation made by the Company cannot be called in question.

Mumbai Ombudsman Centre
Case No. GI - 326 of 2004 - 2005
Shri Gunvant P. Ghelani
Vs
The New India Assurance Co. Ltd.

Award Dated 4.8.2005

Shri Gunvant P. Ghelani alongwith his wife Smt. Kanak Gunvant Ghelani was insured with The New India Assurance Company Limited, D. O. 111200 under policy No. 111200 / 48 / 03 / 08978 for the period 30.10.2003 to 29.10.2004 or a Sum Insured of Rs. 3 lacs each. It is reported that Shri Ghelani had taken the Insurance cover for the first time in 1993 for a Sum Insured of Rs. 65,000 which was increased by Rs. 35,000 and Rs. 2,00,000 in the year 1998 and 1999 respectively for himself and his wife. They had also earned Cumulative Bonus under the said policy. Smt. Kanak Gunvant Ghelani was hospitalized at P. D. Hinduja National Hospital and Medical Research Centre from 17.11.03 to 24.11.03 for chronic pain in Abdomen and investigation. She had undregone Exploratory Laparotomy + Adhesiolysis + Appendicectomy. When Shri Ghelani preferred a claim for the said hospitalisation, the Company’s Third party administrator i.e. TTK Health Care Pvt. Ltd. after scrutiny of the case papers sent a discharge voucher dated 22.1.2004 for Rs. 97,727 i.e. 70 % of the claim amount after disallowing 30 % due to adhesiolysis surgery which was due to tubectomy performed 25 years ago. Not satisfied with the decision of the Company, Shri Gunvant Ghelani represented to the Company stating that his wife was operated for tubectomy i.e. control for child birth as per Government of India propaganda and this was not any disease and as this surgery was done due to sigmoid inflammation it did not have any relation to tubal ligation surgery done 25 years ago. The company after taking an opinion from an Expert Medicolegal Consultant reiterated the decision taken by their TPA.Aggrieved by the decision of the Company Shri Gunvant Ghelani approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his full claim amount. After perusal of the records parties to the dispute were called for hearing. On a full review of the case it appears that the TPA’s analysis of the claim arising out of the presenting symptoms was based on medical history and correctness. In fact the common symptom of abdominal pain was closely looked into to find out the operative notes of the surgeon. The TPA made a critical analysis of the fallout of the previous surgery tubectomy / hysterectomy leading to adhesionolysis and evaluated the contribution as 30 % while the appendicectomy was regarded as the principal surgery from a fresh cause. In the light of the facts and circumstances their analysis is in order and there is no cause for my intervention to alter the terms of settlement which was quite reasonable.

Mumbai Ombudsman Centre
Case No. GI - 256 of 2004 - 2005
Smt. Juliyana Simon Narlya
Vs
United India Insurance Co. Ltd.

Award Dated 5.8.2005

Smt. Juliyana Simon Narlya took a mediclaim Policy from United India Insurance Co. Ltd., Vasai Branch in the year 2001 for herself. The claim arose in the second year when she was admitted to Sushrut Hospital on 19.7.2003 for Lt. Renal Abscess. The Company referred the matter to its panel doctor, Dr. M. S. Kamath for his expert opinion and after getting his opinion, the Company repudiated the claim under Exclusion Cluase 4.1 of the mediclaim policy.

The analysis of the case reveals that the Insured was diagnosed to have renal abscess and chronic Pyelonephritis in July, 2003 for which she was first hospitalised in Possa Hospital and later in Sushrut Hospital. The hospital records indicate, she had high grade fever with rigors, burning micturation. She was investigated with Ultrasonography, CT Scan and IVP etc. to confirm renal abscess. It was reported that since the infection was quite severe, the kidney removal was suggested and accordingly she was operated upon. Their second point was chronic Pyelonephritis is a long standing disease and must have been there for quite sometime which caused serious infection necessitating removal of the Lt. Kidney. The Company's Medical Consultant made a further point that it was a case of obstructive Pyelonephritis which is quite serious and does have symptoms of sustained complications to cause severe infection. In support of the contention, the Company produced a hospital paper from Possa hospital dated October, 1997 which refers to epigastric burning and vomiting and pain in abdomen. The Insured, during hearing as also in written statement, has mentioned that she had abdominal problem but never any renal complications which tallies with the hospital papers produced by the Company in their submission. The issue therefore remain unresolved and the Company seems to have developed their argument about long duration of the disease only on the basis of invasive nature of the disease from out of the ivestigations which were conducted much letter. It appears that Smt. Narlya was suffering from chronic Pyelonephritis which is a bacterial infection of the kidney substance. In chronic pyelonephritis, the kidneys become small and scarred and kidney failure ensues. There was one more expression as 'Obstructive Pyelonephritis' which points to the severity of the disease over a period of time. The Insured contended that she had only symptoms of pain and rigors and vomiting. There was a history of earlier abdominal distress in 1997, when it was diagnosed as epigastric problems. There is a reference in the medical records that similar problem occurred in 1999. The fact remains that there was some recurring problems for quite sometime may be from 1997 or before for which repeated tests were advised. The USG of 1997 did not show any irregularity, however, the further records from 1998 onwards till 2001 i.e. when she took the insurance policy only for her was not available with this Forum. Obviously, therefore, this Forum is left with no alternative but to analyse the case incisively to ascertain the truth. At least this point that she did not suffer any abdominal problem cannot be held as a correct statement, as 1997 treatment did point out that she had epigastric problem for which investigations were done. As regards the behaviour pattern of the disease chronic pyelonephritis, it would appear that the disease could only be diagnosed over a period of time after repeated bouts of pain and complications. As the Insured took the policy for the first time on 8.10.2001 for herself it would be reasonable to conclude that there were suficient indications that her health complications were of grave nature and the medical evaluation of the disease with its

features were manifest, it would be justifiable to conclude that at the time of making the proposal with the Insurance Company, she had certain complications which were not disclosed and therefore the Company did not get a opportunity for evaluating her health status to decide whether to accept or reject the proposal. On this ground, the rejection of the Company following hospitalisation and surgery of Smt. Narlya is circumstantially and medically held valid.

Mumbai Ombudsman Centre
Case No. GI - 206 of 2004 - 2005
Shri Sunil P. Katti
Vs
The Oriental Insurance Co. Ltd.

Award Dated 10.8.2005

Shri Sunil P. Katti was a mediclaim policyholder of the Oriental Insurance Co. Ltd. since 1997 and renewed continously. The claim arose in the year 2001 when he consulted Dr. Tushar S. Mehta of Dr. Sumatilal L. Mehta Clinic for complaints of pain in teeth and as per Dr. Mehta's advice Shri Katti consulted Dr. S. E. Shroff Dental Surgeon of Bay View Clinic who had done surgery and tooth implantation. The Company referred the matter its panel doctor, Dr. M. S. Kamath and later to Dental Specialist Dr. S. R. Jamalabad for their expert opinion and after getting their opinion, the Company repudiated the claim by stating that the disease was pre-existing and it fell under Exclusion Clause 4.7 of the mediclaim policy.

While the Insured claims his dental problems arose suddenly after taking the policy, the Insurance Company i.e. Oriental wanted to prove that the roots were steadily decaying which led to such a stage when not only complete removal of upper teeth was done but Alveolectomy had to be done to save the situation. A critical analysis would resolve the issue. Bay View Clinic discharge card mentions the diagnosis as infected tooth roots and the treatment given 'total extraction with Alveolectomy. Cloure with 8 sutures.' The history case papers record that the Insured was admitted for dental surgery due to bad teeth and for replacement of the lost teeth by titanium dentures. On this, the Company took the opinion of Dr. Shyam Jamalabad, Dental Surgeon and he opined that the surgery is the replacement of the teeth which were earlier removed. Dr. Jamalabad supported his comment by saying that "it is hard to believe Shri Sunil P. Katti's claim that his teeth deteriorated so rapidly in so short a time (3 or 4 years). It is well known that the progress of dental caries is steady but very slow. For a tooth to decay so badly from the onset of caries to the stage where only infected roots remain would in my opinion take at least 10-12 years." He drew the obvious conclusion that Shri Katti's dentition is already in an advanced stage of decay before the commencement of the policy. This view is quite important in the sense that Dr. Jamalabad himself is a dental surgeon and has studied the entire case papers referred to him. In one of the history case papers it is also mentioned that the 'Insured had only a few root left' as he had already lost the remaining teeth before the current admission / treatment.

From all these factual details it appears quite clear that the Insured had a long standing problem which was only being treated from time to time and possibly he was loosing one tooth after another rendering upper jaw virtually toothless for which such a massive surgery had to be done followed by implantation. We have examined that Neoplasm is an abnormal formation of tissue, as a tumor or growth and it grows slowly but steadily at the cost of healthy organism over a period of time. Based on this

medical view, I decide that the contention of the Oriental Insurance Company that the disease was existing with obvious symptoms even before the policy was taken would be acceptable and therefore their repudiation of the claim is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 71 of 2004 - 2005
Dr. Kishore Shah
Vs
United India Insurance Co. Ltd.

Award Dated 16.8.2005

Dr. Kishore Shah was covered as a member under Group Policy issued by United India Insurance Company Limited, Divisional Office - 13 to General Practitioners Association (GPA) Dr. Kishore Shah underwent left eye cataract surgery on 23.2.2003 at Netra Jyot Eye hospital, Mumbai under the care of Dr. Ashesh M. Gala. When he submitted his claim for reimbursement to United India through General Practitioners Association the Company appointed an investigator M/s S. B. Nalluri and Associates to look into the matter. Based on the Investigators report the Company vide their letter dated 26.3.2004 rejected the claim on the ground that the claim could not be substantiated by way of indoor case papers at the doctor's clinic or by way of any other documents. Dr. Kishore Shah contested this rejection which was not considered for which he approached this Forum for intervention of the Insurance Ombudsman for settlement of his claim. Based on the above facts which was available from the records particularly detailed letter issued by Dr. Kishore Shah to the Chairman General Practitioners Association dated 13th April, 2004 and investigation done by the Company through M/s S. B. Nalluri Associates dated 1st March 2004, it was felt that both the parties having represented their case well enough, need for personal hearing may not be there. It is evident that while Dr. Kishore Shah has claimed that he was operated by Dr. Ashesh Gala for left eye cataract therefore he claimed as per procedure, United India had for some reason appointed M/s S. B. Nalluri And Associates, investigator whose report is not conclusive about the surgery details and the lens implantation and bill No. 386 dated 23.2.03 showed lens for an amount of Rs. 4000 which was not regarded as genuine by the Insurance Company. It should be appreciated that this Forum can adjudicate on the basis of documents produced in substantiation of the claim which Oriental examined to lead to the best conclusion. Unfortunately nothing is available to this Forum and it would not serve any purpose to call for the documents now which ought to have been collected at the material time. The special reason for which United India gave the file for investigation is not known nor is the report quite conclusive to draw any conclusion one way or the other. The Insured produced two identical stickers with all information including the identification number identical to justify right eye and left eye cataract lens implantation. This can be examined as United India had settled earlier claim for Right eye. This Forum does not have any power to investigate, independently call for fresh evidences, cross examine the witnesses, summon them or the Investigators appointed by the company for hearing. Accordingly it is strongly felt that Company has to resolve such matters by getting to the bottom of the so called irregularities and allegations made by them against the Complainant i.e. the Insured Dr. Kishore Shah. No result can be expected from this Forum on a claim which has not been comprehensively handled.

Mumbai Ombudsman Centre
Case No. GI - 463 of 2004 - 2005
Shri Peter F. X. Telles

Vs

The New India Assurance Co. Ltd.

