Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11.002.0016
Mr. B. K. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Mediclaim for surgical treatment of Cataract was repudiated under Clause 2.1. Clause 2.1 requires that Hospital or Nursing Home should have been registered with the local authorities and should be under supervision of a Registered and qualified Medical Practitioner. The form 'C' submitted by the Complainant clearly stated that the hospital was duly registered Eye Hospital with Ahmedabad Muricipal Corporation and is run by Dr. S. K. Patel, D.O.M.S. in ophthalmology. The Respondent contended that this registration was done with the Ahmedabad Municipal Corporation for commercial establishment only and not as Hospital required under form-C categorisation. This contention was refuted as the Policy Clause did not communicate any specific requirement contended by the Respondent. Repudiation was set aside. The Respondent was directed to pay the claim for Rs. 17,432/-.

Ahmedabad Ombudsman Centre
Case No. 11.002.0058
Punambhai Gokalbhai
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Complainant lodged Claim towards his hospitalisation and treatment at two occasions in August 2003. Claim repudiated under Clause 4.1 of the Policy. Inception of Policy was in September 2001. Examined the Records and observed that in the History Sheet of the Treating Hospital, it had been noted that the Complainant was a Patient of "KCO/HT + Old ASMI 10 years back". Held that pre-existence of Disease is proved by materials on Records. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0021
Nirmalkumar Surana
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Claim lodged towards expenses incurred by the Complainant in connection with hospitalisation of his Wife. Respondent repudiated the Claim invoking Clause 2.3 of the Policy. Documents and submissions perused. It is observed that hospitalisation of the

Insured was less than 24 hours as stipulated in the Policy Conditions. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 14.002.0415
Manglesh V. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Complainant's wife was hospitalised in two different Hospitals for treatment for Type-II DM & IHD. Claim repudiated on the ground of pre-existence of diseases. The earlier Policy was with United India Insurance Company. After a short break, Proposal was submitted with the Respondent. In the said Proposal Form, the Insured did not disclose the fact that she was suffering from Diabetes Mellitus (DM). Documents and submissions perused. It is observed that the Insured was a Patient of DM for last 15 years. Her Diabetes was one of the causes of Dilated Cardiomyopathy of secondary type and this Vascular complication resulted into Ischemic Cardiomyopathy. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 14.002.0269
Dhaval P. Jha
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Complainant lodged a Claim for Rs. 37,061/- with the Respondent in connection with hospitalisation and treatment of his wife. Respondent, initially offered Rs. 24,520/-, and on representation of the Complainant, enhanced the amount for further Rs. 11,977/- for settlement. Complainant demanded full claim amount without any deduction. Documents perused. It is observed that the original documents submitted by the Complainant were misplaced by the Respondent and the delay in settling the Claim was due to deficiency in service on the part of the Respondent. Held that the Complainant deserves compensation for unnecessary delay as well as blatant deficiency of service. Claim allowed for full amount with 8 % simple interest.

Ahmedabad Ombudsman Centre
Case No. 11.002.0416
T. U. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 25.10.2005

Mediclaim for hospital treatment for the purpose of workup and investigation repudiated under pre-exclusion clause for hospitalisation for diagnostic purpose. The Respondent could establish on the basis of treatment paper and discharge summary remarks that hospitalisation was for diagnostic work up. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.004.0226
N. N. Chokshi
Vs

United India Ins. Co. Ltd.

Award Dated 25.10.2005

Mediclaim for hospitalisation for vomiting and nausea repudiated on the ground that it was for diagnostic purpose. The Respondent contended that only Tablets were prescribed and diagnostic test called sigmoidoscopy and Gastroscopy were done. No other treatment was required or given. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 14.004.0246
Ankit Singhania
Vs
United India Ins. Co. Ltd.

Award Dated 25.10.2005

Mediclaim setttled late by 2 years. The Respondent misplaced the claim papers submitted by party well in time. After two years Claimant was asked to submit copies of Claim documents and claim was settled. Complaint made for compensation for late settlement. Interest @ 8 % per annum allowed and Respondent was directed to pay Rs. 440/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0030
D. M. Bhadange
Vs
The New India Assurance Co. Ltd.

Award Dated 25.10.2005

Mediclaim for treatment of Cataract was repudiated on the ground that the cover for the same was excluded in the Mediclaim Policy. Policy had run for 5 years. For the first 4 years specific exclusion for treatment was printed on the Policy. But in the last year during which the treatment was taken the exclusion clause was not printed. The clause was held to be operative and repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.004.0282
K. N. Zaveri
Vs
United India Ins. Co. Ltd.

Award Dated 25.10.2005

Mediclaim initially regarded as No claim by the Respondent on the ground of pre-existing disease was partially paid by Respondent on complainant's evidencing that the Mediclaim Policy had incepted and continued with another Insurance Company. The Complainant also pursued the Respondent for payment of amount of Claim which was deducted as Non-medical Sundry Expenses. This amount was also paid. The complainant argued for compensation for late settlement, which was allowed there being deficiency in service on the part of respondent. The Respondent was asked to pay interest @ 8 % P. A. directed to pay Rs. 1,700/- to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0145

D. J. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 27.10.2005

Mediclaim for hospital treatment of CRF/Azotension, HTN and swelling both feet on and off for 10 years was repudiated on the ground of pre-existing disease. The Policy incepted in 2.5.2002 whereas the disease was reported to have existed even before 10 years. The Respondent could establish the fact on the basis of hospital record. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0130
S. P. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 27.10.2005

Mediclaim for hospital treatment for Accidental injuries sustained in a Scooter accident was repudiated on the ground of non-compliance of information sought by the Respondent on past health history of the Insured person. The Respondent had asked for information regarding history of sickness (Colitis, Hypothyroid etc). This had no nexus with the treatment of Accidental injury treatment for which the present claim was made. Repudiation was set aside and Respondent was directed to pay Rs. 33,216/-.

Ahmedabad Ombudsman Centre
Case No. 14.003.0410
M. P. Buch
Vs
National Insurance Co. Ltd.

Award Dated 27.10.2005

Mediclaim for hospital treatment of Cataract Operation of both Eyes for Rs. 31,786/- was offered to be settled for Rs. 11,876/- after deduction of Rs. 20,000/- towards restriction of Claim amount of Rs. 10,000/- for each Eye as per Restriction Clause. The Complainant pleaded that no restriction was placed when the Policy incepted. The restriction was unilaterally imposed after 6 years since inception. The Respondent was asked to explain this phenomena of imposing such a restriction in a continuous Policy renewed without any break and having zero Claim experience. It was revealed through the explanation given by the Respondent that such a practice was not in vogue in the other offices of the Company and there was no such Corporate directive. The Respondent's decision to curtail the Claim amount as per restriction was set aside. The total claim amount of Rs. 31,786/- was directed to be paid to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0051
M. S. Shah
Vs
National Insurance Co. Ltd.

Award Dated 28.10.2005

Mediclaim for treatment of surgical treatment of Fibroids Uterus and Myomectomy was repudiated under Clause 4.3, i.e. first years exclusions for Menorrhagia and Fibromyoma. The Complainant pleaded that his Policy had incepted 3 years back. But Respondent could establish that the Policy under the present Claim was renewed after 35 days gap and therfore, first year exclusions were applicable. The repudiation was upheld and the complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.004.0324
A. R. Shah
Vs
The United India Insurance Co. Ltd.

Award Dated 28.10.2005

Mediclaim for treatment Lower Ventricular Failure was repudiated on the ground of pre-existing disease of Diabetes Mellitus. The Respondent could establish the pre-existing of DM being 10-15 years old on the strength of attending Doctor's Certificate. The repudiation wa upheld.

Ahmedabad Ombudsman Centre
Case No. 14.004.0031
A. K. Shah
Vs
The United India Insurance Co. Ltd.

Award Dated 28.10.2005

Mediclaim for surgical treatment of a Lesion on cheek was repudiated on the ground of it being for Cosmetic surgery. The Complainant contended that the increasing size and changing colour of the lesion were suggestive of pre-malignant changes and therefore, it was necessary to undergo the treatment. Histopathological Report also confirmed this. The Repudiation was set aside. Respondent was directed to pay Rs. 4,309/-.

Ahmedabad Ombudsman Centre
Case No. 14.004.0054
A. A. Kapadia
Vs
The United India Insurance Co. Ltd.

Award Dated 28.10.2005

Mediclaim for treatment of Total Knee Replacement (left knee) was repudiated on the ground of pre-existing disease. The Policy had incepted 10 years back and was continued without break earning Cumulative No Claim Bonus. The Respondent argued that in the initial Proposal submitted in the year 93-94, the family doctor had recorded in his certificate that the Insured Person had Rheumatic Arthritis in Right Knee. But the Complainant argued that this was the claim for left Knee replacement and it was different than right knee illness. There was no pre-existence of disease as far as left knee was concerned. It was observed by Hon. Ombudsman that the disease was degenerative and differentiation between right and left knee was not appropriate. Arthritis is the generic disease which was noted to be present in the Complainant at the time of Proposal. Repudiation was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.004.0354

D. V. Shah
Vs
The United India Insurance Co. Ltd.

Award Dated 31.10.2005

Mediclaim, was partially repudiated to the extent of Rs. 6,000/- being the expenses for physiotherapy. The Respondent contended that the receipt for this Rs. 600/- did not bear the date and name of the person taking physiotherapy treatment. Again it was not medically advised or prescribed by doctor. The hospitalization was for removal of two screws which did not require any physiotheraphy. The repudiation was uphed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0161
J. I. Mistry
Vs
The New India Assurance Co. Ltd.

Award Dated 14.11.2005

Mediclaim for hospital treatment Discogenic (L/5/S1) Lower Lumber Pain was repudiated on the ground of hospitalization not justified. The treatment given was in the nature of oral and injectable anti-inflammatory and analgesic medicine by Lumber traction, Acute discogenic Low back pain was conservatively treated by non operative hospitalized treatment. The treating doctor (Specialist Ortho Surgeon) certified that timely treatment of such kind can save the patient from Major Spinal Surgery. The Medical Referee of the Respondent opined that hosptalization was not required for such treatment.

The treating Doctor certified that such a treatment was a recognized methodology for treating such diseases. It was held that according to operative Clause of Mediclaim Policy, hospitalization advised by a duly qualified Surgeon justifies claim under Mediclaim Policy. The Repudiation was set aside and Respondent was directed to pay Rs. 9,770/-.

Ahmedabad Ombudsman Centre
Case No. 11.002.0143
U. C. Bhatt
Vs
The New India Assurance Co. Ltd.

Award Dated 14.11.2005

Mediclaim was repudiated on the grounds of hospitalization for investigation purpose. The claim was for Rs. 22,095/- allowed to be paid for the following reason “Operative Clause of the Mediclaim Policy justifies hospitalization advised by a duly qualified doctor for the present case. The doctor advising hospitalization, treating doctor and the hospital itself were all known to be specialists in expertise and established with credibility in Health care Sector at Ahmedabad.

Ahmedabad Ombudsman Centre
Case No. 11.002.0138
S. A. Modi
Vs
The New India Assurance Co. Ltd.

Award Dated 14.11.2005

Mediclaim for surgical treatment of “Congenital internal Disorder” was repudiated under exclusion clause 4.3 as being treatment in the first year for internal congenital disease.

The Complainant contested that the medical policy had incepted in the year 1998. But the Respondent proved that there was break in renewal and therefore the claim arisen in the first year of Policy. Hence the repudiation was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0117
Ganpatlal Parmar
Vs
The New India Assurance Co. Ltd.

Award Dated 16.11.2005

Mediclaim of a dependent aged more than 24 years of a retired employee having Group Mediclaim Policy was rejected on the grounds of Insured Person not being covered under the Policy.

The Respondent could establish this fact that Insured Person had crossed 24 years and therefore could not be covered under the said Policy. The repudiation was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0157
J. S. Trivedi
Vs
The New India Assurance Co. Ltd.

Award Dated 16.11.2005

Mediclaim for treatment of Accidental injury repudiated on the grounds of hospitalization was not justified. The treatment was for fracture of the proximal Phalynx of little finger, ring finger and Metacarpel of little finger. Medical Referee of the Respondent opined that the Insured Person could have been treated on OPD basis as the subject accident had no implication which required anesthesia to be given which might have required hospitalization.

As the hospitalization was done on the advice of treating Surgeon MS (Ortho) there is no point in denying the claim on the ground of hospitalization not required. Repudiation was set aside and the Respondent was directed to pay Rs. 12,615/-.

Ahmedabad Ombudsman Centre
Case No. 11.004.0096
K. V. Shah
Vs
The United India Insurance Co. Ltd.

Award Dated 21.11.2005

The Mediclaim for hospital treatment of intra-hepatitis Cholestasis was repudiated under Exclusion Clause 4.12 & 4.1

Clause 4.12 excludes treatment arising from or traceable to Pregnancy, child birth including Ceasarian. In the present case the Complainant contested that the disease was induced by contraceptive drugs used for preventing pregnancy. But the case papers revealed that the medicines were taken to regularize the delayed menstrual period. Here the Respondent failed. Clause 4.1 excludes pre-existing disease. In this case the Policy incepted from 14.2.2003 after break and the start of disease Intra

hepatitis Cholestasis could be traced back to November, 2002. The repudiation was upheld and the complaint failed to succed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0177
Greta Anil
Vs
The New India Assurance Co. Ltd.

Award Dated 21.11.2005

Mediclaim for treatment of Low Back Pain due to L5-S1 Disc Prolapse on the grounds of Pre-existing disease. The Policy incepted in June, 1996. The treatment papers indicated that the disease started long back in 1995. The repudiation was upheld. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.005.0368
Girindra Buch
Vs
Oriental Insurance Co. Ltd.

Award Dated 17.11.2005

Mediclaim for surgical treatment of Prolapse Intervertebral Disc was repudiated on the grounds of pre existing disease. The complainant pleaded that her Policy incepted since 28.3.98. But the Respondent refuted it stating that there were breaks in continuity and established that said Policy incepted on 17.09.01. The Respondent proved with the help of hospital records that the Complainant had contracted the said disease long back in 1999.

The pre existence of the ailment could be established and the repudiation was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0188
BB Amin
Vs
The New India Assurance Co. Ltd.

Award Dated 21.11.2005

Mediclaim was repudiated on the grounds that hospitalization was not justified but only OPD treatment was required. The Cancer patient was treated with Hormonal Therapy as an alternative to Chemotherapy. The Chemotherapy treatment became eligible under mediclaim Policy Clause 2.3 even if given on OPD basis i.e. short duration hospitalization. The Medical Referee of the Respondent who is MS. M. Ch (Onco) Cancer Specialist opined about the relevance of such Hormonal Therapy in place of Chemotherapy.

Repudiation was set aside and the Respondent was directed to pay Rs. 7,170/-.

Ahmedabad Ombudsman Centre
Case No. 11.005.0277
E. N. Barlow
Vs
Oriental Insurance Co. Ltd.

Award Dated 28.11.2005

Mediclaim for surgical treatment of Aorta Bifemoral Bypass done in April 2003 on the grounds of pre-existing disease. The insured person had undergone surgery for Aorta Bifermoral Bypass in May 2000. This was taken to be the pre-existing disease at the time of repudiating the present Claim. Hence the repudiation is upheld and the complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case No. 14.004.0105
V. M. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 28.11.2005

Mediclaim for surgical treatment was offered to be settled for Rs. 2,95,780/- by the Respondent which included Rs. 35,000/- towards operating Surgeon's fee. The Operating Surgeon did not want to charge any fee as the Insured Person was also a Doctor. But the Complainant tried to pay him Rs. 1,50,000/- as mediclaim Policy was there to fall back upon the expenses incurred. It was held that this amount was not being charged by the Surgeon, so it cannot become payable. The Claim for Rs. 2,95,780/- only becomes payable with 6 % interest p.a.

Ahmedabad Ombudsman Centre
Case No. 14.002.0166
N. M. Laxmipathy
Vs
The New India Assurance Co. Ltd.

Award Dated 30.11.2005

Mediclaim for hospital treatment of ovarian cyst was repudiated under Clause 4.2. This Clause excludes treatment for any disease contracted within first 30 days of the Policy. The Policy commemced on 25.3.2004 and the onset of ailment was traced on 9.4.2004. Repudiation upheld. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 11.002.0165
R. J. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 30.11.2005

Mediclaim for treatment of a financially dependent son aged 21 not pursuing higher studies was repudiated under Clause 3 (6) of the Group Mediclaim Policy for LIC Employees. This Clause 3 (6) reads "Financially dependent sons upto the age 21 years can be extended upto 25 years if pursuing full time higher studies in a recognized University. In the present case the Insured Person had passed Bachelor of engineering Degree and was on the look out for admission in Foreign University but was not enrolled for higher studies at the time of treatment. So the benefit could not be extended to him. The repudiation was upheld. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 14.004.0154
D. H. Chalishazar
Vs

United India Insurance Co. Ltd.

Award Dated 30.11.2005

Mediclaim under mediguard Policy for treatment of pre-existing disease was repudiated. The Insured Person had pre-existing ailment of Myocardial Infarction at the time of incepting mediclaim policy in 1999, so the Policy was issued with exclusion for the said ailment and related diseases. This Policy was continued without break w.e.f. 1.9.04, when the Complainant switched over to Mediguard Policy. This Policy has a Special feature whereby any pre-existing disease is not excluded after Policy has continued for three consecutive claim free policy years. Now in the said Policy claim for Angiography and Angioplasty occurred in January 2005 i.e. in the first year of switching over to Mediguard Policy.

Vide Respondent's R.O. Letter dated 7.5.04 certain relaxations are given to the existing Policy Holders of Mediclaim Policy switching over to Mediguard Policy. According to that the three years claim free period is to be considered from the inception of the Mediclaim Policy. In the present case Policy incepted since 1999 and there was not a single claim so far. So the present claim becomes payable as the exclusion is not applicable under the relaxations. Repudiation was set aside. Respondent was directed to pay Rs. 2,61,740/-.

Ahmedabad Ombudsman Centre
Case No. 13.002.0251
Shri N. M. Bijlani
Vs
New India Assu. Co. Ltd.

Award Dated 01.12.2005

Mediclaim Repudiated on the grounds that the subject disease of the Insured was an excluded disease as per the policy document issued at the time of renewal even though such an exclusion was not mentioned at the time of commencement of the policy. However, since the matter did not fall within the ambit of the powers of the Ombudsman; the Complainant was advised to take up the grievance at any other appropriate forum.

Ahmedabad Ombudsman Centre
Case No. 11.004.0140
Mr. Pravinchandra V. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 12.12.2005

Repudiation under Mediclaim Policy : The Insured was covered under Mediclaim policy for a continuous period of 4 years. However, since the insured had not disclosed the fact that he has suffering from Chronic Inguinal Hernia and Testicular Swelling and had been operated for Inguinal Hernia 20 years back; Repudiation by the Respondent was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0174
Mr. Ratilal G. Bhavsar
Vs
United India Insurance Co. Ltd.

Award Dated 12.12.2005

Repudiation under Mediclaim Policy on the grounds that Bronchial Asthma is excluded from the scope of Mediclaim Policy and that the Complainant had been hospitalised for Acute Bronchitis. Opinion from Doctors confirmed that the two diseases are related. As a result, the Repudiation of the subject claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0214
Mr. Sanjyay Shandilya
Vs
New India Assurance Co. Ltd.

Award Dated 12.12.2005

Repudiation under Mediclaim Policy on the grounds that the hospitalisation was not warranted. The Complainant's daughter was hospitalised on account of vehicle accident injury. She was unconscious at the time of the injury due to the impact on her head and deep cuts in her left eye cavity with blood clot in her eye. The treatment papers and the fact of accident and Cumulative Bonus earned on the policy testified good claim experience and loyalty of the Policy holder. As such, the decision to repudiate the Claim was set aside and the Respondent was directed to pay to the Complainant the full claim amount.

Ahmedabad Ombudsman Centre
Case No. 11.002.0189
Shri Madanlal Saluja
Vs
New India Assurance Co. Ltd.

Award Dated 12.12.2005

Partial Repudiation of Mediclaim : It was observed that since the Complainant had accepted the claim and had signed the Discharge Voucher as a full and final settlement of the Claim, he was estopped from reopening the subject claim. As such, the decision of the Respondent to repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.004.0098
Dr. Hasmukh J. Desai
Vs
United India Insurance Co. Ltd.

Award Dated 15.12.2005

Partial Repudiation of Mediclaim. The Insurer had deducted Rs. 69,110/- from the subject Claim for Rt. Total Knee Replacement Surgery of which Rs. 50,000/- was towards Operation Charges paid to one Dr. Desai, MS (Ortho) who claimed to be the Chief Surgeon for the procedure. From the arguments, it appeared convincing that the Operation was done by another Dr. Patel who held MS (Ortho) and FRCS qualifications and hence this amount was disallowed. However, the Bill of Dr. Patel amounting to Rs. 19110/- was allowed after deducting discount of Rs. 3,470/- by the Hospital authorities and the Respondent was directed to pay Rs. 15,640/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0192
Ms. Mamta S. Kapadia
Vs
New India Assurance Co. Ltd.

Award Dated 15.12.2005

Repudiation of Mediclaim on the grounds that the subject disease "Acute Intestinal Obstruction" was related to a pre-existing surgery of Acute Appendicitis making the Claim non-admissible. It was observed that the Insured had indeed mentioned in the Mediclaim Proposal Form that she had undergone the said operation. However, the Policy Schedule issued by the Insurer was not subject to Exclusion of any disease whatsoever. The Respondent confronted with the position that inadvertence caused omission of the Exclusion in the Policy Schedule. However, it was held that if despite disclosure of a specific illness in the Proposal, if nothing concerning it found a place in the Contract, it is inappropriate to repudiate a subsequent claim by relating it to the said disease at a subsequent time. As such, the Respondent was directed to pay the full amount in settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11.002.0052
Mr. Navin H. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 15.12.2005

Repudiation of Mediclaim for an operation of Balloon Mitral Valvuplasty done in 2004. The said Mediclaim Policy commenced on 25.07.96. Records showed that the Complainant was operated for Balloon Mitral Valvuplasty on 12.08.96 (i.e. within 17 days from inception of the Policy) Medical opinion shows that such a complication does not occur within 17 days. So the Complainant was surely aware of his ailment prior to taking the policy. As such, the decision to repudiate the subject claim on grounds that it was pre-existing prior to taking the policy was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0353
Shri Rameshchandra N. Patel.
Vs
United India Insurance Co. Ltd.

Award Dated 15.12.2005

Repudiation of Mediclaim on the grounds that the Complainant had a history of Diabetes Mellitus for three years prior to the date of hospitalisation and was not taking any medicines. Since no mention was made of the same in the proposal form for mediclaim and Diabetic questionnaire filled one year prior to the date of hospitalisation; the Repudiation by the Respondent on the grounds of pre-existing disease was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0071
Shri Parshuram M. Vaghel

Vs

The New India Assurance Co. Ltd.

Award Dated 16.12.2005

Repudiation of Mediclaim on the grounds that the disease was pre-existing The Complainant was admitted to the Hospital for Orthopaedic Treatment. It was observed that there were two breaks in renewal of the Policy. As such, the inception of the Present Policy was held to be the date of commencement. The Case papers of the treating Doctor carried notings that the past history of Back Pain commenced before this date of Commencement. As such the decision of the Respondent to Repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre

Case No. 11.005.0342

Smt. Manjuladevi V. Patwari

Vs

Oriental Insurance Co. Ltd.

Award Dated 20.12.2005

Repudiation of Mediclaim on the grounds that the Hospitalisation was done only for Observation. The Complainant was hospitalised for Observations of the detrimental side effects on administration of Oral Chemotherapy drug for Breast Cancer. Thus, it was a case of Therapeutic Observation as contrasted to Diagnostic Observation that is done for Radiological, Pathological Tests etc. Since, the disease was as grave as Cancer, the treatment administered as serious as Chemotherapy and the treating physician, an expert in Cancer treatments, the decision of the Respondent was directed to pay the full and final settlement of Mediclaim.

Ahmedabad Ombudsman Centre

Case No. 11.008.0195

Shri Tripuriray D. Upadhyay

Vs

Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 20.12.2005

Repudiation under Health Shield Policy on the grounds that the disease was pre-existing. The Complainant was hospitalised for Triple Vessel Disease six months after taking the Health Shield Policy. The treatment consisted of Coronary Artery Bypass Surgery. Two Medical Opinions obtained by the Respondent stated that the disease is such that could not have developed within 6 months and is hence pre-existing. No other proof like treatment papers, diagnostic papers, medical statements etc could be produced. Hence presumptive general opinion overrides particularly in the absence of any specific document that showed that the subject disease pre-existed. Hence the Respondent was directed to pay the full and final settlement of the subject claim.

Ahmedabad Ombudsman Centre

Case No. 11.003.0017

Mr. Jayeshbhai M. Dhruv

Vs

National Insurance Co. Ltd.

Award Dated 23.12.2005

Repudiation of Mediclaim. The Complainant was hospitalised for Osteoarthritis (L) Hip requiring a Total Hip Replacement. The claim was preferred for Accidental Injury on the

Left Leg. None of the Case papers indicated any history of accident induced trauma. Much after the Insured was discharged and even after the Repudiation was effected, a Certificate was obtained from the treating surgeon that the operation was done due to alleged fall and injury. The subject disease not having been caused by Accidental Injury as stated in the Claim form, the cause of loss itself became an untrue statement, violating the declaration made in the Claim form. Hence the decision of the Respondent to repudiate the subject claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.002.0152
Mr. Dharmesh C. Trivedi
Vs
The New India Assurance Co. Ltd.

Award Dated 23.12.2005

Repudiation of Mediclaim on the grounds that expenses of hosptalisation for less than 24 hours is not admissible. The Complainant suffered severe pain in Head, Chest and Stomach and in the night these factors compelled him to be taken over for appropriate medical management in a Hospital. However, since the hospitalisation did not conform to the stipulated minimum period as per the Policy Clause, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11.004.0024
Mr. Ashok K. Mehta
Vs
United India Insurance Co. Ltd.

Award Dated 23.12.2005

Repudiation of Mediclaim on the grounds that the Hospitalisation was not justified : The Complainant's daughter fell down resulting into severe/unbearable back pain. As the treatment of the General Practitioner was not effective, she was advised to consult an Orthopaedist who advised Hospitalisation. Considering the fact that the amount claimed was reasonable, the child was a 12 years old girl who had to be lodged in a Hospital on the advise of the Specialist after all efforts taken on a OPD Basis, the Respondent was directed to pay the Claim in full.

Ahmedabad Ombudsman Centre
Case No. 11.002.0055
Smt. Varsha R. Parikh
Vs
The New India Assurance Co. Ltd.

Award Dated 26.12.2005

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Mediclaim policy incepted in 2000. Hospitalisation took place in 2004. Consultation papers of Consultant Surgeon and the Hospital both noted the Clinical History of the Complainant as High Blood Pressure for 10 years. Since both the sources recorded identical history, it was difficult to sustain that both the sources could have committed an identical mistake. As such, the decision of the Respondent to repudiate the subject claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.004.0064
Mr. Kantilal D. Ghelani
Vs
United India Insurance Co. Ltd.

Award Dated 26.12.2005

Repudiation of Mediclaim. The Complainant was hospitalised for Acid Peptic Disorder with Diabetes Mellitus. During the course of the hearing, the Respondent referred that the concerned disease is Gastroparesis and that it had nexus with the pre-existing disease Diabetes Mellitus. It was observed that the symptoms of Acid Peptic Disorder and Gastroparesis were similar. However, since the clinical Summary of the Hospital puts the Insured to be a Patient of Diabetes Mellitus for the last 10 years and since the Mediclaim Policy was accepted subject to the exclusion of Diabetes Mellitus; the decision of the Respondent to Repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0237
Shri Piyush Patel
Vs
New India Assurance Co. Ltd.

Award Dated 09.01.2006

Mediclaim Repudiated on the grounds that hospitalisation was for less than 24 hours and that the subject disease of the Insured was of a Congenital External Condition. The Discharge Certificate of the Operating Surgeon and the exhaustive documents clearly showed that the patient was admitted in the Hospital for 26 hours. The Insured patient was a 2 year Old Child suffering from swelling over Inguinal region since 15 days and that Right Inguinal Harnlotomy operation was administered on the Insured. Since, the Medical Referee of the Respondent inferred that Inguinal Hernia in an infant and young child is a congenital condition, the claim was repudiated. It was observed that the Operating Surgeon who had physical access to the condition of the Patient had reasoned that the swelling had appeared and detected only 15 days prior to surgery. Hence the repudiation was set aside and the Respondent was directed to pay the full claim to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.005.0405
Smt. Urmila A. Gosai
Vs
Oriental Insurance Co. Ltd.

Award Dated 16.01.2006

Repudiation of Mediclaim on the grounds that the patient had taken treatment at Home : It was observed that the patient had taken Oral Chemotherapy treatment at home beyond 60 days of discharge from the Hospital. Since the policy conditions allow Post Hospitalisation benefits within 60 days of discharge from the Hospital, the Repudiation by the Respondent was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre

Case No. 11.004.0228
Shri Khimjibhai N. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 19.01.2006

Repudiation of Mediclaim on the grounds that it was a pre-existing illness. Under the heading "Patient's History", there was a noting of history of Hemiplaegia 12 years back and history of Myocardial Infarction. The Complainant stated that he had not taken any treatment of Haemiplagia. However, the history was recorded by the Hospital on the basis of the information provided by the patient. As such, the decision of the Respondent to repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0100
Shri Laxman C. Advani
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.01.2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Discharge Summary of the Hospital recovered "Old Inferior Wall MI". He had undergone ECG Tests four months before taking the current Mediclaim Policy. The tests clearly showed old inferior wall MI. As such, expenses incurred in connection with pre-existing diseases was not allowed and the decision of the Respondent to repudiate the claim was upheld with no further relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.005.0070
Shri Manoj J. Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.01.2006

Partial repudiation of Mediclaim on the grounds that the diagnostic tests were conducted not for the subject disease. The Complainant was admitted for treatment of P. Falciparum and Vivax Infection. Prior to that, she had undergone X-Ray of Abdomen with Barium Meal, Koch's Abdomen M. T. Colonoscopy etc. since she was suffering from Abdominal Pain. However since the two disorders are independent of each other, the decision of the Respondent not to pay for the Diagnostic Tests was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0060
Mr. Omkar R. Rajput
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.01.2006

Repudiation of Mediclaim on the grounds that the subject disease was related to use of Alcohol. The Complainant was hospitalised for treatment of Pancreatitis. The Personal History noted Alcoholism which has a causative nexus with the subject disease. Since the relevant exclusion clauses were invoked, the decision of the Respondent to repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.002.0199
Mr. Arvind N. Patel
Vs
The New India Assurance Co. Ltd.

Award Dated 24.01.2006

Partial repudiation of Mediclaim. The Complainant was hospitalised after an accident and had preferred a claim under Mediclaim. Ambulance Charges and charges for cost of Hearing Aids were not paid as per policy conditions. Even though the Complainant had stayed for 15 days in the Hospital, on the opinion of the Medical Referee, the Respondent had restricted expenses on hospitalisation to 5 days only which was not considered justified since the Complainant was admitted to a renowned Super Speciality Hospital under treatment of a credible hospital. As such, the Respondent was directed to pay the full Hospitalisation charges as above.

Ahmedabad Ombudsman Centre
Case No. 11.002.0106
Dr. Jayesh H. Upadhyay
Vs
The New India Assurance Co. Ltd.

Award Dated 24.01.2006

Repudiation of Mediclaim on the grounds that expenses of hospitalisation for Ectopic Pregnancy was a part of Exclusion Clause 4.12 viz. Pregnancy. It was observed that the Head Office of the Respondent had in 2004 allowed payment for pregnancies wherein the Foetus develops outside the womb and the same is dangerous to the life of the mother. As such the respondent was directed to pay the full claim amount to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0235
Mr. Ashok C. Patel
Vs
New India Assurance Co. Ltd.

Award Dated 24.01.2006

Repudiation of Mediclaim on the grounds that the Hospitalisation was for less than 24 hours and because the same was for investigation purpose : The Complainant was having severe pain in occipetal and at back of the neck. On the advise of his Orthopaedist, he was admitted to the Hospital. Since the hospitalisation took place on medical advise, the Respondent was directed to pay the Claim in full.

Ahmedabad Ombudsman Centre
Case No. 11.002.0390
Mr. Chandrakant V. Pandey
Vs
The New India Assurance Co. Ltd.

Award Dated 24.01.2006

Repudiation of Mediclaim on the ground that hospitalisation was not necessary. The treating Doctor had diagnosed in-growing toe nail on right foot and was operated for the same on an in-patient basis. The Medical Referee of the Respondent opined that such operations are usually carried out on an OPD basis and does not require

hospitalisation. However, hospitalisation in the instant case was done on the basis of credible medical advice. As such, the respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0201
Mr. Laxmichand P. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 30.01.2006

Partial repudiation of Mediclaim on the grounds that the Patient was hospitalised for less than 24 hours. During Hearing, 2 Discharge Cards were submitted; one of which showed hospitalisation for 9 ½ hours and the other showing 34 ½ hours. However, it was also seen that in the Claim Form filled in by the Complainant, notings of the Date of Hospitalisation was as per the former Discharge Card. Since the Complainant had himself put the date on Claims forms, it was considered unnecessary to go in for any other post-dated certification for the purpose. Since the hospitalisation was for less than 24 hours, the partial repudiation of the subject claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0108
Mr. Mukesh A. Kothari
Vs
National Insurance Co. Ltd.