Award Dated 17.8.2005

Shri Peter F. X. Telles alongwith his wife Smt. Flora Telles was covered under a Mediclaim Policy No. 141500 / 48 / 02 / 00635 issued by The New India Assurance Company Limited, Vasco D. O. for the period from 31.10.2002 to. 30.10.2003. Shri Peter Telles was holding the mediclaim policy continuously from 16.10.1995 to 15.10.2002 and had earned Cumulative Bonus of 30 % under policy No. 1141500 / 48 / 01 / 00222. But when the said policy was due for renewal on 15.10.2002 Shri Telles could not renew the said policy in time and hence there was a gap of 15 days which issued to him from 31.10.2002 with no Cumulative Bonus. Smt. Flora Telles was hospitalized from 21.2.2003 to 28.2.2003 at Wockhardt Hospital and Heart Institute, Bangalore for Coronary Angiography and PTCA Stent to LAD was done on 24.2.2003. When a claim was preferred by Shri Peter Telles to the Company, the Company examined the file and repudiated the claim on the ground of pre-existing diseases. Dissatisfied with the decision of the TPA and the Company Shri Peter Telles represented to the Company which was also turned down. Aggrieved by the decision of the Company, Shri Peter Telles approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman. After perusal of the records parties to the dispute were called for hearing. The analysis of the case reveals that Shri Telles was having insurance cover continuously since 15.10.1995 to 15.10.2002. Thereafter there was a gap of 15 days and the policy was renewed from 31.10.2002 and a fresh policy was granted to him withdrawing all Cumulative Bonus which accrued under the previous policy. The fresh policy was subject to exclusion of sinus bradycardia and thereafter it was withdrawn with an endorsement on the basis of a certificate received from Dr. N. P. S. Savoikar. Smt. Telles had a single vessel disease and Echo Cardiogram gave a clear chit with good L. V. function. As per the provision the policy was treated as new, although in effect it was continuous New India took the opportunity to conditions the break period with exclusion of ‘Sinus Bradycardia’ which though technically correct is morally unfair as the Insured was having it all along which was removed on Doctor’s opinion.

However, as per examination made above it could not be a causative factor for Single Vessel Disease, and therefore, the rejection of New India Assurance Company is held not sustainable.

Mumbai Ombudsman Centre

Case No. GI - 302 of 2004 - 2005

Shri Vijay Narvekar

Vs

The Oriental Insurance Co. Ltd.

Award Dated 17.8.2005

Shri Vijay Narvekar was insured with his family with Oriental Insurance Company under a mediclaim policy. He lodged a claim under the policy for hospitalisation of his son Mast. Ashishkumar V. Narvekar for head injury and vomiting sufered as a result of being hit on the head by a cricket ball. Mast. Ashishkumar received some treatment from their family doctor Dr. (Mrs) Veena R. Patel and was later admitted to H. N. Hospital. However, when the claim was put up to the Oriental Insurace, the TPA M/s Raksh. TPA informed the rejection of the same on 30.6.2003 on the ground that the hospitalisation was not necessary and it was utilised for investigations only.

The examination of this complaint raises only one significant issue viz. whether hospitalisation was or not necessary thus coming under the clause 4.10 of the mediclaim policy. The incident which is narrated refers to a cricket ball hitting the boy, Master Ashish Narvekar. If the ball is ordinary rubber ball or tennis ball, the chances of skull damage or severe concussion damage would be remote. Usually children to not play with the regular cricket ball which is made of wood wrapped and sewn with a different quality of leather. This point is not clear from the narration and it should be taken that a rubber ball or tennis ball must have hit him. The hospital papers mention that the patient was admitted for investigation due to left sided headache. It, of course, recorded a history of left side injury by a cricket ball. However, no vomiting, no blurring of vision or loss of consciousness were reported. Although, clinical examination revealed no abnormality, the CT scan of the Brain revealed minimally displaced fracture of the lateral wall of the left orbit with left ethmoidal & frontal sinusitis. However, the skull revealed no abnormality, All other investigations were normal. The TPA and the Company felt here was no need for hospitalisation where only investigation had been done. There was no criticality or emergency situation to admit the boy. Secondly, the boy received 6 (six) days domiciliary treatment from Dr. (Mrs) Patel which did prove this point. The causality Department admission papers suggest that the patient was admitted with head injury for investigation and under observation. Except the CT scan which gave an indication of some injury, the other results were all normal and the patient was discharged virtually without any medicines or treatment except for sinusitis. In view of this it is felt that the case did not merit a serious re-examination from the point of view of admissibility of the claim which has gone through specialist consultants' examination.

Having made the above analysis, it is found on close scrutiny that Dr. Veena Patel treated the boy, Asish, initially for a few days and the exact condition was not known through her certificate and the recommendation to straightway admit Mast. Ashish was not conrroborated by an exact status of the health before admission as to why it was so urgent. The hospital noted the admission as head injury for investigations. In the certificate of Dr. (Mrs.) Patel it has been mentioned 'blunt injury' and how exactly the accident ocurred causing injury was not mentioned except it was mentioned that the boy was hit by a cricket ball. The final diagnosis thus mentioned that it was a minimally displaced fracture of the lateral wall of the left orbit with left ethmoidal and frontal sinusitis. However, the daily progress report and the type of treatment as mentioned in the hospital papers were indicative of some injury of Left temporal region. In this case, it may have been associated with some injury howsoever caused and may not necessarily be due to a cricket ball hitting in particular. Considering the above issues and the fact that there has been a number of investigations which has identified some positive ailments, complete rejection by the Company cannot be accepted. Nevertheless, it also highlighted that hospitalisation could have been avoided with some important investigations being done to come to a diagnosis and treat him. I, therefore grant the benefit on 50:50 basis as under.

Mumbai Ombudsman Centre
Case No. GI - 370 of 2004 - 2005
Smt. Lata Bhangvi
Vs
National Insurance Co. Ltd.

Award Dated 17.8.2005

Late Shri Sarvottam P. Bhangvi was insured mediclaim policy of New India Assurance Company Ltd. for the year 9.8.2000 to 8.8.2001 and he shifted to Direct Agent Branch

of National Insurance Co. Ltd., Panaji under policy no. 270907 / 48 / 2001 / 8500814 for the year 9.8.2001 to 8.8.2002. The claim arose in the year 2002 when he was hospitalised at Dr. Balabhai Nanavati Hospital for 'Septicaemia c Pneumonia c Peranal abscess'. Whenthe claim was preferred by Shri Bhangvi for reimbursement of the hospitalisation expenses of Rs. 2,15,840/-, the Company investigated the merits of the claim by appointing investigator, Shri V. R. Nawathe.

The point of dispute appears quite clearly identified. National Insurance had rejected the claim on the ground of long duration of diabetes and hypertension as per hospital recording made of past history. A close look at the discharge summary reveals that the history was recroded "patient admitted c c/o Acute onset of breathlessness & chest pain. H/o cough + & boil on (R) Sacral region. K/c/o - DM 30 yrs on & Daonil ½ - 0 - ½. HTN 8 - 10 yrs on Rx. T. Amlopin (10) 1, Tlopressor (50) 1. IHD c LVD 10 yrs - CRF sed in Mar 02". It is evident from the notings that due to long standing diabetes aided by Hypertension there was Isheamic heart Disease giving rise to the renal failure and finally resulting into Septicaemia. The subsequent developments are only logical conclusion of all these ailments. The patient Shri Bhangvi was aged 63 years and diabetes was noted to be 30 years duration which means it started at his age 33 years which speaks of the virulence and intensity of the disease. He was on medicine. His hypertension was of 8 - 10 years duration and Ischaemic heart disease since last 10 years. Apparently he had perianal abscess which was operated upon but the other diseases mentioned were a host of serious diseases like Diabetes Mellitus, Hypertension, Ischeamic Heart Disease, LV Dysfunction, CRF with ASMI. Most of these diseases were long standing and contracted long before the policy was taken and therfore pre-existing. The great risk factors in life, Diabetes Mellitus and Hypertension were of long duration which must have caused stenosis and severe blockages throughout the circulatory system and specially the arteries for which the Insured developed Pneumonia and chronic Renal failure. All these are terminal diseases for which the impact of non-disclosure and being pre-existing could not be overlooked. Accordingly, the decision of National Insurance Co. Ltd. to repudiate the claim cannot be faulted as the Insured's policy was taken only from 1998 from New India and later was switched over to National in 2001.

Mumbai Ombudsman Centre
Case No. GI - 464 of 2004 - 2005
Shri Saifudin A. K. Colombowala
Vs
The New India Assurance Co. Ltd.

Award Dated 17.8.2005

Shri Saifuddin Colombowala was insured under a mediclaim policy issued by The New India Assurance Company Limited since February, 1999. He was hospitalized in Bombay Hospital on 9.7.04 for some complications like low B.P., drowsiness etc and was discharged on 15.7.04. When he put up his claim for reimbursement to New India the same was rejected on the ground that it was not payable as per policy exclusion 4.8 The Insured made a representation which was also turned down for which he approached the Office of the Insurance Ombudsman. Considering the fact that the representation of the Insured was explicit as per his letter dated 16.10.04 to TPA and 2.11.04 to this Forum, and that the TPA and the New India Assurance Company presented this repudiation on the basis of hospital records, it was felt personal hearing need not be taken. The analysis of this case leads to the issue whether the claim which has been rejected is an exclusion under the policy and if so, how it is tenable. The TPA has taken the discharge summary of Bombay hospital where it has been clearly

mentioned that the cause of illness was due to alcohol abuse which was excluded under the policy, hence not admissible The insured mentioned that his blood sample taken by hospital did not show alcohol residue. Secondly his alcohol intake cannot be called “excessive” at all it was quite normal. Thirdly he did not claim under his medical policy since 4/5 years. The issues are different. First of all there is no corroboration of the Insured’s statement from hospital records to the effect that blood sample was tested as the effects were palpably known and examined by them. The point to be noted is the effect of alcohol consumption which has come in the form of findings and examination made by the hospital which does not support the Insured’s contention.

In view of the specific terms of the exclusion clause and the Insured Shri Saifuddin Colombowalla having suffered due to alcohol consumption and being diagnosed as caused by abuse of alcohol which is categorically excluded from the scope of the policy as per 4.8 clause noted above, the repudiation made by the TPA of The New India Assurance Company Limited and endorsed by the Company is held sustainable.

Mumbai Ombudsman Centre
Case No. GI - 354 of 2004 - 2005
Shri Prabhakar Balkrishna Railkar
Vs
The Oriental Insurance Co. Ltd.

Award Dated 18.8.2005

Shri P. B. Raikar was covered under LIC of India’s Mediclaim policy no. 111300 / 48 / 03 / 00061 as a retired employee for a sum of Rs. 3 lakhs for the period 2003 - 2004. He received treatment from Punit Orthopaedic Surgical Hospital, Borivali, Mumbai for about seven weeks between November and December, 2003 for Frozen Shoulder. When he put up his claim to the TPA M/s Paramount Health Services Pvt. Ltd. of the Oriental Insurance Co. Ltd. they rejected his claim on the ground that the treatment was received only as an Outpatient and there was no hospitalisation for a minimum period of 24 hours as per Clause 2.3 of the mediclaim policy. Shri Raikar contested this decision and wrote to the Manager of the Oriental Insurance, Mumbai D. O XI that for all practical purposes it would have been a surgical operation as per definition in the Clause 2.2 and that Clause 2.3 allows certain waivers of minimum stay of 24 hours in the hospital in respect of some disease which should have been a surgical operation as per definition in the Clause 2.2 and that Clause 2.3 allowed certain waivers of minimum stay of 24 hours in the hospital in respect of some diseases which should cover also the illness he suffered from i.e. Frozen Shoulder. The Company did not consider his point of representation but defended the decision of the TPA to repudiate the claim. Shri Raikar thereafter approached this Forum for redressal of his grievances.