Award Dated 31.01.2006

Repudiation of Mediclaim on the grounds that the Claim was made for charges incurred primarily for diagnostic purposes. The Complainant approached his physician on noticing Chest pain and perspiration and was admitted to the Hospital on the advice of the M. D. qualified physician. Since, on admission to a Hospital, tests undertaken are beyond the control of the Patient, the said repudiation was set aside and the Respondent was directed to pay the full Claim amounts.

Ahmedabad Ombudsman Centre
Case No. 14.002.0411
Shri Mukesh R. Ratod
Vs
New India Assurance Co. Ltd.

Award Dated 10.02.2006

Repudiation of Mediclaim on the grounds that hospitalisation was not required. The complainant had suffered an accident which led him to approach an Orthopaedic Hospital. He was operated there for Fracture in Ankle Joint. The said hospitalisation was not done for investigative or diagnostic purposes. Keeping in view the materials on record, the Respondent's decision was set aside and they were directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0037
Mr. Shamjibhai B. Maraviya
Vs
United India Insurance Co. Ltd.

Award Dated 10.02.2006

Repudiation of Mediclaim on the grounds that the subject illness was pre-existing. The Complainant was operated for an Ayurvedic Operation for Fissure in the third year of the Policy. The case papers indicated history of Fistula since 4-5 yrs, Bleeding 4-5 yrs. Since, it got established that the Claim attracts Exclusion Clause, the decision of the Respondent to repudiate the subject claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0318
Mr. Shailesh M. Ramani
Vs
New India Assurance Co. Ltd.

Award Dated 10.02.2006

Repudiation of Mediclaim on the grounds that the subject disease was pre-existing. The Complainant was hospitalised for Angina Pectoris and for Coronary Artery Disease. The Discharge Summary of the Hospital recorded Known Case of Hypertension 20 yrs and Angina for 10 yrs. Since the period Calculated back was prior to the inception of the Policy, the decision of the Respondent to repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0290
Smt. Manoramaben Sheth
Vs
New India Assurance Co. Ltd.

Award Dated 13.02.2006

Repudiation of Mediclaim Policy on the grounds that the subject disease was pre-existing : The Insured was admitted for CABG. The claim was repudiated on the opinion of the Mediclaim Referee of the Respondent since the Discharge Card had noted history of Diabetes Mellitus for 35 years and TB 5 years back and since these facts had not been disclosed in the Proposal Form. It was observed that even if the Complainant would have disclosed Diabetes in the Proposal Form, the policy would have been issued at most with the exclusion of benefits for Diabetes. If Diabetes was excluded, then the number of disease being covered under Mediclaim would be very less and as such denial of cover would extend to denial of justice. As such, the repudiation was set aside and the Respondent was directed to pay the expenses subject to the limits of sum Insured.

Ahmedabad Ombudsman Centre
Case No. 11.002.0272
Shri Rameshbhai M. Maniar
Vs
The New India Assurance Co. Ltd.

Award Dated 20.02.2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Complainant was treated for Myasthenia Gravis. The Discharge Card of the Hospital recorded past history of the same for 4 years. However, it was observed that the Policy incepted before this period. As such, repudiation was set aside and the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. 11.002.0233
Shri K. K. Lahoti
Vs
THe New India Assurance Co. Ltd.

Award Dated 20.02.2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Complainant was hospitalised for Choking Sensation and Chest Pain. The Copy of the Nurse's Record of the Hospital showed history of hypertension and treated diabetes since 10 years. Since, the onset of the disease was prior to the date of inception of the policy, the decision of the Respondent to repudiate the claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0228
Shri Kiran I. Adhia
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.02.2006

Repudiation of Mediclaim on the grounds that the disease was excluded from the ambit of the Policy benefits. It was observed that Bronchial Asthma and its related diseases were excluded under the Mediclaim Policy due to an underwriting decision since inception itself. The Claim for Chronic Obstructive Pulmonary disease referred to chronic lung disorders and was held to be within the excluded diseases under the policy. As such, the decision of the Respondent to repudiate the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.012.0230
Mr. Anilkumar C. Dixit
Vs
ICICI Lombard General Insurance Co. Ltd.

Award Dated 20.02.2006

Repudiation of Mediclaim on the grounds that the subject hospitalisation took place within the first 30 days from the Commencement of the policy. It was observed that the Complainant was having Mediclaim Policy with New India Assurance. Co. Ltd., and he later shifted over for Mediclaim Policy with the respondent insurer. Hence the decision of the Respondent to repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0109
Mr. Krishnakant D. Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated 27.02.2006

Repudiation of Mediclaim on the grounds that the disease was a pre-existing one : The Discharge Summary of the Hospital where the Complainant was admitted for Laprascopic Surgery for Ureteric Stone; pointed out history of a similar complaint 8

years back, which was prior to the date of inception of the Policy. As such, the Repudiation of the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0212
Smt. Arunaben P. Soni
Vs
United India Insurance Co. Ltd.

Award Dated 27.02.2006

Repudiation of Mediclaim on the grounds that Cataract is not covered in the first year of the Policy : The Complainant had been operated for Cataract 13 months after the inception of the Policy. Claim was repudiated since the Insured was having symptoms of Cataract in the first policy year itself and had avoided Operation in the first year in order to avoid the Exclusion Clause. It was observed that the policy excluded “treatment” of Cataract in the first year and not the onset of the disease. Since the hospitalisation took place in the second policy year, repudiation was set aside and the respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 14.004.0288
Shri Ajay R. Mistry
Vs
United India Insurance Co. Ltd.

Award Dated 06.03.2006

Repudiation of Mediclaim due to late submission of Claim papers. It was observed, that the Respondent was first intimated about the hospitalisation nearly 4 months after the event. The Claim forms were submitted with the intimation. The Respondent even after Repudiating the Claim, responded to the Complainant through their letters asking for compliances on facts and documents thus indisputably indicating waiver of the delay. The Medical Referee too opined genuineness of the Claim. Taking a holistic view of the matter, it was decided to direct the Respondent to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11.004.0265
Dr. Hasmukh N. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 10.03.2006

Partial repudiation of Mediclaim on the grounds that Cost incurred for Ceramic teeth was not reimbursable. It was observed that the Complainant had fallen down from a Scooter and had consequent injury over face, lips and teeth. The Respondent agreed to settle the Claim excepting cost of the Ceramic Teeth. It was observed that as per Exclusion Clause 4.7 of Mediclaim Policy, all benefits towards dental treatment are excluded except those arising out of injury which required hospitalisation or treatment. Since, the subject Claim was one of accident where hospitalisation was not disputed, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11.003.0209
Mr. Jagdishchandra M. Mulani
Vs
National Insurance Co. Ltd.

Award Dated 06.03.2006

Repudiation of Mediclaim on the grounds that Hospitalisation was not for the minimum period of 24 hours :: It was observed that the Complainant was hospitalised for Post CABG, CVT and DM for a period of 17 hours. Since, the hospitalisation did not fall within the essential conditions laid down expressly in the Contract, the Repudiation of the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0135
Shri Rakesh N. Suthar
Vs
National Insurance Co. Ltd.

Award Dated 10.03.2006

Repudiation of Mediclaim Policy on the grounds that the subject disease was Congenital : The Insured's son, aged 3 yrs old was operated for phimosis. Medical opinion showed that Phimosis is a general external condition in children, but may also develop in exceptional cases in adults. Treatment is by circumcision, which was done in the instant case. Since, the subject disease is in all probabilities congenital, the decision of the Respondent to repudiate the subject Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0236
Mr. Mahesh P. Sethia
Vs
United India Insurance Co. Ltd.

Award Dated 13.03.2006

Repudiation of Mediclaim on the grounds that the congenital disease was pre-existing : Hospitalisation took place when the child was less than 6 months old. The child died soon after. The Death Slip issued by Civil Hospital indicated Congenital Heart Disease as one of the reasons of the death. Since Mediclaim Policy excluded all benefits for treatment of congenital diseases in the first year of the policy, Repudiation of the Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.005.0191
Shri Jitendra P. Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated 13.03.2006

Repudiation of Mediclaim on grounds that the disease was pre-existing:: While filling up the proposal form for Mediclaim, it was mentioned that the Complainant had Appendix Operation. Hence, the operated Appendix was treated as pre-existing. The subject disease for which Hospitalisation took place was for Appendicular Stump abscess with localised peritonitis. Since the operation was for abscess and since the

abscess had formed in appendicular stump caused by the operated appendix in the past, the latter being excluded in the Policy document itself, the decision of non-payment of the subject Claim by the Respondent was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14.003.0119
Mr. Bhanushanker V. Shukla
Vs
National Insurance Co. Ltd.

Award Dated 20.03.2006

Partial repudiation of Mediclaim :: The Complainant was admitted to hospital for treatment of unstable angina for which he lodged a claim for Rs. 1,77,936/-. The Sum Insured under the policy was Rs. 1,50,000/- + Cumulative Bonus Rs. 7,500/-, totalling to Rs. 1,57,500/- was offered for reimbursement. The Complainant argued that since certain expenses for post-hospitalisation were beyond the said policy year, the same should be reimbursed from the Mediclaim limit of the next year. However, Clause 1.0 of the Mediclaim Policy puts its thrust on the period of insurance. As such, even though the post-hospitalisation benefit period crosses the Policy year, the same is to be allowed subject to the SI + CB for the Policy year in which the actual hospitalisation took place. As such the decision of the Respondent to pay upto the SI + CB was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.004.0250
Shri Smitesh R. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 21.03.2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing. It was observed that the Mediclaim Policy incepted from 1996. The Complainant was admitted to a hospital wherein the Discharge Summary told a history of known case of Diabetes for the last 15 yrs. Another record from the same Hospital showed history of 8 yrs. Since, both the records emerged from the same source, and since the Complainant could not give a cogent reason for the same, it was considered appropriate to note the history of Diabetes for the last 15 years and uphold the decision of the Respondent to repudiate the Claim with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.002.0173
Shri Narendra M. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 21.03.2006

Repudiation of Mediclaim on the grounds that Hospitalisation was done for investigative purposes only. The Complainant was admitted for Urinary Tract Infection under the care of a specialist doctor. Claim was repudiated on the grounds that the Hospitalisation was done for investigative purposes only. The Bills submitted by the Complainant suffered from multiple infirmities like over writing date, amount etc. After

disallowing such Bills, the Respondent was directed to pay the Claim for Hospitalisation since it was done on the advice of a specialist.

Ahmedabad Ombudsman Centre
Case No. 11.002.0186
Shri K. K. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 21.03.2006

Repudiation of Claim for Health Check up under Mediclaim Policy. As per Policy conditions, the Complainant and his family members undertook Medical check up. It was observed that the Policy was first taken from New India Assu. Co. Ltd. for 2 years, Oriental Insurance Co. Ltd. for 1 year, National Insurance Co. Ltd. for 3 years and back to New India Assu. Co. Ltd. for the past 1 year. As per Corporate instructions of the Respondent Insurer, Health Check up benefit will be available if the Insured person is continuously covered by them. As such, it was not found proper to allow credit for renewal of Mediclaim with other Companies for the purpose of availing Health Check-up benefit. As such the decision of the Respondent to repudiate the benefit was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0111
Mr. Bharatkumar C. Thakkar
Vs
National Insurance Co. Ltd.

Award Dated 21.03.2006

Repudiation of Mediclaim on the grounds of pre-existing disease and non-disclosure of material facts. The Complainant was admitted to a Hospital for treatment that included Diabetes. The Hospital papers on record revealed that the Complainant suffered from diabetes well before inception of the Policy which was never disputed by the Complainant. The Proposal forms clearly mentioned that the Insured was having diabetes since long and was taking anti-diabetes drugs. Diabetes questionnaire was also filled up. Despite the disclosure in the Proposal Form, the underwriter decided to accept the risk without any restriction. Thus the grounds for repudiation failed. As such the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 14.004.0281
Mr. Jatin D. Jani
Vs
United India Insurance Co. Ltd.

Award Dated 27.03.2006

Repudiation of Mediclaim : During the course of hearing, the Respondent admitted that the claim should have been paid as there is no lapse on the part of the Complainant. As such, they were directed to pay the full claim amount to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11.003.0256
Smt. Parvatiben B. Solanki
Vs

National Insurance Co. Ltd.

Award Dated 27.03.2006

Repudiation of Mediclaim on the grounds that the hospitalisation was not necessary under the case : It was observed that the Complainant was admitted to the ICU of a Hospital for treatment of Anaemia, Hyper-lipidemia, Chest pain etc on the advise of a Cardiologist. The Respondent relying on the opinion of its Medical Referee repudiated the Claim since treatment given should have been done on OPD basis only. Since, hospitalisation was done on the recommendation of a Cardiologist, the Respondent was directed to pay the full claim amount.

Ahmedabad Ombudsman Centre
Case No. 14.004.0198
Shri Gunvantray C. Shah
Vs
United India Insurance Co. Ltd.

Award Dated 27.03.2006

Partial Repudiation of Mediclaim on the grounds that Claim for home physiotherapy is not permissible. The Complainant was admitted to the Hospital for treatment of Diabetes, Rt. side Haemiplagia, Retinopathy, Neuropathy etc. The amounts paid for home physiotherapy thereafter claimed under post-hospitalisation domiciliary treatment was disallowed to the Complainant. The Respondent raised a query that the physiotherapy had not been done on the prescription from the treating Doctor. The Bill submitted by the physiotherapist however contained the Name & Telephone Numbers of the referring physician. Under the circumstances mentioned, the Respondent was directed to pay the full claim amount.

Ahmedabad Ombudsman Centre
Case No. 14.004.0066
Mr. Nathalal K. Bhatti
Vs
United India Insurance Co. Ltd.

Award Dated 27.03.2006

Repudiation of Mediclaim for non-submission of the required letters from the Complainant. The Respondent could exhibit valid proof of payment and there was no contrary points made out by the Complainant, being absent from the Hearing altogether. As such, the complaint was taken to have been resolved.

Ahmedabad Ombudsman Centre
Case No. 11.002.0221
Mr. B. R. Dodia
Vs
The New India Assurance Co. Ltd.

Award Dated 27.03.2006

Repudiation of Mediclaim on the grounds that hospitalisation was not necessary in the case : It was observed that the Complainant was on the advise of a Cardiologist,admitted to a Hospital for severe hypertension. The Respondent relying on the opinion of its Medical Referee repudiated the Claim since treatment given should have been done on OPD basis only. Since, hospitalisation was done after nealy 16 days of treatment on OPD basis that too on the recommendation of a Cardiologist, the Respondent was directed to pay the full claim amount.

Bhopal Ombudsman Centre
Complaint No. GI/OIC/0106/129
Dr. Ashok Kumar Jain
V/S
The Oriental Insurance Co. Ltd.

Award dated 09.03.2006

The Complainant obtained Medi Claim policy for the period from 08.03.2004 to 07.03.2005 from the Respondent under which claim was lodged, but the Respondent had rejected his claim without giving any solid ground.

The Respondent contended that the Complainant had lodged a claim of his wife with their TPA M/S Paramount Health Services Pvt. Ltd. as she has some problem in her eyes which developed due to accident as she slipped in toilet of the Compartment of Train while travelling from Gwalior to Trivandrum. Their TPA investigated the case and observed that the Complainant's wife was suffering with C.C.F type IV (D) as per the findings of doctors of the hospital Shree Chitra Tirunal Institute of Medical Science & Technology, Trivandrum. (The disease is not due to trauma and injury which rules out it to be a traumatic). Respondent's panel Doctor Dr. D. P. Agarwal has also confirmed that the patient was suffering from congenital or pre-existing and not due to trauma (injury). On the basis of Doctor's opinion and hospital records & investigation report their TPA i.e. M/S Paramount Health Services Pvt. Ltd. repudiated the claim under clause 4.1 i.e. pre-existing disease which is excluded in the policy. The Respondent also contended that the Complainant has filed a complaint case No. 342/2004 against the Railway before the Distt. Consumer Forum Gwalior, which has been dismissed, vide order-dated 14.07.2005.

A case on the same matter has been decided by the District Consumer Forum Gwalior and an appeal is pending before State Consumers Grievances Redressal Commission Bhopal. Hence the complaint is not entertain-able in this office as per rule No. 13(3)(c) of Redressal of Public Grievances Rule 1998 which reads as " the complaint is not on the same subject matter, for which any proceeding before any court, or Consumer Forum, or arbitrator is pending or were so earlier". Hence the Complaint is filed as closed.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/0106/124
Mr. Mohan Lal Garg
V/s
The New India Assurance Co. Ltd.

Award dated 24.02.2006

The Complainant had taken the Medi claim policy for the past 4 to 5 years and his wife Smt. Angoor Bala Garg fell down from the stairs on 10.06.2005 and got injuries on her head. The Complainant consulted Dr. R. C. Mehta and went to Indore on 13.06.2005 to consult Dr. Ashish Bagri who advised the complainant to admit her in M/S Bombay Hospital, Indore. Necessary tests and investigations were carried out and it has come to the conclusion that there is a small tumor in her head. After discharge from the hospital the Complainant submitted the claim with the respondent but the Respondent's TPA repudiated the claim.

The Respondent stated that the Complainant was covered under medi claim policy No. 450200/48/04/75866 w.e.f. 27.01.2005 to 26.01.2006 covering the Complainant himself (age 63 years) and his wife Mrs. Angoori Bala Garg (age 57 years). The complainant

lodged a claim for his wife with TPA i.e. M.S Family Health Plan who is authorized by IRDA to settle the claim. The TPA repudiated the claim on 21.07.2005 after scrutinizing the documents submitted by the Complainant. It was found that the treatment for which the Complainant was hospitalized could have been done as out patient and hospitalization was not required; hence the claim was repudiated as per policy condition.

The Respondent also stated that as per the discharge summary, the patient was diagnosed as H/O fall. VERTEBROBASAL INSUFFICIENCY, MENINGIOMA BRAIN. The patient had a fall on 10th June 2005 and there was no injury and there was no immediate consultation or treatment. During the entire Hospitalization period oral medicines were given and there is no evidence of active interventional medical management requiring hospitalization. Investigations unrelated to the present ailment were also done during this hospitalization. Investigation like MRI Brain and Ultras Sound abdomen does not require hospitalization and can be done on out patient basis. The procedure does not require the patient to be hospitalized. This is clearly mentioned in the policy under standard exclusion 4.10 which states as " charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." Hence the claim was repudiated and the same was communicated to the Complainant.

It is observed that the Complainant was hospitalized only for different investigations/tests and during the hospitalization no treatment was given to her. During hospitalization only oral medicines were prescribed. It is also confirmed by the Respondent's specialist doctor that the disease was not acute and no definite treatment was given to the patient and that these tests can also be conducted on OPD (out patient) basis and hospitalization was not needed. Therefore the expenses incurred clearly falls under exclusion No. 4.10 of the policy which state that " Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/0106/130
Mr. Arvind Kumar Yadav
V/s
The New India Assurance Co. Ltd.

Award dated 23.02.2006

The Complainant's wife Smt. Asha Yadav is a Neuro patient and was covered under LIC group Medi claim policy with The New India Assurance Co. Ltd. She was admitted in Bombay Hospital Indore and total expenses incurred for Rs. 9182/- was submitted to the Respondent but the Respondent repudiated the claim.

The Respondent stated that the Complainant lodged a claim for his wife for Rs. 10,551/- for hospitalization from 14.04.2005 to 15.04.2005. That out of total expenses of Rs. 10,551/- claimed by the complainant, Rs. 6649/- was charged for various tests at Hospital. Rs. 300/- for doctor's visit, Rs. 400/- for room charges, Rs. 363/- for

medicines during hospitalization and Rs. 1470/- charged for surcharge. Further medical bill of Rs. 402/- dated 18.04.2005, bill of Rs. 219/- of 23.04.2005 and bill of Rs. 748/- of 04.05.2005 were claimed for reimbursement.

The Respondent also stated that in the discharge summary, that on examination the patient's blood pressure was normal. CNS-HMF was normal, eye movements are normal, Saccades are normal, Fundus normal, and No Sensory Motor deficit, rest all functions are normal. Patient was admitted with chronic complaints. In view of her neurological symptoms MRI brain with angio was done, which was normal, all blood investigations were found to be within normal limit. Further the medicines prescribed during hospitalization was Methyl OBAL, meant for Vitamin. Neuvasca capsule meant for Vitamin, Evion meant for vitamin, Selgin Tab meant for Parkinson, Nitrest Tab meant for sleep.

Respondent also stated that as per their panel Doctor's opinion, admission was not necessary as no definite clinical findings were there nor any major treatment was given to the patient to justify her admission. The expenses so incurred is nowhere connected to any medical/surgical treatment but has been incurred for diagnostic purpose only. The investigations could have been done on outpatient basis, without the necessity of admission for the same. In view of the same, it is very clear that the patient got herself admitted for investigation purpose only and she was quite normal at the time of admission.

Therefore the expenses incurred clearly falls under exclusion No. 4.10 of the policy which state that " Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/0106/128
Mrs. Sushma Nigam
V/s
National Insurance Co. Ltd.

Award dated 27.02.2006

The Complainant was covered under Senior Citizen of Indore Nagar Nigam and accordingly the Respondent issued the health insurance policy No. 250500/46/03/8500494 w.e.f. 14.03.2004 to 04.02.2005. All of a sudden there was a severe pain in back as well as in legs of the Complainant and as such she consulted the doctor, who advised her to get admitted in M/S Gukuldas Hospital, Indore. During the course of hospitalization the expenses incurred was about Rs. 10,000/- to 12,000/-. The Complainant submitted her claim with the Respondent but they rejected her claim.

The Respondent stated that the Complainant was admitted in the hospital with the complainants of Spondolisthesis Grade II, L4-L5 with Acute Lumbago radiating to left leg. The claim was adjudicated by the TPA M/S M.D.India Healthcare Services (P) Ltd., Pune on the basis of the documents submitted and the claim was repudiated under the policy conditions stating " the patient is admitted for low back pain, patient given only oral medication, all investigations only done. The above case can be managed on domiciliary basis and hospitalization is not necessary, hence the claim is repudiated as hospitalization was primarily for investigation purpose".

The Respondent also stated that the patient was treated with medicines and all these medicines could have been managed on domiciliary basis. The patient was admitted on 13.11.2004 and discharged on 15.11.204, the MRI and CT scan was done on 14.11.2004, both simultaneously with report date 15.11.2004 and the patient was discharged on the same day. Further the patient was advised for treatment/investigation in Gokuldas Hospital Ltd. She was given Pain relieving tablet (Nimulid BD) with conservative medicines such as Ocid and calcium capsule Alpha cal Plus before the investigation and then was discharged after getting the reports. The report filled by Dr. A. K. Jinsiwale and certified by hospital seal shows present condition of the patient as " some what better may need surgery in future" and same is advised in discharge card also, with advise for physiotherapy for Lumber Spine Lysthesis Grade I, which does not require in-patient treatment, with post discharge medicines which are to be managed on domiciliary basis. It is clearly visible in the document that no specialized care has been given in the hospitalization to justify the hospitalization. The line of treatment shows that the treatment given could have been managed on domiciliary basis, and thus it is evident that the patient was admitted primarily for diagnosis purpose only. This is clearly mentioned in the policy under standard exclusion 4.10 which states as " charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." Hence the claim was repudiated and the same was communicated to the Complainant.

It is observed that the Complainant was hospitalized only for different investigations/tests and during the hospitalization no treatment was given to her. During hospitalization only oral medicines were prescribed. It is clearly visible in the document as well as the Complainant confirmed at the time of hearing that during hospitalization neither any injection was given nor any bottle was transfused. It is also observed that no specialized care has been given in the hospitalization to justify the hospitalization and that these tests can also be conducted as OPD (out patient) basis and hospitalization was not needed. Therefore the expenses incurred clearly falls under exclusion No. 4.10 of the policy which state that " Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/0206/141
Mr. Shankar Lal Goyal
V/s
National Insurance Co. Ltd.

Award Dated

The Complainant had taken Medi claim policy No. 321100/48/01/8501970 from the Respondent. The Complainant stated that his wife had fallen sick and was hospitalized on 19.01.2003 and was operated for Hernia and discharged from the hospital on 25.01.2003. The Complainant also stated that he intimated to the Respondent on 20.01.2003 and submitted all the documents in respect of the claim on 21.04.2003, but

the respondent repudiated his claim stating therein that the claim papers were not submitted in time as per policy condition No. 5.4.

The Respondent stated that the Complainant reported them without complete documents on 05.05.2002. Subsequently they had written letter to the Complainant on 01.07.2002 to submit the required papers, but the Complainant did not submit the required papers and as such they had no other alternative but to close the file vide their letter dated 21.04.2003 under policy clause 5.5 which states as “the insured shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall give the company such additional information and assistance as the Company may require in dealing with the claim”. In the instant case the Complainant had not provided the reports and documents called from him vide their letter-dated 01.07.2002, which was the violation of Condition No. 5.5 of the policy. In view of the same they had closed the claim file. The Respondent also contended that they had obtained the opinion from their panel doctor who had opinioned vide his letter dated 12.05.2002 that “the patient is known to have obesity, hypertension, Osteo Arthritis Knee and vertigo. Duration of these diseases should be asked to know whether diseases are pre-existing or not.” In view of the same they asked the Complainant to submit the documents vide their letter-dated 01.07.2002, which the Complainant had not submitted in time. The Respondent also stated that the Complainant had taken up the matter with their Head Office on 29.04.2005 and they replied to their Head Office through their Regional Office vide their letter dated 26.05.2005 and now the Complainant is approaching this office after approximately one year and 10 months of our letter informing him our final decision i.e. on 21.04.2003, the time limit of one year as given under the policy is over and the matter is time barred.

The Complainant was absent during the hearing. Notice was sent by post to the Complainant on 01.03.2006 at the last known address to which earlier correspondences were made. It appears that the Complainant is not interested in resolving the dispute; hence the case is filed as closed.

Bhopal Ombudsman Centre
Complaint No. GI/OIC/1205/121
Mr. Ashok Panjawani
V/s
The Oriental Insurance Co. Ltd.

Award dated 30.01.2006

As per the Complainant all of a sudden his mother fell sick and was hospitalized at Bombay Hospital, Mumbai on 13.08.2005. He informed the Respondent and asked for cash less facility but they advised him to make the payment to hospital and subsequently the Respondent will issue the cheque to the Complainant. Accordingly the Complainant submitted all the claim papers to the Respondent and the Respondent rejected his claim on the plea of Asthma. Thereafter the Complainant’s mother again fell sick and was admitted in M/S Ayushaman Hospital on 06.10.2005. Again the complainant submitted all the claim related papers along with the claim bill which was also rejected by the Respondent on the same plea.

The Respondent stated that the Complainant’s Mother took the Medi claim policy for the first time at the age of 61 years w.e.f. 29.12.2004 to 28.12.2005. Complainant’s Mother reported the claim on the first year policy on 13.08.2005 for the ailment suffered due to Asthma & Pulmonary Koch’s, which existed for the last 3 to 6 years. In view of the same their TPA has rightly repudiated the claim under policy clause 4.1.

It is observed from the discharge card of Bombay hospital of August 2005, submitted by the Complainant to the TPA, the Complainant's mother was suffering from Asthma for the past 2 to 3 years and Pulmonary Koch's existed for the last 5 to 6 years. The Complainant's mother had taken the policy for the first time in Dec. 2004 viz. the disease existed prior to taking the policy. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/UII/1105/103
Mr. Prasanna Kumar Jain
V/s.
United India Insurance co. Ltd.

Award dated 19.01.2006

As per the Complainant, he is working as an Assistant Engineer in Kolar Piriyojana and is an income tax payee for the last 12-13 years and as per the advice of his friend he took the Medi Claim policy for himself and for his family w.e.f. 15.04.2005 and paid premium for Rs. 2776/-. On 03.06.2005 he fell down and was admitted in M/S Ayushman Hospital and discharged on 13.06.2005 and incurred expenses for Rs. 16700/- for the said treatment. The Complainant submitted the bill on 18.06.2005 along with all the supporting papers to the Respondent's TPA M/S Med Save Health Care and it was given to understand that his claim would be settled by 21 days. At the time of discharge, the doctor advised him for surgery (diskectomy with Laminectomy) and the approximate expenses would be about Rs. 50000/- as confirmed by the doctors. But later on after lot of correspondence his claim was rejected by the M/S Med Save Health Care on 16.09.2005 as per policy exclusion clause No. 4.1. Policy taken on 15.04.2005, disease is pre-existing prior to inception of the policy.

The Respondent stated that the Complainant was hospitalized on 03.06.2005 and discharged on 13.06.2005 and the claim was processed by their TPA M/S Med save Health Care Ltd. and they repudiated the claim on the following grounds:

1. The Complainant was hospitalized on 03.06.2005 after 48 days from policy inception with complaints of severe pain in back and in knee joint since last 7 days.
2. Diagnosed as PID l5-S1 with Spinal Stenosis with Compression Fracture of D12 Vertebra.
3. MRI study reveals – Anterior Wedge Compression Fracture of D12 Vertebra. Medical opinion reveals that there is no evidence of fresh fracture as there is no oedema.
4. As per MRI report and film compression the Fracture is old Fracture.
5. The treatment advised on the discharge card suggests Discectomy with partial Laminectomy which according to the medical Experts of Med save, their TPA, treatments advised for old injuries and not for fresh injuries, therefore the hospitalization and the treatment followed is for old complaints and not for fresh complaint.

Thus since the MRI film and report shows no evidence of fresh fracture and the policy has been taken barely 48 days back, the disease is pre existing i.e. prior to policy exception and hence the claim is not payable as per exclusion clause 4.1 of the Mediclaim policy.

It is observed that the Complainant as per MRI report and film compression the Fracture is old Fracture. Further as per the medical expert of Med save (Respondent's TPA) treatments are advised for old injuries and not for fresh injuries, therefore the hospitalization and the treatment followed is for old complaints and not for fresh

complaint which occurred prior to taking the policy. It is also observed from the discharge card, treatment advised Discectomy with partial Laminectomy. These treatments are advised at later stage and not for fresh injuries. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/0905/063
B. S. Choudhary
V/s
National Insurance Co. Ltd.

Award dated 28.10.2005

As per the Complainant he had taken Medi claim policy No. 321100/48/04/8501123 from the Respondent. The Complainant stated that he had fallen sick on 24.12.2004 and doctors advised to admit him in the hospital. Specialist doctors were called and various tests had been arranged. On receipt of test report the cause of disease was known and accordingly treatment was given to him. He was discharged from hospital on 29.12.2005 and thereafter treatment was carried on for about one month. Respondent's TPA i.e. M/S Paramount Health Services Pvt. Ltd. rejected his claim as per policy condition no. 4.10 i.e. he was admitted for only for test.

The Respondent stated that the Complainant was admitted in the hospital w.e.f. 24.12.2004 to 29.12.2004 due to complainants of Headache, fright and chest pain in Bapat Hospital & Laparoscopy Centre, Indore. The Respondent also stated that as per the complainant he was treated and later on when his condition deteriorated Specialists were called, but as per the discharge Card Specialist Dr. B. B. Gupta attended from the first day onwards. The Respondent stated that as per the Complainant his condition was not improving and some tests were arranged by them and on the basis of those test reports, treatment was given. On this point the Respondent stated that the reports, which were arranged by the complainant, were normal. Further Dr. B. B. Gupta confirmed in his certificate-dated 28.06.2005 attached in the file were under the head of report – NAD -which means No Abnormality Detected. In this case the attending doctor had confirmed that nothing abnormal is detected from the report i.e. no indication of positive existence or presence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing home. In view of the same the claim was repudiated under clause 4.10.

It is observed that in this case the attending doctor had confirmed that nothing abnormal is detected from the report i.e. no indication of positive existence or presence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing home. In view of the same the claim is not tenable under clause 4.10, which states that " Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." Hence the complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/OIC/0805/057
Mr. Sanjeev Dubey
V/s
The Oriental Insurance Co. Ltd.

Award dated 25.10.2005

As per the Complainant he had taken the medi claim policy no. 151208/48/06/01444 w.e.f. 19.10.2004 to 18.10.2005 which is continuously renewed for the last 5 years without any break of insurance wherein he had shown that his mother was suffering with high blood pressure and Arthritis. Complainant stated that on 01.02.2005 his Mother fell sick due to vomiting and paralytic attack and was admitted in M/S Choithram Hospital w.e.f. 02.02.2005 to 08.02.2005, where treatment was given. But his case was rejected on the plea that it was a pre-existing disease, by the respondent's TPA M/S Paramount Health Services Pvt. Ltd.

The Respondent stated that Mr. Sanjeev Dubey along with his family members were covered w.e.f. 19.10.2001. While taking the first policy No. 48/2002/0614 Mr. Dubey had declared that his Mother Mrs. Sushila Dubey was suffering from Hypertension & Arthritis and it may be treated as "pre-existing diseases". Accordingly, onward policy till now has been issued excluding Hypertension & Arthritis. The Respondent also contended in his reply that his mother Mrs. Sushila Dubey was admitted in M/S Choithram Hospital w.e.f. 02.02.2005 to 08.02.2005 and was diagnosed to be suffering from Hypertension, Chronic obstructive pulmonary diseases and right cerebellar infarct (as per the noting in the discharge card). On going through indoor case paper, the patient is a known case of Chronic obstructive pulmonary diseases since 10-12 years and was on regular treatment for the same. Similarly the patient was also known case of hypertension since 10-12 years and also on treatment for the same. Thus it is clear from the documents submitted by the Complainant that the ailment for which the patient has been admitted are pre-existing and related/directly arising from pre-existing ailment which the Mother of the complainant was suffering since 10-12 years i.e. prior to commencement of the policy. In view of the same they rejected the claim.