The Scrutiny by this Forum reveals that the Insured / Complainant Shri Raikar attended Punit Orthopaedic Surgical Hospital from time to time between November and December, 2003 and received treatment for acute pain in shoulder which was diagnosed as due to Calcified tendons. This is a degeneration process and always makes it a long standing treatment for which although the treatment is continuous it does not immobilise the patient nor does it require hospitalisation. Shri Raikar’s point was that the Clause 2.3 does mention some diseases specifically in which 24hrs hospitalisation is waived but with the technology advancement in medical science, his ailment i.e. Frozen Shoulder should also have been considered and included under the waiver clause 2.3. This proves the point that Shri Raikar understood the reason as to why the claim was repudiated but he wanted a special consideration to cover his disease as a special dispensation under the same clause although the disease was not

included. The matter has been closely examined at this Forum and our view point would be whetever the furture medical science would adopt with the passage of time and force the Mediclaim Policy to be attuned to the future requirement would not be a point of consideration for this Forum since the present claim is under the existing policy terms and conditions which was issued to Shri Raikar. The provisions are absolutely clear and hospitals do have an OPD section which caters to various needs of treatment. A number of diseases not requiring hospitalisation or cannot be even afordable are taken by the patients. Such treatment would always remain outside the scope of hospitalisation policy which is exactly the present Mediclaim Policy. Moreover, the Mediclaim Policy is governed by a cardinal principle of reimbursement of the expenses 'necessarily and reasonably incurred' and therefore such expenses which are incurred as outpatient would not be considered within the purview of the policy. The Complainant's plea that it should be then considered as domiciliary hospitalisation treatment would also not be acceptable as per definition 2.4 put down in the Mediclaim Policy and therefore the repudiation made by the Company is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 572 of 2004 - 2005
Shri Vasant P. Malvankar
Vs
National Insurance Co. Ltd.

Award Dated 18.8.2005

Shri Vasant P. Malvankar was covered under Mediclaim Policy issued by the National Insurance Company Limited, Unit 270905, Goa under Policy No. 270905 / 48 / 03 / 8500222. On 13.10.2003 Shri Malvankar was hospitalized at Vrundavan hospital, Mapusa for sudden loss of consciousness and on 15.10.2003 he was referred to Goa Medical College for further management. As his condition was not improving his family members shifted Shri Malvankar to Jaslok Hospital, Mumbai on 16.10.2003 and he was discharged on 26.10.2003 after the treatment. The diagnosis at Jaslok hospital was Diffuse encehalopathy Grade III, hepatic, alcohol + HCV without localizing signs presented by Chronic constipation with limpomatosis. There was also a diagnosis Adult Hirschasrpung's disease. When a claim was preferred by Shri Vasant Malvankar for the said hospitalizations to the Company, the Company repudiated the claim under clause 4.8 of the mediclaim policy. Being dissatisfied with and aggrieved by the decision of the Insurance Company Shri Malvankar approached this Forum. After perusal of the records parties to the dispute were called for hearing at Goa.

The analysis of the case do not require much time to come to the conclusion although the presenting symptoms were multifarious while basically it gave symptoms of severe constipation requiring purgatives on a regular basis, it was associated with chronic hepatits, with diffuse hepatic encephalopathy as alcohol induced, consequently aggravating the complications for which proper diagnosis was difficult. The diagnosis "Hirschsprung's disease" is an important finding and it was evident that the Insured was nursing this disease for quite sometime and most possibly it would have been a congenital condition and repeated complications would have been there in the childhood as is evident from the admission made by him before the Ombudsman when the pointed question was asked to him to which he replied in affirmative.

In fact the whole case history is not available but there must have been recurring complications which got attended to at a later stage when it gave rise to many other complications. This has been no doubt accelerated by his alcohol intake as has been clearly noted in the case history of Jaslok hospital. It is clear that coupled with the

congenital problems of non-development of normal nerve network of lower colon, the aggravation came with hepatic dysfunction and all these diseases were longstanding and invasive which progressed over a period of time to be rightly called both pre-existing (4.1) and also abuses of alcohol (4.8) for which rejection of the Company cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 028 of 2004 - 2005
Smt. Simintini Parkar
Vs
National Insurance Co. Ltd.

Award Dated 22.8.2005

Smt. Simintini Parkar took mediclaim policy from The National Insurance Co. Ltd. since 1999 for a Sum Assured of Rs. 1,00,000/-. The Company settled two claims during the period 2001 - 2002 for Multiple Fibroids and Endometrium. The Insured approached National Insurance Co. Ltd. for her claim after her hospitalisation at Bombay Hospital for Fibroids. The claim was processed by M/s Paramount Health Services and they informed the Company its decision to repudiate the claim under Exclusion Clause 4.1 of the Mediclaim Policy and accordingly the Company informed the same to the Insured.

The claim under the Policy period 2003-04 was not considered by the TPA and the Company on the basis of a specific policy provision which comes along with some benefits like Cumulative Bonus in case of regular and continuous renewal of the policy exactly before the expiry of the policy as under :

“Cumulative Bonus will be lost if policy is not renewed on the date of expiry Waiver : In exceptional circumstances the seven days extension in period of renewal is permissible to be entitled for cumulative bonus although the policy is renewed only subject to Medical Examination and exclusion of diseases.”

It is evident from the above clause that the renewal of the policy assures continuity of the Insurance so very important to earn and continue with uninterrupted benefits under the policy not exactly of cumulative bonus alone but get an assurance of coverage on the same terms and conditions of the previous policy. It is, therefore, in his/her own interest that the Insured should ensure uninterrupted insurance and in that course, he/she should be serious and sincere to confirm that the Insurance Company has received the premium and renewed the cover. He/she should not rest assured that the cheque for getting renewal is acting at that point in time as his/her agent and the duty enjoins on him/her to ensure that the money has been received by the Insurance Company.

The other periods were marked by breaks varying between 6 days to 30 days which indeed smacks of casualness and consequent violation of policy terms. The Insured lost her Cumulative Bonus accruals but the Company did settle her two claims in 2001-02 period for Fibroids and Endometriasis. The diagnosis was proliferative fibroids. Usually, these occur in numbers and require repeated surgeries. The Company having settled earlier claims had obviously roused the expectation of settlement for the third time for the same disease. However, since the renewals were always with gaps as shown above, the Insured, had lost moral support of getting the benefit of accommodation. Usually, in such cases the practice is to apply to the Company for waiver for their consideration as per the provision and the Company, if satisfied, would consider renewal only after medical examination and exclusion of diseases. Neither

this was done nor it would have gone through with the provisions as they are since there was infringement of the provision with such delays four times. Accordingly, the Company's action in rejecting the claim on the ground of non-renewal cannot be faulted as the premium was actually accounted for only after the expiry of the previous policy.

Mumbai Ombudsman Centre
Case No. GI - 309 of 2004 - 2005
Shri Anjum M. Samel
Vs
National Insurance Co. Ltd.

Award Dated 22.8.2005

Shri Anjum M. Samel preferred an appeal against National Insurance Co. Ltd. through his letter dated 12.8.2004 basically complaining against delay in settlement of the claim put up by him for his mother's hospitalisation. After examining the papers initially, the Officials of the Forum felt that as the claim was fully settled as per the limit of the Sum Assured + Cumulative Bonus amount, the principal reason for registering the claim on the grounds of non-settlement of partial settlement or dispute on legal construction of the policy etc. as per Rule 12 of the RPG Rules was not violated and therefore may not be registered. However, the Complainant, Shri Samel had insisted registration of the complaint on the ground of delay in settlement of the claims for which it was registered and both the parties were provided with suitable notices.

On a deeper examination it appears that the Complainant's contention under his letter dated 12.8.2004 is primarily concerning deficiency in service, insensitive approach and poor response of the TPA and the Company. The examination reveals that his contention is acceptable which underscore the need that the State owned Companies in particular should be more proactive and responsive. National Insurance Company has also put up their point of view in the form of a self-contained note to mention that after the discharge from the hospital the lodgment of the claim by the Complainant was delayed by more than 30 days and since the claim was processed by their TPA M/s Heritage Health Services Pvt. Ltd. which was a new arrangement, the procedural delay could not be avoided. They also held the view that since pre-hospitalisation and post-hospitalisation expenses would also be covered under the total expenditure, 60 days after discharge following hospitalisation would normally be counted in the total duration and with all these factors the claim was settled on 14.6.2004 for Rs. 1,14,000/- being maximum amount payable under the policy i.e. Rs. 80,000/- Sum Insured + Rs. 34,000/- as Cumulative Bonus.

Under the terms of RPG Rules, specifically Rule 12, the Ombudsman intervenes in the matter of delays in settlement of claims where settlement is not made for one reason or the other and very often Ombudsman's intervention hastens the process of settlement. The type of complaint made by the Complainant, Shri Anjum Samel is only on account of delay in settlement for which he has asked for interest payment and compensation for harassment and mental agony. Admittedly, Company should have been more responsive and prompt in settling the claim put up by the Complainant for his mother and more so, after they were informed of her demise. The Company's point that first of all lodgment of the claim is delayed by the Complainant by more than 30 days would not hold ground as he did inform his mother's hospitalisation and progress of treatment well before. However, only point comes is the fact that the Company fully settled the claim up to the maximum amount available within 5 months after obtaining neccessary

clarifications and got a valid unqualified “full and final” settlement discharge from the Complainant. The genuine intention of the Company to settle the claim in full was not lacking but could be the procedural delay was contributed by introduction of TPA system, a new procedure, approved by the IRDA but the Company Should take the resposibility for their sluggishness as well. The Company raised the issue that after the full satisfaction of the Company the TPA released the cheque while the Complainant did not raise any issue at that time.

The IRDA Regulation, 2002 has put down the basis of treatment of such delays and it would appear that the Complainant was not merely asking for interest amount which would be a very paltry amount for 4 months on the basis of the market practice. What was effectively put forth by him was the insensitive approach of the TPA and the Company for which no monetary award is being passed on an otherwise a settled claim. However, the following order is passed on the Company for overhauling their system of working.

Mumbai Ombudsman Centre
Case No. GI - 304 of 2004 - 2005
Shri Himatlal Mafatlal Shah
Vs
The Oriental Insurance Co. Ltd.

Award Dated 24.8.2005

Shri Himatlal Mafatlal Shah along with members of his family was insured under Mediclaim Policy of the Oriental Insurance Co. Ltd. since 1993. His wife Smt. Gunvanti Shah was hospitalised at S. R. Mehta Cardiac Institute for evaluation of heart disorder. The claim was preferred by Shri Himatlal Shah on behalf of his wife Smt. Gunvanti Shah for reimbursement of hospitalisation expenses. The Company referred the matter to its panel doctor, Dr. M. S. Kamath, Medicolegal Consultant, for his expert opinion and after getting his opinion, the Company informed the Insured on 5.11.2003 its decision to repudiate the claim.

The analysis of relevant records produced to this Forum would reveal the following. Smt. Gunvanti H. Shah, the insured, was admitted in Suchak Maternity & General Hospital on 8.4.2003 with the compliant of chest pain with headache, nausea and palpitation. The diagnosis was mild hypertension with Unstable Angina and she was discharged on 10.4.2003 with an advice for Coronary Angiography. Later on, the insured hospitalised in Smt. Sushilaben R. Mehta & Shri Kikabhai Premchand cardiac Institute, Mumbai on 7.6.2003 for left sided chest pain. There was a mention that she had complaints of chest pain radiating to left arm, back with history of dispnoea and she was mentioned as a known case of Hypertension also Coronary Angiography was done on 7.6.2003 and she was discharged on 8.6.2003. The Company has rejected the claim on the ground that CAG is a diagnostic test which could have been done at OPD. On a close scrutiny of the medical records from both the above hospitals it is observed that the insured was already diagnosed by Suchak Maternity Hospital have mild hypertension with Angina Unstable type and she was advised for bed rest for 10 days and certain medicines were prescribed. The Insured was also advised for Coronary Angiography test. The claim was settled by the Company. After strictly following the medical advice given by the Suchak Hospital the insured had undergone test for Coronary Angiography which was already suggested by Suchak Hospital at S. R. Mehta Hospital. Thus it cannot be termed that only for diagnostic purpose CAG was done although no further immediate treatment was suggested except prescribing certain medicines. Apart from this argument, it is to be noted that the insured was discharged

from Suchak Hospital on 10.4.2003 with an advice for Coronary Angiography which she followed through admission to S. R. Mehta Hospital on 7.6.2003. The argument would be that if Suchak had the facility to conduct CAG and the patient would have stayed back for a day more and the Company would not have grudged extra payment anyway. It would have justified the procedural format eg. Investigation was done, diagnosis was made, treatment was given and all expenses were necessarily incurred for reimbursement. The same thing has happened on a different date in a different hospital duly equipped with the facility which should be payable. In a different context, it could be argued that she has followed up the procedure within 60 days of discharge from Suchak and if for CAG it is felt that OPD treatment would be good enough, it could come over under post-hospitalisation period of 60 days as well as and thus payable.