It is observed that the Complainant's Mother was admitted in M/S Choithram Hospital w.e.f. 02.02.2005 to 08.02.2005 and was diagnosed to be suffering from Hypertension, Chronic obstructive pulmonary diseases and right cerebella infarct (as per the noting in the discharge card). It is also observed that the said disease is due to hypertension and the same is excluded in the policy under clause No.4.1 that state as "All diseases/injuries, which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial Mediclaim policy taken from any of the Indian insurance companies shall be taken, provided the renewals have been continuous and without any break." Hence the complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/0905/069
Mr. Mahesh Malga
V/S
The New India Assurance Co. Ltd.

Award dated 10.11.2006

As per the Complainant he had taken Medi claim policy No. 450700/48/04/75452 and his son was hospitalized on 03.05.2005 due to dislocation of bones in the neck and doctors advised for the operation. As per the doctor the patient may also suffer from paralysis. Doctors diagnosed the disease as " Torticollis – traumartie AAD". After admission in the hospital on 03.05.2005, preparation for a major operation was arranged on 04.05.2005 and necessary tests such as X-ray, C. T. Scan etc. were arranged as per the advise of the doctors. But on the date of operation MRI was arranged and it was observed that the gap in between "vertebra" has been reduced and accordingly the operation could be postponed. In view of the same, doctors plastered

the patient from shoulder to head for 1.5 months. The patient is still under observation and if necessary, he would be operated in future. Since the doctors advised the patient to undergo an operation, the patient was admitted in the hospital and subsequently discharged from the hospital on 04.05.2005. The Complainant submitted all the papers to the TPA i.e. M/S Family Heath Plan Ltd. but they repudiated the claim on the basis that the patient was admitted only for test which is not correct.

The Respondent stated that the Complainant had taken the medi claim policy w.e.f. 16.07.2004 to 15.07.2005 covering self, wife and two sons. The complainant lodged a claim for his son for Rs. 8864/- as his son was hospitalized from 03.05.2005 to 04.05.2005. That out of total expenses of Rs. 8864/- claimed by the complainant, Rs. 6900/- pertains to MRI diagnosis, Rs. 1000/- towards room rent, Rs. 300/- towards doctor's fee Rs. 14/- towards medicine, Rs. 50/- towards registration and Rs. 600/- towards service charges. The Respondent also stated that diagnosis mentioned in discharge card of CHL Apollo Hospital is Torticollis ? Traumartie AAD and as per Doctor's pocket Medical dictionary. Indian Edition 1995, Torticollis means a contracted state of cervical muscles. The expenses so incurred is nowhere connected to any medical/surgical treatment but has been incurred for diagnostic purpose only. The investigations could have been done on out – patient without the necessity of admission for the same. Hence the expenses incurred clearly falls under exclusion No. 4.10 of the policy. In view of the same the claim was repudiated.

The Complainant was absent during the hearing. Notice was sent by post to the Complainant on 19.10.2005 at the last known address to which earlier correspondences were made. It appears that the Complainant is not interested in resolving the dispute; hence the case is filed as closed.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/0905/079
Mr. Ram Kishore Agrawal
V/s
The New India Assurance Co. Ltd.

Award dated 21.11.2005

As per the Complainant he had taken the medi claim policy No. 451402/48/04/75022 for the first time from 29.06.2004 to 28.06.2005, which was renewed by him on due date w.e.f. 29.06.2005 to 28.06.2006. After renewing the policy the Complainant's wife complained of pain in the stomach and was admitted in M/S Bombay Hospital, Indore where operation was held on 09.07.2005 for hernia and total expenses incurred by him was Rs. 65030/- including medicines. The Respondent's TPA M/S F.H.P.L. Hyderabad repudiated his claim on the plea of pre-existing disease. The Complainant also mentioned that his wife's hernia had developed in two/three months.

The Respondent stated that their TPA M/S Family Health Pan Ltd. Bhopal repudiated the Complainant's claim on the ground of policy condition no. 4.1 as this ailment was pre existing. As per the exclusions of Mediclaim Policy Condition 4.3 states that during the first year of the operation of insurance cover, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal diseases/defects, Fistula in anus, piles, Sinusitis and related disorders are not payable. If these disease are pre existing at the time of proposal they will not be covered even during subsequent period of renewal too. In the instant case the Complainant had himself stated in his letter dated 22.09.2005 that Hernia had developed 2-3 months before operation, whereas the operation was performed on 09.07.20005 at M/S Bombay

Hospital at Indore. In view of the same it is clear that the Hernia was pre-existing during the first year medi-claim policy effective from 29.06.2004 to 28.06.2005, but the Complainant lodged the claim in the second year policy, as he knew well that Hernia is not covered during the first year policy.

It is observed that the Complainant's wife was suffering with Hernia prior to two or three months of operation viz. 09.07.2005 as stated by the complainant himself and as such the disease of Hernia existed on the first year of the policy. The said disease is excluded in the policy under clause 4.3 which state as "that during the first year of the operation of insurance cover, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal diseases/defects, Fistula in anus, piles, Sinusitis and related disorders are not payable. If these disease are pre existing at the time of proposal they will not be covered even during subsequent period of renewal too." Hence the complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/1005/091
Mr. Laxman Kashi Nath Bari
V/S
The New India Assurance Co. Ltd.

Award dated 29.11.2005

As per the Complainant he was covered under LIC group Medi claim policy and his son Master Shubam was admitted in M/S Vatsalya Nursing Home from 08.02.2005 to 11.02.2005 and from 15.02.205 to 17.02.205 and had submitted the claim with the Respondent on 18.02.2005 and 25.02.2005 respectively. The Respondent demanded the discharge card, which he had submitted on 17.03.2005 but the Respondent did not accept the said discharge –cum-receipt card and demanded separate discharge card on thick paper. Thereafter the Respondent asked to submit a questionnaire on 18.04.2005, which he had completed and submitted on 09.05.2005. The Complainant also stated that the Respondent had also paid him a claim of the same hospital for the period from 17.05.2005 to 18.05.2004. So far the Respondent has not settled the Complainant's claim.

The Respondent stated that the Complainant submitted two claims of Rs. 2501/- and of Rs. 1425/- for hospitalization expenses of his son Master Shubam for the period from 08.02.2005 to 11.02.2005 and 15.02.2005 to 17.02.2005. During the course of processing of both the claims, the respondent asked the Complainant to submit the discharge card for which the Complainant submitted the receipt instead of discharge card. On their further asking for the discharge card the Complainant submitted a discharge on the letterhead of Dr. Ashok Shah. In the absence of proper discharge card the Respondent showed his inability to settle the claim. The Respondent also stated that they had arranged for the investigation and as per the investigator's report, Vatsalya Children Hospital, where Master Shubam was admitted both the times, is not concurring with the definition as mentioned in Condition 2.1 of the medi claim policy clause. The said hospital is neither registered with the local authorities nor having minimum 10 inpatient beds nor fully equipped operation theatres and fully qualified nursing staff under its employment round the clock. In view of the same they have repudiated the claim on bonafide and valid grounds.

During the hearing the Complainant could not confirm any thing about the statement of the Complainant's treating doctor that the hospital does not have any nursing staff. Further it was observed that the said nursing home/hospital in which treatment was

carried out, do not fall under the definition of hospital/nursing home as per Group Medi claim policy.

HOSPITAL/NURSING HOME: means any institution in India established for indoor care and treatment of sickness and injuries and which either

a) has registered as a hospital or Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner OR

b) Should comply with minimum criteria as under:

   i) It should have at least 15 in patient beds.

   ii) Fully equipped operation theatre of its own there ever-surgical operations is carried out.

   iii) Fully qualified nursing staff under its employment round the clock.

   iv) Fully qualified Doctors should be in charge round the clock.

   (N.B. In Class 'C' Towns condition of number of beds be reduced to 10)

The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/0905/075
Mr. Vipin Kumar Agrawal
V/s
National Insurance Co. Ltd.

Award dated 18.11.2005

As per the Complainant he had taken Medi claim policy No. 320102/48/04/8502493 for the last four years from the Respondent. The Complainant stated that on 15.10.2004 his wife had fallen sick and consulted doctor at Mhow and after the test, it was found that she was suffering from Malaria. On 16.04.2005 she was hospitalized at M/S Choiuth Ram Hospital at Indore and it was also observed that she was suffering from Jaundice. At the time of admission his wife was six months pregnant. Prior to this she has one child and there was one abortion also. During the course of admission his wife was treated for Jaundice and Malaria and no treatment was given for pregnancy. The complainant also stated that during the time of discharge from the hospital, hospital authorities have mentioned in the discharge card in col. of diagnosis as "G2 P.A. C32 week pregnancy and Jaundice". Respondent's TPA i.e. M/S Paramount Health Services Pvt. Ltd. rejected his claim as per policy condition no. 4.12 i.e. Treatment arising from or traceable to pregnancy is not payable.

During the hearing the Respondent informed that their TPA M/S Paramount Health Services Pvt. Ltd. has issued claim payment cum discharge voucher for Rs. 17168/- (Claim amount of Rs. 17293/- less 125/- for registration expenses). A copy of the said voucher was also handed over to the Complainant during hearing. Respondent also contended that as soon as the Complainant will submit the discharge voucher duly signed by him, their TPA would issue the cheque. In view of the circumstances stated above, the grievance of the Complainant has been redressed as the Respondent approved the entire claim, hence the complaint is filed.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/0905/084
Mr. Gopal Das Mangal
V/s
National Insurance Co. Ltd.

Award dated 18.11.2005

As per the Complainant he had taken Medi claim policy No. 320102/48/04/8501187 for the last six years from the Respondent. The Complainant stated that on 15.07.2005 he had fallen sick and was admitted in M/S Suyash Hospital. Dr. Upendra Soni treated him from 15.02.2005 to 20.07.2005 and diagnosed the disease as swelling in throat and also arranged for biopsy and discharge from the hospital on 20.07.2-005. He was again admitted on 08.08.2005 in M/S Gokul Das Hospital where Dr. Arun Agrawal operated him. But the Respondent's TPA i.e. M/S Paramount Health Services Pvt. Ltd. rejected his claim as per policy condition no. 4.8 i.e. convalescence, Gen Debility, use of intoxicating drugs (drugs, smoking tobacco etc) & Alcohol are not payable.

The Respondent stated that the claim is dealt by their TPA and as per the note sheet the claim has been repudiated due to General Debility, use of intoxicating drugs (drugs, smoking tobacco etc) & Alcohol. As per discharge card the use of Beedi etc. is clearly mentioned and cause of disease is excluded as per exclusion condition no. 4.8 of the policy, hence the claim is not payable.

During the hearing the Respondent informed that their TPA M/S Paramount Health Services Pvt. Ltd. has regretfully acknowledged the mistake on their part and will dispose the case before 25th November. 2005.Respondent is directed to decide the claim on merit within 30th November 2005. If the Complainant is not satisfied with the decision taken by the Respondent, the Complainant would be free to approach this forum with a fresh complaint. The complaint is thus disposed of.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/1005/087
Mr. Madhu Sudan Dalal
V/s
National Insurance Co. Ltd.

Award dated 30.11.2005

As per the Complainant he had taken Medi claim policy No. 321100/48/04/8503246 since 10 years from the Respondent. The Complainant stated that he had fallen sick on 11.07.2005 & consulted Dr. Bhagwat but his condition deteriorated instead of improving. The complainant also stated that he was feeling uneasiness and losing his memory and as such again consulted the doctor who advised him to be admitted in the hospital & advised him for certain tests. After these tests the Doctors came to the conclusion that he has Alzheimer's disease for which he will take time to recover and as such he was discharged from the hospital. Respondent's TPA i.e. M/S Paramount Health Services Pvt. Ltd. rejected his claim as per policy condition no. 4.10 i.e. he was admitted only for tests.

The Respondent stated that the Complainant was admitted in the hospital from 18.07.2005 to 19.07.2005. In the Complainant's intimation letter, he had wrongly informed the TPA that the patient was suffering with chest pain and is admitted in Hospital for treatment. The Complainant was under the treatment of a Neuro Physician Dr. Abhay Bhagwat and not under any Cardiologist for Heart treatment. He not only contacted him but was also referred by Neuro Physician Dr. Abhay Bhagwat for admission to the hospital. In the reference letter the finding had been mentioned as 'degenerative dementia'. From intimation itself facts were misrepresented/concealed which is against the basic principal of utmost good faith. In the certificate issued by Dr. Bhagwat on 11.08.2005, it is certified that the Complainant is non-diabetic, non-hypertensive and there is no history of Coronary Artery Disease and the patient was suffering from Alzheimer's disease. During hospitalization he was given only oral

Medication as is clear from the cash memos of the medicines, prescription and also reference letter of Dr. Bhagwat which states that the admission was only for diagnostic purpose. Regular tests were conducted along with MRI of the Complainant, which confirms the diagnosis of Dr. Bhagwat that the Complainant was suffering from degenerative process of Brain, also known as Alzheimer's disease. Respondent also stated that the discharge summary also confirms that all the tests were normal and the Complainant was only suffering from Degenerative Dementia and was advised oral medicine only proving that hospitalization was unwarranted for treatment but served only the purpose of diagnostics and tests. In view of the same the claim was repudiated under clause 4.10 which states that " charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable."

It is observed that in this case the attending doctor had confirmed that nothing abnormal is detected from the report i.e. no indication of positive existence or presence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing home. As such the claim is not tenable as the same is excluded under policy clause 4.10.Hence the complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/UII/1005/086
Mr. Sudhir Javkhedkar
V/s
United India Insurance Co. Ltd.

Award dated 17.11.2005

As per the Complainant he had taken a Medi-claim Policy No. 190103/48/04/00483 from the Respondent and is renewing the same w. e. f. 16.10.1997 without any break in insurance not for a single day and has also not taken any claim so far. All of a sudden his wife developed severe pain in the stomach on the mid night of 22.10.2004. She was admitted at 02.00 hours on 22.10.2005 in Pushpanjali Hospital, which was nearer to his house. The Respondent had repudiated his claim on the ground that the hospital is not having 15 beds while in the policy no such condition/clause was mentioned.

The Respondent stated that the complainant is also an insurance agent working with the Respondent's Beresia Road Branch and has full knowledge of medi-claim insurance policy. Besides he has sold many medi-claim policies to insurance customeRs. Based on policy terms and condition the TPA M/S Medsave has disallowed the claim as the concerned hospital " Pushpanjali Hospital, Bhopal" does not have 15 in patient beds. The respondent also stated that the Complainant mentioned that due to acute abdomen pain he had to admit his wife to the hospital, which is near to his house. Our point is that had there been a mental hospital or veterinary hospital near to his house would he have hospitalized his wife just because it is near to his house? The main purpose of condition of 15 in patient beds is to provide better hospital facility and services to the patient. Hence the patient should have been taken to the hospital having 15 in patient beds. The Respondent also contended that there are hospitals nearby to his residence having 15 in patient beds, namely Ayushman, Shekhar Hospital, and Life Line Hospital etc. The Complainant could have admitted his wife in one of these hospitals.

During the hearing complainant informed that he is working as an agent of LIC since 1988 and with the Respondent since 1989 and his residence is at Gulmohar colony (E-8 Arera Colony). The hospital where he has taken the treatment is about one kilometre

from his house. He also contended that M/S Ayushman Hospital, M/S Shekhar Hospital and M/S Life Line Hospital all are about 2 to 2.5 Kms from his house. During the hearing the Complainant contended that he went to Ayushman hospital in late hours of the said day but the Hospital authorities refused admission on the pretext that there in no attending doctor and since there is no previous record (as he has never consulted them), this may be a suicide case. The Complainant also informed that he forgot to visit the other nearby hospital such as M/S Shekhar Hospital and M/S Life Line Hospital although he had brought his wife in car and these hospitals were also near by to his house.

It is observed that the Complainant was working as an Agent of the Respondent since 1989 and had also sold various Medi Claim policies to different clients and as such it cannot be ruled out that he was not aware of the policy conditions. Further the complainant could not justify the reasons why he had not visited M/S Ayushman, M/S Shekhar Hospital and M/S Life Line Hospital although he and his wife were in their own car and the hospitals are also nearby to his house in the radius of two Kms. It is also unbelievable that in late hours there were no doctor in M/S Ayushman Hospital and they had not admitted his wife as narrated by the complainant. Hence the complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/UII/1005/085
Mr. Om Prakesh Jain
V/s
United India Insurance Co. Ltd.

Award dated 29.11.2005

As per the Complainant he had obtained Medi Claim Policy No. 191202/48/03/00306 and his claim was rejected by M/S Med Save Health Care (Respondent's TPA). He had submitted the claim on 16.12.2004 and Respondent demanded certain papers vide their letters dated 07.01.2005 and 27.01.2005, which he has complied, even then the Respondent rejected his claim. The Complainant also informed that he suffered with the disease of Hepatitis 'B' on 4.06.2004 for which he took treatment and the Respondent reimbursed the claim. For the same disease the Complainant was referred to two specialist doctors who informed that the disease was serious. Now the Respondent's contention is that the treatment taken by him in Mumbai does not pertain to any disease.

The Respondent stated that the Complainant was suffering from Hepatitis 'B' and hospitalized in M/S Suyash Hospital, Indore from 04.06.2004 to 06.06.2004 and was paid the claim of Rs. 6367/-. Further the Complainant got hospitalized at M/S Golden Park Hospital Vasai Road, Distt. Thane from 19.10.2004 to 21.10.2004 and submitted his claim against hospital expenses for more than 24,000/- to their TPA i.e. M/S Med Save. This time the claim of the Complainant was treated as NO CLAIM on the report of their panel doctor, Dr. R. K. Bisarya. Dr. Bisarya stated in his report that the Complainant/patient was hospitalized for checkup for different investigations only and during hospitalization no treatment was given to him. More over the investigation done during this period could be done on OPD (out patient) basis and hospitalization was not needed. In view of the same the claim was treated as NO CLAIM.

It is observed that the Complainant was hospitalized only for different investigations/tests and during hospitalization no treatment was given to him. It is also confirmed by the Respondent's specialist doctor that these tests could also be

conducted on OPD (out patient) basis and hospitalization was not needed. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/0905/078
Mr. Rewa Ram Choudhary
V/s
The New India Assurance Co. Ltd.

Award dated 07.12.2005

As per the Complainant, he is working as an Agent in LIC and is a member of Chairman Club of LIC. His medi claim premium had been paid to the respondent for the last five years. He developed back pain and after consulting local doctors, a bone specialist advised him to get M.R.I. done. The M.R.I Report revealed a problem of slip disc for which the doctor advised him to undergo an operation. The operation was performed on 27.07.2004 and bills were submitted to the Respondent. So far the Respondent has not settled the Complainant's claim.

The Respondent stated that the Complainant was covered under CM Club Member (Agency Code 333247) for Rs. one lac since Sept. 2000. The Complainant had taken treatment at M/S Curewell Hospital Pvt. Ltd. Indore for low backache and had been diagnosed PIVD L4 L5/L5 SI with spinal cannal stenosis and had been treated for the same for the period from 26.07.2004 to 03.08.2004 and a claim for Rs. 37827/- was submitted to their TPA i.e. M/S Medi Assist on 27.10.2004. The Respondent also stated that while processing the claim their TPA observed that the Complainant had H/O low backache 6 year back and now diagnosed PIVD L4 L5/L5 SI with spinal cannal stenosis and treated for the same. Since the aforesaid Complainant was covered under the policy w.e.f. 01.09.2000, the condition of the Complainant was pre-existing prior to commencement of the policy/coverage i.e. Sept. 2000. Accordingly, their TPA vide their letter dated 19.01.2005 have conveyed to the Complainant about inadmissibility of his claim in accordance with the Exclusion Clause 4.1 i.e. " All disease/injuries which are pre existing when the cover incepts for the first time". Since the Complainant has history of backache for the past six years, the claim falls under pre-existing i.e. Exclusion Clause 4.1 of captioned Group Mediclaim policy and hence the claim is not admissible under the policy.

It is observed from the papers and contention of the Respondent that except the prescription of Dr. D. K. Jain dated 21.02.2004 where it is mentioned that " H/O back pain 6 years" and on the basis of the said prescription Respondent's TPA had come to the conclusion that the Complainant's disease was pre existing. Besides the Respondent's TPA has also not taken any expert doctor's opinion which shows that the disease was pre-existing. Further Respondent has failed to produce the original of the said prescription, as there was some cutting in the said document. Further the Respondent's TPA has ignored the noting of the Doctor of M/S Curewell Hospital Pvt. Ltd, Indore where the treatment was taken by the Complainant, it is shown in the column of Complaints with duration as 1. Low backache – 20 days, 2. Numbness Rt. Lower limb – 20days.

Looking at the above circumstances it is not proved that the Complainant was suffering with this illness for the last six years, on the contrary it is proved beyond doubt on the basis of the Hospital papers that the Complainant was suffering from this disease since 20 days. Further, had the Complainant suffered from this disease for the past six

years, he would not be able to drive the two wheeler and to move in rural areas to procure the business. The decision of the Respondent to repudiate the claim on this ground is unfair and unjust. Respondent is directed to pay the claim amount of Rs. 37, 592/- (Claim bill for Rs. 37827/- less Rs. 50/- registration fee less Rs. 185/- telephone expenses) to the Complainant.

Bhopal Ombudsman Centre
Complaint No. GI/NIA/1105/106
Mr. Shyam Sunder Pandey
V/s
The New India Assurance Co. Ltd.

Award dated 28.12.2005

As per the Complainant he is a retired Admn. Officer of LIC and is covered under LIC group Medi Claim policy and is suffering from Cervical Spondolysis, Vertigo, Dizziness and diabetes for the last 15 years and due to increase of age his problem of In-balance shot up. In view of the same he Consulted Dr. Abhay Bhagwat on 07.09.2005 who advised him to get admitted in the hospital. He was admitted to CHL-Applo hospital from 07.09.2005 to 09.09.2005. During admission in the hospital the doctors conducted various tests such as MRI of Cervical Spine with MRA Brain. He submitted his claim bill for Rs. 11016/- on 13.09.2005 to the Respondent but the respondent repudiated his claim on the ground that the patient was not required to be admitted in the hospital.

The Respondent stated that the Complainant was covered under group medi claim policy of LIC. The complainant lodged a claim for himself for Rs. 11,016/- for the hospitalization from 07.09.2005 to 09.09.2005. Out of total expenses of Rs. 11,016/- claimed by the complainant, they found that Rs. 50/- was for registration, Rs. 7500/- pertains to CT scanning, Rs. 1200/- towards room rent, Rs. 950/- for other tests, Rs. 950/- towards doctor's fee, Rs. 151/- towards medicine, and Rs. 215/- towards service charges. The Respondent also stated that the medicine prescribed during hospitalization was Glycomet (meant for diabetes), Stamlo Beta Tab (meant for Blood Pressure) and Becadexamin (Vitamin Capsules). Further during the time of discharge the Complainant was prescribed Franxit (meant for anxiety) Draminate (meant for giddiness), Stamlo Beta (meant for Hypertension) Unicobal plus (Vitamin Capsule) and Glycomet (meant for diabetes). Further the discharge card states that on examination the Complainant's vitals were stable with pulse 88/min, BP 150/80 Hg., normal systemic and general examination, normal cardiac and carotid auscultation, neurologically conscious, oriented, normal speech, normal papillary reaction with EOM normal gag, tone and power. His DTR were diminished in all four limbs. Planters were down going bilaterally with normal sensory and cerebeller system examination. His blood investigation and biochemical profile were within normal limits with normal blood, sugar level. Respondent also stated that as per their panel Doctor's opinion, admission was nowhere necessary as no definite clinical findings were there nor any major treatment was given to the patient to justify his admission. The expenses so incurred is nowhere connected to any medical/surgical treatment but has been incurred for diagnostic purpose only. The investigations could have been done on outpatient basis, without the necessity of admission for the same. In view of the same, it is very clear that the patient got himself admitted for investigation purpose only and he was quite normal at the time of admission. Hence the expenses incurred clearly falls under exclusion No. 4.10 of the policy. In view of the same the claim was repudiated.

It is observed that the Complainant was hospitalized only for different investigations/tests and during the hospitalization no treatment was given to him. It is also confirmed by the Respondent's specialist doctor that these tests could also be conducted on OPD (out patient) basis and hospitalization was not needed. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Complaint No. GI/NIC/1105/101
Mrs. Chaya Sanjay Lalka.
V/s
National Insurance Co. Ltd.

Award dated 28.12.2005

As per the Complainant her husband Late Shri Sanjay H Lalka was covered under group Medi Claim Policy and he was hospitalized on 08.12.2004 for Pneumonia. During the course of treatment, it was found that he was suffering from Sepsis/Pneumonia with ARDS/HIV positive and consequently during the course of treatment he died on 16.12.2004. Total expenditure incurred by her for treatment of her husband was Rs. 87060.90 and the bills were submitted to the TPA of the Respondent and all the formalities in connection with the claim were complied with, but the Respondent rejected her claim under policy exclusion clause No 4.9. The Complainant also stated that at the time of taking the policy neither the Respondent nor TPA of the Respondent indicated that in case any person being HIV positive will not be entitled to claim the benefit from the company. If fact the Complainant and her husband and all the members covered under the said policy were medically examined by their panel doctors, which by itself shows that her husband was hale and hearty at the time of taking the policy. The Complainant also stated that she is a widow having three minor children along with widowed Mother-in-law to support and she has neither any LIC policy of her husband nor any property left over by her husband to support her family. In fact she had taken huge loan for the treatment of her husband.

The Respondent stated that the insured Mr. Sanjay H Lalka was covered under our group Medi claim policy with floater issued to Dakhshin Bharat Kutchhi Dasha Oshwal Jain Ekkam. Late Mr. Sanjay Lalka was hospitalized at M/S Anand Hospital Indore on 08.12.2004 for complaints of pyrexia and acute respiratory distress syndrome in a known sero-positive case. The root cause of this is HIV positive. This is excluded under Exclusion No. 4.9 of our group Medi Claim policy which states as " All expenses arising out of any condition directly or indirectly caused to or associated with Human T-cell Lymphotropic Virus Type III (HTLB –III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or condition of a similar kind commonly referred to as AIDS". The Respondent also stated that the wife of the deceased person i.e. the Complainant was requesting them to consider the case on compassionate grounds and to pay the claim, but they regret their inability to pay the claim as this is excluded under the policy.

It is observed that the husband of the Complainant was covered and at the time of insurance, he was hale and hearty but subsequently suffered with the disease, which is excluded in the policy. It is a shocking proposition that the right to live a healthy life should depend on the ability of a person to pay for the treatment. In the instance case the Complainant incurred over Rs. 87000/- to save the life of her husband but could not succeed. On the contrary the Respondent had rightly repudiated the claim under policy clause 4.9 as policy specifically states that the expenses incurred due to AIDS are not payable. However looking at the plight of the Complainant, and the fact that she and

her husband was hale and hearty at the time of taking the policy and had incurred more than 87,000/-on the treatment of her husband, I should decide the case sympathetically. Moreover the Complainant also stated that her husband had no LIC policy or has also not left any property. Further for this treatment she had taken a loan. Respondent was directed to pay the ex-gratia claim amount of Rs. 50,000/- to the Complainant on compassionate basis.

Bhopal Ombudsman Centre
Complaint No. GI/UII/1105/098
Mr. Rajendra Kumar Agarwal
V/s
United India Insurance Co. Ltd.

Award dated 29.12.2005

As per the Complainant, he had insured his son Mr. Vijit Agarwal under the Medi Claim Insurance Policy No. 190300/48/03/00745. In the month of Jan. 2004 he suffered from Hypertension and blood pressure for which he was given treatment. When there was no improvement he was referred to M/S Bombay Hospital Indore and subsequently claim bill was submitted to the Respondent. The Respondent rejected his claim under policy cause 4.10 i.e. admission for investigation only which is not correct.

The Respondent stated that the claim was dealt with by their TPA M/S Med Save Group, Bhopal and they treated the claim as NO Claim as in the discharge card of Bombay Hospital it is mentioned that " C/o (complaining off.) marked obesity – 8 years that the patient is having marked obesity for more than 8 years". It also mentioned that Patient gained weight 7-8 years back from 45 Kg. to 106 kg. This clearly shows that he was over weight before the policy was taken. Thus he was having excess weight when the policy was taken. This becomes a pre-existing disease and not payable under 4.1 of the policy clause. The Respondent also stated that the patient was admitted only for investigation which is not payable under policy clause 4.10, please refer discharge card wherein it is mentioned that " treatment given – TRP/BP/10 chart, Strict BP Monitoring, salt restriction, reducing diet." It means the admission was only for investigations/tests, which could have been done as OPD case and all the advice could be given in the clinic. In view of the same, admission in the hospital is not justified and the claim is not tenable.

It is observed from the discharge card that the patient was suffering for the last 8 years viz. he was suffering from this disease before taking the policy hence the disease was pre-existing. It is also observed that the Complainant was hospitalized only for different investigations/tests and during hospitalization no treatment was given to him, and the tests can carried out could also be conducted on OPD (out patient) basis and hospitalization was not needed. Hence the complaint is dismissed without any relief.

Chandigarh Ombudsman Centre
Case No. GIC/4/NIC/15/06
Shri Ramesh Chander Sharma
Vs
National Insurance Co. Ltd.

Award Dated 14.10.2005

FACTS : Shri Ramesh Chander Sharma was covered under mediclaim policy since 11.2.2000. At the time of renewal of policy on 11.2.03 for the year 2003-04, he paid premium cheque in advance to Development Officer on 7.2.03. However, he was asked to pay additional premium on 24.2.03, which was also paid by him. However, the policy

was made effective from 25.2.03, thereby causing a break. He took up the matter with the Development Officer and was assured that corrective action would be taken, but nothing happened. He approached the Administrative Officer, who also regretted vide letter dated 31.12.03 that condonation of break cannot be allowed. Feeling aggrieved, he filed a complaint in this office on 5.4.05 urging that the insurer be advised to condone the delay so as to make the policy continuous since delay was not caused due to any omission on his part.

FINDINGS : A copy of letter dated 16.8.05 addressed to insured was sent by the insurer to this office together with an endorsement to the effect that policy in question will be treated as valid from 8.2.03 to 7.2.04 instead of 25.2.03 to 24.2.04. It was contended that the grievance of complainant was redressed as the continuity for policy for 2003-04 was ensured. However, the complainant filed another representation vide letter dated 24.8.05 stating that as the subsequent policies for the years 2004-05 and 2005-06 were issued w.e.f from 25.2.04 and 25.2.05 respectively, the endorsement for the year 2003-04, resulting in break in policies for these two years. He suggested that dates for these policies were also required to be antedated so that his mediclaim policy remained continuous.

The representative of the insurer furnished written reply sent by Sr. Divisional Manager, wherein it was pointed out that since the cheque for the policy period 2004-05 was dated 16.2.04 and for the policy period 2005-06 it was dated 21.2.05, the commencement of these policies cannot be shown w.e.f 11.2.04 and 11.2.05 respectively as requested by the insured.

DECISION : Held that the stand taken by the insurer is not tenable as further break in the policies was caused by the failure of insurer to effect timely rectification of policy for 2003-04. Since it took two years, subsequent policies were issued in the meantime with reference to the earlier date of expiry of policy for 2003-04 i.e. 24.2.04. The net result of the decision of the insurer is that what has been given by one hand, has been taken away by the other. The delay in rectifying the policy for 2003-04 is deplorable which resulted in compounding of errors for the subsequent policies. Ordered that correction be made in the subsequent policies for the year 2004-05 and 2005-06 by issuing necessary endorsements in order to maintain continuity of policies.

Chandigarh Ombudsman Centre
Case No. GIC/147/NIC/11/06
Smt. Manjit Kaur
Vs
National Insurance Co. Ltd.

Award Dated 07.11.2005

FACTS : Smt. Manjit Kaur had taken an overseas mediclaim policy from DO Faridabad for visiting USA for the period 11.1.05 to 10.5.05 and later got it extended up to 9.7.05. The policy inter alia covered illness restricted to US $ 10,000. She paid premium amount of Rs. 31,182. Her husband who followed her to USA also took similar policy for the period 25.4.05 to 8.7.05. Before the issue of policy, she underwent mandatory health check up and reports were found to be normal. While her husband was given coverage of illness for US $ 5 lakh, in her case it was restricted to US $ 10,000. She felt cheated as she had also paid the same premium as her husband had paid. No claim was filed under the policy. She urged that since the premium has been charged in excess, the proportionate excess premium together with interest thereon, should be refunded to her. She took up the matter with the insurer and was informed that illness cover in her policy was US $10,000 instead of US $ 5 lakh due to a clerical mistake.

She was actually covered for US $ 5 lakh. Hence no refund was due. She stated that she was not satisfied by the explanation furnished by the insurer and requested that her grievance be redressed.

FINDINGS : On behalf of insurer it was admitted that policies for the complainant and her husband were issued under plan B-2, which included visit to USA/Canada. The insured had submitted proposal form and medical examination report. However, while entering particulars in the computer against "original of physician report attached", 'No' was entered. As a result illness cover was restricted to US $ 10,000 as against standard US $ 5 lakh. It was also admitted that in the event of claim, US $ 10,000 would have been paid to the claimant immediately and for the balance amount, the insured may have undergone some inconvenience. It was stated that there is no provision in the policy for charging premium proportionate to the sum insured.

DECISION : Held that the insurer has admitted the mistake. It is a serious deficiency in service and in the event of any claim, the insured would have faced a serious problem. Having regard to the fact that the policy is so tailored that there is no provision for charging premium proportionate to the sum assured, ordered that she should be paid Rs. 3,000/- on ex-gratia basis for the inconvenience and agony caused to her. The insurer was also advised to have the matter looked into for appropriate action, so as to avoid recurrence of such omissions in future.

Chandigarh Ombudsman Centre
Case No. GIC/78/UII/11/06
Shri Raj Kumar Duggal
Vs
United India Insurance

Award Dated 17.11.2005

FACTS : Shri Raj Kumar Duggal had taken a mediclaim policy for his wife Smt Usha Duggal for the period 01.10.03 to 30.09.04 for sum insured of Rs 30,000 which was renewed w.e.f. 1.10.04 to 30.09.05 for sum insured of Rs. 60,000. She was admitted in hospital during Mar/April'04 for which claim was duly settled. She was again admitted in hospital on 24.9.04 and died on 14.10.04. He lodged a claim for Rs 35,000 with TPA. He was informed that total sum insured of Rs.30,000 had already been exhausted during March 2004. His contention is that the part claim which pertains to the period after renewal of policy was wrongly repudiated.

FINDINGS : The representative of insurer pointed out that as the hospitalization had taken place during the currency of the previous policy, notwithstanding the fact of renewal of the policy, the claim was not payable. The logic put by him was that the sum insured had been exhausted at the time of commencement of hospitalization, therefore the benefit of renewal and the sum insured thereof will not be admissible for the simple reason that the hospitalization had commenced during the currency of the previous policy. On enquiry as to whether the claim would have been payable if she had been admitted on 1st of October, 2004, he replied in the affirmative.

DECISION : Held that the rationale given by the insurer for refuting the claim was untenable. There is no point in getting the policy renewed, if the claim arising in respect of treatment during the policy period is not payable. While claim pertaining to treatment for 29.9.04 and 30.09.04 is not payable as the sum insured had been exhausted, the claim for treatment from 1.10.04 to 14.10.04 is definitely payable since the policy had been renewed w.e.f 1.10.04. It cannot be construed that any claim in respect of hospitalization which commenced during the currency of the previous policy

will not be entertained even if it substantially relates to the period after renewal. Therefore, ordered that the claim in respect of treatment from 1.10.04 to 14.10.04 be paid.

Chandigarh Ombudsman Centre
Case No. GIC/7/NIA/15/06
Shri Girdhari Lal Tikoo
Vs
New India Assurance Co. Ltd.

Award Dated 29.12.2005

FACTS : Shri Girdhari Lal Tikoo had taken a mediclaim policy on 2.2.99 from BO Jammu after completion of medical test and other requirements as advised by company's panel of doctors. He had disclosed in the proposal form that he had been successfully operated upon for prostrate (TURP) during 1993 and mentioned that the same had been permanently cured. He underwent Angiography and Angioplasty in April 1999 and filed the claim which was repudiated. However, Distt Consumer Forum gave an award in March 2005 in his favour ordering that the claim amount was payable with interest. He continued renewing the policies thereafter and earned cumulative bonus of 35%. No exclusion was indicated in any of policy at the time of renewal. However, when he got the policy renewed for the year 2005, an endorsement was made to the effect that prostrate and heart diseases were excluded from the scope of the policy. He took up the matter with the Branch Manager, Shalimar Road. He was verbally informed that it was a mistake and rectification thereof was promised. However as nothing was done, he filed a complaint urging intervention in the matter as exclusion in respect of diseases which occur during the policy period is not permissible.

FINDINGS : On behalf of insurer it was pointed out that while processing the proposal for renewal it was noticed that complainant had suffered from heart ailment and the claim for the same was repudiated by Raksha TPA on the grounds that it was a pre-existing disease. Hence an exclusion endorsement to this effect was made. The complainant however stated that the contention of the insurer that it was pre-existing disease was not accepted by the District Consumer Forum and evidence produced by the insurer was held to be insufficient. The representative of insurer pointed out that appeal has since been filed in the State Consumer Forum. It was further mentioned that excluding prostrate was justified since as per complainant's own declaration at the time of inception of policy, he had undergone surgery for the same in 1993.

DECISION : Held that the endorsement regarding exclusion of heart disease was not warranted as the District Consumer Forum has held that it was not a pre-existing disease. Therefore, making such an endorsement is contrary to the findings of District Consumer Forum. Accordingly, I order that same may be expunged. If eventually the appellate court upholds the contention of the insurer, heart disease will automatically be treated as a pre-existing disease, irrespective of the fact whether an endorsement to this effect is made in policy or not. As regards the endorsement in respect of prostrate is concerned, it has no particular significance because whether it is specifically excluded or not, it stands excluded under general exclusion clause of the mediclaim policy on the basis of disclosure by the complainant. Therefore, the complainant should not have any grievance on this account.

Chandigarh Ombudsman Centre
Case No. GIC/23/NIC/11/06
Shri Harvinder Arora

Vs

National Insurance Co. Ltd.

Award Dated 02.01.2006

FACTS : Shri Harvinder Arora had taken a Mediclaim policy for sum insured of Rs. One lakh from DO-I Jalandhar for the period 13.11.03 to 12.11.04. He suffered acute pancreatitis and was hospitalized for three months in Batra Hospital fom 7.3.04 to.9.3.04 and in Patel Hospital from 9.3.04 to 11.03.04. He also remained admitted in DMC, Ludhiana from 11.3.04 to 25.5.04. He incurred an expenditure of Rs. 4.75 lakh on his treatment. The claim filed by him was rejected on the grounds that the acute pancreatitis was caused due to alcoholism. He filed a complaint in this office on 26.4.05, requesting intervention in getting the claim paid to him. He stated that this was not a valid ground for repudiation as he was not an alcoholic.

FINDINGS : As per discharge summary of Patel Hospital and expert medical opinion, the patient was a known case of chronic alcoholism. He was admitted in hospital complaining of vomiting. He was diagnosed to be a case of post alcoholic acute pancreatitis and shifted to DMC hospital, Ludhiana. As claim pertained to an ailment which was the result of alcoholism, it was contended on behalf of insurer that claim fell within exclusion under clause 4.8 of standard mediclaim policy. The complainant stated that he is not a habitual drinker, but admitted that he consumes liquor occasionally. However, treatment taken by him had no nexus with consumption of alcohol. The complainant pointed out that the diagnosis in DMC, Ludhiana did not disclose that his ailment was the result of alcoholism. After perusing the case history and discharge summary issued by Patel Hospital, insurer's panel Dr. Bhalla opined that alcohol intake for a long period (at least 5-7 years) is the commonest cause of pancreatitis and is usually precipitated by a heavy bout of alcohol. He expressed the view that as the claimant is a known case of chronic alcoholism as per record with Patel Hospital, the disease is definitely an outcome of the same.

DECISION : Held the claim is inadmissible in view of documentary evidence produced by the insurer to the effect that the complainant's ailment was due to alcoholism for which he was treated. The complaint was, accordingly, dismissed.

Chandigarh Ombudsman Centre

Case No. GIC/163/UII/14/06

Shri Ved Prakash Mendiratta

Vs

United India Insurance Co. Ltd.

Award Dated 17.01.2006

FACTS : Shri Ved Prakash Mendiratta had taken a Mediguard policy from BO Ludhiana for the period 29.3.05 to 28.3.06. He was taken ill on 4.7.05 and remained admitted in M/s Preet Hospital Model Town, Ludhiana upto 8.7.05. He claims to have informed the insurer and submitted all the documents for settlement of claim, but despite personal visit and telephonic reminders the claim was not settled. He sought intervention of this office for early settlement of claim.

FINDINGS : Sr. DM pointed out that Shri Mendiratta was covered under Mediguard policy. His claim was referred to panel doctor Dr. B. C. Singla, who confirmed that insured was admitted for infected right big toe dorsally and diabetes mellitus and was discharged on 8.7.05. The doctor opined that claim was payable if the policy has run continuously for three years. The earlier policy for the period 29.3.04 to 28.3.05 was

mediclaim policy. However, the insured opted for mediguard policy for the period 29.3.05 to 28.3.06. The claim record revealed that insured had been paid a claim under mediclaim policy for eye operation, diabetic maculopathy and uveits phacoemulsification with IOL implantation. It was stated that the current claim relates to diabetic foot which is a complication of diabetes mellitus for which he was hospitalized earlier also.

In the discharge certificate given by Preet Nursing Home, where he underwent eye operation, he was shown to be suffering from diabetes for the last 5-6 years. It was urged that even if it is assumed that he was suffering from diabetes for only five years, the claim will not be admissible; moreover he got the Mediclaim policy converted into a Mediguard policy w.e.f. 29.3.05. As per exclusion clause 4.1 of the policy, the claim is not admissible as claim in respect of any pre-existing disease becomes admissible only after three claim-free years. As the policy was converted only a year before, the claim was not payable. The complainant contended that he received policy bond without terms and conditions of the policy.

DECISION : Held that the claim may not be payable as per terms and conditions of the policy. But the insurer has not been able to produce any satisfactory evidence to establish that the terms and conditions of the changed policy were made known to the insured. The complainant seems to be oblivious of the fact that new policy contains some limitations for a specified period. Therefore, giving the complainant benefit of doubt, ordered that 50 % of claim amount be admitted and terms and conditions of the Mediguard policy be issued to him. Further, ordered that this will not form a precedent for settlement of any claim in furture.

Chandigarh Ombudsman Centre
Case No. GIC/185/NIC/14/06
Shri R. K. Uppal
Vs
National Insurance Co. Ltd.

Award Dated 20.01.2006

FACTS : Shri R. K. Uppal got his mediclaim policy renewed from DO-II Chandigarh for the period 16.2.04 to 15.2.05 for sum insured of Rs. 2.5 lakh for self and Rs. one lakh for his wife. During the currency of the policy, he was hospitalized after he had a complaint of backache. After investigation, he underwent surgery for spinal disc on 23.7.05 at Mukat Hospital Chandigarh. He submitted claim papers with the insurer, but despite reminders the claim was not settled. Eventually he was informed on 11.10.05 that the claim has been repudiated on the advice of TPA.

FINDING : The TPA concluded that the claim was non maintainable as claim was for treatment of disc disease which develops gradually over a period of years and hence it was a pre-existing disease. It was stated that Shri Uppal aged 54 years had taken fresh mediclaim policy from 16.2.04 to 15.02.05 and got it renewed from 16.2.05 to 15.2.06. The claim was preferred for treatment of disc disease. The insured has been having low back pain off and on for one year as per discharge summary dated 25.7.05. It confirms that this was a pre-existing disease. Besides, the scrutiny of claim by TPA revealed that it was a case of PIVD LS-S with sciatica (right) SLR-50^0 R-40^0. As the said disease develops gradually over a period of time, it was concluded that it was pre-existing at the time of inception of policy. Hence, the claim was repudiated and the complainant was informed n 26.9.05. The sole basis of repudiation is MRI impression

reflecting degenerative changes. The other plea taken by the insurer that at the time of purchase of policy the complainant did not disclose the material fact that he was having disc problem, does not find any mention in the letter of repudiation. The insured pointed out that he had problem of backache for a period of one year only and that he was not aware of it earlier, nor had he taken any treatment.

DECISION : Held that it would be illogical to repudiate the claim solely on the basis of MRI impression. It is a fact of life that degenerative changes do take place with advancing years. But the impact of such changes is known only when these become symptomatic and a doctor is consulted for treatment. As per discharge summary, by his own admission the complainant had back pain for past one year, off and on. He underwent surgery in July 05. By then his policy had run for one year and five months. Unless insurer is able to establish that he had taken treatment prior to purchase of policy the presumption would be that the disc problem arose after purchse of policy. Besides, exclusion clause 4.1 of the policy provides that a disease would be treated as pre-existing only if the insured had knowledge of the same before the purchase of policy. A person may suffer from a disease without knowing about it, until it becomes symptomatic. The fact that MRI impressions reflected changes cannot ipso facto imply that the complainant had knowledge thereof. This is required to be supported by some additional evidence regarding treatment having been taken. It would not be a valid assumption that as certain diseases take long time to develop, the insured must also be aware of them. Had that been the case, the important ingredient of *knowledge of disease* would not have been incorporated in the terms and conditions of policy. In this background the repudiation of claim was held not to be in order. Accordingly the insurer was directed to settle the claim.

Chandigarh Ombudsman Centre
Case No. GIC/267/NIC/14/06
Pankaj Kalia
Vs
National Insurance Co. Ltd.

Award Dated 28.03.2006

FACTS : Shri Pankaj Kalia had taken a mediclaim policy for self and family from BO Gurgaon. His mother took ill and was admitted in Escorts Hospital Faridabad. He sent requisite documents to M/s Genins India Ltd, the TPA for extending cashless facility, which was denied. His grievance is that he had to bear all the expenses and undergo harassment. He sought intervention of this office for compensation on account of harassment suffered by him.

FINDINGS : The complainant's mother had a complaint of DM & HT which were recently diagnosed. It could not be said with certainty whether it was a pre-existing disease or not The complainant argued that the cashless facililty is rendered meaningless if it is eventually denied The procedures involved in availing the cashless facility are cumbersome resulting in inconvenience. The representative of the insurer expressed the view that the cashless facility cannot be extended in an open ended manner without exercise of due caution, otherwise the company may end up paying claims which would not have been payable as per policy terms and conditions.

DECISION : The point at issue is whether cashless facility has to be extended in all cases once the card is issued or only in cases where prima facie the liability appears to be indemnifiable. Held that interference with the decision of the insurer was not warranted as the insurer has to exercise its judgement and discretion in each case on

the basis of facts and circumstances. The insured was advised to submit claim to TPA for consideration on merits.

Chandigarh Ombudsman Centre
Case No. GIC/209/NIC/11/06
Ashok Aggarwal
Vs
National Insurance Co. Ltd.

Award Dated 20.02.2006

FACTS : Shri Ashok Aggarwal took a mediclaim policy from DO-I Chandigarh for the period from 3.2.05 to 2.2.06. While coming back from Shimla to Chandigarh, he felt severe pain in his back on 4.4.05. He could not sleep properly. Next day he visited CMC Hospital, Sector-17, Chandigarh and got himself examined. He was admitted and advised MRI, After completion of treatment he filed claim papers with supporting documents for reimbursement of Rs. 13,442. He was informed by M/s Family Health Plan, TPA vide letter dated 20.7.05 that his claim did not fall within the purview of policy as it related to a pre-existing condition. He filed a representation on 21.7.05 with the TPA, a copy of which was also endorsed to Sr. DM Chandigarh. He stated that as he did not have back pain earlier it could not be construed as a pre-existing disease. However, the decision conveyed to him earlier was reiterated vide letter dated 3.10.05. He, therefore, sought intervention of this office for getting the claim settled.

FINDINGS : The complainant contested the conclusion of TPA that hospitalization was for management of a pre-existing disease. He stated that he had not suffered backache earlier. It was a sudden onset of pain and on the advice of physician, he underwent MRI which did reveal some problem in his back, about which he was completely ignorant. The representative of insurer stated that as per finding of expert group of TPA, it was treated as a pre-existing disease on the ground that conditions revealed in MRI develop over a period of time. Since it was a fresh mediclaim policy, it was a case of pre-existing disease. Therefore, the claim was not payable.

DECISION : For refuting a claim on the grounds of it being a pre-existing disease, it is necessary to establish that claimant had been under treatment prior to purchase of policy or had knowledge thereof. In the instant case, based on the treatment record it may be correct to assume that ailment was pre-existing since it is a case of fresh policy. But condition for exclusion listed in 4.1 also provides that exclusion shall not apply if in the opinion of panel of doctors, insured person would not have known of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance. The medical team has not given any opinion as to whether insured was in the know of the disease at the time of purchase of policy. Therefore, giving benefit of doubt to the complainant, it was ordered that the claim liability be admitted.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1061/2005-06
Dr. S. Balasubramanian
Vs
The New India Assurance Co. Ltd.

Award Dated 30.09.2005

Dr. S. Balasubramanian and his wife Smt. B. Indirani were insured under mediclaim with New India Assurance Co. Ltd. Smt. B. Indirani was hospitalized from 08.04.2004 to 16.04.2004 with a diagnosis of recurrent incisional hernia and abdominoplasty was

done. The Insurer repudiated the claim on the ground that as per the panel doctor's opinion recurrent incisional hernia was a re-occurrence of the previous hernia, the patient had undergone previous incisional hernia in the year 2001 and the policy was from 2002, hence the disease is pre existing and not payable.

As per the record Smt. Indirani was covered under mediclaim policy from March 2002, she was hospitalized for the hernia in April 2004, the symptoms of the same was 2 years prior to the hospitalization i.e. from April 2002, the commencement of the disease falls subsequent to the inception of the policy and the insurer failed to prove that the incisional hernia was in existence prior to inception of the policy. This forum referred the matter to a medical specialist and as per his opinion the subsequent repair in April 2004 is a fresh episode, and It is irrelevant to name the hernia as recurrent or inter muscular. Hence, this forum observed that hernia of 2004 remains a fresh episode. However, this forum observed that the complainant having undergone incisional hernia in the year 2001 but not disclosed the same in the proposal form, the same cannot be a ground for the insurer to repudiate the claim. Hence, this forum allowed 75 % of the admissible claim amount.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1105/2005-06
Shri K. S. Duraiswamy
Vs
The New India Assurance Co. Ltd.

Award Dated 10.10.2005

Shri K. S. Doraiswamy was covered under Good Healthy Policy for credit card holders with M/s New India Assurance Co. Ltd., from August 2000. He was hospitalized from 20.05.2004 to 29.05.2004 the diagnosis of Coronary Artery Disease and he underwent a Coronary Bypass Graft (CABG) on 22.05.2004. The Insured repudiated the claim on the ground that he was a known case of hypertension with history of Anterior wall Myocardial Infarction (AWMI) and Reinfare recently, if the same was disclosed at the time for proposing insurance in July 2002 they would have deleted both ailments from the scope of the policy.

The complainant had a AWMI in 1983 which had not been disclosed in the Proposal form, but the Angio taken in 1986 in US did not reveal any major cardiac ailment. In view of the fact that there was no manifestation of the heart disease in the subsequent 20 years, this forum held that the significance of the suspected AWMI of 1983 diminishes and this cannot be a ground for repudiation. As regards hypertension if the complainant had been suffering from elevated hypertension for as long as 21 years and his hypertension had been a strong contributing factor for his Triple Vessle disease, the same should have manifested at a much earlier point of time, hence non disclosure of hypertension is not significant enough to repudiate the claim. Hence allowed ex-gratia payment to the extent of 50 % of the admissile claim.

Chennai Ombudsman Centre
Case No. NIL
Shri C. Nageshwara Rao
Vs
The United India Insurance Co. Ltd.

Award Dated 13.10.2005

Shri C. Nageswara Rao was covered under Mediclaim policy with United India Ins. Co. Ltd. Since 1993 onwards. He was hospitalized from 20.8.04 to 02.09.2004 for Coronary Artery Disease for which he underwent CABG surgery on 24.08.04. He preferred a claim with the insurer and the same was rejected by them on the ground of pre existing disease. The Insurer contended that the complainant had undergone treatment for Coronary Artery Disease (CAD) in March 1997 and a claim was also settled by them. While renewing the policy in 1998 - 1999 there was break in insurance for one day, hence the claim in August 2004 is for a pre existing disease.

From the records, it was observed that the complainant was very insurance conscious and remitted the renewal premium in advance. The matter regarding condonation of one day break pertaining to 1998-99 policy has not been attended to by the appropriate authorities of the insurer. Further, the insurer was aware that the complainant underwent CAD in 1997 and at the time of renewal they had not excluded the disease in the policies since 1998-99 and specifically mentioned 'None' under the column 'subject to the exclusion'. This forum was of the opinion that the insurer was empowered to condone delay upto 30 days, where the break is only for a single day, complainant having been insured for 11 years remitting the premium well before the due date, this case is fit for condonation of delay of a single day. Hence direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1136/2005-06
Shri R. Jaya Kumar
Vs
The New India Assurance Co. Ltd.

Award Dated 25.10.2005

Shri Jayakumar and his wife Smt. Ajita Jayakumar were covered under Mediclaim policy for the period from 28.09.2004 to 27.09.2005. Smt. Ajita Jayakumar was hospitalized on 22.02.2005 for Zyoptic laser correction of Hypermetrophia of both eyes. His claim was repudiated by M/s TTK Health Services, TPA of the insurer on the grounds that it is a cosmetic surgery and not admissible under exclusion 4.5 of the policy.

This forum observed that the exclusion 4.5 of Mediclaim policy excludes any treatment done for cosmetic reasons only. The attending doctor certified that Smt. Ajita Jayakumar was suffering from a hypermetrope of + 4 which is a severe visual disability and progressively increases and at a stage when there is a contact lens intolerance, lasik refractive surgery is recommended. It is clear that lasik surgery has been done to deal with the optical illness which was disabling the person, hence for no reason it can be termed as treatment for cosmetic reason. As per GIC guidelines 1998 lasik surgery is reimbursable under the mediclaim policy for Karatotomy of the insured having more than (-) 7 refractive error develops after issue of insurance. Karatotomy is a case of 'short sightedness and hypermetropia is far sightedness. The attending doctor certified the severity hypermetropia having a reading of +4 to be equivalent in severity to myopia of (-) 7 and above. Hence when laser surgery is allowed for Karatotomy of (-) 7, the same methodology for treatment for hypertrope of +4 is to be reimbursed under mediclaim policy. The attending doctor also certified hypermetropia of +4 both eyes which has been gradually increasing for the past 6 months to establish that the same necessitated surgery. Therefore, direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre

Case No. IO(CHN)/11.2.1135/2005-06
Shri N. Krishnaswamy
Vs
The New India Assurance Co. Ltd.

Award Dated 10.11.2005

The complainant, Shri N. Krishnnaswamy was insured under Good Health Policy for Citi Bank Card Holders (for the past 10 years continuously), with The New India Assurances Co. Ltd. for a sum insured of Rs. 1,50,000/-. The insured underwent Coronary Angiogram and Angioplasty in Vijaya Heart Foundation and TPA's of the insurer as against claimed amount of Rs 1,45,551/-, approved Rs. 1,27,025/- as the policy clause 1,1(a) of the Good Health Policy states Hospitalization expenses incurred for treatment of any one illness under agreed package charges will be restricted to 80 % of the actual package charges or the sum insured whichever is less.

The insured contended that the hospital billing section had clubbed the various input costs of surgery in one head as 'Angio + PTCA Charges' and mentioned as package in the bill foot note and because of the mentioning of the package the insured had reduced the expenses to 80 %. He, has therefore claimed the balance of the hospitalization charges towards post hospitalization as it will be within the sum insured of Rs. 1,50,000/-.

The Forum felt a reading clause 1.1 and 1.1(a) of the Good Health policy makes it clear that for a surgery/treatment which is not charged on 'package basis' but is charged by giving break up details of the entire expenses, a cap on the expenses involved is applicable as per condition clause 1.1 of the policy. By the application of this clause, it is noted that the amount reimbursable works out to Rs. 1,10,030/- as per working given by the insurer subsequent to hearing. However, after applying clause 1.1(a), restricting the claim to 80 % for the package charges of Rs 90,185/-, the claim amount works out to Rs. 1,27,025/- which stands already paid by the insurer. Under the circumstanes, this Forum observes that the insured has not been deprived of any amount due to him under the policy. Regarding the contention of the insured that post-hospitalization expenses have not been paid by the insurer, it is to be noted that clause 1.1(c) which is a sequel to clause 1.1 specifies that the limits for the various categories of expenses would also include all pre and post hospitalization expenses pertaining to any one illness. In the present case, since the limits had already exhausted for the hospitalization expenses, the insured is not eligible for the post hospitalization expenses and complainant is not entitled to get any relief.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.03.1137/2005-06
Shri K. Babu
Vs
National Insurance Co. Ltd.

Award Dated 14.11.2005

The complainant Shri K. Babu was insured under mediclaim policy with National Insurance Company Ltd. for the period 19.04.04 to 18.04.05. The insured was hospitalized in Medindia Hospitals from 30.01.05 to 15.02.05 for acute Pancreatitis and Cholecystitis with Choledocolithaisis for which an open cholecystectomy and CBD exploration and T Tube drainage was done and preferred for claim reimbursement.

The insurer repudiated the claim on the grounds that it was first year policy but the patient was detected to have as large as 3 cm stone in the gall bladder and that large stone could not have developed within just 9 months of policy inception. Hence, it was

treated as pre-existing and the claim was not payable, whether the insured was aware or not, if the symptom/disease was pre-existing.

The insured contended that he was never aware that he was having the stone and only when he felt the pain just prior to the hospitalization, the stone was diagnosed by way of scan. Hence, the question of the stone being pre-existing and he being aware of it did not arise.

Dr. K. Shriram, Panel Doctor of insurer contended that major surgery of gall bladder stone of that size would have taken 2 to 3 years to develop and hence, would have been pre-existing. Secondly the insurer contended that the insured underwent Gastrojejunostomy in the year 1981, which was not declared in the proposal form at the time of availing the policy. Thirdly, the LFT taken at the time of admission revealed the reading of Gamma GT as 956 international units as against the normal reading of 40 found as per test taken at the time of acceptance of proposal. This abnormal increase just after 9 months of taking policy showed that the insured was alcoholic as this particular test is co-related to the level of alcoholism. The consumption of alcohol was also disclosed in the proposal form.

The forum perused various documents submitted and felt that the insured was consulting the family doctor on and off for the past two years for abdominal pain could have been due to peptic ulcer and no investigation was done to confirm the ailment. He was hospitalized primarily for Cholecystitis and Choledocolithaisis for which a Cholecystectomy was done. The attending doctor has certified that the insured has no history of alcoholism and his disease is not related to alcoholism.

The Forum is of the opinion that the non-disclosure of the surgery 1981 by the complainant in the proposal form does not absolve the insurer from liability. In the light the above facts, the forum granted an ex-gratia award of 50 % of the admissible medical expenses and insurer, was directed to reimburse the claim accordinly.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.3.1143/2005-06
Shri Rajesh S. Mehta
Vs
National Insurance Co. Ltd.

Award Dated 15.11.2005

The complainant's parents, Shri. Sathyendra B. Mehta and Smt. Indira S. Mehta were insured under mediclaim policy with National Insurance Company Ltd. from September 1998 onwards. Smt. Indira S. Mehta was hospitalized in Apollo Hospital for dyspnoes Borderline Coronary Artery Disease, NIDDM Hypothyroidism and Bronchial Asthma. The claim was repudiated by Medicare TPA Services (I) Pvt. Ltd., on the grounds that 'This is the 5th year policy but the member had diabetes and hypothyroidism for the last 10 years, both of these predisposes to heart ailment. Moreover, the angiography report shows Borderline CAD. So the claim is for investigation and evaluation. Hence, claim is not admissible and not payable. The Insurer in their self-contained note stated that the claim was repudiated, invoking exclusion clauses 4.1 and 4.10 of the policy, which excludes all diseases at the time of inception of the policy.

The insured contended that the insurer have rejected the claim on two entirely contradictory grounds. On the one hand, the insurers contended that the existence of 'Diabetes Mellitus and Hypothyroidism' for 10 years were pre-disposing factors for heart ailment suffered by the insured and hence, the claim is not payable whereas on the other hand they have taken the diametrically opposite stand saying that the insured

was not having any heart ailment and that she was only evaluated for the heart ailment. The insured also pointed out that the policy only excludes Diabetes Mellitus and not the predisposing factors for heart ailment. Hence, on this ground also, the insurer's contention does not hold good. The recording of known case of IHD was based on the findings of the present evaluation only.

The Forum pointed that the exclusion clause 4.1 incorporated by the insurer was as per the old exclusion clause which has since been rescinded and replaced by the present clause which stated that only pre-existing diseases are excluded. The discharge summary also stated that the insured was a known case of IHD, though the duration of the disease was not known. The link between the Diabetes Mellitus and Coronary Artery Disease has not been established by the TPA and how far accelerated the heart ailment of the insured in the present case, for which, panel doctor of insurer stated that 'Diabetes Mellitus is one of the major risk factors related to Coronary Artery Disease. However, by virtue of the Diabetes Mellitus, insured being medically managed, it cannot be concluded that Diabetes Mellitus is the proximate cause for the Coronary Artery Disease and is no doubt a risk factor for CAD among various factors detected / undetected. As per tenets of insurance, any risk to be the proximate cause has to be the pre-dominant and the most direct and efficient cause. In the light of the fact that various factors can predispose CAD, to conclude DM has been the proximate cause for the CAD is an aspect which does not stand sufficiently established. As regards, Hypothyroidism, the same argument holds good.

In the light of foregoing discussion, the forum held that the insurer is not justified in repudiating the claim and the claim warrants consideration. The insurer is directed to entertain the claim and pay the admissible medical expenses. However, it is to be noted that expenses pertaining to treatment of diabetes and hypothyroidism which were pre-existing to the inception of the policy, are not admissible.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.3.1174/2005-06
Shri Bhawarlal Gandhi
Vs
National Insurance Co. Ltd.

Award Dated 21.11.2005

The complainant, Shri Bhawarlal Gandhi and his spouse Smt. Vasantha Gandhi were covered under mediclaim policy with National Insurance Co. Ltd. Smt. Vasantha Gandhi was admitted in Apollo Hospital for Lacunar Infarct in right parieto occipital and right frontal region, bilateral knee osteorthritis, diabetes mellitus, systemic hyper tension and lumbar spondylosis of L1-L5 vertebra. Claim was repudiated by the TPA of the insurer, Family Health Plant Ltd, on the grounds that as per medical opinion, the present hospitalization was for the investigation and evaluation of the ailment and no active management (only oral medication), which could have been done as outpatient.

Complainant contended that Insured was having pain in the neck for which therapeutic/ayurvedic medicines were given. Though the neck pain temporarily subsided, there was continuous loss of weight to the extent of 5 kg per month. She also had complaints of headache and giddness. The doctor treating her, administered some medicines and advised that if the problem did not subside with medicines, they will have to undergo surgery.

The medical records submitted before the Forum were perused. As per the discharge summary, the diagnosis is lacunar infarct in right parieto occipital and right frontal region, bilateral knee osteoarthritis, diabetes mellitus systemic hypertension and

lumbar spondylosis and anorexia. She was referred to Dr. Surnarayanan in view of her complaints who suggested X-ray both knees and X-ray cervical spine which revealed osteoarthritis and cervical spondylosis respectively. However, the diseases of 'Bilateral knee osteoarthritis, Diabetes Mellitius (for 2 months), Hypertension (for 2 years on antihypertensive) ad lumbar spondylosis having been in existence already and insured under treatment for the same, except diabetes, prior to the hospitalization, any further investigation and treatment by way of hospitalization was not necessary as far as these ailments were concerned. Further, the medical records show a history of weight loss of about 5 kg in a month with anorexia which needed investigation and treatment. It was also noted that the need for hospitalization and plan of treatment were matters to be decided by the attending doctor only, taking into consideration the condition of the patient and severity of complaints. In the case on hand, it is evident that insured had headache on and off and continuous neck pain alongwith loss of weight and anorexia, and was advised for admission by the consultant neurologist and nerointensivist of Apollo Hospital, Dr. Deepak Aujundas and plan of treatment was advised by the attending doctor. Hence, the insurer's contention that the claim, in it's entirety attracts exclusion clause 4.10 of the policy and hence not admissible, does not stand to reason.

Forum concluded that the insurer is not justified in repudiating the claim in toto, and to meet the ends of justice, the insurer was directed to entertain the claim and pay 75 % of the admissible hospitalization expenses.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.4.1209/2005-06
Smt. S. Lakshmi
Vs
United India Insurance Co. Ltd.

Award Dated 23.11.2005

The Complainant, Smt. S. Lakshmi, who was insured under mediclaim policy with United India Insurance Co. Ltd. since 27.03.02, was hospitalized in Apollo Specialty Hospital Chennai for intestinal obstruction and underwent 'Adhesions Released and Herino Plasty'. The insured's claim for reimbursement of medical expenses was repudiated by Family Health Plan Ltd, the TPA of the insurer on the grounds that hospitalization was for management of an ailment which was related to a pre-existing condition.

The insured contended that her ailment was not pre-existing, as she developed hernia just 3 months before the hospitalization and the intestinal obstruction was due to casarian done 11 years ago. The insured submitted a certificate from the attending doctor in support of their contention.

Dr. Vijay Kumar, Representing TPA, contended that the incisional hernia, which has caused intestinal obstruction, was due to the earlier caesarian, as the present ailment was related to a pre-existing condition, claim was repudiated. Dr. Vijay Kumar also contended that whenever the normal structure is being cut or opened, a defect takes place and any strain will lead to complications such as incisional hernia. If the Caesarian had been disclosed in the proposal form at the time of taking the first policy, the insurer would have excluded the incisional hernia from the scope of the policy.

Forum pointed out that what remained after the caesarian done 11 years ago and also at the time of inception of policy was only a scar tissue. 'A Scar Tissue' cannot be categorized as a disease or an injury and as such, it cannot be regarded as a pre-existing disease or injury within purview of exclusion of clause 4.1 of the policy and it

is therefore the relevant exclusion clause 4.1 of the policy does not have any application to the present case. Hence, the insurer is not justified in repudiating the claim on the grounds that the present ailment arose out of the caesarian undergone by the insured 11 years before. As regards non-disclosure of cesarean which took place about 11 years, it is noted that as there was no complaint for 11 years which was an indication of the health of the policy holder, insurer's stand for non disclosure fades into insignificance.

Forum concluded that the insurer's repudiation of the claim on the grounds of pre-existence is not sustainable and hence directed insurer to entertain the claim and pay the admissible medical expenses to the insured.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.5.1192/2005-06
Shri S. Radhakrishnan
Vs
The Oriental Insurance Co. Ltd.

Award Dated 28.11.2005

The Complainant, Shri S. Radhakrishnan was insured under mediclaim policy with the Oriental Insurance Company Ltd. since October 99. The insured was hospitalized in Pondicherry Institute of Medical Sciences for sleep Apnoea for which he underwent 'Adenoidotomy and Synachiae Release'. The insured's claim reimbursement of medical expenses was repudiated by M/s Medicare, TPA of the insurer on the grounds that symptom existed prior to the inception of policy, based on their panel (ENT) doctor's opinion that it was a pre-existing disease, as such adenoidal enlargement occurs from childhood.