Mumbai Ombudsman Centre
Case No. GI - 479 of 2004 - 2005
Shri Jaysinh Doshi
Vs
The New India Assurance Co. Ltd.

Award Dated 24.8.2005

Shri Jaysinh Doshi who was covered under a Mediclaim policy No. 111800 / 48 / 03 / 08817 issued by The New India Assurance Company Limited, D. O. 111800 for a Sum Insured of Rs. 5,00,000 with 15 % Cumulative Bonus had approached this Forum with a grievance that the Company had rejected his claim of Rs. 89,500 for Obstructive Sleep Apnea under exclusion clause 2.3 of the mediclaim policy. Shri Doshi had represented to the Company stating that if hospitalisation would have taken place then the cost would have increased, hence he asked the Company to have a re-look into the matter and simultaneously approached this Forum for redressal of his grievance. His contention was that he was advised by Dr. J. S. Sorabjee to use the Devilbiss Auto Adj. CPAP machine to enable him to get proper sleep. On going through the documents submitted to this Forum by both the parties it was found that the case was very clear and there was no need for holding any personal hearing. It is to be noted that Mediclaim policy covers only hospitalisation expenses for medical / surgical treatment incurred at any Nursing Home / Hospital in India and in this case it was clear that there was no hospitalisation at the hospital and only advice was given by Dr. J. S. Sorabjee for purchase of the instument. This also gives clear evidence that sleep disorder was diagnosed as a singular problem and the patient did not present many sided issues to be sorted out as is done in a hospital through various diagnostic investigations. Even if there was hospitalisation for a minimum period under policy condition 2.3 read in conjunction with Condition 1(D) the expenses for apparatus which are not on the body system as such but are external adjuncts fitted for a limited period for getting good sleep in this case, would fall outside the scope of Mediclaim policy for coverage.

'In the facts and circumstances the claim of Shri Jaysinh Doshi for the expenses incurred for the treatment of Obstructive Sleep Apnea is not tenable.

Mumbai Ombudsman Centre
Case No. GI - 333 of 2004 - 2005
Shri Pradip S. Dhuri
Vs
National Insurance Co. Ltd.

Award Dated 25.8.2005

Shri Pradip S. Dhuri and Smt. Pradnya P. Dhuri were covered under a mediclaim policy since 9th January, 2001 with National Insurance Company Limited, D. O. 6, Mumbai. In July 2003, Smt. Pradnya was admitted to Kulkarni Hospital at Jogeshwari, for giddiness. She was diagnosed to be a case of Iron Deficiency Anemia with Cervical Spondylosis. Shri P. S. Dhuri lodged his claim for reimbursement, the Company rejected the same on the ground that as Menorrhagia was reported to be her ailment since last 4 years as per hospital records, the present ailment of anemia would be a pre-existing ailment as Menorrhagia causes anemia. Aggrieved at the decision of the Company, preferred an appeal agaist the Company before Ombudsman. The analysis of the case reveals that the hospital papers have recorded “Menorrhagia” for 4 years. Menorrhagia is excessive bleeding at the time of a menstrual period, either in number of days or amount of blood or both. The Company came to the conclusion that the she was anaemic because of loss of blood systematically because of menorrhagia. While this would be possible from the medical view point, it should be noted that in some cases, it could be due to a variety of reasons including basic iron deficiency. In absence of the diagnosis and treatment taken by Smt. Dhuri four years back Menorrhagia and Anemia, it would remain unfounded. Strictly speaking this type of disclosure is not normally expected of a lady to mention in the proposal form as in some form or other this ailment is experienced by a large number of persons at varying degrees and unless diagnosed by a Doctor, nobody takes that serious note of the ailment to be mentioned in the proposal form. The Complainant in his letter dated June 26,2004 has contested this notion on the ground that even 4 years back in 1999, she had recorded 12.6 gms Hemoglobin against normal range for females 12 to 16 gms. This was adequate and therefore, since anaemia can occur due a varied reasons and here it was iron deficiency identified, the most common for ladies, coupled with other ailment of spondylolysis the conclusion would be to strike a balance. In reality this type of treatment is done at home after necessary investigations which is quite common but as the Company has not raised that issue and the Insured having been investigated at the Hospital followed by some treatment, a reasonable view would be to grant 50 % of the expenses only, with the contributory factors like excessive bleeding playing its part as well.

Mumbai Ombudsman Centre
Case No. GI - 411 of 2004 - 2005
Shri Pravin Raghunath Vartak
Vs
The New India Assurance Co. Ltd.

Award Dated 25.8.2005

Shri Pravin R. Vartak took a mediclaim policy from The New India Assurance Co. Ltd., Vasai D. O. for a period from 19.9.2003 to 18.9.2004 for a Sum Assured of Rs. 30,000/- for each members of the family. The claim arose in the year 2004 when his son Kumar Dhaval P. Vartak was admitted to Dr. Raut E. N. T. Hospital on 18.04.2004 for Septoplasty operaton and got discharged on 21.04.2004. Shri Pravin submitted all the claim papers to M/s Paramount Health Services Pvt. Ltd. for reimbursement of the hospital expenses. On 26.7.2004, they informed Shri Vartak that his claim is not admissible and it fell under Exclusion Clause 4.3 of the Mediclaim Policy which excludes coverage for treatment of sinusitis and related disorder during the first year of the operation of the insurance cover.

Let us examine the discharge card of Dr. Raut ENT Hospital and specially the diagnosis arrived at. The history says “c/o cold off and on since 2 months. Nasal Obstuction Rt. Side.” Diagnosis made was “DNS Rt. Chronic Rhinitis and the treatment

was “Operation”. “Septoplasty done under GA” on 19.04.2004. Septoplasty is plastic surgery of the nasal septum and it is required to be done to correct deviated nasal septum. This becomes necessary to prevent repeated cold infections, cold allergy, running nose or similar complications. Under the instant case the aliment was “Chronic Rhinitis” which is characterised by “mucous membrane becoming thinned and fragile. Overgrowth / increased secretion of the membrane” is the resultant effect. The complications mentioned in the analysis of the disease requiring surgery fits in with the Insured’s and would a pre-existing condition going by the age of the policy which was taken first time in September 2003 only. The surgery was done on 19.04.2004 i.e. within 7 months of the inception of the policy. The Complainant maintained that the surgery done was “Septoplasty” and not for “Sinusitis” which is correct. However, he failed to appreciate the medical connotation of “Sinusitis”. A ‘Sinus’ is a cavity and cavity can occur anywhere in the body. However, the specific reference to sinusitis would mean inflammation of a sinus specially, a paranasal sinus. The pre-disposing factors include inadequate drainage, which may result from presence of polyps, enlarged turbinated or deviated septum, chronic rhinitis etc. Exactly that has happened with the Insured as he was operated for deviated septum giving rise to chronic rhinitis. Hence, the genuine name ‘sinisitis’ is in order for invoking as per exclusion clause 4.3 being done in the first year of operation of the policy. Moreover, it is not acceptable that the unusual growth of the nasal septum would occur in a span of 6 / 7 months to give so much problems to the Insured that he would be forced to take course of surgery which is usually the last resort particularly in respect of a sensitive organ like nose. In the facts and circumstances, the decision of the Company i.e. New India Assurance Co. Ltd. to repudiate the claim is in order.

Mumbai Ombudsman Centre
Case No. GI - 229 of 2004 - 2005
Shri Shantanu Dilsukhrai Chhaya
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Shri Shantanu Dilsukhrai Chhaya and his wife Smt. Nishtha S. Chhaya was covered under a Mediclaim policy No. 140100 / 48 / 03 / 10933 issued by The New India Assurance Company Limited, D. O. 140100 for a Sum Insured of Rs. 5,00,000 with Cumulative Bonus. It is reported that they were continuously insured from 1996. Shri Shantanu D. Chhaya was hospitalized for Acute Bronchitis with DM c HT c Obstructive Sleep Apnea Syndrome and when Shri Shantanu Chhaya filed the claim for Rs. 61,000/- for the said hospitalization to the New India, the TPA of the Company M/s Paramount Health Services Pvt. Ltd. after scrutiny settled the claim for Rs. 11,000/- after deducting Rs. 50,000 towards the CPAP machine which as per the Insurance Company was not payable. Not receiving any favourable response from the Company, Shri Shantanu Chhaya approached the Office of the Insurance Ombudsman. Records were perused and the parties to the dispute were heard. The main dispute under this claim is the payment of an appartus which was required by Shri Shantanu D. Chhaya to ward off his problems The basic treatment received by him in the hospital was admitted by the Company under the terms of the policy but was not settled due to non-receipt of discharge voucher from Shri S. D. Chhaya. A close scrutiny of the policy would reveal that Mediclaim policy covers hospitalisation expenses for medical / surgical treatment at any Nursing Home / Hospital in India” - as defined, as in patient, or “on domiciliary treatment” under domiciliary hospitalisation benefits under specific circumstances.

Hence on this ground the claim for CPAP machine fell outside the scope of the policy and therefore, the repudiation of the Company to that extent is sutainable.

Mumbai Ombudsman Centre
Case No. GI - 261 of 2004 - 2005
Shri Nishikant D. Kerkar
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Shri Nishikant D. Kerkar was covered under Mediclaim Policy issued by The New India Assurance Company Limited, Divisional Office 112500 under citizens' Co-operative Hospital Limited from 19.5.2003 to 24.5.2003 for upper GI bleed following drug induced gastritis with oesophageal varices (old) and Left Foot cellulities (Cirrhosis of Liver (Old). When a claim was preferred by Shri Nishikant Kerkar for the said hospitalization to the Company, Company repudiated the claim invoking clause 4.8 of the mediclaim policy. His representation for reconsideration of the claim was also turned down by the Company. Hence aggrieved by the decision of the Insurance Company Shri Kerkar approached this Forum for redressal of his grievances.

The scrutiny of the diseases does not take much time to conclude that it was a case of basic liver complications. Cirrhosis of liver which was caused by alcohol consumption as is the common cause and thus mentioned as "alcoholic liver disease". In fact all the complications gastritis, Oesophageal varices, GI bleed 'deuodenitis, peptic ulcer, malena, haematemesis and cellulites are all due to liver problems alcohol induced. All these are logical conclusions of alcohol abuse and excessive drinking habits giving rise of Cirrhosis of liver.

As the entire group comes under main laid of liver disease due to alcohol and as per the exclusion clause 4.8 the decision of the Company to repudiate the claim on the above ground need not be interfered with.

Mumbai Ombudsman Centre
Case No. GI - 225 of 2004 - 2005
Shri Ramnik J. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 29.8.2005

Shri Ramnik J. Shah alongwith his wife and son took the Mediclaim policy for the first time on 15.10.1999 from The New India Assurance Company Limited Divisional Office 111300 which was renewed continuously. Shri Ramnik J. Shah was hospitalized at The Bhatia General Hospital from 17.7.2003 to 19.7.2003 for chest pain. When Shri Shah preferred a claim the Company repudiated the claim on the ground that it fell under exclusion clause 4.10 and their contention was that the hospitalisation was only for investigations and the findings were not consistent with diagnosis. Aggrieved by the decision, Shri Ramnik Shah approached this Forum for redressal of his grievance. Shri Ramnik J. Shah submitted that he was admitted to the hospital under a regular medical advice and the investigations revealed that he had heart ailments which was treated by medicine. Accordingly, the Company's contention that the hospitalisation was not necesary and that it was utilized for the purpose of investigations without any illness for which treatment had to be done, was not established. The dispute is regarding the Company treating the admission to hospital for investigation purpose which would fall

under exclusion clause 4.10. However, various investigations conducted did not show any abnormality and exact positive existence of illness. He was prescribed medicines primarily to control Hypertension, possible unfavourable lipid profile and S.O.S. Sorbitrate. The Mediclaim Policy is governed by the Policy terms and conditions and it starts with the operating clause of "reasonably and necessarily" incurred expenses to be reimbursed. Read in conjunction with the clause 4.10, it would be natural to conclude that as oral medicines were suggested on the basis of some investigations which could very easily have been done as an outpatient, the provisions of the clause are applicable.