The insured contended that the surgery was done for curing the breathing problem and not for snoring problem and that he was having the breathing problem only 2 years prior to the hospitalization. The insured submitted the attending doctor's certificate in support of his contention.

The insurer's contention is that as per discharge summary, the insured suffered from loud snoring during sleep for the past 5 years. But as regards the diagnosed ailment of 'Sleep Apnoea', the history is not specified in terms of number of years. Hence, the insured was suffering from 'Sleep Apnoea' for 5 years does not stand to reason. The insurer's panel doctor's opinion that such adenoidal enlargement occurs from childhood is a geenral statement regarding the nature of the ailment, and hence, cannot be regarded as a conclusive proof, with respect to the present case, to establish that the disease existed prior to Oct 99. However, as explained above, it cannot be construed that mere snoring would have immediately resulted in the diagnosed ailment of Sleep Apnoea at the time of availing the first cover on Oct 99. Since, neither the medical records establish pre-existence of the ailment nor the insurer has been able to prove pre-existence in terms of exclusion clause 4.1 and the attached note (a) and (b), the Forum hold that the repudiation of the claim on the grounds of pre-existence of the ailment is not maintainable. The insurer has also contended that the insured was a hypertensive and a diabetic, which were not declared at the time of availing the mediclaim cover in Oct 99. It is noted from the discharge summary that insured was a 'known hypertensive and diabetic on regular treatment but the duration of presence of these ailments have not been indicated. Hence, on the basis of recording alone, the insurer cannot conclude that the insured was suffering from hypertension and diabetes in oct. 99. The insurer has also not established any nexus between hypertension/diabetes and the present ailment. In the light of the foregoing

discussions, the insurer to entertain the claim and pay the admissible medical expenses to the complainant subject to policy terms and conditions.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.3.1205/2005-06
Shri T. V. Sadagopan
Vs
National Insurance Co. Ltd.

Award Dated 05.12.2005

Mr. Sadagopan and Mrs. S. Saranayaki were insured under mediclaim policy with The New India Assurance Company Ltd. from 28.6.91 to 27.6.96 and after a gap of 165 days with National Insurance Company Ltd. from 10.12.96 till 9.12.2005. Smt. Saranayaki underwent a Bye pass surgery in May 1995 and this information was disclosed in the proposal form submitted to National Insurance Company Ltd. in December 1996. Smt. Saranayaki was hospitalised from 29.4.04 to 8.5.04 for “DM type II/CAD/HTN/Old Hemiplegia Right with Dysphasia status post CABG/Fresh Anterior wall Non Q Wave MI”. The claim for reimbursement of medical expenses was repudiated by the insurer, National Insurance Company Ltd, on the grounds that as per the medical opinion of their TPAs, Family Health Plan Ltd., the present hospitalization was for management of an ailment, which was related to a pre-existing condition (Ischaemic heart Disease (IHD) was subject to exclusion clause 4.1.

During the hearing, Complainant contended that he had declared the heart ailment suffered by his wife in 1995 in the proposal form at the time of proposing mediclaim policy in December 1996 and the policy was issued without any endorsement for exclusion of heart ailment. He also argued that his wife was enjoying cumulative bonus under the previous policy issued by New India and the present insurer also allowed 30 % cumulative bonus under the policy for the period 1997-98 which tantamount to renewal of old policy and delay was condoned. The insurer and TPA represented that it was an error not to mention “heart ailments” as a specific exclusion in the policy 1996-97. The Insurer argued that, since the heart ailment suffered by the insured was disclosed in the proposal form, it was automatically excluded from the scope of the policy by virtue of printed exclusion clause 4.1 of the policy.

The forum pointed out the word ‘none’ mentioned in the exclusion clause of the policy, and the insurer replied that it was a computer error. The insurer also admitted, that by mistake, they allowed cumulative bonus of 30 %. The Forum also pointed that it is indisputable that as per basic tenets, insurance covers an unforeseen event and under the same principle pre-existing diseases are excluded from the scope of cover of a mediclaim policy. Hence, in the said case Ischaemic Heart Disease is a pre-existing disease as far as the policy issued for the year 1996-97. However, it is felt that the insurer has misled the insured in to believing that when insurance was given in 1996, it was considered as a renewal of previous policy issued by New India for the year 1995-96 and hence, the existing disease Ischaemic Heart Disease was not considered excluded under the 1996 policy and its renewal. Therefore, the forum allowed the claim on ex-gratia basis to an extent of 60 % of the admissible expenses.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.4.1238/2005-06
Shri S. Prabhakar
Vs
United India Insurance Co. Ltd.

Award Dated 16.01.2006

Mr. S. Prabhakar has taken mediclaim policy with United India Insurance Co. Ltd. for the period from 8.6.04 to 7.6.05. Complainant, with severe back pain got admitted in Apollo Hospital on 29.11.04 and on contacting Third Party Administrators for cashless treatment they turned down the claim stating that pre-existence of ailment prior to policy could not be ruled out. Hence he got repudiation letter dt. 8.5.05 on the grounds that the present hospitalization was for the management of an ailment, which was related to a pre-existing disease.

During the hearing, Complainant produced a copy of the health check up report taken on 23.6.04 and contended that he was not having any symptom of any ailment at that time also. Insurer contended that complainant should have been aware of his ailment since the treatment given to him is Therocotomy and D6 decompression and fusion was at the 3rd stage of the disease. They also represented that the operation is usually done in an advanced stage and hence the ailment could not have developed within a short period To support, their stand, they argued that they relied on the Master health check up report, which revals that ESR 1 hr was 67, hence the Complainant would have been aware of his ailment. The forum pointed out that Master Health check up did not specify any indication about the ailment or suggestive treatment for Tuberculosis. The discharge summary of the present hospitalization did not indicate any previous history of treatment for tuberculosis. Insurer has not conclusively established that the Complainant was aware of the existence of the disease at the time of proposing for insurance or that the Complainant had taken any consultation, treatment or medication for the disease for which claim has been made; hence the repudiation of the claim by the Insurer is not justifiable. Direction was given to the Insurer to process and settle the claim as per the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.5.1200/2005-06
Smt. N. Jayalakshmi
Vs
Oriental India Insurance Co. Ltd.

Award Dated 16.01.2006

Mrs. N. Jayalakshmi, the complainant represented that her husband had availed Mediclaim Policy with Oriental Insurance Company Ltd. since July 2002. She had taken treatment for pain in both knees at M/s. Ganga Hospital Coimbatore from 30.09.2004 to 04.10.2004 and the claim for the same was settled. She was again admitted after two weeks when she underwent total knee replacement. However, claim was repudiated by the insurer on the grounds of pre existence of ailment. The representation to grievance cell of the insurer for re-consideration was not responded to. Hence she approached the forum.

During the hearing the representative of complainant contended that the treatment was availed only during the 3rd year of policy and that she did not suffer from ailment prior to the inception of the first policy and therefore the insurer's contention of pre-existence was not tenable. Insurer contended that under the 3rd year of the policy the claim was reported which was settled by TPA. After about two weeks the insured was again admitted in Hospital and in the narration of discharge summary it was stated that pain in the knee existed for more than 1 ½ year, whereas in the discharge summary of first hospitalization history of pain in the knee was recorded as One year. The insurer also contended that the proposal form at the renewal of third year policy, while increasing sum insured from Rs. 1 lac to Rs. 2 lacs, was obtained but the insured did

not reveal about knee pain which she was suffering and that she had already taken treatment. Hence, insurer contended that there was suppression of material fact. Under the circumstances the Ombudsman directed insurer representative to seek specialist medical opinion on the aspect of possibility of pre-existence of disease and the insured to submit to the insurer as well as this forum the relevant records of past treatment taken prior to hospitalization. The opinion of Dr. Kailsam, obtained by insurer does not reveal that the complainant/insured person was aware of the disease at the time of proposing for insurance in July 2002. The complainant submitted certificate from family doctor, for the past six years, which reveal that the insured had knee problem only from 2004 and that too it was an acute one and not chronic one. It is observed by the forum that at the time of submission of proposal for the renewal of 3rd year policy for enhancement of sum insured from Rs. 1 Lac to Rs. 2 Lac for the period 3.7.2004 to 2.7.2005, the complainant was suffering from knee problem which was not disclosed in the proposal form. Increase in sum insured during the currency of a policy is similar to taking a new policy for the increased sum insured and hence, disease which were existing prior to increase in sum insured are to be construed as pre-existing diseases to the increased sum insured. Under the circumstances, when it recorded that Smt. Jayalakshmi was having symptoms of the disease prior to July 2004 it can be reasonably concluded that she was affected by OA prior to July 2004. Hence, OA stands excluded from the increased sum insured i.e. Rs. 1 Lac. Therefore, the insurer was directed to settle the claim as per the original sum insured proposed at the time of inception of the policy in July 2002 as per the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.5.1159/2005-06
Mrs. Usha Kalyani
Vs
Oriental India Insurance Co. Ltd.

Award Dated 16.01.2006

Mrs. Usha Kalyani had taken overseas mediclaim policy with Oriental Insurance Company Ltd., for a period from 14.06.2004 to 11.10.2004 and she has also been covered under mediclaim policy with the same insurer for the past three years and had not made any claim so far. Complainant reached United States on 14.06.2004. During her stay there, the complainant had intermittent fever and incurred medical expenses for which claim was preferred. Claim was repudiated by the Insurer based on the letter received from Heritage India Services Pvt. Ltd., who are the Indian agents for M/s. Corris America. According to Heritage, the complainant had a past history of Malaria Typhoid TBC etc, according to Doctor's note, and the same was not disclosed in the proposal form while taking the cover. Hence, Insurer repudiated claim on the grounds of 'pre-existing' condition. Insured, during hearing, contended that past medical history of malaria, typhoid, TBC and other infectious disease was nearly 14 years before and Complainant did not remember their occurrence in the distant past when filling proposal form. Complainant also contended that the entire medical expenses were for the numerous diagnostic tests to evaluate the source of the intermittent fever and not for treatment.

The Forum directed the Insurer to obtain the medical opinion to clarify the issue of pre-existence as there is no conclusive evidence that the disease for which treatment was availed in USA was pre-existing and it emerges that the intention of the insurer is to elicit information about the previous treatment for major ailment like malaria/typhoid by the proposer, that too contracted more than 14 years back, does not tantamount to suppression of material fact. It deserves reiteration here medical opinion too holds that

"in India every citizen will have malaria/Typhoid at some time in their life and so there is no importance of it being declared". Hence, insurer's stand of the disease being pre-existing and therefore refuting is not tenable. Hence, direction was given to settle the claim as per terms and conditions of the policy and complaint is allowed.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.3.1207/2005-06
Shri Umesh Viswanath
Vs
National Insurance Co. Ltd.

Award Dated 20.01.2006

The complainant, insured under mediclaim policy since 1996, started getting episodes of mild headache during the 1st week of April 2004, which subsequently became severe and the frequency also increased. Dr. Venkatesh Babu a renowned eye specialist and Dr. Anand Kumar M. S. ENT specialist ruled out any pathology defect in the eye and as well as in the ENT. The complainant availed of acupuncture under Dr. P. S. Lalitha, which had mild effect. Shri Umesh Viswanath subsequently developed facial weakness on the right side and consulted Dr. Deepak Arjundas, renowned neuro physician of Vijay Health Centre, who treated him as out patient. His condition further deteriorated and the doctor advised emergency admission for intensive treatment to rule out cerebro vascular accidents or tumor. The complainant preferred a claim towards hospitalization with the insurer and the same was repudiated.

The complainant during the hearing contended that he started experiencing severe headache for 5 to 6 days. It would start suddenly in the night at 10 p.m. and used to last for nearly 2 hours. As the frequency and duration of the pain was more, he was asked to undergo ENT/Eye check up, these tests ruled out any abnormality. Hence, he went in for acupuncture treatment for 15 days by paying Rs. 150/- per session. For all these expenses, he had never made any claim against the insurer even though he was insured under mediclaim policy for the past 9 years. He contended that seeing his condition when he was taken to Dr. Arjun Das, the admission was urgently advised and he was taken on a wheel chair and promptly put on observation. The investigations were conducted and the diagnosed ailment was "Cluster Headache" for which he was medically managed with the advice to follow up after discharge from the hospital.

The insurer contended that prior to this hospitalization the complainant availed treatment as out patient for the same ailment. The medicines prescribed in discharge summary were the same, which was prescribed to the complainant prior to hospitalization as out patient. The insurer is of the opinion that the ailment could have been managed as out patient. The insurer also stated that they referred the matter to panel doctor who opinioned that the complainant was admitted for evaluation purpose. Further, the insurer also obtained opinion from Neuro Physician Dr. R. V. Anand, who also confirmed that the patient could have managed as out patient. Therefore insurer argued that their repudiation is in order.

During the hearing, the forum pointed out that the opinion of panel doctor and Neurophysician was only post facto in nature and the attending doctor who had physically examined the complainant, should decide on the basis of the condition of complainant at the time of hospitalization. The Forum referred the observations made on the patient on examination, at the time of admission. There is also a certificate of attending doctor Dr. Deepak Arjundas which reads as follows : 'Mr. Umesh Viswanath was treated as out patient by me since 3.5.04 on 13.5.04 he was presented with acute onset of severe headache not subsiding with medicines and since his clinical

examination revealed right UMN facial weakness with a drift upper limb, he was advised urgent admission for intensive treatment and further investigations to rule out cerebro vascular accident/tumor lession etc.,

From the above mentioned records and discussion, Forum observed that there has been a definite diagnosis of an aliment viz. cluster Headache and the conditions of insured warranted hospitalization as is evident in the noting of the discharge summary as well as certificate of the attending doctor. Under the circumstances the Forum felt that insurer cannot refute liability in the said case and hence was directed to settle the claim as per policy conditions.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.3.1253/2005-06
Shri K. Suryanarayanan
Vs
National Insurance Co. Ltd.

Award Dated 02.03.2006

The Complainant claim with the insurer for hospitalization expenses and domiciliary hospitalization expenses of his father to the tune of Rs. 88,139.50, was settled by the insurer to an amount of Rs. 28,271/- only. During the hearing TPA expressed that they allowed Rs. 28,271/- being hospitalization expenses and disallowed Rs. 59,868/- towards post operative expenses since the discharge summary did not contain any advise by the doctor for further treatment and they received only bills without any supporting documents. The forum questioned the TPA regarding the major components that the TPA disallowed and the reason for the same. The TPA contended that they disallowed nursing charges, physiotherapy charges, ambulance charges, dressing charges since the discharge summary did not indicate any further treatment and the patient had improved at the time of discharge. For the specific query of the forum to the doctor who represented the TPA, whether the condition of the patient required further post hospitalization treatment, doctor agreed that the condition of patient warrants further treatment particularly physiotherapy.

The mediclaim policy allows For “Post Hospitalization expenses”, which are “relevant medical expenses incurred during the period up to 60 days after hospitalization on disease/illness”. The insured Shri K. Krishnamurthy was hospitalized for stroke-left cerebral hemorrhage and it is to be acknowledged that a patient recovering from the same would require physiotherapy and nursing for a further period of time. The same has also been stated by the attending doctor. In light of above discussion, forum felt that there are no justifiable grounds for denial of the expenses incurred - post hospitalization, and insurer was therefore directed to settle the rest of the expenses claimed subject to policy terms and conditions, but without any interest.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.8.1255/2005-06
Shri J. Martin Joseph Selvaraj
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 03.03.2006

Insured had taken a Hospital Cash Plan Insurance Policy with Royal Sundaram Alliance Insurance Co. Ltd. for the period from 2.5.05 to 1.5.06. On 19.10.05, the insured

suffered unsteadiness with slurring of speech and got admitted to Vijaya Hospital. The diagnosis was acute infarct in posterior limb of the internal capsule (blood clots in the brain) and treated for 10 days. He preferred claim with Royal Sundaram for Rs. 10,000/- (According to Hospital Cash Plan, Insurer will reimburse Rs. 1,000/- per day for any hospitalization; Since he was admitted for 10 days, he claimed for Rs. 10,000/-). Royal Sundaram rejected the claim stating that the ECHO report revealed that the hypertension, of which the present illness is complication, existed prior to the inception of the policy.

The Insured represented for reconsideration of his claim on the grounds that nowhere in the hospital records, it was mentioned that he was having long hypertension and that he was not a hypertensive patient till the day he entered the hospital. The insured also contended that he was not given treatment for hypertension but only for 'Acute infarct in the posterior limb of the internal capsule.

The insurer contended that as per ECHO report the moderate concentric LVH was probably due to Hypertension which is longstanding, hence the treatment is for complication of pre existing disease and hence, the claim was repudiated.

During the hearing this forum pointed out that this was only the opinion of the panel doctor of the insurer and insurer had not produced any record to substantiate that the ailment for which the insured was hospitalized was in existence at the time of proposing for insurance. The forum also noted that there is no medical record evidencing the history of hypertension and on the contrary the discharge summary says "not a known DM/HTN/IHD". Under the circumstances the insurer's contention that the present ailment is a complication of pre-existing hypertension stands un-established and hence, insurer was directed to settle the claim subject to sum insured and other policy conditions.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1237/2005-06
Dr. Krishnaswamy
Vs
The New India Assurance Co. Ltd.

Award Dated 21.03.2006

The complainant was insured under a Mediclaim policy with New India Assurance Co. Ltd. from Feb 2000 onwards and in Feb 04, insured shifted from the Mediclaim policy to a Health plus Mediclaim policy. He was hospitalized from 28.04.05 to 11.05.05 for coronary Artery Disease and underwent CABG surgery and represented for reconsideration of his claim on the grounds that the disease for which claim was made was not pre-existing, as the "pre-existing disease revealed at the time of diagnosis will becme payable provided the insured was not hospitalized for the same disease in the last four years".

The insurer contended that the claim was rejected on the following grounds : a) CABG comes under circulatory diseases and are excluded from the scope of the said policy b) The patient has been suffering from MVP and the same was not disclosed at the time of proposing for insurance. c) The non-disclosure alongwith the intentional increase in the sum insured in the Health Plus policy clearly shows that the insured is taking advantage of policy.

The forum perused the available medical documents and it appears that apart from hypertension which was apparently diagnosed during the Master Health check up done

in Feb 04 and Diabetes Mellitus which was also declared in the proposal form, there was no other existing illness at the time of taking the Health plus policy in Feb 04 and at the time of the renewal in Feb 05 the insurer has included “Circulatory disease” amongst the ailments excluded. The matter was referred by this Forum to a Medical specialist Dr. S. Somasundaram, consultant cardiologist, as the term circulatory diseases is a very generalized term and it is not specific, excluding “Circulatory Disorders” is a very sweeping action whereby the insurer has deprived the insured of cover for disease of almost all the organs of the body.

Insurance is based on the tenets of good faith and transparency on the part of both the insured as well as the insurer. Therefore the rationale of subsequently excluding circulatory disorders in the second year of the health plus policy is unjustifiable. A basic underlying tenet in any insurance contract is the principle of ‘uberrimae fides’ - utmost good faith and natural corollary to this is the duty of disclosing material facts which is to be observed by both the insured as well as the insurer. Apart from the duty of disclosing material facts at the time of concluding the contract the duty rises again at the time of renewal of the policy. In the light of above discussions the insured is not justified in repudiating the claim, therefore forum directed the insurer to settle the claim.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1302/2005-06
Dr. Rupa Swaroop
Vs
The New India Assurance Co. Ltd.

Award Dated 28.03.2006

The complainant availed Good Health policy since 1999 with The New India Assurance Co. Ltd. However, during 2002, despite her reminders to Citi Bank the policy was not renewed in time and there was a break of nearly six moths. During 2004 she underwent hysterectomy and claim was allowed by the insurer. Again from 27.7.05 to 28.7.05, She was hospitalized for cataract operation. However the claim for cataract operation was repudiated by the TPA stating that the policy condition was modified in Oct 2004 and cataract was excluded for 3 years. The complainant contended that her claim for hysterectomy was settled in Jan 04, hence there seems to be some discrepancies in the interpretation of policy conditions. She also contended that at the time of taking the policy in 2002, the waiting period was one year; however the same was suddenly changed to 3 years.

The representative of New India stated that the complainant was covered under Good Health Policy with Citi bank since November 2002 and she preferred claim for cataract surgery and TPA M/s. TTK Healthcare repudiated invoking policy condition 4.3 and as per this policy exclusion the waiting period is 3 years. The Forum questioned the insurer why the waiting period was increased from 1 year to 2 years, 3 years to 5 years, the insurer replied that due to bad claim experience their company had taken decision.

The forum observed that on the date of repudiation the insured had completed 2 years and 9 months of cover. It is also noted that frequent changes have been made in the policy conditions. The policy being a group policy with a wide spread of insured persons, communication of the changed policy conditions has not been effective as is seen in the said case where the conditions applicable for the Oct 03 policy have been wrongly intimated to the insured as policy conditions applicable for Oct 04 as admitted

by the TPA's in their letter to the insured dated 3.9.05. It is therefore the opinion of this forum that frequent changes in the policy and the same not being effectively communicated to the insured has placed the insured in a disadvantageous position. Therefore to meet the ends of justice, Forum granted an ex-gratia settlement of 50 % of the admissible claim amount.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.4.1309/2005-06
Mr. K. M. Murali
Vs
United India Insurance Co. Ltd.

Award Dated 29.03.2006

The complainant represented that he had taken a Mediclaim policy with United India Insurance Co. Ltd. for more than 10 years. The insured got admitted in Apollo Hospital for sudden chest pain and TPA of the insurer repudiated his claim on the grounds that the claim was for a pre-existing disease whereas insurer's panel doctor was of the opinion that it was a valid claim The insurer forwarded entire claim papers to their panel doctor for elaborate opinion which was forwarded to the TPA and TPA did not reconsider their decision. The insurer; however was of the opinion that the claim could be settled by TPA, since that hospitalization was mainly due to chest pain since 2 months prior to admission and based on panel doctor's opinion.

TPA of United India represented, the complainant was administered for Coronary angiogram. The complainant is hypertensive, chronic smoker, alcoholic and admitted in the hospital for chest pain. The patient was having hypertension for 7 years and diabetes for 3 years. Diagnosis also reveals ischaemic changes and blood sugar level was also very high and patient's chest discomfort subsided after taking treatment. Therefore, the representative of the TPA contended that hospitalization is for the management of an ailment which was a pre-existing condition and hence, not covered under the policy.

The forum also required whether the complainant can produce any medical records to establish that he was not having diabetes or hypertension prior to inception of policy. The complainant expressed that no such records are available and he cannot produce the same. The TPA stated that when the medical record states diabetes mellitus 3 years and hypertension 7 years, they did not feel the need to get any more evidence.

The forum pointed out to the complainant that it was his duty to disclose the pre-existing diseases to the insurer. The panel doctor's opinion was that "the ischaemic heart disease may not have been pre-existing at the time of inception of the mediclaim policy and even if it was pre-existing the patient would not have been aware of its existence, HTN, DM and smoking are a few risk factors among many others for coronary ischaemic heart disease.

It therefore emerges that there is no medical evidence of Ischaemic Heart disease being a pre-existing condition in the insured and even if it was pre-existing there is no evidence of the insured being aware of the same. However, the insured has not produced any medical record to disprove the noting in the discharge summary regarding the pre-existence of diabetes and hypertension. Under the circumstances, the forum granted an ex-gratia settlement of the claim at 50 % of the admissible claim amount.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.4.1311/2005-06

Mr. D. Gopalkrishnan
Vs
The United India Insurance Co. Ltd.

Award Dated 30.03.2006

The complainant had taken mediclaim policy with United India Insurance Co. Ltd. since 2001. On 11.08.05, his wife Smt. Sathya was hospitalized for hernia operation and discharged on 17.08.05 and gave intimation to M/s. Family Health Plan, TPA of the insurer on 13.08.05 and received a reply that cashless facility cannot be given as the present complaint was related to LSCS which was pre-existing disease.

Insured contended that his doctor opined that the operation was not due to a pre existing disease and also not due to previous operations; hence, he submitted the relevant papers to the TPA in Sep 05. The TPA has repudiated their quoting the reason as “pre-existing disease”.

TPA stated that Mrs. Sathya who was covered under the mediclaim policy had undergone the surgery for incisional hernia. They also contended that Cashless facility was denied on the grounds that she had undergone the caesarian operation 5 years back - prior to inception of the policy, which was not disclosed when they signed the proposal form in 2001. The claim was repudiated on the grounds that hernia was due to LSCS surgery done on her five years back and hence, is due to a pre-existing condition which is not payable under the policy.

It is to be noted that incisional hernia is due to previous surgery for which an incision would have been done in the abdomen leading to the weakening of the abdominal wall. It therefore emerges that what was in existence at the time of inception of the policy was only the scar tissue of the LSCS and hernia by itself was not pre-existing and as such, it cannot be said to be pre-existing within the purview of exclusion clause 4.1 of the policy so as to eschew the claim made by the insured, as there is no proof on record that the hernia for which the treatment was taken by the insured was existing prior to inception of the policy. Under the circumstances the insurer is not justified in repudiating the claim on the grounds of pre-existence of the disease.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.2.1246/2005-06
Mr. Dominic David
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

The Complainant Mr. Dominic David and his wife Mrs. Suganthi were covered under LIC Group mediclaim policy. He preferred claim for his wife who sustained injury due to road accident on 31.01.05. The claim was repudiated on the grounds that 24 hours hospitalization condition was not complied with.

When the insured established that the insurer was wrong and the hospitalization was for 31 hours, the insurer changed their stand and rejected the claim on a new ground that hospitalization was not required as per their panel doctor’s opinion as the treatment was given for lacerated wound which is a simple injury and contusion over scalp.

The Forum perused documents and noted that Mrs. Suganthi was brought to the hospital with injuries due to a fall from the bike, and the patient was profusely bleeding and could not even stand firm. She had fallen head over heels causing a bulge on the left side of the head. When first aid was given, after becoming stable, the surgery was preformed with local anesthesia and sutures were put. The backside of the right palm

was torn. Forum acknowledged that it is doctor who attends to the patient decides as to whether hospitalization is warranted and the decision of the insurer to repediate the claim is based on panel doctor's opinion which is only a post facto opinion, given without examining the condition of the patient at the material time of treatment.

In the light of above discussion, Forum felt that the insurer is not justified in repudiating the claim and hence, directed the insurer to process and settle the claim as per terms and conditions of policy.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.4.1326/2005-06
Shri V. Venkataraman
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant Mr. V. Venkatraman and his wife were covered under mediclaim policy with United India Insurance Co. Ltd. His wife was hospitalized for a dental treatment and surgery was conducted. He preferred claim for hospitalization but M/s. Family Health Plan TPA of the insurer rejected the claim under policy exclusion clause 4.7 which excludes reimbursement of dental treatment. The insured contended that the said exclusion is applicable for dental treatment or surgery only if there is no hospitalization whereas his claim is for the hospitalization of surgery/operation of dental caries under local anesthesia, and hence, the said exclusion 4.7 is not applicable. He also pointed out that as per condition no. 2.3 of the policy, dental surgery is reimbursable under the policy if the patient is discharged on the same day and condition for stay of 24 hours is not applicable.

The insured contended that the doctor who is giving the treament has to decide whether hospitalization was necessary or not.

The insurer contended that the patient had complaints of tooth ache and underwent tooth removal which does not require hospitalization and could have been managed as an out patient. The insurer relied on the exclusion 4.7 and contended that dental treatment is exclusion and they are not liable for this Claim as per policy condition. Hence, insurer repudiation is in order, The insurer further contended that condition 2.3 of the policy cannot be considered unless the definition of 'Hospital and Nursing Home' mentioned in the policy met with. In this case Dr. L. P. Mohan Dental Hospital did not meet with requirements of the definition of hospital and does not have minimum 15 beds.

The Forum perused the documents submitted and observed that both discharge summary and hospital bill did not contain the inpatient details like Room No. or bed no. and other treatment given during the course of hospitalization except that teeth were removed under local anesthesia and were sutured. The complainant has not produced any substantiating evidence that the above said hospital is having minimum number of beds as stipulated by the policy and the Forum concluded that the treatment was taken in a hospital which did not have the minimum number of beds as stipulated by the policy, and hence, the insurer is right in rejectinng this claim.

Chennai Ombudsman Centre
Case No. IO(CHN)/11.8.1310/2005-06
Shri E. Natarajan
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 31.03.2006

The Complainant, Shri E. Nataraj and his wife Smt. Revathy Nataraj were covered under a Health shield Insurance Policy issued by Royal Sundaram Alliance Insurance Co Ltd. Smt. Revathy underwent a total abdominal Hysterectomy with bilateral Salpingo Oophorectomy. Claim with the insurer for reimbursement of the medical expenses was partly settled for an amount of Rs.58,712/- and a balance of Rs. 13,555/- was disallowed on the grounds that the same was towards Hormone Replacement Therapy which was an exclusion under the policy.

The insured contended that the particular medicine was for treatment of Endometriosis and not for Hormone Replacment Thearapy and submitted a letter of the attending doctor to this effect.

The insurer contended that they understand from the medical records that Mrs. Revathy Nataraj was prescribed to take Lucrin Depot preparation, which would amount to Hormone Replacement Therapy, which is specifically excluded under the policy. But, the complainant after the repudiation obtained a certifcate that the medicine was prescribed for treatment of Endometriosis and not Hormone Replacement Therapy. The discharge summary as well as Histopathology reports did not mention about Endometreosis. The insurer also referred the matter to their panel doctor, who also opined that the treatment was given for Hormone Replacement Therapy.

The Forum referred the case to a medical specialist who has opined as follows :- There is no mention of presence of Endometriosis in the operation notes or in the Histopathology notes. Hence, There is no indication to prescribe Lupride Depot post operatively. From the records submitted, it emerges that there has been no diagnosis of Endometriosis in Smt. Revathy Nataraj. Even the attending doctor has stated that the treatment of Lucrin Depot was given to suppress any possible microscopic endometriotic deposits and that she did not have any active Endometriosis. It therefore, follows that the treatment of lucrin Depot was not a necessity since the ailments for which it was administered was not diagnosed to be in existence in Smt. Revathy Natraj. The Health Insurance Policy envisages reimbursement of medical treatment necessarily and reasonably incurred, for the positive existence of an ailment and not for prophylactic treatment given for the presumption of a disease. Under these circumstances, the Forum held that the said treatment of administering Lucrin Depot does not fall under the scope of the Health shield Policy.

Delhi Ombudsman Centre
Case No. GI / 434 / OIC / 04
Smt. Bhagwati Devi Soni
Vs
Oriental Insurance Co. Ltd.

Award Dated 17.02.2006

Smt. Bhagwati Devi Soni was represented by Shri Ram Dayal and The Oriental Insurance Company Limited was represented by Smt. Usha Kashyap, Manager.

The complaint was lodged on 28.10.2004 by Smt. Bhagwati Devi Soni, for medical treatment of her husband, late Shri Giriraj Prashad Soni, who retired from LIC of India, Ajmer Office. As per the complaint letter, Shri Giriraj Prashad Soni was insured with The Oriental Insurance Company Limited. Premium of Rs. 1,272/- was paid on 28th March, 2003 for the year 2003 - 2004, Shri Giriraj Prasad Soni fell sick on 12.05.2003 and was admitted to Sant Francis Hospital and he expired on 17.05.2003. Smt. Bhagwati Devi Soni submitted mediclaim form etc. on 2nd June, 2003 to OIC, Ajmer

claiming an amount of Rs. 15,516/-. The forms and other relevant documents were submitted to TPA Paramount Health Services Ltd., on behalf of the Oriental Insurance Company Limited. The complainant till date had not received the claim amount.

Smt. Usha Kashyap, represented the Insurance Company on the date of hearing did not have any papers and she appeared with a very casual approach mentioning claim pertains to their Mumbai Office. The Oriental Insurance Company Limited was asked by this forum on 8th November, 2004 to give para-wise comments on the complaint. The Insurance Company till date had not submitted their comments.

There is a Fax copy from The Oriental Insurance Company Limited, D. O. 11, Mumbai to the Regional Office, New Delhi dated 1st February, 2005 that they are unable to trace the documents of this claim. It is more than one year, the Insurance Company has not been able to trace the documents pertaining to the claim and Hon'ble Insurance Ombudsman, therefore, is constrained to pass an Order against the Insurance Company to make a payment of Rs. 15,516/- to Smt. Bhagwati Devi Soni, wife of deceased Sh. Griraj Pradad Soni, alongwith interest @ 8 % p.a. from 2nd June, 2003 to the date of actual payment. The order shall be implemented within 30 days of the Award. The compliance of the same shall be intimated to the office for information and record.

Delhi Ombudsman Centre
Case No. GI / 480 / OIC / 04
Shri M. L. Saxena
Vs
Oriental Insurance Co. Ltd.

Award Dated 28.02.2006

The complaint was heard on 22nd February, 2006. The complainant, Shri M. L. Saxena, was present accompanied by his son, Shri Ratnesh Kumar Saxena and nephew, Shri Avinash Saxena. The Insurance Company was represented by Smt. Usha Kashyap, Deputy Manager.

Shri M. L. Saxena, a retired Administrative Officer of LIC of India, filed a complaint with this Forum on 10.11.2004 wherein he had mentioned that two mediclaims for Rs. 7,615/- submitted to Paramount Health Services Private Limited being Third Party Administrator Oriental Insurance Company Limited, had not settled his claims.

The representative of the Insurance Company contested that Smt. Bitto Rani, wife of the complainant, was admitted in the hospital for investigation purposes and the same could have been done on OPD basis so the claim is not payable. However, they have not communicated the decision to Shri M. L. Saxena, Shri M. L. Saxena, during the couse of the hearing, stated that his wife, Smt. Bitto Rani, had Vertigo problem and he had first consulted Dr. Vinay Kumar Agarwal who has prescribed certain medicines and advised MRI Brain, ENT Evaluation and Blood Sugar (PP). Shri Saxena decided not to go for examination as advised by doctor on 21.04.2003 but wanted to wait thinking that medicines would cure the illness. Since the condition of his wife did not improve, he again visited Dr. Vinay Kumar Agarwal on 08.01.2004 wherein he had prescribed certain medicines along with MRI Brain and hospitalization, Smt. Bitto Rani was admitted in Dharamdutt City Hospital, Bareilly on 09.01.2004 and discharged on 10.01.2004 after the necessary tests were carried out.

The contention of Shri Saxena was that hospitalization of his wife was warranted for carrying out the tests since his wife had not recovered after her first examination on 21.04.2003.

Hon'ble Insurance Ombudsman agreed with the observations made by Shri Saxena and, therefore, passed the Award that Oriental Insurannce Company Limited should pay an amount of Rs.7,615/- along with interest of 8 % per annum from the date of claim less the month for processing time till the time actual payment is made to the complainant, Shri M. L. Saxena for the treatment and tests of his wife, Smt. Bitto Rani, in Dharamdutt City Hospital, Bareilly after due scrutiny of bills since it is only after hospitalization and carrying out the tests, it has become possible to know the gravity of the illness. The Insurance Company's observation that the treatment could be done as out patient is not correct especially in this case where Smt. Bitto Rano has already complained of Vertigo proble on 21.04.2003.

With regard to the second claim of Rs. 1,695/-, neither the Insurance Company nor Shri M. L. Saxena could produce any documents. In case, Shri Saxena is able to produce documents, Oriental Insurance Company Limited is advised to examine the case and settle his long pending mediclaim.

The Award shall be implemented within 30 days of receipt of the Award. The compliance of the same shall be intimated to the office for information and record.

Delhi Ombudsman Centre
Case No. GI / 571 / UII / 04
Shri Krishan Lal
Vs
United India Insurance Co. Ltd.

Award Dated 29.03.2006

Shri Gopender Kumar, Son of the complainant, Shri Krishan Lal, was present and the Insurance Company was represented by Shri Rajesh Gupta, Deputy Manager and Dr. Biswajit Singh.

The complainant lodged a complaint with this office on 18.01.05 that he has taken a mediclaim policy from United India Insurance Company Limited from 25.05.2003 to 24.05.2004. Shri Gopender Kumar was hospitalized in Sir Ganga Ram Hospital for surgery on 26th January, 2004 and had preferred a claim for Rs. 31,980/-. The Insurance Company vide their letter dated 17th November, 2004 repudiated the claim as the present hospitalization is for the management of an ailment, which is related to a pre-existing condition. Shri Gopender Kumar had suffered a fracture 8 years back and he had been perfectly well for 6 ½ years. He had further mentioend in his letter that he did not mention the same in proposal form because he did not remember that he ever had a fracture nor he considered it material to disclose this in proposal form even though if he had disclosed the same, there would have been no effect on the rating / acceptability of the proposal. However, prior to the hospitalization, he had difficulty in walking for sometime and the doctors at Sir Ganga Ram Hospital advised him for hospitalization. This hospitalization is not directly related to the treatment for fracture taken by him 7 years ago and certificate of Dr. Gaggan Chadha confirming this fact was attached.

The Insurance Company presented the case that it was a pre existing disease and even the certificate of New Delhi Scan Research Institute dated 16.01.2004 mentions

that C. T. findings suggest degenerative changes effecting the left hip joint subsequent to trauma.

After hearing both the parties, Hon'ble Ombudsman found that the argument of Shri Gopender Kumar that he did not consider material to disclose this in the proposal form that he suffered a fracture 8 years back is not reasonable. He claimed that he filled the proposal form on the advice of the agent. The Agent is not supposed to know of any previous history of any ailment and it is for the proposor to give full details of any disease that might have taken place. The Insurance Company on receipt of the information could either accept the proposal without any condition; or accept the proposal with condition or reject the proposal. Shri Gopender Kumar has not left any of the three options to Insurance Company to execise by not disclosing that he had suffered a fracture 8 years. back. Further, radiologist report dated 16.01.2004 findings suggest degenrative changes effecting the left hip joint, Hon'ble Insurance Ombudsman therefore, upheld the decision taken by the Insurance Company for repudiating the claim.

Delhi Ombudsman Centre
Case No. GI / 520 / OIC / 04
Shri Daljeet Singh
Vs
Oriental Insurance Co. Ltd.

Award Dated 30.03.2006

The complainant, Shri Daljeet Singh, was present and the Insurance Company was represented by Shri S. K. Sharma, Branch Manager.

Shri Daljeet Singh had lodged a complaint to this Forum on 29.12.2004, wherein he had mentioned that his wife, Smt. Bhupinder Kaur, was admitted in Sir Ganga Ram Hospital on 13th February, 2004 and discharged on 21st February, 2004 with complaint of severe bone and joint pains since 1 ½ months, swelling in both lower limbs for 10 days, tenderness and stiffness of body for 10 days. He has further complained that his mediclaim was not settled by Genins India Ltd., TPA, for the Oriental Insurance Company Limited. The Insurance Company vide its letter dated 4th January, 2005 addressed to this Forum advised that the claim has been filed as 'No Claim' as the same was not falling under the policy terms and conditions i.e. not admissible because of essentially insured admitted for investigation which is not covered under the policy schedule.

The Insured at the time of the hearing mentioned that he has been regularly insured with the Oriental Insurance Company Limited from 1996 and he had to admit his wife in Sir Ganga Ram Hospital because she complained of severe bone and joint pains since 1 ½ months, swelling in both lower limbs for 10 days, tenderness and stiffness of body for 10 days. The Insurance Company contested that insured was hospitalized only for investigation purpose which could have been done as an OPD basis.

Hon'ble Insurance Ombudsman had examined the papers submitted by the complainant and on going through the discharge certificate issued by Sir Ganga Ram Hospital, Hon'ble Insurance Ombudsman observed that Smt. Bhupinder Kaur was in hospital for 7-8 days and she was suffering from definite disease for which investigations / treatment were mandatory in a hospital set up. In the discharge certificate it is mentionsed that Smt. Bhupinder Kaur has been suffering from recent onset of bone & joint pains of 1 ½ months duration and there were no significant past history, noncontributory and have prescribed medicines for the same.

Hon'ble Insurance Ombudsman, therefore, passed an Award that Sh. Daljeet Singh be paid the expenses incurred by him for his wife, Smt. Bhupinder Kaur, when she was admitted in Sir Ganga Ram Hospital from 13th February, 2004 till 21st February, 2004. The Award shall be implemented within a period of one month from the date of receipt of the Award.

Guwahati Ombudsman Centre
Case No. 11.003.0027/05
Shri Satyanarayan Agarwala
Vs
National Insurance Co. Ltd.

Award Dated 06.12.2005

Facts (Statements and counter statements of the parties)

The insured (wife of the complainant) was admitted in hospital on 09.06.2003 (insurance cover was effective as per the policy from 23.03.2003 to 22.03.2004) for treatment of Fibromyoma of Uterus and died in the OT. The claim for indemnification of expenses incurred was lodged but repudiated by the insurance company on the plea of application of exclusion clause.

The Insurance Company contended that the exclusion condition is the factual expression of the policy coverage and accordingly there was nothing wrong in application of such exclusion clause and consequent repudiation of the claim.

Point (s) for determination

Under the facts and circumstances whether the Exclusion Condition of the policy was applicable.

Decision & Reasons

On the reverse side of the Policy certificate it is printed, amongst others, as follows :-

"IMPORTANT EXCLUSIONS :

FOLLOWING ARE THE EXCLUSIONS FROM THE SCOPE OF COVER

Expenses for treatment of cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia or fibromyoma, hernia, hydrocele congenital internal diseases, fistula in anus, piles, sinusitis and related disorder under first year's Policy".

The terms and conditions printed on the reverse side of the policy is part of the policy contract itself and cannot be treated separately or as isolated part of it. Whether the holder of the policy was aware of it or not is, however, an entirely different question. But prima facie it will have to be presumed that parties are bound by the terms unless the contrary is pleaded and shown by evidence, explanations, as the case may be. Here, I find nothing to that effect. There is hardly any scope to interfere because the treatment was within 'first year's policy' aforesaid.

Order / Award : The complaint stands closed.

Guwahati Ombudsman Centre
Case No. 11.003.0038 (GIC)
Shri Phanindra Deka
Vs
National Insurance Co. Ltd.

Award Dated 31.01.2006

Facts (Statements and counter statements of the parties)

The Complainant procured mediclaim Insurance Policy covering himself & father. Father was operated for Calculus Cholecystitis on 11.11.04.

The Insurance Company repudiated the claim on the ground of pre existing diseare.

Decision & Reasons

Policy period is from 08.10.04 to 07.10.2005. The complainant's father was hospitalized on. 09.11.04. The case summary in Hospital Discharge Certificate shows he had been undergoing treatment since last 1 (one) month. Photocopy of initial prescription dtd. 04.11.04 also indicates the disease started from 04.10.04, if not earlier. Although the proposal form was not submitted so what was written in the proposal form about the health condition could not be known. However presuming observation of "utmost good faith" is applicable in all Insurance dealings, so had this been declared the consideration of underwriting would have been different.

Award / Order

In view of the findings, there is nothing to challenge the decision of repudiation of claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.0104/2005-06
Shri P. Hanumantha Raju
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 03.10.2005

The complainant purchased a mediclaim policy for the period 8.10.2002 to 7.10.2003 which was renewed without any break till 2003-04. However, for the period 2004-05, it was renewed with a gap of 114 days. He underwent cataract surgery on 23.2.2004 and lodged a claim with the insurance company for Rs. 15,900/-. The claim was rejected on the grounds that the policy was a fresh one and as per exclusion 4.3 the treatment of cataract during first year of operation of policy was excluded. Complainant contended that the delay was purely on account of non receipt of renewal notice. Insurer contended that the complainant first consulted doctor on 15.1.2005 when there was no mediclaim policy in existence. Cataract was pre-existing at the time of proposal.

Held : As regards non-receipt of renwal notice, the policy condition is very clear and not considered. Regarding existence of cataract, it is observed that there was no valid policy as on 15.1.2005. The policy was renewed after considerable delay. Genuine delays upto 30 days are condoned by the insurer. In this case the delay was beyond the condonable period. Insurers are justified in rejecting the claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.149/2005-06
Shri A. Nageshwar Rao
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 03.10.2005

Complainant and his family covered under mediclaim poilcy for the period 20.10.2003 to 19.10.2004. His eleven year old son was admitted to hospial on 21.6.2004 for sub acute bowel obstruction. He was earlier hospitalised in 1997 for gastric pull surgery. The insurer contended that the disease was pre-existing at the time of inception of policy.

Held : The TPA and insurance company did not adduce any evidence in support of their version that the surgery of 1997 had a nexus with the bowel obstruction in 2004. It is not shown by the insurer that in seven years, the patient experienced post operative complications and consulted doctor for any ailment arising from the operation in 1997. Since the insurer could not provide any justification for their decision of repudiating the claim, they were directed to settle the claim immediately.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/14.004.067/2005-06
Dr. M. Radhakrishna Murthy
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 17.10.2005

Complainant was covered under tailor-made medical policy issued to doctors of Indian Medical Association. Andhra Pradesh. He was hospitalised on 30.1.2003 for acute coronary heart disease at Dubai. on his return to India, he was admitted to hospital On 20.2.2003 and was diagnosed to suffer from single vessel disease with LV dysfunction. The insurer repudiated the claim on the grounds that the disease was pre-existing. Complainant contended that he underwent TMT test in May, 1990 while on a trip to Tirupati and the exercise was carried out for the full time of twelve minutes. Insurer referred the file to their panel cardiologists who opined that the patient was a diabetic since 10 years and hypertensive since 14 years and both these are risk factors for the present ailment. The cardiologist opined that ECG taken at Tirupati in 1990 showed old inferior wall change suggestive of old inferior myocardial infarction.

Held : The fact that there could have been a silent myocardial infarction was not denied by the complainant during the hearing proceedings. He stated that there could have been a silent one and I understand that if a patient undergoes test, with such changes ECG at any time changes are bound to be there lifelong. Complainant suppressed the fact that he was diabetic type-2 since 1993. Cardiologists stated that coronary artery disease was a chronic one and takes months to develop. As such, insurer is justified in repudiating claim. Complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.0118/2005-06
Shri V. Ranga Raju
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 17.10.2005

Complainant covered under mediclaim policy for the period 16.9.2003 to 15.9.2004. He underwent CABG on 14.7.2004. The claim was repudiated on the ground that the disease was pre-existing. The complainant stated that the problem came suddenly while he was on trip to Badrinath and therefore he had to cut short his visit. The insurer contended that Hypertension was pre-existing and this disease cannot develop within nine months.

Held : Hospital records referred to existence of ailments for the previous two to three months only. No evidence shown that the insured was aware of the existence of the disease when he took the policy. No proof furnished regarding hypertension or any other ailment before September, 2003. Repudiation not based on proven or established facts and therefore unjustified. The complaint is admitted.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.008.148/2005-06
Shri Y. Madhusudan
Vs
M/s. Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 24.10.2005

The complainant covered under a Health Shield Policy for Sum Insured of Rs. 1 lac for the period 25.02.2005 to 24.02.2006. he was advised to undergo Coronary Angiogram and was admitted in the hospital on 08.06.2005. He was diagnosed to suffer from Double Vessel Disease. He lodged claim, which was rejected on the grounds that hospitalization was primarily for investigation/diagnostic procedure. The complainant contended that CAG requires admission to a hospital and it is impossible to have this procedure as an outpatient.

Held : The complainant went to the hospital that Class II Effort Angina and was advised to undergo Coronary Angiogram.The outcome of the test revealed presence of Double Vessel Disease which could be medically managed and did not warrant surgery. The policy specifies, "...positive existence or presence of any ailment....". The positive existence of Double Vessel Disease showed up in the CAG Test.

Insurer directed to pay the claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.193/2005-06
Shri Nayak Rama Raya
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 27.10.2005

The complainant and his wife were covered under Universal Health Insurance Scheme upto 25.4.2005. Insurer declined to renew the policy. Insurer contended that the policy was applicable to the people below the poverty line. They requested the complainant to produce proof of being a BPL family. They even suggested alternative mediclaim policy. It was held that universal health scheme was offered by the insurer under instructions from the Government of India with effect from August 2004. There was a directive to cover only BPL families under the policy. The insured did not produce any proof of being a BPL family. Insurer's decision to repudiate the claim is upheld. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.139/2005-06
Smt. T. Veerakumari
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 31.10.2005

The complainant's husband died on 9.1.2000. Claim intimated to the insurer on 29.5.2001 after a delay of 14 months. The claim repudiated on the grounds of inordinate delay.

Held : Insurer was convinced with the genuiness of the claim. Their objection is only to the delay. Insurer was directed to honour and pay the claim.

Hyderabad Ombudsman Centre

Case No. IO(HYD)/G/14.002.079/2005-06
Shri K. Manmadha Rao
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 03.11.2005

Complainant was hospitalized for surgery of hip after a fracture in December 2003. He submitted a claim for Rs. 44,547/- to the TPA. The TPA procesed the claim and informed the complainant by e-mail that his cheque would be sent shortly. However, the insured never received the cheque till April 2005. The complainant contended that all his letters to the TPA and the insurer did not yield any response. It was held that as on the date of hearing the complainant received an amount of Rs. 44,047/-. They requested for an award of interest owing to the inordinate delay. The insurer being the principal must be held accountable for his agent's misdeeds. He has to pay interest to the insured as per IRDA guidelines and Rs. 5,000/- as compensation for mental agony.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/14.002.173/2005-06
Shri Y. G. Ravi Kumar
Vs
The New India Assurance Co. Ltd.

Award Dated 28.11.2005

Complainant was continuously insured under mediclaim policy since 05.12.1995. He was hospitalized three times - (i) on 26.07.2004 - Claim settled (ii) on 21.12.2004 - Claim repudiated & (iii) on 25.05.2005 - Claim settled. All the three hospitalizations were related to eye problem. The insured contended that he had diabetes only from June 1999. The insurer contended that the discharge summary mentioned diabetes for 10 years i.e. from 1994, therefore, repudiation was justified. It was held that the insurer settled two claims for the same ailment. They have not considered the certificate from the treating doctor, which confirms that he had diabetes only from 1999. They also failed to take note that he had 9 years claim free experience. In the absence of any evidence showing dates of consultations etc., the insurer is ordered to honour and pay the claim as per the terms and conditions of the policy.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.170/2005-06
Shri Mhd. A. K. Jeelani
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 20.12.2005

The complainant covered his mother and his family under a Universal Health Insurance Policy for the period 19.07.2004 to 18.07.2005. His mother was hospitalized on 01.06.2005 with symptoms of shortness of breath on exertion. She was diagnosed as suffering from hypertension with IHD and left ventricular dysfunction. A claim for Rs. 10,995/- towards hospitalization expenses was preferred. The claim was rejected on the grounds that hypertension and diabetes were pre-existing at the time of hospitalization. The complainant contended that hospitalization was on emergency basis. She never had any major complications. She was a diabetic and hypertensive at the time of purchase of the policy. He purchased this policy at the insistence of the agent. He merely signed the proposal form. The insurer contended that the insured suppressed material facts at the time of filling up the proposal. It was held that the

insurer did not support their contention by taking an expert's opinion on the probable duration of the problem or whether the condition could be asymptomatic. The complainant's contention that patient suffered chest pain for the first time is accepted as the insurer did not refute his contention. Evidence of any kind to the contrary that diabetes did not develop between July 2004 and June 2005 was not furnished The insurers are directed to honour and process the claim as per the terms and conditions of the policy.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.203/2005-06
Shri V. Ramamohan Rao
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 20.12.2005

The complainant and his wife were covered under mediclaim policy for the period 08.07.2004 to 07.07.2005 for a sum insured of Rs. 1,40,000/- each. He underwent PTCA on 23.09.2004 and incurred an expenditure of Rs. 2,08,523/-. His claim was rejected by the TPA on the grounds that the disease was pre existing and fell under exclusion No. 4.1 of the policy. The complainant contended that he was a non-insulin dependent diabetic and the disease was under control with drugs. When he went for a routine check-up to ascertain his diabetes status, he was told that his ECG needed further evaluation. Upon the doctor's insistence he was admitted in the hospital where it was confirmed that he has Double Vessel disease. While purchasing the policy he submitted his latest sugar and ECG to the insurance company. He never had any symptoms of chest pain etc.

Held : The complainant's contention that he was a diabetic was not refuted by the insurer. The TPA Panel Doctor on 24.11.2004 stated that the claim is paid. The same doctor on another note dated **09.01.2006 (Post-dated)** stated that the claim was genuine and payable. This was subsequently struck off and the same doctor has again noted that the "Claim is preexisting present at the time of taking policy" and further has "passed" the claim. The treating doctor certified that the hypertension was detected only on admission while diabetes was present since last 10 years. Since the insurer/TPA did not produce any evidence in support of their contention the decision of the TPA is very harsh on the complainant The insurers are directed to pay the claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.218/2005-06
Shri Goli Hariprasada Rao
Vs
M/s. New India Assurance Co. Ltd.

Award Dated 20.12.2005

The complainant purchased a mediclaim policy. He underwent Sterotactic Radio surgery on 24.06.2004 and was discharged on 25.06.2004. He incurred an expenditure of Rs. 47,665/- A claim was rejected by the TPA on the grounds that the patient had symptoms for the last 5 years, prior to inception of the policy, pre-existig and not payable. The complainant contended that his son had covered him under a group mediclaim policy with Oriental Insurance for the periods 1999-2000 and 2000-2001.

When the policy expired on 19.07.2001 he approached the respondent insurer and policy for the period 24.08.2001 to 23.08.2002 was issued and was renewed without a break upto 23.08.2004. He consulted Apollo Hospital on 18.03.2003 for the first time as he had complaints of reduced hearing, giddiness, unstable gait and visual problems. Severity of the problem was brought to light only after investigations. However, reduced hearing and ear related problems were present since 4 or 5 years. The fact that there was a growth in his ear was told to him only on 18.03.2003. The gap of 35 days in renewal was accidental and not deliberate. He was insurance conscious and had covered himself regularly since 1997. The insurer contended that because of the break of 35 days the policy should be considered as fresh. Further the discharge summary mentions that the problem was in existence since 5 years. It was held that reasons for the break of 35 days as stated by the insured is accepted.

The complainant was regularly insured since 1997 and should not be penalized entirely for a break beyond his control. At the same time the insurer cannot be expected to consider this as a regular policy since a break of 35 days is beyond the condonable period of 30 days. Insurer is directed to pay 75 % of the amount claimed on ex-gratia basis.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.003.190/2005-06
Shri P. Ajit Kumar Jain
Vs
M/s. National Insurance Co. Ltd.

Award Dated 20.12.2005

The complainant purchased Janarogya Policy for the first time for the period 26.07.2003 to 25.07.2004. The policy was renewed on 03.09.2004. He was hospitalized on 04.10.2004 with complaints of piles. He lodged a claim with the insurer for Rs. 2015/- The insurer rejected the claim on the grounds that the policy was renewed with a break and therefore treated as a fresh policy, piles was an exclusion under the first year clause 4.3, hospitalization was for less than 24 hours. The complainant contended that the insurer refused to accept the renewal premium when he went to pay on 19.07.2004. Therefore, the renewed policy should not be treated as fresh policy. The insurer contended that they never refused premium and he was asked to produce original policy to correct the agency code, tampered documents, were submitted by the insured. Therefore, they were correct in repudiating the claim. It was held that the condition of hospitalization for minimum 24 hours is stated clearly in the policy. There is no scope to direct the insurer to change their decision.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.185/2005-06
Shri B. Raghava Shetty
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 23.12.2005

The complainant was covered continuously under mediclaim policy from 31.03.1994 to 30.03.2005. He was admitted in November 2004 with complaints of chest discomfort and was treated for MI and Heart Block. He submitted bills for Rs. 33,118/- The insurers TPA settled the claim for Rs. 29,748/- The complainant contended that he was

entitled to receive the balance and he was put to financial hardship and mental tension due to undue delay. The insurer contended that 10 % of the claim amount was deducted for diabetes and hypertension which were in existence since 13 years.

Held : The insurer and the TPA were unable to give any coherent answer as to the basis of 10 % deduction. They referred to the Discharge Summary which stated that hypertension for 13 years not on treatment. There was no mention about DM. The insurers confirmed that the insured was continuously insured since 31.03.1994, no policy condition was shown for 10 % deduction made As such the insurer was directed to pay Rs. 3,305/- being the balance of claim and Rs 180/- towards bank charges deducted.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.180/2005-06
Smt. Radha Ramachandra
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 29.12.2005

The complainant and her husband were covered under Mediclaim Policy for the period 09.10.2002 to 08.10.2003 for a Sum insured of Rs. lac each, and for the period 09.10.2003 to 08.10.2004 for Rs. 2 lakhs each. She underwent Knee surgery on 07.10.2004 and lodged a claim with the TPA for Rs. 1,18,463/- The TPA after repeated follow up settled her claim on 04.10.2005 for Rs. 1 lac. The complainant was aggrieved with the deduction in the claim and represented the matter repeatedly to the TPA who did not give her any response. The Insurer contended that the complainant consulted a doctor on 23.04.2003 for her Knee ailment. Therefore for the policy effective 09.10.2003 the disease is pre-existing. Coverage of Rs. 1 lac only is available for this ailment since at the time of first detection the coverage was for this amount. The additional sum insured of Rs. 1 lakh taken in the policy effective 0910.2003 would not cover the present surgery, in view of the insured being aware of the ailment as on the date of increase of sum insured.

Held : Insurer's representative could not provide any reason for lack of proper response. The insured did not dispute consulting a doctor for knee problem on 23.04.2003. She contended that she was not aware that she would have to under go knee surgery. The insurer contended that the complainant was definitely aware of the symptoms and hence increased the sum insured. The complainant referred to incorrect noting of cumulative bonus. The insurer admitted that there was an error and conveyed that the correct amount of cumulative bonus would be Rs. 9,500/- for the policy period 09.03.2003 to 08.10.2004. The insurer's contention that when insurance policy/enhancement of sum insured is effected after the insured came to know or experience the symptoms of the desease the insurershould not be required to pay for the treatment of related disease, is accepted. The insurers are directed to rectify the policy in terms of cumulative bonus and pay Rs. 9,500/-. The TPA and the insurer took inordinately long time to settle the claim and are directed to pay interest on Rs. 1,09,500/- as per IRDA Rules.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.005.257/2005-06
Shri Ravindra Hippalgaonkar
Vs
Oriental Insurance Co. Ltd.

Award Dated 06.02.2006

The complainant and his wife were covered under a Mediclaim policy since the year 2000 continuously. They underwent health checkup on 01.06.2005 and submitted the bills to the office for reimbursement. His claim was rejected on the grounds that there was a break of 15 days in renewal of policy for the year 2003-04.

The complainant contended that before availing health check up, he wrote a letter to the insurer seeking permission. Had the insurer informed him that he was not eligible, he would not have incurred the expenditure. The insurer contended that the policy expired on 12.03.2003 and was renwed on 28.03.2003 after a gap of 15 days. To avail the benefit of health check up the policy should be in force for 4 continuous years without a break and the policy should be claim free.

Held : The complainant did not give any specific reason for the break of 15 days in renewal of the policy. His contention that he went ahead after oral confirmation from the office is not accepted. He may not have stated the facts on phone giving all policy details. Since this was only a health check up which could be deferred till receipt of written confirmation, the insurers were well within their rights in denying the benefits as per policy terms and conditions.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.0262/2005-06
Smt. Indira Murthy
Vs
New India Assurance Co. Ltd.

Award Dated 06.02.2006

The complainant's husband was covered under a mediclaim policy for the period 13.12.2003 to 12.12.2004 for a sum insured of Rs. 2,00,000/-. He was admitted to hospital on 10.11.2004 with complaints of chest pain and discomfort. He was diagnosed to suffer from Single Vessel Disease. He was posted for by-pass surgery on 16.11.2004, but he died on 16.11.2004 due to massive cardiac arrest. The claim was rejected by the TPA on the grounds that the deceased had hypertension at the time of hospitalization. The complainant contended that her husband developed chest pain and discomfort for the first time on a trip to Mangalore. The next time was on 10.11.2004. Her husband was continuously insured for the last 7 years. He had mild Diabetes, which was under control with oral medication. The policy issued to him did not carry any exclusion. The insurer contended that there were discrepancies in the duration of hypertension. Their panel doctor opined that hypertension was a contributing factor to the present ailment. The insurers did not bring on record any evidence to show that the competent authorities did not make the alterations in the hospital records. The insurer admitted that the policy was in force for 10 years without a break. Prior to the insured's death, an Overseas Mediclaim policy was purchased after submission of investigation reports including medical reports. The insurers were apparently satisfied and issued the policy. There is no tangible evidence to show that the insured suffered from Hypertension before the inception 10 years ago. Insurer's rejection of the claim is unjustified.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.221/2005-06
Smt. Radha Swamy
Vs

New India Assurance Co. Ltd.

Award Dated 10.02.2006

The complainant was covered under Mediclaim policy for the period 18.08.2004 to 17.8.2005 for sum insured of Rs. 2,00,000/-. She was also covered for an additional sum insured of Rs. 1,00,000/- under her daughter's Group Mediclaim policy, which was issued to her by her employer. She underwent bilateral knee replacement and incurred an expenditure of Rs. 3,00,000/-. The TPA servicing the group Mediclaim policy settled the full sum insured under the policy. The TPA under the individual policy rejected the claim on the ground that the disease was pre-existing.

She contended that the disease was not pre-existing and she never had any pain at the time of purchasing the policy. The insurer contended that the complainant was diagnosed to have Grade III Osteoarthritis, which takes a long time to develop.

Held : The treating doctor clearly mentioned that the pain was insidious in nature, which indicates that the onset of the pain was not sudden. Discharge summary states that there was deformity of the knee joints. The policy under which the claim was paid by National Insurance Co. included in its scope pre-existing diseases, while the policy under which the claim was denied excludes pre-existing diseases, as it is an individual policy. Insurer's decision upheld.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.0307/2005-06
Smt. K. Narassaratnam
Vs
Oriental Insurance Co. Ltd.

Award Dated 01.03.2006

The complainant and his wife covered under Mediclaim policy for the period 13.01.2003 to 12.01.2004 for Rs. 1,00,000/-. The policy was further renewed for the period 13.01.2004 to 12.01.2005. The complainant's wife underwent Total knee Replacement and submitted a claim for Rs. 1,56,756/-. The claim was rejected under clause 4.1 (pre-existing disease clause).

The complainant contended that they had no knowledge of the necessity of knee replacement before taking the policy. She confirmed that she underwent Total knee Replacement for left knee in 2002. Had they known about the problem in the other knee, they would have gone for increase in sum insured. Further the surgery was performed in the second year of policy. The discharge summary for the hospitalization in 2002 revealed the presence of Bilateral Arthiritis Knee. Therefore she had Osteoarthritis in both knees. Since policy was taken for the first time from 13.01.2003, the problem was pre-existing.

Held : From the documents submitted she was diagnosed as suffering from BIlataral Arthritis of the knees prior to 07.11.2002. The panel doctors of the TPA presented extracts from medical dictionary. Based on the available evidence it is held that the insured was suffering from knee problems in both knees as of November 2002. Insurer's decision is upheld.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.356/2005-06
Shri N. Venkateshwara Rao
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant's wife covered under Mediclaim policy was hospitalized on 4 occasions between 30.04.2004 to26.06.2004. The TPA repudiated all these claims on the ground that the ailments were pre-existing. The complainant contended that his case was heard earlier in this office and vide Award No. 128/2004-05, a favourable decision was given to him. This time too the rejection was on similar grounds. The insurer contended that the policy for the period 16.05.2002 to 15.05.2003 was renewed with a gap of 35 days. As this delay was not condoned, it was considered a fresh policy with imposed exclusions. All the hospital records indicate that the patient was a known case of DM/CAD/Peripheral Nephropathy. It was observed that in the earlier instance the patient was hospitalized during the period November 2001 and December 2002. The insurer rejected the claims then based on their panel cardiologist's opinion that the disease would take more than 2 years to develop. This office observed that the said opinion obtained by the insurer was based only on records but not on any evidence allowed these claims. The current case differs from the earlier one in that they arose during the period 2004-05; and, since policy taken for the period 16.05.2002 to 15.05.2003, after the claims for which an award was passed, was treated as a fresh policy with the exclusions on the face of it and the ailments with which the insured suffered for which claims are made happen to be similar to the ailments which are excluded on the above policy, the decision taken by the insurer is found justified.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.368/2005-06
Shri S. Chandrsekhara Shastry
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant's daughter covered under Mediclaim policy was hospitalized on 25.04.2005 for Estropria V. Pattern and surgery was done on 26.04.2005. The TPA repudiated the claim on the ground that external congenital diseases were excluded under the policy under exclusion 4.8. The complainant contended that he was a policyholder since the last 3 years and the current policy had a Cumulative Bonus of 15 %. Defect in his daughter's vision was noticed only after she joined school in the year 2003. Had they noticed this at the time of her birth they would have done the surgery then itself instead of waiting for so long. The insurer pointed out that the photo given to the TPA for the photo identity card clearly showed the squint. This itself was proof of the existence of the disease prior to issue of the policy. It is observed that the photo clearly shows the squint in the eyes. In view of this, whether the defect was noticed or not from the date of birth, definitely it was noticed prior to the issue of policy. Keeping in view the policy conditions, the decision taken by the insurer is justified.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.355/2005-06
Shri Ramachandra Agarwal
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant and his wife were covered under a Mediclaim policy for a sum insured of Rs. 3,00,000/-. She was admitted to hospital with complaints of chest pain on

13.12.2003. She was diagnosed to suffer from recurrent Angina and was advised CABG. She was discharged on the same day and admitted to another Hospital. There she was diagnosed to suffer from DM, CAD etc. she underwent PTCA and was discharged on 21.12.2003. Since there was some post operative complication she was readmitted on 23.12.2003 and after treatment was finally discharged on 29.12.2003. The insured claimed an amount of Rs. 4,99,984/- towards expenses. The insurer did not settle her claim. She contended that she was covered since 1997 and the policy issued for the period 2003-2004 had a cumulative bonus of 25 %.

The insurer stated that as per the case sheet of the hospital, the patient had undergone AWMI in 1996. As such the disease was pre-existing at the inception of the policy.

During the hearing the insured's representative stated that she had insurance cover right from 1994. Pressed for evidence, the insured could not produce any. The insured also contended that the insurer paid her AWMI claim in 1999.