In the light of the above findings the decision of the Company to repudiate the claim is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 240 of 2004 - 2005
Smt. Nayana A. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 30.8.2005

Shri Ashwin Jamnadas Shah and his family members were covered under the mediclaim policy of the New India Assurance Company Ltd., for Rs, 1,00,000/- each since 1999. The policy was issued with exclusion of Diabetes. Shri Ashwin Shah was admitted to Bharatiya Arogya Nidhi Hospital for chest pain under the care of Dr. Mahesh K. Shah and on his advice Shri Shah was transferred to Sir Hurkisondas Nurrotamdas Hospital was diagnosed as having Coronary Artery Disease (Anterior Wall Myocardial Infraction) + Cardiogenic Shock and was performed PTCA (Percutaneous Transluminal Coronary Angioplasty) He submitted all the documents pertaining to the claim to the TPA M/s. Paramount Health Services Ltd. for processing the claim. On 22.10.2003, they informed the Insured about their decision to repudiate the claim under Exclusion Clause 4.1 of the mediclaim policy stating that the Insured was a known case of Diabetes Mellitus since 20 yrs. The Company also referred the matter to its panel doctor, Dr. M. S. Kamath for his Medicolegal opinion after receiving a legal notice from M/s Little & Co. Ltd. on behalf of Shri Shah.

On close scrutiny of the above complaint together with all relevant documents it is evident that the Company's issuance of policy was subject to exclusion of diabetes and related diseases. The Company has explained that their Computer Software Package does not admit longer space in respect of exclusions and therefore the word diabetes is appearing illnesses directly related to the disease would get exclusions from the scope of the policy. Shri Shah being on regular medicine for diabetes which also necessitated taking insulin injection which has proved him to be a known case. This indoor case papers may not have been received by the TPA for which they quoted the reference elsewhere by the hospital doctor that he was diabetic for many years. However, the repudiation letter written by the TPA and the Medicolegal Consultant's opinion received by the Company could clear the doubt that Insured was suffering from diabetes since 20 years.

The Insured has raised an issue that admittedly he suffered from diabetes but the hospitalisation was for heart ailment for which Angioplasty was done and therefore the claim should be settled. The analysis which should follow as a counter argument to this view of the Insured would be that diabetes Mellitus which is insulin dependent usually occurs at a young age of 25 / 30 yrs. It is a chronic disorder of carbohydrate metabolism, marked by hyperglycemia and glycosuria and resulting from inadequate

production or use of insulin. The Medical Theory confirms that there is an increased incidence of large vessel altherosclerosis and Myocardial infarction in patient with insulin and noninsulin dependant diabetes mellitus. Coronary Artery Disease is the most comon cause to occur Diabetes Mellitus in adults. Diabetes Mellitus is an independent risk factor for coronary artery disease. As the Insured's policy is from March 1999 and the hospitalisation for PTCA took place in October, 2003, the Company's repudiation of the claim us upheld and becomes sutainable.

Mumbai Ombudsman Centre
Case No. GI - 180 of 2004 - 2005
Shri Nandkishore Goenka
Vs
National Insurance Co. Ltd.

Award Dated 31.8.2005

A Group Mediclaim Policy No. 260800 / 46 / 2002 / 8500045 was issued by Bank of India to its Cardholders and they renewed their Mediclaim Policy with various Insurance Companies. Shri Nandkishore Goenka was covered under the said Policy of Bank of India. Shri Goenka had undergone a right eye cataract operation at Bombay Hospital and after hospitalisation he preferred a claim to the National Insurance Co. Ltd. The Company repudiated the claim on 20.11.2003 stating that Right eye surgery was excluded from the policy hence the claim fell under Exclusion Clause 4.1 of the Mediclaim policy.

The issue on which the dispute arose is whether the policy issued by 'National' after taking over from 'Oriental did contain an exclusion of Cataract surgery or not. The next issue which arises in our mind is why did this shifting of insurance take place ? It is found that Bank of India's Group Mediclaim Insurance got shifted from New India to Oriental and the Insurance Company taking the business enforced their underwriting decision to exclude certain illness already contracted. It could be due to the fact that already the entire group with heterogeneous health factors pose a claim potential far higher than estimated for which the particular Insurance Company wanted to keep off from known cases developing into further claims. It goes against the principle of continuous insurance between the four Public Sector Units but they could well argue of following this principle for individual medical insurance policy but not for Group covers where control on individual health data for past illness is difficult to access.

New India by their certificate dated 12.4.2004 confirmed that they settled the Cataract surgery on left eye for Rs. 57,187/- on 12.10.1998. They also confirmed that they excluded by-pass surgery and diabetes from the scope of their policy. Oriental took the policy in 2001 and promptly excluded all three diseases including cataract which obviously meant in the other eye i.e. right eye. They also excluded Brain Tomour surgery vide their certificate dated 10.5.2001 and their policy for the period 1.1.2001 to 31.12.2001 issued to Shri Goenka. This was accepted by the Insured, Shri Goenka and he did not object at that time that he would not like these exclusions. Moreover, it was a contract between the two parties with underwriting terms, which were optional to the Insured at that time. However the document was allowed to be renewed and at the renewal the exclusions did not specifically appear but that the new document renewed the earlier policy with all terms and conditions was mentioned. Even otherwise the effect would be the same as per clause 4.1 of the policy. The selection against the risk offered of a person of above 70 yrs of age is the decision of the Company and this Forum cannot call in question underwriting terms or acceptance offers now once the document has been issued and accounted for.

Based on the factual position and aided by the certificates issued by the Insurance Companies who granted insurance to Shri Goenka, I find no reason to interfere with the decision of National Insurance Co. Ltd. to reject the claim for right eye cataract surgery for Shri Goenka.

Mumbai Ombudsman Centre
Case No. GI - 241 of 2004 - 2005
Shri Sinclair Mendonca
Vs
National Insurance Co. Ltd.

Award Dated 2.9.2005

Shri Sinclair Mendonca alongwith his father Nerrys Mendonca was insured under an Individual Mediclaim policy No. 250601 / 48 / 03 / 8502369 issued by National Insurance Company Limited, through Varishield Health Care Limited. Shri Sinclair Mendonca at the time of proposing for insurance in the year 2002 had disclosed in the proposal form that his father was suffering from Asthma, cancer, Heart stroke renal problems. However, National Insurance Company in their column of exclusion had excluded only Asthma as per policy issued in the year 2002, while under the policy No. 250610 / 48 / 03 / 8502369 which was issued for the period 2003 - 2004 there were no exclusions on the face of the policy against Shri Nerrys Mendonca. Shri Nerrys Mendonca was hospitalized at Holy Family Hospital, Mumbai from 16.1.04 to 21.1.04 and again on 12.3.04 to 22.3.04 for Acute Exacerbation of COPD and when he preferred claims for the said hospitalisations the company, based on the opinion of their panel doctor, repudiated both the claims on the ground of pre-existing illness by invoking clause 4.1 of the mediclaim policy and also non-disclosure of the material fact. Not satisfied with the decision of the Company, Shri Sinclair Mendonca represented to the company and approached before the Insurance Omdusman with a complaint against the Company.

After perusing the records both the parties to the dispute were called for hearing. It seems the essential dispute is regarding the exact nature and scope of the disease Chronic Obstructive Pulmonary Disease (COPD), vis - a vis Bronchil Asthma. On close scrutiny it would appear that the Company's approach was extremely theoretical. While repudiating this case the Company did not take the allied or similar symptoms which the Consultant has categorically mentioned. It is also a known fact that bronchial asthma for longer duration develops into COPD. Moreover the entire group of Pulmonary disease is the whole range which into COPD and rather be called with the generic name and hence the charge of non-disclosure or pre-existing illness cannot be held against the Insured as the Company has taken a narrow view or hair splitting view of the disease.

National Insurance Company Limited is directed to settle the claim of Shri Sinclair Mendonca in respect of his father Shri Nerrys Mendonca's hospitalisation at Holy Family Hospital, Mumbai from 16.1.04 to 21.1.04 and again on 12.3.04 to 22.3.04 for Acute Exacerbation of COPD.

Mumbai Ombudsman Centre
Case No. GI - 294 of 2004 - 2005
Shri Rasiklal Dagli
Vs
United India Insurance Co. Ltd.

Award Dated 8.9.2005

Shri Rasiklal Dagli was covered under mediclaim policy No. 020300 / 48 / 03984 for the period 06.11.2002 to 05.11.2003 for a Sum Insured of Rs. 2 lacs with Cumulative Bonus. He was continuously covered under the mediclaim policy since 5.11.1996. Shri Rasiklal Dagli had preferred a claim to the United India and the Company repudiated the claim under exclusion clause 4.1. Shri Dagli's representation to the Company was also turned down and hence aggrieved Shri Rasiklal Dagli approached this Forum for justice. Records have been perused and parties to the dispute were called for hearing.

Ombudsman made a specific inquiry from Shri Dagli as to whether the recording of 1992 of his having Angina was in order and he replied that he received treatment form Hinduja Hospital but which cannot be called as a heart attack which was evident from the reports made available to him at that time. On this basis he felt, his claim was valid and should be considered. The dispute is essentially on the issue that the Insured received an earlier claim in 1998 for Myocardial Infarction under the policy from united India which was a heart disease while the specific claims for three hospitalizations between July and September, 2003 for unstable angina transient ischaemic attack (TIA) and coronary artery disease have been rejected.

In the facts and circumstances, the decision of the Company to reject the claim on grouds of non-disclosure and pre-existing illness as per clause 4.1 of the Mediclaim policy is sustainable.

Mumbai Ombudsman Centre
Case No. GI - 220 of 2004 - 2005
Shri Prabhakar D. Tawde
Vs
The New India Assurance Co. Ltd.

Award Dated 12.9.2005

Shri Prabhakar Dattatraya Tawde alongwith his wife Smt. P. Tawde was insured with The New India Assurance Co. Ltd. since 2000 for a sum insured of Rs. 1,00,000/- under a Mediclaim Policy. Shri Tawde and his wife got admitted at Nisargopchar Gram Seva Trust for Arthritis and obesity from 16.06.2003 to 16.07.2003 and after taking treatment, Shri Tawde preferred a claim to the Company for reimbursement of the treatment expenses. He submitted all necessary documents to TPA, M/s Paramount Health Services for processing the claim. After scrutiny of the papers, the TPA informed Shri Tawde that the claim fell under Exclusion Clause 4.13 of the mediclaim policy i.e. Naturopathy treatment which is not payable.

This Forum had the opportunity of examining similar type of claims lodged in respect of some other cases where a different forms of treatment technique was taken. One should be very clear about the policy terms and conditions and the exact scope of coverage. It has to follow the exclusions and therefore, applicability of the policy. The treatment received by the Insured and his wife from "Nisargopchar Gram Seva Trust" is easily marked by the name of the Institution which professes to treat in a natural way, under natural surroundings, with various natural processes of system overhauling through yogas, upasanas and vipasanas which come under the system of 'Naturopathy'. It was registered as a Trust and not as a Hospital Nursing Home. This is an alternative system of treatment and a school of medicine which is now gaining ground. What would happen later or should be done now to consider this form of treatment is beyond the issue for consideration by this Forum now but it clearly falls outside the scope of the Mediclaim policy issued to the insured. The insured and his wife was diagnosed as having arthritis and had obesity as well. Even for arthritis there is no need for hospitalization and receive long-drawn treatment. It is treated at home

unless there are complications of life theatening nature. The Insured has admitted that out of Rs. 16,315 claimed by him Rs. 12,000/- was for staying. Similarly, for obesity which follows a dietary regimen over a period along with some exercises. The Insured in his letter dated 08.09.2003 admitted that he knew it was a naturopathy treatment but the clause has not explained further about inclusions or exclusions and that some of the Doctors were practising Allopathis as well. This Forum has examined the entire course followed there and is convinced that the treatment followed a package e.g. dietary, exercises, yoga system, meditation, adequate rest Ashram - like life maintance techniques and some natural / herbal groups of medicines. The exclusion clause 4.13 clearly rules out coverage for these and therefore, the rejection of the claim by the TPA and Company is sutainable.