To evidence the payment a photocopy of the account extract from the bank was furnished. Nowhere did the account extract have any details relating to the payment made by the insurer. However it was observed that the policy had 25 % bonus mentioed on it. This should not have been available in the event of claim. Since there is evidence for Mediclaim cover only from 10.03.1997, it has to be concluded that the insured did not have any policy prior to this date. Since she was treated for AWMI in 1996, the insurer did well in rejecting the claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.0327/2005-06
Shri E. Raghavan
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant and his wife enrolled themselves under the Medical Plan for IDBI customers with effect from March 2001. The complainant was hospitalized on 06.12.2004 with complaints of epigastric discomfort. During the course of treatment it was revealed that the patient was suffering from CAD with Triple Vessel Disease. He was advised to undergo a stent placement surgery and discharged on 14.12.2004. He was readmitted in the hospital on 19.12.2004 for PTCA procedure. He incurred a total expenditure of Rs. 1,93,000/-. The TPA rejected the claim on the ground that the patient was a known case of CAD for the last 4 years as stated in Form-1. The complainant stated that he enrolled in the scheme after he submitted all test reports as called for by the TPA. He was admitted for the first time on 06.12. 2004. Cashless facility to the extent of Rs. 15,000/- was paid to the hospital directly. Another amount of Rs. 20868/- was paid to him. He provided all the clarifications to the TPA about their query regarding pre-existence of any disease. The 4 year period Referred to Bronchial Asthma and not CAD. This was the first time he was aware of Cardiac Problem. The insurer contended that the patient not only suffered from IHD but also Hypertension. The insured had HTN since 8 years, which means even before the policy incepted. To resolve the dispute regarding the exact duration of IHD, the entire case sheet of the hospital for the hospitalization in 2004 was called for. Nowhere in the case sheet was it noted that the patient had IHD. The treating doctor observed on 11.12.2004 that "his CAG showed TVD. This problem is recent" Therefore, the insurer's contention that the insured had a pre-existing problem is disallowed. The insured's contention that it was a

clerical error made by the hospital is accepted. About HTN-the insurer accepted his proposal only after satisfying themselves that he was an “acceptable risk” after scrutinizing all health related documents. The first claim was settled by the TPA’s panel of doctors. They did not raise any objection till a complaint was lodeged for his second claim. Since the claims are not on account of any pre-existing condition, the insurer and the TPA are hereby directed to honour both claims alongwith interest as per IRDA guidelines and an amount of Rs. 5,000/- towards damages.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.0354/2005-06
Shri Om Prakash Garg
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant was insured under a Mediclaim policy. He was hospitalized from 10.09.2005 to 11.09.2005 with complaint of pain over both ankles since 4 months. He was diagnosed to suffer from Seronegative Rheumatoid Arthritis. Polyarthritis. The treatment given included only oral drugs. The claim was rejected on the ground that hospitalization was not necessary for the nature of treatment given and as such the claim fell under exclusion 4.10 of the policy. The complainant stated that this was his fourth year of continuous insurance and his first claim in 4 years. The admission was as per the treating doctor’s advice. The panel doctor submitted that no one would straight away go in for hospitalization for this type of complaint, and a course of outpatient treatment is tried. The insurer stated that no previous treatment was taken. The insured submitted that he did not have any out patient papers to show. In view of the policy conditions and since the insured could not produce any treatment papers pertaining to the pre-hospitalization period, the insurer’s decision is upheld.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.0367/2005-06
Shri D. Ramesh Babu
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant and his wife were covered under Andhra Bank Aarogyadaan policy for the periods 17.07.2004 to 08.06.2005 and from 09.06.2005 to 08.06.2006. His wife was admitted to hospital from 27.07.2005 to 03.08.2005 for L4/L5 disc injury. The MRI scan report stated that the patient had Anterior Osteophytes in L4-L5 vertebrae and Lumber Spondylosis. The TPA rejected that claim on the ground that the claim fell under the pre-existing disease exclusion. The complainant contended that about 3 months prior to the admission, his wife slipped and fell while fetching water. She had to be hospitalized, as the pain was unbearble. The insurers stated that neither the line of treatment nor the ailment requires the patient to be admitted as in-patient. As per exclusion 4.10 any treatment towards investigations can be allowed only if accompanied by medical treatment, necessitating hospitalization. In the repudiation letter sent to the insured, the insurer/TPA harped on the fact that the disease was pre-existing. However in their note to this office they raised 2 new issues which are not taken by this office as this was not mentioned in their letter to the insured. Neither the insurer nor the TPA brought any evidence to show that she was definitely suffering from back pain before the insurance was taken for the first time. The complainant

stated in detail the reasons and necessity for the hospitalization, which have not been counted by the insurer/ TPA through any acceptable reasoning or evidence.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.305/2005-06
Shri D. Bhagchand Pokarna
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant purchased a Mediclaim policy for the first time to cover himself and his wife for a sum insured of Rs. 2 lakhs for the period 09.01.2004 to 08.01.2005. He was admitted to hospital on 09.09.2004 with complaits of chest pain. He underwent Coronary Angiogram and was diagnosed to suffer from Triple Vessel disease. He was advised to undergo CABG. The surgery was conducted on 25.09.2004. The TPA rejected the claim on the ground that TVD takes a long time to form and was present at the time of taking the policy. The complainant contended that the policy was accepted after he submitted all his diagnostic reports. The chest pain developed for the first time in September 2004 only. He also had a few policies with LIC, which were accepted after tests etc. The insurer contended that the angiographic changes as seen in the hospital records would take at least 2 years to develop. The treatment was for the management of a pre-existing ailment only. The panel doctor of the insurer produced the case sheets of the hospital where the insured was first admitted. It is observed that the patient was a known Hypertensive since 1989 and was on various drugs to control the same. The insured conveniently replied in the negative to the Hypertension questionnaire in the proposal form. The reports also indicate that he suffered Old Inferior Wall Myocardial Infarction. The panel cardiologist also stated that the ECG furnished at the time of proposal was not normal. Details of the proposals submitted by the complainant to LIC after medical examination were called for. One of the policies was accepted after the imposition of Health Extra. The complainant deliberately tried to mislead the insurer and deliberately tried to suppress material facts about his health only to take advantage of insurance benefits.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.315/2005-06
Shri T. C. Sampath Kumar
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant's wife purchased an Overseas Mediclaim policy for the period 30.03.2005 to 27.07.2005 (120 days). She complained of chest pain and was hospitalized on 26.05.2005. She was readmitted and was advised to undergo angiogram A stent was implanted to Left Anterior Descending Artery. The insurer rejected the claim on the ground that the policy specifically excluded CAD treatment. The complainant contended that CAD was a general term and referred to a variety of conditions in different contexts. The treatment undergone in Hyderabad was to treat a specific condition of correcting a block in the diagonal branch of the Left Anterior Descending Artery. The chest pains that his wife had in USA had nothing to do with the earlier surgery. The blockage was in an entirely different segment of the artery and not even remotely connected to the previous stent. The insurer brought their panel cardiologist for the hearing. He stated that the Left Anterior Descending Artery was a

branch of the same vessel. The new lesion was very close to the diagonal branch where the earlier stent was implanted. Owing to the confusion in the opinions of the doctors, the file was referred to an independent doctor who categorically stated that although the lesion is at a new site, it was on account of the earlier disease. The new problem was attributable to the earlier condition. It was held that the insurers were not arbitrary in their decision to repudiate the claim. Insurers decision is upheld.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.012.342/2005-06
Shri N. J. Rao
Vs
ICICI Lombard General Insurance Co. Ltd.

Award Dated 31.03.2006

The complainant and his wife went on a trip to USA on 08.06.2005 and purchased an Overseas Mediclaim from the respondent company On 25.07.2005, his wife consulted a doctor in USA who noted “Complaint of persistent mostly dry cough for more than 6 weeks”. The symptoms started when the complainant was in India The hospital diagnosed the problem as cough of unclear etiogy, possibly secondary to allergies. The claim was denied under the pre-existing condition exclusion. The complainant stated that during their stay she suffered from consistent cough that was not amenable to OTC medicines. The insurer’s agent there advised him that she could avail treatment at any nearby hospital. The doctor’s noted that the previous medical history had not in any way contributed to her present ailment. The documents submitted by both parties indicate that the disease was present before the compainant’s departure to the USA. Also the complaint was continuous through the 6 weeks before she consulted the doctor in USA. Since the medical reports unambiguously indicate the existence of symptoms prior to her departure from India and in view of the wordings of the policy, the insurers decision to repudiate the claim is upheld.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.004.0194/2005-06
Shri Preetivardhan Upadhyay
Vs
United India Insurance Co. Ltd.

Award Dated 01.03.2006

The complainant purchased a mediclaim policy for the first time to cover himself for a sum insured of Rs. 50,000/- for the period 3.6.2004 to 2.6.2005. He was admitted to Kasturba Hospital, Manipal on 21.07.2004 with complaints of Low Back Ache of 15 days duration. He was diagnosed to suffer from Inter Vertebral Disc Proplapse L4-L5. He underwent Laminectomy and Discectomy and was discharged on 11.08.2004. The insurer vide letter dated 06.09.2004 rejected the claim on the ground that the ‘complaints and procedure done are for a pre-existing condition and hence falls under Exclusion No. 4.1 of the policy’.

The TPA’s Panel doctor opined that the patient was only 28 years old and he suffered from Intervertebral Disc Prolapse without any history of accident/fall. This was highly improbable within 2 months of inception of policy.

After the insured approached the office of the Hon’ble Insurance Ombudsman, they conducted an investigation and it was found that the insured had taken treatment as an

outpatient for the complaint of low back ache since 17.03.2004 much before the inception of the policy. The insurer produced a copy of the Investigation Report.

The report clearly states that the complainant was treated as an out-patient on 17.03.2004 for complaints of Low Back Ache. The pain/problem was in existence since 3 weeks, which means sometime in Mid-February, well before the policy incepted on 03.06.2004. It is also observed that he underwent out-patient treatment on 18.06.2004 and 30.06.2004 for backache. None of this was disclosed to the insurer. The insurers are justified in disowning liability on the claim.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.0261/2005-06
Shri S. V. Rao
Vs
New India Assurance Co. Ltd.

Award Dated 01.03.2006

The complainant, his wife and son were covered under Mediclaim Policy on 28.10.2002 for a sum insured of Rs. 1,00,000/- each. This was first policy with the office of the insurer. The complainant's son consulted an orthopedic surgeon on 05.01.2003 with complaints of low back ache with bilateral radicular pain to the thigh since 10 days. The Third Party Administrators (TPA), vide letter dated 04.02.2003, rejected the claim on the ground that 'the ailment was pre-existing at the time of taking the policy which was not disclosed as per the rules' The complainant's son consulted Manipal Northside Hospital in November 2004 as the pain had not subsided despite the earlier surgery. He was admitted into the hospital and underwent Laminectomy and Discectomy on 04.11.2004. He was discharged on 07.11.2004. The TPA vide their letter dated 13.12.2004 rejected the claim on the ground that the disease was pre-existing.

His son fell from the scooter which skidded off on 07.12.2002. Although his son did not suffer any external injury, he suffered terrible back pain thereafter. The hospital case history revealed that the patient was suffering from low back pain radiating to the thighs since one month i.e., 07.12.2002 The summary revealed 'no history of injury'. The records of the second surgery reveal that the problem persisted for more than one year nine months.

The MRI report does not indicate anything attributable to injury/fall/trauma. There is no mention of injury or Road Traffic Accident in both medical records.

The complainant's contention that his son sustained a fall from scooter a few days prior to the first surgery in January 2003 is not substantiated. In fact the discharge summary states 'No history of injury'. The discharge Sumary for the second hospitalisation too states that there was 'No complaint of Trauma' During the hearing proceedings the complainant was not in a position to explain why the fall from Scooter was not disclosed to the doctors at both hospitals. I concur with the insurer that the 'fall theory' was concocted by the complainant as an after thought only to take advantage of insurane benefits. In view of the same, I decline to interfere with the decision taken by the insurer. Complaint is **Dismissed.**

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.005.0349/2005-06
Shri P. V. Ramalingeshwara Rao
Vs

Oriental Insurance Co. Ltd.

Award Dated 17.03.2006

The complainant's father was covered under the Mediclaim policy for the period 06.08.2004 to 05.08.2005 for a sum insured of Rs. 1,50,000/-. He was hospitalized from 20.09.2004 to 22.09.2004 with complaints of shortness of breath. He was diagnosed to suffer from RHD. He died on 06.11.2004 while undergoing treatment. The claim was repudiated on the grounds that the disease was pre-existing. The complainant contended that his father was hale and healthy at the time of taking the policy. The TPA contended that the insured was having the relevant complaints of shortness of breath for the previous 4 years. Further the hospital records indicate that he was a known case of RHD. The TPA panel doctor stated that the disease had to be in existence since much before the policy. Treatment was also taken for other ailments, which are allowed and expenses incurred for treatment of RHD are excluded. The insurers are to settle the claim in respect of treatment taken on these two days.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.008.0302/2005-06
Shri Jogabrata Chatterjee
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 06.03.2006

The complainant was covered under the insurer's Health Shield Medisafe for the period 20.07.2005 to 19.07.2006. He was hospitalized on 03.09.2005 with complaints of lump in the Right Breast. The TPA opined that Severe Fibrocystic Disease of the breast requiring surgery is pre-existing. The complainant contended that there was pain with tendernesss a few days prior to the hospitalization. He was advised surgical excision. In case the insurer was in doubt they could have got the matter investigated. The insurer contended that the policy was in force for little over than 1 ½ months when the claim was made. Their repudiation was supported by an opinion from that of a specialist. The insurer stated during the hearing that they relied on the discharge summary to repudiate the claim. The complainant stated that pathological report revealed the tumor was benign. The out-patient card and the discharge summary state the lump was noticed only 3 days prior to admission. The insurer is directed to honor the claim and pay.

Hyderabad Ombudsman Centre
Case No. IO(HYD)/G/11.002.255/2005-06
Shri M. Hanumantha Rao
Vs
New India Assurance Co. Ltd.

Award Dated 21.11.2005

The complainant covered his mother under a Mediclaim policy for the period 23.04.2003 to 22.04.2004. She underwent treatment in September 2003 for septicema and her leg was amputated. The insurer/TPA did not settle her claim for long. The insurer conveyed that they had discontinued their tie-up with the TPA, Medicare Services Ltd. as their handling of the claim was far from satisfactory. They observed that the insured was a diabetic since 3 years while the insurance was in force with them from April 2003 only. Since the treatment taken and the amputation of leg were

directly related to the pre-existing complaint of Diabetes, the claim was repudiated under clause 4.1 of the policy. The insured produced copies of earlier insurance and it is found that the coverage is in existence since 1999. Diabetes is said to be from November 2000 which is more than a year and a half after the commmencement of insurance. The insurers are directed to honour the claim.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.003.54/2005-06
Dr. Santhosh Kumar M. N.
Vs
National Insurance Co. Ltd.

Award Dated 27.10.2005

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 is as a result of non-settlement of a mediclaim by the TPA of the insurer under Pol. No. HSIMP002336-A-B-C-X-Y. There were two claims favouring the husband and wife. Even as the proceedings were pending before the Hon'ble Insurance Ombudsman, the claims were settled by the insurer-though after considerable delay. The insurer stated that the TPA concerned was terminated subsequently although there are a few more cases pending with them and the complaint in dispute was one such, which, however, they settled as soon as the matter was reported to them. On verification of the case records, however, it was found that the complainant had taken up this matter earlier with the head office of the insurer at Calcutta and hence the entire blame could not be heaped up only on the TPA. In any case, as the claim was settled, the miscellaneous expenses incurred by the complainant in pursuing this case amounting to Rs. 3,600/- was ordered to be paid by the insurer, as the complainant was found blemish less in his transactions and the inordinate delay was caused directly due to the negligence of the TPA and the insurer.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.005.153/2005-06
Shri N. P. Thomas
Vs
Oriental Insurance Co. Ltd.

Award Dated 17.11.2005

The comlaint 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. 2005/06 covering the period 23.06.2004 to 22.06.2005. The complainant aged about 64 years was given medical insurance under the Universal Health Insurance Plan. The policy was canvassed by the agent and Dev. Officer of the insurer and a column related to previous health condition left-blank in the proposal was not noticed by anyone. The complainant was at the Indira Gandhi Co. Op. Hospital, Kochi from 17.12.2004 to 24.12.2004 for Transient Cerebral Ischaemia and he had also taken treatment at Lisie Hospital, Kochi from 27.12.04 to 5.1.2005 for Hemorrhoids. The insurer alleged suppression of previous medical history and contended that Hemorrhoids was a first year exclusion. However, their contentions in relation to the treatment of Ishaemia was found unacceptable. At the time of hearing the representative of the insurer said that an amount of Rs. 6,500/- would have been admissible to the complainant had there been no suppression of medical facts. The suppression of facts being not proved and as the Insurance Agent, Dev. Officer and the office had also kept quiet for a very long time about the blank column in the proposal form, it was found unfair to charge the complainant with malafide intentions. Moreover,

the complainant was a retired Head Master of a School. In the circumstances, an amount of Rs. 6,500/- as opined by the insurer as other wise would have been admissible was awarded to the complainant thus partly setting aside the total repudiation of the Claim.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.158/2005-06
Smt. Mariamma Rajan
Vs
New India Assurance Co. Ltd.

Award Dated 22.11.2005

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules 1998 relates to repudiation of a claim under Pravasi Suraksha Kudumba Arogya Pol. No 760106/47/2001/80780 issued by the respondent. Smt. Mariamma, one of the beneficiaries had undergone surgery for ASD clusure (congenital heart defect) at St. Gregorios Cardio Vascular Centre on 5.4.2004 and the claim for Rs 1,00,000/- was repudiated by the insurer since congenital diseases came under Exclusions 1 and 3 - Section VII of the policy. It was true that the complainant was not aware of the existence of the disease in her; but, the policy excluded all congenital diseases and ASD was clearly a congenital disease. In the aforesaid circumstances, the action taken by the insurer in repudiating the claim was found justifiable and the complainat was dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.159/2005-06
Shri Krishnakumar
Vs
New India Assurance Co. Ltd.

Award Dated 23.11.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 stems out of repudiation of a mediclaim by the insurer under Pol. No. 761001/03/01127. The complainant's son was a known case of Meningitis and therefore the cover for the boy was with the exclusion of Meningitis and connected diseases. From 29.6.04 to 30.6.04, the boy was an inpatient of AIMS Kochi with complaints of constipation and urinary incontinence. An MRI/LS scan of the spine was also done as there was history of Meningitis. The TPA of the insurer had rejected the claim after consultation with their panel Doctor concluding that the hospitalisation was in connection with Meningitis. But, urinary incontinence and constipation was not directly connected to meningitis and hence this Forum directed the insurer to allow the claim partially after disallowing the MRI charges, which was only for diagnostic reasons in the wake of a history of meningitis.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.181/2005-06
Shri V. S. Baburjan
Vs
New India Assurance Co. Ltd.

Award Dated 08.12.2005

The complaint under N. 12(1)(b) read with Rule 13 of RPG Rules 1998 arose out of partial payment of a medi claim by the insurer. Mr. Anupam, S/o. Mr. V. S. Baburajan

had met with an accident on 18.10.2003 and was admitted to Tricuhur Heart Hospital. On 28.10.2003 he was discharged and was referred KMC & H, Kovai, since he had to attend interview/written examination on 30th and 31st October 2003. The patient was discharged from KNC & H on 31.10.2003. Insurer reimursed all expenses but Rs. 19,401/-, since they felt that the unpaid amount was not reasonably and necessarily incurred by the complainant. On verification, Honourable Insurance Ombudsman directed to pay Rs. 7,785/-, which was reasonably necessarily incurred by the complainant.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.184/2005-06
Shri K. Vijayakumar
Vs
New India Assurance Co. Ltd.

Award Dated 27.12.2005

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a medi claim. The complainant Shri K. Vijayakumar had taken an Individual Medi claim policy for the period 18.9.2002 to 17.9.2003, based on his proposal dated 18.9.2002. The said policy was renewed only on 30.09.03, 12 days after the expiry of the earlier policy. The complainant had claimed reimbursement of expenses incurred by him for the treatment of cataract under the second policy issued for the period 30.9.03 to 29.9.04. The insurer rejected the claim stating that the said claim is not payable as per policy clauses 4.1 and 4.3 which excludes pre-existing diseases and 1st year exclusion of the treatment expenses of certain diseases including cataract. Insurer considered the second policy as a fresh one and not as a renewal since they had collected a fresh proposal dated 30.9.03 against the subsequent insurance. The complainant argued that since the first and second policies were issued on the basis of the first proposal dated 18.9.2002, as clearly stated in the policies, he was made to believe that the second policy was in perfect continuity of the first one issued on 18.9.2002. Though insurer contended that the error in giving a wrong proposal reference was a typographical mistakes detected only at the present stage, this Forum ruled that the decision of the insurer repudiating the claim was illegal and hence the same was set aside. The complainant was granted Rs. 15,292.50 (subject to compulsory deductions, if any) towards medical reimbursement under the disputed policy.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.003.156/2005-06
Shri Ravi Ramankutty
Vs
National Insurance Co. Ltd.

Award Dated 11.01.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 relates to delay in settlement of a medi claim by the insurer under Pol. No. 571400/48/04/8500098 held by the complainant. During the currency of the policy, the insured had undergone angioplasty at a cost of Rs. 2,10,000/-. Since the sum insured under policy was Rs. 1 lakh, the insured had claimed the said amount. The insurer had kept quiet for a very long time to take a decision after an initial response that the claim was inadmissible because of the first year exclusion clause. However, the insurer, in

their self-contained note, and oral testimony admitted that the claim was payable and that the delay was caused only due to inadvertent misplacement of the case file which was by now traced. The insurer was ready to settle the claim for the sum insured of Rs. 1 lakh and the complainant was satisfied about the offer. The complaint was, therefore, disposed of directing the insurer to settle the claim for Rs. 1 lakh immediately.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.201/2005-06
Shri T. P. Bhaskaran
Vs
New India Assurance Co. Ltd.

Award Dated 18.01.2006

The complaint under Rule 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 is resultant to repudiation of a medi claim preferred by the complainant in relation to the treatment of his wife. The medi claim is from a Group Insurance Policy issued by the respondent covering LIC employees. The compainant's wife had undergone treatment at Cure Siddha Clinic, Palayamkottai incurring an expenditure of Rs.29,431.90. The insurer rejected the claim on the plea that the hospital did not have the specified number of inpatient beds and therefore as per the policy conditions the claim was not admissible. On verification, it was found that the hospital in dispute had only 8 beds and it did not come under the definition of a hospital as per the policy conditions. In the circumstances, the rejection of claim by the insurer was found in order and hence the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.004.266/2005-06
Shri M. Sivaramakrishna Iyer
Vs
United India Insurance Co. Ltd.

Award Dated 23.02.2006

The complaint under Rule 12(1)(b) read with Rule 13 of th RPG Rules, 1998 relates to repudiation of a medi claim for Rs. 14,935.93 under Pol. No. 101400/48104/05201 held by the complainant. He had, in all, three spells of treatment - the two earlier treatments were for bone fracture and hernia - these two claims were honoured by the insurer. The third treatment was for heart ailments. In the hernia treatment discharge summary, the Doctor had written that the patient was hypertensive for 20 years without any further corroboration thereon. The complainant pleaded ignorance of any problem of hypertension and he said before the heart problem, he was not taking any medicine for hypertension. In any case, he was not aware of the problem if at all it existed in him. The insurer had relied entirely on a remark written by the Doctor and it had no supporting evidence to solidify the contention. The complainant - retired Principal of a reputed Engineering College was very forthright and straight forward in all his answers. The contention of the insurer without adequate medical records to support the same was not acceptable to the Forum. The insurer was therefore advised to honour the claim subject to verification of all bills.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.003.288/2005-06
Shri Joseph P. M.
Vs
National Insurance Co. Ltd.

Award Dated 22.03.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 Relates to repudiation of a claim under the Jana Arogya Scheme by the insurer. The complainant's son Ajeesh Joseph was having head and ear ache. When the local treatment resulted only in recurrence of the problem, the boy was taken to the OP section of the PVS hospital. He was admitted there on 27.8.05 and discharged on 28.8.05 after ophthalmological evaluation and CT scan. The diagnosis being vascular headache, the boy was eventually referred to a psychologist for counseling. The insurer repudiated the claim saying that, out of the total of Rs. 2,500/- claimed for, Rs. 1,900/- was the charges for CT scan and Rs. 110/- was lab charges. Since the entire process was gone through only for the purpose of evaluation the insurer repudiated the claim in toto. However, on verification of the records, it was found that the boy was admitted in the hospial only as per medical advice and hence the room rent/boarding charges etc. amounting to Rs. 490/- was payable. Therefore, the repudiation was partially approved and the boarding/nursing etc. expenses amounting to Rs. 490/- was allowed in favour of the complainant.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11.002.284/2005-06
Smt. N. K. Nisha
Vs
The New India Assurance Co. Ltd.

Award Dated 28.03.2006

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RGP Rules, 1998 relates to partial repudiation of a medi claim by the insurer. The complaiant - an employee of LIC - was a member of the Group medi claim policy issued by the insurer. She had undergone Lasik eye surgery at Arvind Hospital, Coimbatore for correction of Myopic Astigmatism. Originally, the insurer had rejected the entire claim for RS. 21951/- saying that the surgery was done for cosmetic reasons. Subsequently since the refraction in the left eye was to the extent of - 11, the insurer had allowed 50 % of the claim and further again allowed Rs. 600/-; in all Rs. 11,575/- was paid. For the right eye, the refraction was - 4 only. However, the hospitalization charges amounting to Rs. 1,200/- and Rs.500/- towards the scan expenses were fully payable. The surgeon's charge was Rs. 20,000/-. Therefore, in total (Rs. 10,000/- + Rs. 1,200 + Rs. 500/-) Rs. 11,700/- was payable to the complainant and the insurer had already paid 11,575/- (Rs. 10,975 + Rs.600/-). The balance of Rs. 125/- was allowed in favour of the complainant and the complaint was disposed of.

Kolkata Ombudsman Centre
Case No. 259/15/003/NL/9/2004-2005
Mr. Bhima Prasad Maiti
Vs
National Insurance Company Ltd.

Award Dated 21.11.2005

Facts & Submissions:

The complaint is regarding delay in issuing Identity Card against Mediclaim Insurance Policy for Cashless Facility. Shri Bhima Prasad Maiti took a mediclaim policy from National Insurance Company Limited for himself and his wife for the period 21.06.2004 to 20.06.2005. At the time of issuance of the policy, the name of the Insurer's TPA provided in the policy was M/s. Family Health Plan Ltd., Kolkata. Shri Maiti stated that

when he received the policy the requisite Cashless Identity Card with photo for himself and his wife was not there. He wrote to TPA on 22.07.2004 informing them of non-receipt of the card for 2004.

National Insurance Company Ltd. informed the complainant that photo ID card through their agent had been delivered to him but Shri Maiti refused to receive the same. Under this letter the photo ID card was sent under Registered Post. The complainant vide his letter dated 15.11.2004 clarified that no agent had called on him on 10.09.2004. He also sought confirmation that the enclosed photo ID card actually contained photographs embossed thereon for identification for Net-work hospital so that he could avail cashless facility. If the photograph was not there then proper photo ID cards were not issued and thereby he would be deprived of the facility of cashless card.

The complainant stated that an emergency medical problem due to detection of Glaucoma in his eye arose for which he had to undergo laser surgery at Apollo Gleneagles Clinic. In the absence of cashless card, he had to fend for himself from meager financial resources, even though he had a valid medical insurance cover.

National Insurance Company Limited stated that the complainant took a Mediclaim Policy along with his wife, Smt. Dipa Maiti for the period from 21.06.1999 to 20.06.2000. The policy was renewed in time without any break. The complainant got his Photo Identity Cards from the concerned TPA, Family Health Plan Ltd. pertaining to Policy Year 2003-04. But the next year he complained to the insurance company about non-receipt of the Card from the TPA till July 2004, although he had renewed the Mediclaim Policy in time for the period 21.06.2004 to 20.06.2005 vide Policy no. 101000/48/2004/8500866. On receipt of the complaint the insurance company referred the matter to Shri Pradip Dutta, representative of FHPL on 27.07.2004 to take necessary action. On 14.09.2004, Shri Dutta visited the insurance company and handed over two Photo Identity Cards of Shri & Smt. Maiti. These were sent to the complainant at his residence on 22.09.2004 vide Registered A/D letter dated 20.09.2004. From the postal acknowledgement, it was established that Shri Maiti got two Photo Identity Cards and his grievances over the issue had been redressed.

Decision : There is no dispute that the complainant did not receive the photo ID cards for 2004 along with policy. He immediately brought the matter to the notice of the TPA and sought their advice as to how to approach the hospital for reimbursement in the absence of ID card. The complainant followed up the matter by writing at regular interval to the insurance company and the TPA but there was no specific reply received by him. The complainant also alleged that he failed to avail of the cashless facility at Apollo Gleneagles Clinic.

We have noted the action taken by the insurance company as well as TPA on the basis of the complaint received by them. The fact of the matter is that the card which was issued to the complainant was without his photograph and without any signature of the issuing authority. There is nothing in the IRDA's instructions which approve issuing a card which would serve no purpose for claiming reimbursement of expenses. On the contrary IRDA did not find favour with the idea of issuing photoless card as that could lead to fraudulent claims. The insurance company has brought a letter from the Apollo Gleneagles Clinic to the fact that the complainant never produced the card for cashless facility and that he voluntarily made the payments. It is too late in the day for the insurance company to take shelter behind the reply issued by Apollo Gleneagles Clinic as late as on 21.09.2005. The insurance company /TPA never bothered to look into the grievance of the complainant that there was a failure of the contractual obligation in spite of persistent follow up by the Insured. Now they have sought to justify their action

by relying unsuccessfully on the supposed instructions issued by IRDA and on a certificate issued by Apollo Gleneagles Clinic.

In the instant case instead of acting on the complaint lodged by the complainant, National Insurance Company and the TPA began their damage control exercise rather than giving any specific answer to the questions/issues raised by the complainant was put to mental anxiety and harassment for no fault of his. He deserves compensation for what he went through during the pendency of the complaint.

The complaint has claimed a compensation of Rs. 5 lacs which is equivalent to the total sum insured of himself and his spouse under the policy. There is no basis given by the complainant for the quantum of compensation claimed. Considering the totality of the facts and circumstances of the case, we consider that an award of exgratia payment of Rs. 50,000/- would be fair and reasonable and would meet the ends of justice.

Kolkata Ombudsman Centre
Case No. 416/12/003/NL/12/2004-2005
Shri Ramendra Nath Ghose
Vs
National Insurance Co. Ltd.

Award Dated 23.11.2005

Facts & Submissions:

The complaint is regarding loading of premium at the time of renewal of the Mediclaim Insurance Policy.

Shri Ramendra Nath Ghose had a Mediclaim Insurance Policy with the United India Insurance Co. Ltd. for the last 16 years upto age of 76 years and the premium was fixed accoring to the premium schedule. But when he reached/attended 77 years as on 16.7.2004, a loading of premium of 60% was charged on the basic premium by United India and in a similar case, National Insurance Co. Ltd., charged a loading of 100% on the basic premium. Initially there was no explanation for arbitrary imposition of 100% loading by the Insurance Company. But after a representation to the Manager, National Insurance Co. Ltd., Kolkata on 18.10.2004, the Insurer clarified that “Premium tariff based on sum assured and age are the minimum chargeable rates. Insurers are at discretion to charge higher premium on the basis of risk perception. Accordingly all insured above 75 years is charged 100% loading by this office.”

The complainant contended that such discretionary and arbitrary imposition of loading charges (varying from 60% to 100% with different Insurance Cos.) based on the premium of risk perception above the age 75 years, superceding the premium tariff schedule for 75 to 80 years was injudicious, immoral and bad in law. If at all the risk perception above the age of 75 years was to be considered which was by no means fair, as benefit of Medical insurance to senior citizens was a social responsibility of Government, then the premium tariff above the age of 75 years might reasonably be revised, so that insurer could ascertain same from the outset. The complainant has sought relief of 100% loading charges over and above the premium schedule.

National Insurance Company stated that the insured agreed to take the policy knowing fully well that there was loading of premium equitable to 100% on the original premium. The following details were given in the self-contained note :-

A) “The proposal duly filled by Mr. Ramendra Nath Ghosh was received by our office on 08/07/2004 with copy of the previous Mediclaim Insurance Policy issued by United India Insurance Co. Ltd., which was due for expiry on 16/07/2004.

B) The proposal was for a single individual aged 77 years.

C) The previous insurer had inserted the following condition on the subject policy"

The Enhanced Sum Insured Will not be Applicable To Any Treatment in Connection With Respiratory Tract Infection With CCF.

D) The insured was enjoying a Cumulative Bonus of 40% (Rs 21,600/-) in rupee terms.

E) At the time of acceptance of proposal it was told to the representative of broker, the business source for this particular premium that a loading equivalent to 100% of the original premium will be charged if we assume this risk.

F) After hearing our acceptance norms and only after being convinced the insured agreed to place the proposal with 100% loading.

G) We issued the Policy in accordance inserting the same condition as in the previous policy.

H) Later the insured had complained about the loading to our "Customer Grievance Cell" at Corporate Office. On being asked to reply we had stated that "Tariff denotes the minimum chargeable premium and individual insurer is free to charge higher premium based on "RISK PERCEPTION".

I) We perceived this particular case as "Higher Risk" because the age of the insured was above 75 years and being a single insured person.

Decision : The complainant's Mediclaim Policy wa effective for last 16 years before it was transferred to National Insurance Co. Ltd. The last policy with United India had a loading of 60% over the basic premium. When the policy was issued by National by enhancing the loading to 100%, the complainant did not raise any objection before conclusion of the contract or even after the policy was issued. In fact, the only representation to the Insurance Company was filed 3 months after the commencement of the cover, that too, after this forum asked him to file suitable representation.

It was also observed that the policy with National was renewed two months before expiry of the policy with United India. Therefore, the complainant was never under any emergency situation, which might have compelled him to accept 100% loading as a last resort. In other words, the 100% loading of premium was paid by the complainant knowingly. Accordingly, the complainant's acceptance of the loading was not under any undue influence of coercion from the Insurance Company.

The prerogative of the Insurance Company to load premium can not be disputed. In view of the above position, no further intervention is proposed for the policy under consideration. However, the insurance company should review the claims experience at the end of policy period and consider suitable reduction in loading at next renewal.

Kolkata Ombudsman Centre
Case No. 489/11/005/NL/01/2004-2005
Sri. Pranjivandas B. Ajmera
Vs
The Oriental Insurance Company Ltd.