The claim of Shri Prabhakar Dattatraya Tawde for reimbursement of treatment expenses incurred for himself and his wife Smt. Sulbha P. Tawde at Nisargopchar Gram Seva Trust for Arthritis and Obesity from 16.06.2003 to 16.07.2003 is not sustainable.

Mumbai Ombudsman Centre
Case No. GI - 355 of 2004 - 2005
Shri Kirit J. Bhatt
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12.9.2005

The Oriental Insurance Co. Ltd. had issued a Mediclaim policy to Shri Kirti J. Bhatt covering all his family members since 1989. He preferred a claim to the Company after hospitalisation on 07.11.2003 at Bhatia General Hospital under the care of Dr. Hemant Thakkar and was diagnosed as having CVA with Hypertension and was discharged on 13.11.2003. He claimed reimbursement of his hospitalisation expenses of Rs. 26,000/- from the Company. The claim was processed by M/s Raksha TPA and vide their letter dated 20.05.2004 they infromed the Insured that the claim is not tenable as it fell under Exclusion Clause 4.1 of the mediclaim policy.

The issue is only regarding a break in insurance cover which was in force since July 25th, 1989 until 1998 when the premium amount was realised on 28.07.1998 and cover continued as such. The Company's point of view was as the cheque was dishonoured there was a break which was not condoned. The Insured's contention was that he was assured by the concerned official that upto 7 days break, condonation would be possible and that all benefits under the policy would be granted. Accordingly, the Cumulative Bonus was allowed as per accrual. He felt the Company was unreasonable with otherwise a loyal person who was with the Company for 15 years.

A close scrutiny reveals that the discontinuance of the policy was due to dishonour of the cheque the Insured submitted which is no doubt a strong adverse point. However, the Insured's explanation that anticipated amount did not come and without checking the balance, he gave cash amount after knowing that the cheque was dishonoured. At this point condonation could have been officially applied for by the Insured for granting by the Office Manager which he did not do as allegedly he was assured by the dealing officer of a positive action. This can be accepted by the action of the Company as they granted him Cumulative Bonus any way. Considering the fact that hypertension was already there when he was insured with the Company since 1989 strictly speaking the charge of pre-existing illness or non - disclosure cannot be levelled that way in the true sense. Taking the lapse to be bonafide and granting the fact that on suitable

application the Company could have considered the condonation of 3 days break as per the policy provision, I take a lenient view to grant the Insured 75 % of the admissible expenses. The 25 % deduction is justified as the cheque was not honoured on time which is indeed an offence.

The Oriental Insurance Co. Ltd. is directed to pay 75 % of admissible expenses incurred by Shri Kirit J. Bhatt in respect of his hospitalisation for Cerebro Vascular Accident (CVA) at Bhatia General Hospital from 07.11.2003 to 13.11.2003. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 306 of 2004 - 2005
Shri Ravilal Dedhia
Vs
The New India Assurance Co. Ltd.

Award Dated 12.9.2005

Shri Ravilal Dedhia was insured under a Mediclaim Policy alongwith his wife Smt. Javeraben R Dedhia since 1995 with a Sum Insured of Rs. 1,00,000 each. He lodged a claim for his hospitalisation on 18.2.04 under policy No. 140300 / 48 / 03 / 11043 The hospitalisation led to the diagnosis of Apraxia of speech and Aphonia with cortico basal ganglionic degeneration for which he was investigated and treated. When he lodged a claim the same was rejected on the ground that only investigation and evalution have been done at the hospital which should have been done as outpatient as there was no urgency to get hospitalized. The Insured thereafter approached the Insurance Ombudsman for redressal of his grievances. The point of dispute really relates to the nature of disease, the investigation conducted the final diagnosis made and the treatment received which are strongly suggestive fo a long drawn neurological and circulatory disorder. The mediclaim policy operates within certain limitations set upon by the terms and conditions of the policy. One important condition which is 4.10 appearing under broader exclusion head. It would be seen that the Company took both the defences (a) that the disease was pre-existing arising out of the exclusion “Diabetes and related diseases” from the scope of the policy and (b) there was no need for hospitalisation. It is however, no doubt acceptable that longer suffering from diabetes can cause various circulatory problems in the entire system and certainly in brain and finally lead to even unrelated complications on a long term basis. He has admitted that since the patient was wheel - chair bound, it was not possible to investigate on OPD basis which otherwise proves the Company’s point of view. Essentially, therefore, strictly as per the policy terms, the repudiation of the Company could be held in order.

In the facts and circumstances The New India Assurance Company Limited is hereby directed to settle the claim for 50 % of admissible expenses incurred by Shri Ravilal Dedhia for his hospitalisation being a reasonable settlement considering the nature of ailments leading to number of complications uncommon in nature.

Mumbai Ombudsman Centre
Case No. GI - 392 of 2004 - 2005
Smt. Usha Manohar Puntambekar
Vs
The Oriental Insurance Co. Ltd.

Award Dated 13.9.2005

Smt. Usha Puntambekar alongwith her husband Shri Manohar Puntambekar was continuously insured under the Mediclaim Policy issued by The Oriental Insurance Company Limited from 21.1.1993 till 20.1.1998. As he could not renew the policy, a fresh policy was issued by The Oriental Insurance Company Limited from 29.1.1998 with a gap of 8 days. The Company had issued a fresh policy from 29.1.1998 to 20.1.1999 without any Cumulative Bonus. From 29.1.1998 the policy was thereafter renewed regularly. Smt. Usha Puntambekar was hospitalized at Sadanand Danait hospital for mild diffuse annular bulge at L_1 - 2, L_2 - 3 and L_3 - 4. When she submitted the claim to the TPA of the Oriental Insurance Co. Ltd. M/s. Raksha TPA Pvt. Ltd. repudiated the claim on the ground of pre-existing illness invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision she represented and approached this Forum for justice.

The analysis of the case reveals that Smt. Usha Puntambekar was having low back pain particularly in the leg and it was mentioned that it was so since 5-8 years and further analysis reveal that it has only been characterized as back pain which many experience particularly the ladies after a certain age. Hence the disease was not identified and diagnosed before 5-8 years as has been in 2003 following various investigations. Moreover the MRI Scan revealed that it was mild diffuse annular bulges and moderate left paracentral disc herniation which can always take place even as an aging processes considering the age of the Insured. The TPA and the Company have taken the ailment as 8 years standing and not 5 years standing which could be an alternative mode of argument. However, going by the loyalty factor which makes it a continuous period of insurance for more than a decade as at the time of hospitalisation i.e. March 2003, I am of the view that suitable consideration must be made to consider the Insured's genuine claim. In fact if it was for 5 years, it would be a borderline case. Again, the fact that the policy was not renewed on time for whatever reasons cannot be ignored and therefore, 25 % deduction of the admissible expenses would be justifiable to resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI - 531 of 2004 - 2005
Smt. Flora M. Gracias
Vs
The New India Assurance Co. Ltd.

Award Dated 13.9.2005

Smt. Flora M. Gracias alongwith her family members was insured under mediclaim policy of the New India Assurance Co. Ltd. since 2002. The policy was issued with exclusions of diabetes, obesity and related complications. She preferred a claim to the Company after her hospitalisation at Prince Aly Khan Hospital from 19.07.2004 to 29.07.2004 for Strangulated Vental Hernia. The claim was processed by M/s TTK Healthcare Services Pvt. Ltd. and on 11.10.2004 they informed the Insured about their inability to settle the claim as it fell under Exclusion Clause 4.1 of the mediclaim policy. Not satisfied with the decision of TPA, she represented to the Company. The Company in turn referred the matter to Dr. A. V. Patil of Expert Medicolegal Consultancy for his opinion and accordingly, the Company repudiated the claim on the basis that the disease was pre-existing and also mentioned that the proposal form does not reveal the history of the past LSCS (Caesarean) surgery.

An analysis of the relevant record submitted to this Forum would reveal the following. As per the mediclaim policy issued in June, 2002 cover for diabetes, obesity related complications was excluded. The Insured was hospitalised in Prince Aly Khan Hospital

during the period from 19.07.2004 to 29.07.2004 for Strangulated Ventral Hernia. While going through the clinical notes it is observed that the insured had history of peritonitis and LSCS i.e. Caesarean surgery in 1978. The insured in her letter dated 14.12.2004 to the Company has admitted that she had LSCS in 1978 & 1984. In the present hospitalisation the insured had Strangulated Vetral Hernia. Incisional Hernia arises through a surgical scar and Vental Hernia occurs through the abdominal wall. If streching and thinning of an abdominal scar occure, pressure from abdomen may cause protrusion of part of the gut. It is an acceptable fact that from the past LSCS done, there would always be a possibility of occurrence of Vental Hernia and in the instant case obstructed Strangulated Hernia occurred in the region of previous surgery of LSCS. From the above records it becomes quite clear that the occurrence of strangulated Vental Hernia is due to the previous LSCS the insured had. Surgical intervention in the health is an important intervention which should have been disclosed irrespective of the age of the surgery. Had she disclosed this operation in the proposal form the Insurance Company would have taken appropriate decision before issuing policy. The Company took a further expert opinion on the issue and the doctor held the view that the earlier two surgeries acted as a trigger coupled with obesity of the Insured. Since LSCS was pre-existing prior to the submission of the proposal the claim is not entertainable under Clause 4.1 which is produced hereunder.

4.0 The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of :-

4.1 All diseases / injuries which are pre-existing when the cover incepts for the first time.

Accordingly, the decision of the Company to reject the claim under Clause 4.1 of the mediclaim policy is acceptable and this Forum has no ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI - 446 of 2004 - 2005
Dr. Anand N. Nathwani
Vs
The Oriental Insurance Co. Ltd.

Award Dated 16.9.2005

Dr. Anand N. Nathwani took a mediclaim policy from the Oriental Insurance Co. Ltd. covering himself and his family members under policy no. 124200 / 48 / 04 / 818. Dr. Nanthwani preferred a claim of fracture neck femur of his mother - in - law for a sum of Rs.
1,13,847/-. As the claim was processed by M/s Rakha TPA and after proper scrutiny of the expenses incurred, they passed the claim for Rs. 78,920/-. The Insured represented to the Company for balance amount of payment which was not considered as the Company upheld the decision of the TPA he approached the Insurance Ombudsman. The complaint was gone through as per the records made available to this Forum The dispute is regarding non-payment of Rs. 34,926.64 by the Insurance Company which is composed of basically the private nursing charges of Rs. 31,050. On going through the relevant records, it is observed that the Insured had a fall for which she was admitted in Bhatia General Hospital for necessary treatment. The X-ray revealed fracture of left neck femur which was treated rather conservatively perhaps

considering that the lady was 76 years of age. A total cost of Rs. 1,13, 847 was filled by the Complainant and Rs. 78,920 was paid.

The TPA observed that Bhatia General Hospital equipped with all infrastuctural facilities including nursing facility. Hence need for engaging private nurses does not arise. This would be outside the purview of the policy and going by the clause 1.0 which essentially serves the basic insurance principle of paying only necessarily and reasonably incurred costs, I find the decision of the Company in disallowing the private Nursing charges and equipment charges is quite reasonable and this Forum finds no need to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI - 441 of 2004 - 2005
Smt. Ila J. Rupani
Vs
The New India Assurance Co. Ltd.

Award Dated 19.9.2005

In the matter of the above complaint the dispute is relating only non-settlement of Rs. 20,000/- pertaining to surgery costs of hernia incurred by Smt. Ila J. Rupani. She was hospitalized for her complaints which required abdominal hysterectomy, appendectomy and ventral incisional hernioplasty during her hospitalization between 26.2.04 to 3.3.04 under care of Dr. Dastur. The company paid the claim for Rs. 71,857 through their TPA M/s Paramount Health Care out of Rs. 91,875 leaving out Rs. 20,000 odd amount for hernioplasty on the ground that it was incisional hernia arising out of past surgery which happened to be delivery by caesarian section (LSCS) in 1973. Smt. Rupani felt that it was an unreasonable stand of the company which was wrong and her claim was unnecessarily held up. She therefore, approached the Ombudsman's Forum for redressal.

The analysis reveals that the TPA has gone by the Caesarian Section which had to be done as back as 1973, i.e. more than 30 years back. This is quite surprising to note the last sentence which gives a feeling all females having caesarian surgery would have hernia and there would not be any other independant cause of hernia. Infact there are a number of causes for hernia with different forms with different presenting symptoms. The company has disregarded the specialist's opinion provided by the Insured that the hernia developed over a period of a year only and normally the development of hernia takes place over a period of time for which the policy from 1997 would be quite a long period to reckon such a contingency. If all abdominal surgery would give rise to hernia then the company should exclude cases of all "hernia" as such from the scope of the policy whenever the answer to abdominal surgery would be positive. This will again expose them to further scrutiny which would be difficult to satisfy.

In view of the above analysis it would appear that there is a case for setting aside the company's rejection and accept the claim in full.

Mumbai Ombudsman Centre
Case No. GI - 351 of 2004 - 2005
Miss Jully Pukhraj Jain
Vs
The New India Assurance Co. Ltd.

Award Dated 21.9.2005

Miss Jully Pukhraj Jain had approached the Office of the Insurance Ombudsman with a grievance against The New India Assurance Company Limited, D. O. 110800 for non

settlement of her claim under Mediclaim policy No. 110800 / 48 / 02 / 02580. Miss Jully Pukhraj Jain was hospitalized at Bombay at Bombay Hospital and Medical Research Centre, Mumbai for Appendicitis with Endometritis. When she preferred a claim for the said hospitalisation the Company, repudiated the claim invoking clause 4.1 and 4.8 of the mediclaim policy. The analysis of the case reveals that the Company rejected the claim on the basis of their panel doctors opinion who was himself is an Obstetrician and Gynaecologist. It was their conceded opinion that endometrosis which was diagnosed was long standing and she was operated upon for appeandectomy and extensive endometrosis also as a part of infertility investigation. The examination of the file reveals the fact that she had pain in the abdomen from 2 months and the pain in the abdomen from 2 months and the pain was in right and left iliac fossa. It is also mentioned that the pain was not related to menstrual cycle. She was operated for appendectomy and during the surgery it was found that she had endometriosis and the doctor had performed endometral biopsy with D & C. She had also undergone a mythelene blue patency test which is done only as a part of infertility investigation. The Company rejected the claim on the ground of pre-existing illness (clause 4.1) and being an infertility treatment (clause 4.8) of the Mediclaim Policy. Thus Company's rejection on the ground of infertility / sterility treatment as per clause 4.8 of the mediclaim policy is acceptable. However, there was other complaints and the primary one for which she was hospitalized was chronic appendicitis. Based on this confirmation and actual health status of Ms. Jully Jain it is felt that appendicectomy should be payable which justifies hospitalisation and as per the doctor's statement she had suffered from both appendicitis and endometriosis which was detected on laparoscopy in operation theatre. In the facts and circumstances the total repudiation of the claim by The New India Assurance Company Limited is hereby set aside and restricted to the rejection of expenses towards reimbursement of treatment of endometriosis, biopsy and D & C and admission of expenses for Appendicectomy only. As it would be difficult to segregate the amount and the respective services relating to appendicectomy it would be fair to approve the claim on 50 % basis. The New India is hereby directed to settle the claim on 50 % basis of the overall admissible amount.

Mumbai Ombudsman Centre
Case No. GI - 243 of 2004 - 2005
Smt. Jayshree Bhadresh Mehta
Vs
The New India Assurance Co. Ltd.

Award Dated 22.9.2005

In the matter of above complaint, Smt. Jayashree B Mehta approached the Office of Ombudsman by her letter dated 02.08.2004 regarding non-settlement of her claim for Tympanoplasty which was rejected by The New India Assurance Co. Ltd., Dombivali Branch. It is reported that Smt. Mehta was hospitalised at Snehal ENT Clinic with complaints of pain, swelling and discharge in both ears. She was diagnosed as having Bilateral Otitis Media for which surgery was done on 02.05.2003 and she was discharged on 03.05.2003. However, her claim was rejected by New India on the ground that Otitis Media could not have developed suddenly but over a long period for standing complications for which the illness was pre-existing and the claim non-payable, vide their letter dated 09.07.2003 which was followed up by the Company consequent upon representation of the Complainant and finally concluding with their letter dated 28.06.2004.

The analysis of the case reveals that the hospital discharge card had given the diagnosis as Bilateral Otitis Media leading to left Tympanoplasty on 02.05.2003. Earlier she was treated at Vardhaman Clinic and as per their prescription cum reference certificate it was a case of discharge from left ear since 15 days. The impression was noted as “perforation of ear drum Lt. Side” and antibiotics given as medicines. She was thereafter referred to Dr. Dinesh Vadher. The said doctor had his own clinic where she was admitted on 02.05.2003 for surgery. The detailed treatment received by her was examined by the Medical Consultant and specialist of the Company. After analysing the episode, he opined as under as per his certificate dated 20.06.2003.

“Chronic Sup Otitis media is a long standing disease of the middle ear due to repeated infection of the URTI for many years. This claim could not be admissible due to chronicity of the disease which is pre-existing”.

Accordingly, the Company rejected the claim on 09.07.2003 and immediately thereafter the Insured represented the case through a certificate from the treating doctor, Dr. Dinesh J. Vadher vide his certificate dated 10.07.2003 that Smt. Mehta was suffering from the complaints since 15 days and that examined her only 15 days back. The notable point is that he certified that he examined her only 15 days back but what had happened before that was not known to him. The policy was inoperative since July, 2001 and the claim was lodged in the second year only. The history noted in the case papers reveal that she had pain, swelling and occasional discharge from the ears. She also developed deafness and on examination revealed a hole in the eardrum. Bilateral Otitis media is inflammation of the ear with presence of fluid in the middle ear accompanied by symptoms of repeated local infections. The main symptoms are pain in the ear, drainage of fluid from the ear canal and local infections. The main symptoms are pain in the ear, drainage of fluid from the ear canal loss of hearing. The treatment through antibiotics and decongestants fail to deliver on long term basis and depending on the nature and progress of the disease, surgery is recommended in this case. Tympanoplasty was done to cure a cronic inflamatory process in the middle ear and also to restore sound transmitting mechanism of the middle ear and also to restore sound transmitting mechanism of the middle year as allegedly she had a hole in the eardrum. It is therefore evident that the disease was long-stating for which it was pre-existing and there was non-disclosure of complaints at the time of taking the policy.

In the facts and circumstances, the decision of the Company to repudiate the claim as per Clause 4.1 of the policy is sustainable and the Complainant’s plea to admit the claim is non-tenable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 403 of 2004 - 2005
Shri Rajendra Singh Bhasin
Vs
The Oriental Insurance Co. Ltd.

Award Dated 22.9.2005

Shri Rajendra Singh Bhasin had taken an Individual Mediclaim Policy covering himself and his family members from The Oriental Insurance Company Limited. D. O. 9. The policy was taken for the firs time in the year 1999 for a Sum Insured of Rs. 1,00,000 which was continuously renewed thereafter. Master Harmeet Singh Bhasin son of Shri Rajendra Singh Bhasin was hospitalized at Breach Candy Hospital and Research Centre, Mumbai from for Revision of Pilonidal Sinus Scar. When Shri Rajendra Singh

Bhasin preferred a claim for the said hospitalisation the Company came to a conclusion that the claim was not payable. The contention of the Company was that as it was a plastic surgery the claim was not payable as per clause 4.5 of the mediclaim policy. Not satisfied with the decision of the company Shri Bhasin represented to one company but the company upheld the decision of repudiation. Aggrieved by the decision of the Company, Shri Rajendra Singh Bhasin approached the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. Records were perused and the parties to the dispute were called for hearing The analysis of the case reveals that Pilonidal Sinus as a "cyst containing hair hair follicer and sebaceous glands usually found at sites marking fusions of developing sections of the body in the embryo. Surgical removal is the best course by plastic surgery". He mentioned that his wife Smt. Darmanjee Kaur also suffered from the same disease.

After examination of all these presenting symptoms "revision of Pilonidal Sinus Scar" would appear somewhat compatible in the sense that the multiple abscess would have left some scar marks which was explained to this Forum by Shri Rajendra Singh Bhasin to give a graphic description of how painful these were to cover parts of the body and both his wife and son used to get repeated sprouts of boil and secretion through the wounds which had to be contained by medicines and surgery followed by appropriate long term treatment. In a bid to cure a patient if surgery is resorted to and has to be of a plastic / grafting nature one can't help. The way we mean palstic / cosmetic surgery to remove an awkwardly visible unpresentable body / health feature, the pilonidal surgery was not the one to fall in that category. Thus the said surgery cannot be called cosmetic or aesthetic or palstic in that sense for which it was excluded from the scope of the policy. However, a sharper analysis through documents made available to us coupled with medical theory regarding the above disease would point to a fact that the ailment was distinctly of some duration. The Mediclaim Policy is governed by the cardinal principle of reimbursing only the "reasonably and necessarily incurred" expenses. Hence any excess amount, more than necessary, may be passed on to the Insured.

Based on the analysis it would only be proper to impose a deduction of atleast 30 % on the admissible expenses for the hospitalisation and treatment availed by Master Harmeet from 9.10.2001 to 18.10.2001 for Revision of Pilonidal Sinus Scar and related treatment and allow the claim for settlement which has been denied to him.

Mumbai Ombudsman Centre
Case No. GI - 324 of 2004 - 2005
Shri Digvijaysingh Zala
Vs
The New India Assurance Co. Ltd.

Award Dated 26.9.2005

Shri Digvijiaysingh Zala approached the Office of Ombudsman with his complaint dated 06.09.2004 that his wife's hospitalisation expenses has not been paid by The New India Assurance Co. Ltd, D.O. 142000 on the ground that the disease was pre-existing as per their letter dated 04.08.2004. His representation was also not considered them for which he felt that despite getting insurance cover under a policy no. 142000 / 48 / 02 / 03458 issued by The New India as renewal, the Company's rejection was unreasonable.

The facts were analysed in line with the documents forwarded to this Forum. It appeared Smt. Gitaba Zala, wife of Shri Digvijaysingh Zala suffered from pain in

abdomen and was admitted to Ashirwad Nursing Home. The ailment was detected to be hernia and was repaired with prolene mesh and release of omental adhesion. The diagnosis was “Incisional Hernia”. The Company’s consultant opined that the expression suggests that it was ‘Incisional’, therefore, there must have been prior surgery over the abdomen to give rise to incisional ventral hernia.

Let us examine the operation notes and we quote “Repair of Incisional Prolene Mesh Hernia with Exploration and relax of Omental adhesions with appendectomy retro caecal under GA.” The Insured later wrote a letter to the Company admitting the fact that his wife was operated for caesarian section 1998 at the time of delivery but as per Dr. Shetty who performed the surgery there was no linkage between the two. An analysis of Dr. Shetty’s certificate dated 18.12.2003 did mention about umbilical hernia with apendicitis and abdominal adhesions. She underwent release of adhesions of umbilical and midline hernia which was confirmed by the doctor. The Insured also admitted the previous surgery at the time of hearing which was also not disclosed in the proposal form. As the name suggests it was ‘incisional hernia’. Secondly, there was adhesion which was released. Appendectomy was done as an additional safeguard after opening the abdomen to prevent any possible future complications. Considering the pre-disposing factor viz. Caesarian surgery in 1998 which was also not disclosed, the claim also being exactly on the 2nd year of the policy, the Company’s rejection on the ground of Exclusion Clause 4.1 is acceptable.

The claim of Shri Digvijaysingh Zala for reimbursement of medical expenses in respect of hospitalisation of his wife Smt. Gitaba Zala for Incisional Hernia at Ashirwad Nursing Home for the period from 14.06.2003 to 18.06.2003 is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 515 of 2004 - 2005
Shri Kiritkumar Sompura
Vs
The New India Assurance Co. Ltd.

Award Dated 27.9.2005

Shri Kiritkumar Sompura was covered under mediclaim policy issued by New India Assurance Co. Ltd. D. O. 111700 since 1998. He was admitted at Dr. Balabhai Nanavati Hospital from 16.07.2004 to 19.07.2004 for Transient Ischemic Attack. After hospitalisation he preferred a claim for the reimbursement of the medical expenses incurred at the hospital from the Company. The Company, New India Assurance rejected the claim through Raksha TPA on 08.10.2004 on the ground that the Insured is a known case of Hypertension since 6-7 years and Hypertension is proximate cause for the Transient Ischeamic Attack therefore the claim comes under Exclusion Clause 4.1. The Insured preferred an appeal against the rejection which was also not considered for which he approached the office of Insurance Ombudsman vide his letter dated 07.12.2004.

The discharge summary of Nanavati Hospital did mention that he had Transient Ischaemic Attack following sudden development of problems with upper and lower limb weakness. The other notings were “No h/o fall, LOC (loss of consciousness), vomiting, convulsion or slurred speech”. However, he has a “k/c/o HTN - taking amlopress (5) 6-7 yrs. No h/o DM, IHD etc.” Against this background the TPA rejected the claim just by quoting exclusion clause 4.1 which appears abrupt and not properly reasoned out.

Transient Ischaemic Attack is the result of temporary disruption of the circulation to part of the brain due to embolism, thrombosis to brain arteries or spasm of the vessel walls. The symptoms may be similar to those of a stroke but patients recover within 24 hours. Embolism is a condition in which an embolus becomes lodged in an artery and obstructs its blood flow. It is most likely the cause in this case as after the temporary attack the patient became alright soon after and there was no long standing fall out or after effects of the same. In the particular instance, the Insured was non-diabetic and had a largely favourable lipid profile. He had good LVRF. MRI showed “brain with diffuse, h/o no acute infarct encephalomalacic area. Left vertebral artery is hypoplastic with slow flow, rest of arteries normal”. Predominantly this is a sudden development and could be that hypertension as a circulatory disorder would be a predisposing factor but to dominantly mention this as the sole cause would be wrong in this case with other favourable health parameters. The TPA’s lack of analysis has merely made their viewpoint restrictive which the Company has accepted.

However, the Insured was taking medicines and possibly for quite sometime before the policy was taken and even the prescription of Dr. Pingale mentioned the diagnosis and medicines in October, 2001. The hospital recording of 6 - 7 years makes it around the policy period or slightly before that time. Even the urge to take mediclaim for such a low Sum Insured could have been felt by the Insured around the same time. To that extent there was no disclosure by the Insured as by inference he knew about it. Hence, I decide that as the period hepertension is isrtually borderline and trautient ischaemic attack could be of independant origin arising out of embolus, at least 50 % of the claim should be paid with benefit given to the Insured.

The New India Assurance Co. Ltd. is directed to pay 50 % of admissible expenses incurred by Shri Kiritkumar Sompura in respetct of his hospitalisation at Dr. Balabhai Nanavati Hospital for Transient Ischaemic Attack on ex-gratia basis. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI - 558 of 2004 - 2005
Shri Sachidanand N. Kini
Vs
The New India Assurance Co. Ltd.

Award Dated 27.9.2005

Shri Sachidanand N. Kini took the mediclaim policy for the first time on 20.7.2001 from The New India Assurance Company Limited, Divisional Office 111800 covering self and his wife Smt. Narmada S. Kini for a Sum Insured of Rs. 4 lacs each. Smt. Narmada S. Kini was hospitalized at Lilavati hospital, Mumbai for Hoshimoto’s Thyroiditis with Goitre. When a claim was preferred by Shri Kini the Company referred the file to their Medico-legal Consultant and based on their opinion repudiated the claim invoking clause 4.1 of the Mediclaim policy. Not satisfied with the decision of the Company, Shri Kini represented to the Company which was turned down. Aggrieved by the decision of the Company, Shri Kini approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. The records made available to this Forum were gone through. The contention of the Company was that claim attracted clause 4.1 of the policy because as per the Indoor case papers Smt. Kini had suffered from Goitre in 1983 and hence the disease was pre-existing whereas the contention of Shri Kini was that his wife had taken eltroxin in 1983 for physiological goitre treatment for 3 months and she was completely cured. He further stated that as

he had the policy from 1998 and had earned Cumulative Bonus it is clear that he had not claimed anything and so the Company's contention that the ailment was pre-existing was not correct. Hashimoti's thyroiditis is a form of autoimmune thyroiditis that affects women eight times more ofter than men. Clinically there is an enlarged thyroid and hypothyroidsim. The treatment is life-long replacement therapy with thyroid hormone. The issue before us is sutainability of the claim in such a situation. It is a fact that she was under treatment, may be even as back as 1983. However, it was detected to be hypothyroidism and Goitre even that time she was given treatment and typically 'eltroxin' tablet. It was noted further that she stopped it later. The Medical theory says it should be continued life long or in whatever form iodine intake should be ensured. It is also well known that a stage called 'euthyroid' gives no apparent symptoms but having suffered the disease once, duty of declaration of the same before the policy was taken in April, 1998 was with the Insured and it was more pronounced after the gap of 3 months when she proposed again in July 2001 as she failed to renew in April 2001.

With all the tests which gave the propgressive and invasive status of the disease, the insurance taken after a break only from July 2001 would always remain a suspect apart from positive treatment record of 1983 and the forewarning of long drawn treatment of this disease. Accordingly the decision of the Company to repudiate the claim on the basis of clause 4.1 being pre-existing disease and also a non-disclosure of material fact cannot be faulted.

Mumbai Ombudsman Centre
Case No. GI - 401 of 2004 - 2005
Shri Gopal K. Shah
Vs
The Oriental Insurnace Co. Ltd.

Award Dated 28.9.2005

Shri Gopal K. Shah alongwith his wife and son was covered under mediclaim policy issued by The Oriental Insurance Company Limited, Borivali D. O. for the period 7.8.2003 to 6.8.2004. Shri Shah had taken the policy initially for the period 27.6.2002 to 26.6.2003 but was not renewed in time hence there was a gap. Smt. Bhavna G. Shah wife of Shri Gopal Shah was hospitalized at Grant Medical Foundation, Ruby Hall Clinic from 7.11.2003 to 9.11.2003 for Rt. Retinal detachment + Scleral buckling. When a claim was preferred by Shri Shah to the Company, the claim was repudiated invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Shah represented to the Company but the Company reiterated the stand of repudiation taken by their TPA. Aggrieved by the decision of the Company Shri Gopal Shah approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. On perusal of the records it was found that submissions of both the parties were on record and hence it was decided not to call the parties for personal hearing. The analysis of this case reveals that Smt. Bhavna Shah was operated for retinal detachment and scleral buckling at Grant Medical Foundation at Ruby hall clinic hospital and it was an emergency operation. The findings in the Discharge Summary states that she had keratectomy. Keratectomy is an operation in which a part of the cornea is removed, usually a superficial layer. This procedure is now frequently done by an excimer laser, either to correct refractive errors by reshaping the surface of the cornea or to remove diseased corneal tissue. It would be seen that the complications of diminished vision and related problems were distinctly before the policy was taken and certainly after the onset of first policy if not even much earlier. Myopia is a problem which sets in early childhood and the number

at which the vision gets corrected goes on increasing with passage of time until it is stabilized at age around 20 or so with exceptions. Keratectomy was well before 2nd policy was taken which was not disclosed before The Oriental Insurance Company at the time of renewal of the policy taken with a gap of more than a month for which it was treated as a fresh policy. Moreover other problems of scleral bukling could also be due to some injury or disease about which this Forum has no knowledge for lack of medical data.

Based on the above analysis the Company's rejection of the claim on the ground that it was pre-existing cannot be faulted as the policy was from August, 2003 as a fresh one.

Mumbai Ombudsman Centre
Case No. GI - 596 of 2004 - 2005
Shri Praveen Kumar
Vs
The New India Assurance Co. Ltd.

Award Dated 29.9.2005

A Group Mediclaim Insurance Policy was issued by the New India Assurance Co. Ltd. to Life Insurance Corporation of India covering the employees and their dependents. Shri Praveen Kumar was covered under the same scheme. The claim arose in the year 2004 when his son Mast. Karthikeya Saxena hospitalised at Kanpur Medical Centre Pvt. Ltd. for treatment of correction of Nasal Deformity which was done with Cartilage graft taken from Right ear. He preferred a claim of Rs. 18,042/- from the Company. The Company referred the matter to their panel doctor and based on the opinion received from the doctor, the Company repudiated the claim stating that the deformity of nose treatment falls under Exclusion Clause 4.5 of the mediclaim policy and their inability to settle the claim.

The important point of dispute seems to be whether the surgery was necessitated because of a deformity already in existence or the deformity was due to trauma for which surgery was necessary. The Complainant maintained that it was a post traumatic deformity in nose and there was an episode of fall when the child was young as corroboration he forwarded a certificate from Dr. (Mrs.) Chandreyee Luthra of Kanpur Medical Centre Pvt. Ltd. dated 17.05.2005. The certificate states that Mast. Kartikeya Saxena who was treated by her for Nasal deformity was brought to her on 13.07.2001 following an accident for which although he was not hospitalised despite heavy bleeding he was treated at house. According to doctor this must have left a deformity on his nose for which corrective surgery was necessary. The Complainant, Shri Praveen Kumar put forward his argument based on this certificate and strongly felt that the rejection of the Company was wrong. The examination of the discharge card would reveal that while the diagnosis was mentioned as post-traumatic deformity of nose. The operation notes recorded "correction of nasal deformity done with a cartilage graft taken from (R) ear". Basically, the Company's rejection was based on this operation note as they felt that it was a case of plastic surgery coming under Exclusion Clause 4.5. The policy was issued to LIC covering all their employees and it enjoyed cover for pre-existing ailments and Shri Praveen Kumar was covered since 1989. The child was born thereafter and was well covered under the policy since inception. Exclusion Clause 4.8 excludes congenital external disease or defects or anomalies and read in conjunction with 4.5 which reads "cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness" would also not be payable. The definition of palstic surgery as per Oxford Medical dictionary would be "reconstruction of deformed or damaged parts of the body. If performed simply to improve appearance plastic surgery is called cosmetic surgery or aesthetic surgery but most plastic surgery involves the treatment and repair of disfigurement and disability caused by burns, major accidents and correction of congenital defects." The above definition in fact gives the scope of plastic surgery and

includes a number of cases within its fold. It would include accidents an internal or external congenital disorders. The only point comes immediately as to how the accident occurred, What was the immediate impact and how was it treated. The insured / complainant has failed to produce any document evidencing accident, while he produced a certificate from a doctor it was a from stairs. We must not forget that the certificate was issued on 17.05.2005 i.e. long after the rejection of the claim by New India and therefore it would be aimed at restoring the claim which was lost, and the expression “the injury must have left a deformity on his nose” does not speak well of the certificate about the accident. It left doctor herself in doubt about the incident and its impact. Secondly, it seems the trauma was allowed to be there causing whatever injury and deformity it must have done without any correction at that stage. The argument that the child was not ready to undergo the surgery at that time would not hold water as even children below one year are being operated upon if there would be an urgency. The only other course of selecting the time of operation would be called as planned surgery and in fact plastic surgery would be one such which doctors often feel would be taken later and it could be so in the particular instance. The intention of the clause to allow plastic would be a fire fighting exercise to allow the surgery then and there. Alternatively time was allowed to see the course the injury would take and decision to operate or not would be taken when complication would again arise. Thirdly, by allowing long time to elapse after the accident or so-called direct impact on the tip of the nose, the immediacy had been sacrificed and with it the direct cause or trigger and compulsion for surgery. In absence of any medical data on the fall, injury, treatment and exact impact as a permanent injury or otherwise, such conclusions based on circumstances and facts as presented later are not only covincing but acceptable. Based on this argument, the Company’s rejection on the ground that it was primarily a plastic surgery and falling under clause 4.5 cannot be faulted.