Award Dated 25.11.2005

Facts & Submissions:

The complaint is regarding repudiation of claim under Mediclaim Insurance Policy on the ground that the sum Insured under the policy was exhausted by paying earlier claim and no sum was available for paying the claim under consideration.

Sri. Pranjivandas B. Ajmera was having Mediclaim Policy with the Oriental Insurance Company Ltd. which was being renewed from year to year without any break. He

lodged 3 claims under the policy No. 274/2004 for the period 29.07.2003 to 28.07.2004. The first 2 claims were settled involving payment of Rs. 1,05,000/As a result of this settlement the full sum insured plus cumulative bonus was exhausted. When the 3rd claim for Rs. 35,935/- was lodged on 11.07.2004 under the same policy within the same period M/s Heritage Health Services Pvt. Ltd. TPA of the insurance company repudiated the claim on the ground that the sum insured under the policy for the period ending 28.07.2004 was exhausted and no balance was available for paying the claim of Rs. 35,935/

The present complaint is against repudiation of the 3rd claim of Rs. 35,935/- by Heritage Health Services Pvt. Ltd. Oriental Insurance Company Ltd. The complainant has contended that his Mediclaim policy was not only old but also renewed from time to time without any break or default. He stated that his treatment continued after 28.07.2004 i.e., during the next renewal period of 29.07.2004 to 28.07.2005. As the policy was renewed before expiry of the earlier policy he had earned the sum insured of Rs. 1.00 lakh under the renewed policy. He therefore argued that his claim for Rs. 35,935/- should be adjusted under the policy for the period from 29.07.2004 to 28.07.2005. As regards his contention that his treatment continued beyond expiry of the policy on 28.07.2004. he referred to the certificate from the attending doctor who confirmed his physical fitness for resuming normal work from 20.09.2004 - which meant that he was under treatment prior to the date of fitness. Since his treatment continued up to 20.09.2004 he should get the benefit of coverage under the renewed policy from 29.07.2004 to 28.07.2005.

The complainant has submitted that High Court judgement appearing in Times of India, Kolkata dated 08.10.2004 and 11.02.2005 expressed the view that the Insured should not be deprived of social security which was the object of Mediclaim Policy introduced by the National Government.

Decision : Wherever a claim is filed in respect of a treatment under a particular policy period the claim is to be considered against the sum insured under the said policy. There is no doubt that after paying 2 claims the sum insured under the policy for the period ending 28.07.2004 was exhausted and no sum was available for paying the 3rd claim of Rs. 35,935/-. The complainant has claimed that the sum assured under the renewed policy for the period ending 28.07.2005 for reimbursing his claim should be available for the reasons stated above. The contention is not acceptable. The 3rd claim has been filed under the Mediclaim Policy 274/2004 within the same policy period and therefore, the sum assured under the same policy period is to be considered for the purpose of allowing the claim. Since no sum assured was left after meeting the earlier 2 claims the 3rd claim cannot be paid under the policy. The benefit of sum assured of the renewed policy is not available in the present case.

Kolkata Ombudsman Centre
Case No. 697/11/002/NL/03/2004-2005
Smt. Maitreyee Banerjee
Vs
The New India Assurance Co. Ltd.

Award Dated 30.01.2006

Facts & Submissions:

The complaint is regarding repudiation of claim under Mediclaim Insurance Policy.

Smt. Maitreyee Banerjee was admitted to Woodlands Hospital on 11.10.2004 for operation of her hernia. She had earlier intimated Medicare TPA Services (I) Pvt. Ltd. on 11.10.2004 and requested for cashless facility as per TPA's guideline and format.

TPA turned down the request for cashless facility on 19.10.2004. Subsequently, she filed a claim form with all papers and documents to Medicare TPA Services (I) Pvt. Ltd. on 19.11.2004. TPA repudiated the claim on 12.12.2004 on a vague and untenable ground with a copy to the insurance company. The complainant requested for reconsideration but it was again truned down by TPA on 05.02.2005. The complainant submitted that the TPA related her hernia to the previous abdominal operation namely C.S. and Hysterectomy. These operations were done prior to inception of the policy and hence the claim relating to hernia was not payable.

The New India Assurance Company Ltd., stated that they issued the policy to the complaint for the period from 12.11.2003 to 11.11.2004. The policy was renewed with Cumulative Bonus of Rs. 30,000/- for sum Insured of Rs. 1.00 lakh. In column 4 & 5 of the self-contained note the insurance company gave the background of the case as well as the ground for the decision taken by them :-

“Claim was preferred for re-imbursement of medical expenses towards treatment of Hernia with Medicare TPA Services (I) Pvt. Ltd. They processed the claim and considered it as non-admissible. The case of hernia was related to the previous abdominal operations namely C.S. & Hysterectomy - which were done prior to taking the insurance company policy, i.e., the case was termed as pre-existing one (Clause : 4.1)”.

Decision : Medicare TPA Services (I) Pvt. Ltd. rejected the claim of the complainant on the basis of opinion received from their panel doctor Dr. Priyadarshan Majumdar which is as under :

“THE PRESENT CONDITION OF HERNIA IS RELATED TO THE PREVIOUS ABDOMINAL OPERATIONS NAMELY C.S. & HYSTERECTOMY. THESE OPERATIONS WERE DONE PRIOR TO INCEPTION OF POLICY. HENCE THE CLAIM IS NOT PAYABLE.”

The point for consideration here is whether the present ailment of hernia could be traced back to the earlier two operations, first in 1978 for C.S. and second in 1995 for Hysterectomy. We find that in the application for cashless facility the complainant disclosed Cesarean Section in 1978 and Hysterectomy in 1995 against past medical history. The complainant nowhere stated that in the proposal form for taking the policy these operations were disclosed and the policy was issued with the exclusion of these two operations. In her representation to the TPA the complainant also did not produce any document or opinion of the attending doctor to establish that present operation of hernia was not linked to the earlier two operations she had. She merely stated that the time gap between two operations with the present operation was too long for such relationship. She only referred to some personal discussions with a few Surgeons that hernia could not be related to the past two operations. But we have opinion of the panel doctor which was quite categorical in holding that the previous abdominal operation namely C.S. and Hysterectomy were the cause of the present ailment of hernia. The complainant has not produced any opinion or document to displace the opinion expressed by the panel doctor linking hernia to the earlier two operations and thereby making hernia as pre-existing disease for the purpose of repudiation of the claim.

Vs

National Insurance Co. Ltd.

Award Dated 16.02.2006

Facts & Submissions:

The complaint is regarding repudiation of claim on ground of first year Exclusion Clause No.4.3 of the Mediclaim Insurance Policy.

Shri Nimai Chandra Bhattacharjee underwent an operation of his prostrate gland (TURF) on 23.03.2004 under prior intimation/information of the Insurance Company on 27.1.2004 and 17.3.2004 respectively which were not replied to by the Insurance Company keeping the complainant in dark. The claim was rejected by the Insurance Company on 9.7.2004, as the subject claim was within one year from the inception of the policy and fell under Policy Exclusion Clause No.4.3. This was not known to the complainant. He represented against the decision of the Insurance Company on 23.02.2005 mentioning that this rule could not be invoked in his case because no prospects along with the proposal form was supplied to him, nor his signature obtained. The complainant's main contention was that the Insurance Company deliberately and intentionally withheld the Rules and Regulations framed/enumerated in the prospectus and his aforesaid two letters were not replied by the Insurance Company.

The insurance company gave the reasons in detail in respect of the repudiation which was reproduced as under :-

1. "The insured has proposed the Insurance in Company's prescribed proposal form in which he certified that **"I have read the prospectus and I am willing to accept the coverage subject to the Terms, Conditions & Exceptions prescribed by the Insurance Company therein."** It means that the Insured was well aware of the Policy Coverage & Exclusions.
2. This is for your kind information that Prospectus is supplied to Insured along with Proposal Form.
3. The proposal was accepted as per his declaration, And an amount of Rs. 2120/- towards premium has been paid by him vide Cheque No.631407 dt.31.03.2003 drawn on Canara Bank-Gaya.
4. A receipt has been issued against collection of that premium vide Money Receipt No.01631, dated 31.03.2003.
5. The Company has issued a Policy with full terms & conditions of cover granted under this policy and a policy was delivered to him which has already been acknowledged.
6. The insured lodged the claim under above Policy on 03.02.2004. (Letter posted by him on 27.01.2004, which we received on this day).
7. In above letter he had informed us that he was going to be Hospitalized on 28.01.2004 for Prostate Gland.
8. After discharge from hospital he submitted the required papers to us, e.g. claim from, Prescription, Bills/Cash Memo, Admission & Discharge Certificate.
9. While processing the file it was observed that the insured was operated and Treated for "Benign Adenolaimy omation Hyparplasia of Prostate.
10. As per exclusion no.4.3 of the Policy the expenses incurred during 1st year of the policy on Treatment/operation of "Benign Prostate" is excluded under the policy.

11. As per Policy condition mentioned above the claim is not admissible & hence the claim was repudiated, which was informed to insured vide our letter dt.09.07.2004."

Decision : The policy was issued on the basis of a proposal duly filled-in and signed and accepted by the Insurance Company on payment of requisite premium. In the instant case, the complainant signed the proposal with an understanding that he had understood and accepted the general terms and conditions of the policy, as enumerated in the prospectus. Insurance Policy is a concluded contract of insurance based on proposal form and the terms/conditions/exclusions of the policy are binding on both the parties. Insurance Company issued complete policy documents to the policy-holder and most of the terms of coverage under the policy supplement to the terms of prospectus. Hence, the plea that the complainant could not have the knowledge of 1st year exclusion of the disease stated under Exclusion Clause No.4.3 of Mediclaim Policy is not justified and tenable. As per policy conditions, the claimant is supposed to give intimation of hospitalisation and to submit claim papers within the stipulated time limit which did not amount to admitting the liability under the Policy.

Considering the above position, we agree with the Insurer's view that the operation and treatment for "Benign Adenoalaiomy omation Hyperplasia of Prostate" for which expenses were incurred, are excluded during the first year of the operation of insurance cover under Exclusion Clause No.4.3 of the Mediclaim Insurance policy.

Kolkata Ombudsman Centre
Case No. 003/11/003/NL/04/2005-2006
Shri Debasis Chakraborty
Vs
National Insurance Company Limited

Award Dated 15.03.2006

Facts & Submissions:

The complaint is regarding repudiation of claim under Mediclaim Insurance Policy.

Shri Debasis Chakraborty took a Mediclaim policy covering himself, his wife and daughter for a sum of Rs. 25,000/- each. He filed a claim for Rs. 25,000/- for his wife Smt. Debjani Chakraborty for her treatment in hospital on 09.01.2004 although the hospital bill came to Rs. 82,997.37. The insurance company repudiated the claim for two reasons :-

a) The disease for which the treatment was undertaken was pre-existing.
b) The bill for the expenses was not submitted in time.

The complainant submitted that his wife used to feel slight pain in her leg occasionally since childhood after exertion in sports etc. She used to consult a Homeopath who diagnosed the ailment as nerve trouble. It used to be cured in a day or two and there was no difficulty in maintaining normal life. Recently, she was taken for a thorough check up for X-ray by an Orthopaedic Surgeon and the ailment was detected. The ailment was not known even long after the policy was taken. If the insured had known he would have taken a policy for a higher cover for the treatment of his wife. As regards late submission of the bill there was no mention of the time limit in the policy. In this case, the agent who collected the form advised him that the claim was to be lodged within 75 days after discharge. Accordingly, he submitted the claim on 09.01.2004 vis-a-vis the discharge dated 19.11.2003. He requested that the delay in submission of the bill should be condoned as it was due to misunderstanding or due to communication gap.

National Insurance Company Ltd. stated the insurance cover was granted from 15.09.2003 to 14.09.2004 under Group Mediclaim policy, as a beneficiary of Golden Multi Services Club. On scrutiny of the claim the insurance company found that the patient was suffering from osteolytic lesion neck of femur and all along the shaft. They also found that the Insured had a history of pain left hip radiation to left knee since childhood 10/12 years. As regards submission of the claim intimation of hospitalization was given on 11.12.2003 after a lapse of 30 days from the date of her hospitalization from 11.11.2003. In view of the above, the insurance company repudiated the claim both on ground of pre-existing disease and also for delay in intimation of the claim under 5.3 of the Mediclaim Insurance policy.

Decision : We find from the Discharge Certificate of Peerless Hospital & B.K. Roy Research Centre that Smt. Debjani Chakraborty was admitted to the hospital on 11.11.2003 and was operated on 12.11.2003. The final diagnosis as per certificate was *"Osteolytic Lesion neck of femur & all along the shaft? fibrous dysplasia with Cortiacal affection area".* They also gave the following clinical history of the patient *"C/O pain (L) hip & knee since childhood. Mild restriction of (L) hip No other features".*

In view of the above diagnosis and clinical history, the insurance company held that the patient was having an ailment which was pre-existing prior to the date of commencement of the policy. The nature of the disease and the treatment undertaken confirmed that the patient had a history of pain existing prior to the commencement of the policy. We also note that while representing against the repudiation, the complainant did not submit any documentary evidence from the doctor that history of illness was not the direct cause of the present illness for which the claim was made.

As the claim was rightly repudiated under clause 4.1 of the policy, the other ground for repudiation i.e., violation of policy condition No. 5.3 is not discussed as the exercise is found to be academic.

Kolkata Ombudsman Centre
Case No. 068/11/003/NL/04/2005-2006
Smt. Sona Das
Vs
National Insurance Company Ltd.

Award Dated 17.03.2006

Facts & Submissions:

The complaint is regarding repudiation of claim under Mediclaim Insurance Policy.

Smt. Sona Das was covered under a Mediclaim Policy from 12.03.2004. She felt sudden right abdominal pain and on 22.07.2004, consulted her house physician, Dr. Samar Banerjee. The doctor advised USG, which revealed multiple Calculi of Gallblader. Based on the USG report, the attending physician Dr. Sandip Khan advised the complainant to get hospitalized. Accordingly, the complainant got admitted to S.C. Bagchi, Arogya Sadan and Research Institute Pvt. Ltd. on 18.08.2004, where she underwent Cholecystectomy under GA on 25.08.2004 in a case diagnosed as "Choleithiasis". Following discharge on 03.09.2004, Smt. Das filed a claim under Mediclaim Policy along with all documents on 04.10.2004. However, M/s FHPL, the TPA of the insurance company repudiated the claim on the ground of "pre-existing" disease.

The complainant filed representation with the insurance company stating that existence of the disease was not within her knowledge. She contended that the pain was sudden and there was no pain before 22.07.2004, the day she consulted the family physician. The complainant argued that it was impossible for her to judge that the disease existed

before. In support of her contention, she submitted a certificate dated 31.12.2004, from Dr. S.Banerjee confirming that GB Calculi was not detected before 22.07.2004. The doctor also pointed out that no one could predict the onset/origin of the disease as it became evident when the patient was investigated. Despite such representation, the insurance company did not settle the claim.

National Insurance Company Ltd. stated that it was clear from the prescription of the attending physician of Dr. Sandip Khan that the complainant was a known diabetic (394/140) and a patient of chronic Cholecystitis with Cholelithiasis. USG report showed tha Pelvicalyectasis in right kidney occurred due to old episode of UTI. The complainant was also known hypertensive. As per the medical opinion of Dr. Tapas Choudhuri, the disease certainly was 'pre-existing' at the time of policy inception.

Decision : We find from records that there was no documentary evidence that the symptoms of the disease manifested to a perceivable degree at the inception cover. The insurance company did not respond to the representation, supported by family physician's certificate, highlighting the question of knowledge. Other than the USG stating "Chronic Cholecystitis with Cholelithiasis", no document prior to July '04 has been furnished by the insurance company. Incidentally, at the time of her first consultation on 01.08.2004, Dr. Khan had the benefit of USG report and, therefore, it was not surprising that he would have recorded/diagnosed the disease as "Chronic Cholecystitis".

The medical opinion referred to by the insurance company did not categorically confirm the disease as "pre-existing". On the contrary, the doctor wanted further documents for detailed study of the claim. No evidence was available to suggest that the documents sought by the doctor were actually collected and submitted to him for his final opinion. In the circumstances, the medical opinion can not be considered as complete and conclusive in favour of holding the ailment as "pre-existing".

In view of the above we do not find enough justification for repudiation of the claim for the reasons stated above and we, accordingly, reverse the decision.

Kolkata Ombudsman Centre
Case No. 078./11/003/NL/05/2005-2006
Smt. Saroj Devi Bhimsarai
Vs
National Insurance Company Ltd.

Award Dated 31.03.2006

Facts & Submissions:

The complaint is regarding repudiation of mediclaim on ground of pre-existing disease.

Smt. Saroj Devi Bhimsarai took a Mediclaim Policy from National Insurance Co. Ltd. for the period from 27.06.2002 to 26.06.2003. Her husband, Shri Bishnu Prasad Bhimsaria was hospitalized at Belle Vue Clinic on 28.01.2003 for treatment of the disease Syndrome X with G.E.R.D. with multiple small cerebral infraction and discharged on 1.2.2003. She claimed reimbursement of medical expenses of Rs. 33,632/-. But the claim was rejected by the Insurance Company vide their letters dt 9.1.2004, 18.2.2004 and dt.28.2.2005 on the ground that the illness was a pre-existing disease. She represented against the decision on 9.1.2004 contending that her husband was not hospitalized for diabetics or hypertension. This fact was established from the discharge certificate. He was admitted for GERD about which the Insurance Company was silent in their repudiation letter. She also pointed out that there was claim for her husband earlier with the Insurance Company which was allowed without raising any question of

diabetes or hypertension. As there was no response to her representation, she approached this forum for relief of Rs. 33,632/- plus Rs. 10,000/-.

National Insurance Co. Ltd. stated that the claim was repudiated on the basis of opinion given by the doctors. The following points have been given in the note :-

"The Insured had been suffering from GERD along with HTN & DM, etc., and hospitalized since 28/1/2004 to 1/2/2003 in Belle Vue Clinic under Dr. M. Saha and preferred claim for Rs. 33632/55.

Our doctors opined that the policy incepted since 27.6.2000 and as per their reports dated 21/8/2004 and 30/11/2004 the root cause to be SYNDROME X or a complication or DM, etc., which are long pre-existing and the claim is not payable.

Therefore, as per doctors advice, etc., the claim is not payable and was repudiated vide our repudiation letter dated 18/2/2004 and further confirmed vide our letter dated 18/2/2005."

Decision : We find from the discharge certificate of Belle Vue Clinic dt.01.02.2003 and the certificate dt.12.09.2003 from Dr. Manoj Saha, the attending physician that the patient was under supervision of Dr. Saha in the nursing home w.e.f. 28.01.2003 with complain of severe headache and chest discomfort. He was a patient of hypertension and diabetic for last 1 1/2 to 2 years. He was discharged on 01.02.2003 with a diagnosis of Syndrome X with GERD with Multiple Small Lacunar Infraction in the brain.

The insurance Company repudiated the claim vide there letter dt.09.01.2004 on the following grounds :-

"You are a patient of Gastro Oesophageal Reflux along with moderately severe hypertension with diabeties mellitus and other. Later mentioned two disease as medical science relates or narrates are long existing. So it attracts exclusion 4.1."

The complainant represented against the decision and on receipt of the representation, the Insurance Company again sought opinion from a medical specialist, Dr. R.N. Banerjee. While seeking his opinion, the following particulars were submitted by the Insurance Company vide their letter dt. 5.11.2004 to Dr. Banerjee:-

"1) Policy Details : Policy first incepted from 27.06.2001, "Renewed continuously and last one on 27.06.2003.

2) First Claim : In the year 2002 said Insured suffering from "Acute Diarrhea with dehydration Gall Bladder Stone with Polyp." And claim was admitted as per advice of panel Doctor, Dr. K.K.Arora and claim was paid.

3) Second Claim : Claim for treatment of Gastroesphageal Reflux Disease. Our Panel Doctor, Dr. T. Guha has given his opinion for admissibility of claim at first hand but later on he revised his opinion vide his report dt.21.08.2004 and accordingly the claim was repudiated."

Dr. Banerjee in his opinion dt.30.11.2004 held the view that the disease was pre-existing and was inadmissible under exclusion 4.1 of the Mediclaim Insurance Policy. The detailed opinion is reproduced below"-

"I have gone through the above noted claim and the papers as circumstantial evidence. We cannot examine the patient and hence have to depend on the findings of the doctor (Physician) under whom the patient was admitted.

I find several discrepancies in the certificate issued by the attending physician Dr. Manoj Saha on 12.09.2003. He (Dr.Saha) asserted in his Certificate that Shri Bishnu Bhimsaria was admitted with severe headache, chest discomfort and hypertension and Diabetes mellitus and discharged the patient with diagnosis of

SYNDROME X WITH GERD WITH MULTIPLE SMALL LACUNERS INFRACTION IN BRAIN.

SYNDROME X : Is obesity arteriosclerosis changes in the arteries - big and small, high lipids and high blood pressure - a complication of Diabetes mellitus where the patient developed insulin resistance and the patient have received either oral or Insulin medication for at least 5 to 10 years. It takes a long time to develop 1 1/2 to 2 years is quite a short period to deveiop SYNDROME X - as certified by Dr. Saha. The statement appears incorrect and hence, disease Diabetes mellitus appears pre-existing -and much earlier that 1st inception of the policy.

HEADACHE : Is due to high blood pressure and atterselersis of Cerebral arteries, high lipids and multiple infarcts in the brain - all due to Diabetes mellitus & Syndrome X.

GERD : Sudden severe Gastroesophageal reflux disease necessitating hospital, a nursing home admission and Chest (Pain due to GERD) all are due to multiple (Sudden) small infracts in the brain - root cause being Syndrome X a complication of long standing Diabetes - which has been willfully, consciously and deliberately kept in hidance with some ulterior motive during inception of the policy and hence it attracts clause 4.1."

In view of the opinion of Dr. Banerjee, the Insurance Company reiterated their earlier decision to repudiate the claim.

We find that the Insurance Company initially took opinion of Dr. T. Guha for repudiating the claim. In view of the representation, the Insurance Company again consulted a senior doctor who confirmed earlier opinion of the panel doctor. In view of the clear and conclusive opinion of Dr. R.N.Banerjee, we agree with the repudiation of the claim by the Insurance Company.

We also do not find merit in the contention of the complainant that the Insurance Company did not raise any objection on the ground of hypertension and diabetes at the time of settling the claim of 2002. We are of the view that each claim is to be decided on merit taking into account the facts and circumstances of the claim. The earlier claim paid for acute diarrhea with dehydration, Gall Bladder Stone with Polyp. was not apparently related to hypertension and diabetes and that might be the reason for the Insurance Company not raising any objection to the payment of the claim.

Under the circumstances, we hold that the Insurance Company was justified in repudiating the claim.

Kolkata Ombudsman Centre
Case No. 117/11/003/NL/05/2005-2006
Dr. N. K. Lall
Vs
National Insurance Co. Ltd.

Award Dated 31.03.2006

Facts & Submissions:

The complaint is regarding repudiation of mediclaim on ground of pre-existing disease.

Dr. N. K. Lall had a mediclaim policy since 1998 with National Insurance Company Ltd. He filed a claim for the first time claiming reimbursement for knee surgery of his wife Smt. Manju Lall during the policy period from 14.06.04 to 13.06.05. But the claim was rejected on the ground that there was a delay in renewal of the policy by few days prior to 2002. The complainant represented against the decision taken by M/s. Genins India Ltd. vide his letter dated 09.12.04 contending that the first treatment was started on

15.03.1999 and the break in policy for few days took place after 2001-02. He, therefore, submitted that the treatment was started during the validity of the policy between 03.04.98 to 03.04.99 and not during the break period. He further submitted that his wife had to go for the surgery only because of a fall during the policy period 2004-05. As there was response to the representation, the complainant has approached this forum and sought a relief of Rs. 3,25,520/-.

The complainant further submitted that the claim was made during the valid policy period of 14.06.04 to 13.06.05. It was a renewal policy and not a fresh one. He further submitted that the policy did not mention that knee problem was excluded from the scope of reimbursement.

National Insurance Company stated that their TPA M/s. Genins India Ltd. repudiated the claim on the ground that the disease was pre-existing with reference to the break in the policy for the year 2002-03. They have enclosed a copy of the letter dated 03.12.04 from Genins India Ltd, addressed to Shri N.K.Lall giving the following reasons for the repudiation of the claim.

"You have started your policy from 1988 (03.04.98-02.04.99). The next year renewal policy is not enclosed, thereafter the policy was taken from 26.05.00 - 25.05.01 with no cumulative bonus and that from 04.06.01 - 03.06.02 with 10% cumulative bonus (though there had been a break). Then your policy started from 14.06.02 with a sum insured of Rs. 1,00,000/- with a nil C.B. Subsequently from 14.06.03 - 13.06.04 with a 5% CB and from 14.06.04 - 13.06.05 with enhanced sum insured of Rs. 2,50,000/- and a CB of Rs. 15,000/- though the CB should be only Rs. 10,000/-. Thus your present claim falls under 3rd year policy. There is a break in the policy as is also evident from the policy copy of the year 2002-03 and hence cannot be considered as a continuous policy since 1998. For this claim purpose your policy is taken as incepted on 14.06.02.

Your medical documents for the year 1999, 2000, 2001 clearly suggest that you have been suffering from the problem of knee joint with deformity and were on medication for the same. There are clear evidence in your claim file that you had the present problem prior to the inception on 14.06.02. Thus going by the above findings, we are reluctantly constraiined to close the claim file as "No claim" as per clause 4.1 of the mediclaim policy.

Sl No.	Policy Year	Policy Number	Policy Period	No. of days Break
1.	1999-2000	8500087/1999	21.5.99 to 20.5.2000	NIL
2.	2000-2001	8500555/2000	26.5.00 to 25.5.01	06 days
3.	2001-2002	8501102/2001	04.6.01 to 03.6.02	10 days
4.	2002-2003	8500257/2002	14.6.02 to 13.6.03	10 days
5.	2003-2004	8500197/2003	14.6.03 to 13.6.04	NIL
6.	2004-2005	8500223/2004	14.6.04 to 13.6.05	NIL

Decision : We find from the above policy details since 1998 that the complainant took mediclaim policy from National Insurance Company first in the year 1999 i.e., on 31.05.99 after a lapse of 49 days from the previous policy with New India Assurance Company effective from 03.04.98 to 02.04.99. The first renewal with National Insurance was done after a lapse of 6 days and no CB was allowed. Then there was a break of 10 days in 2001 the policy was issued with CB of Rs. 10000/-. Further, in the year 2002 the policy was renewed after a break of 11 days without CB. Thereafter policy was continuously renewed up to 2004-05. If no CB had been allowed in 2000-01, the next

year CB should have been Rs. 5,000/- instead of Rs. 10,000/- as allowed by the insurer although there was a lapse of 10 days. Secondly, for the policy year 2004-05 CB should have been Rs. 10,000/- instead of Rs. 15,000/-, which has been pointed out by the TPA in their repudiation letter.

In the instant case, we observe from the medical documents for the year 1999, 2000 & 2001 that the patient had been suffering from knee joint with deformity and was on medication. This fact has also been admitted by the claimant. Had the policy been continued with no break since 03.04.98, the claim could have been allowed. But in this case, the policy has not been continuous and the lapse had not been condoned by the insurer. Therefore, the claimant cannot enjoy the benefit of the earlier policies. In view of this, the disease suffered during the earlier period is deemed to be pre-existing because of the break in the renewal of policy. We, accordingly, uphold the decision of repudiation by the insurer company.

Lucknow Ombudsman Centre
Case No. G - 21 / 11 / 04 / 05 - 06
Shri G. C. Mehta
Vs
United India Insurance Co. Ltd.

Award Dated 25.01.2006

The complainant a retired Executive of M/s Hindalco Industries Ltd. lodged a Mediclaim with United India Ins. Co. Ltd. The claim was for a relapse of previous illness. The claim towards pre-hospitalisation and post hospitalization expenses were denied this time on the ground that the second hospitalization was sequel to the relapse of his earlier illness on 13.03.04 and he had already been reimbursed towards pre and post hospitalization expenses payable as pre the terms and conditions of the policy.

The complainant was discharged on 17.12.03 from the hospital and on relapse of the disease he consulted a doctor on 13.03.04, which means the disease relapsed within 105 days from the date of discharge. Hence it was a case of continuous period of illness within the meaning of policy condition no. 3.

Having concluded that the second hospitalization was in continuation of occurrence of same illness for which consultation was made by the complainant on 13.03.04., Hon'ble Ombudsman agreed with the argument of the Insurer. As the pre - hospitalisation expenses of total 30 days and post hospitalization expenses of total 56 days had already been allowed to the complainant, he was entitled for reimbursement of 4 days post-hospitalisation expenses only. The complaint was disposed off accordingly.

Mumbai Ombudsman Centre
Case No. GI-332 of 2004-2005
Shri Shirishbhai R. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 16.11.2005

Shri Shirishbhai R. Shah who was insured with The New India Assurance Company Limited was having the policy since March, 2001 which was renewed every year. Shri Shrishbhai Shah was hospitalised from 2.3.2003 to 3.3.2003 at Shreyas Hospital for IHD with HTG with APD with Obesity. When the claim was preferred by Shri Shirishbhai Shah, for the expenses incurred at the said hospital, the Company asked Shri Shah to submit certain documents which he submitted and the Company vide their letter dated

5.3.2004 repudiated the claim stating non-disclosure of material facts. Not satisfied with the decision of the Company Shri Shah represented to the Company and the Regional Office of the Company on 17.7.2004 concurred with the decision of the Divisional Office of repudition. Aggrieved by the said decision Shri Shirishbhai R. Shah approached this Forum for redressal of his grievance. Records have been perused and parties to the dispute were called for hearing on 3rd August, 2005.

The relevant records submitted to this Forum have been scrutinized. The diagnosis was mentioned as 'IHD with HTG with APD with Obesity' in the Discharge Form issued by Shreyas hospital during the hospitalisation of the insured from 2.3.03 to 3.3.03. Elsewhere it was written "IHD with obesity and anxiety". There was a mention in the Indoor case papers that the Insured was having history of "Hypertension R_x irregular" which meant he was not on regular medicine. He had hyper cholesterolaemia and he was having complaint of heaviness in upper body and abdominal distension at the time of admission in the hospital. A deeper analysis of the records would reveal insured was a case of Hypertension with obesity and hyper cholesterolaemia. He was also diagnosed of having hyper-triglyceride which could cause Ischaemic problems for which he was treated and claim has been lodged. The Insured was also obese and the very fact it was written as a disease could well go as a further favourable feature for IHD and coupled with Hypertension it would be difficult to accept that Insured was not aware of it as the history tells that he was on irregular medicine.

On the basis of above analysis, the repudiation of the claim by The New India Assurance Company is justified on the grounds of non-disclosure and pre-existing illness and this Forum has no strong evidence to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI-200 of 2004-2005
Shri Dhiresh U. Munvar
Vs
United India Insurance Co. Ltd.

Award Dated 18.11.2005

Shri Dhiresh U. Munvar was insured under mediclaim policy of the United India Insurance Co. Ltd. since 1999 and renewed it continuously and enjoyed Cumulative Bonus of 25 %. The claim arose under policy no. 022000/48/03/00269 during the period 12.07.2003 to 11.07.2004. Shri Munvar was admitted to Padmashree Nursing Home on 31.12.2003 with a complaint of high fever which was diagnosed as Retroviral disease and after taking treatment he was discharged on 11.01.2004. Shri Munvar preferred a claim to the Company for reimursement of treatment expenses by submitting all required documents to M/s Medicare TPA Services (I) Pvt. Ltd. for sprocessing the claim. Accordingly, after scrutiny of the documents they informed Shri Munvar that the claim is not payable as it fell under Exclusion Clause 4.9 of the mediclaim policy. Shri Munvar was not satisfied with the decision of TPA, he represented his case to the Company along with a certificate from Dr. Pradip P. Shah dated 22.06.2004. The company referred the matter to its panel doctor, Dr. (Mrs.) G. J. Sunavala and accordingly the claim was repudiated by the Company.

The analysis of the case reveals that the repudiation is centering around the exclusion of any disease out of various deficiency syndrome or condition of a similar nature commonly referred as AIDS, as per Clause 4.9 of the mediclaim policy. The facts of the

case are available on hospital case papers and the issue is resolved through pathological examination. The treatment package administered treatment of positive retroviral status following retrovital infection. The Insured's contention that initially it was pneumonitis and not HIV related disease cannot be upheld on the medically accepted and established view points that the effects like abdomen distension, high fever, loose motions, chest related diseases are nothig but a comprehensive group of symptoms originating from the complications of retroviral disease. Let us examine the exact meaning of retroviral diseases. Retroviruses have been implicated in the development of somes cancers and are associated with conditions characterized by an impaired immune system. They are also used as vectors in gene therapy. It obviously points to an immune system incapable of reacting to pathogens or tissue damage. This may be due to a genetic diorder, disease process or drugs such as corticosteroids or immunosuppressive agents given to treat a disorder that inhibits immune functions. It also points to another fact that most of the symptoms would be so repetitive and invasive in nature that the Insured cannot take a stand that he did not know what was going on. In other words, these ailments would be already existing.

Having regard to the factors responsible to cause such infections which broadly belongs to the ground of complaints/infections mentioned above falling under HIV + symptoms. Hence, the rejection of the claim by the Company under Exclusion Cause 4.9 cannot be overlooked and the decision of the Company to reject the claim is upheld.

Mumbai Ombudsman Centre
Case No. GI-386 of 2004-2005
Shri Sunil B. Labde
Vs
The New India Assurance Co. Ltd.

Award Dated 25.11.2005

Shri Sunil B. Labde who was insured under policy No. 112500/48/03/03182 had approached the Office of the Insurance Ombudsman with a complaint against The New India Assurance Company Limited for non settlement of his claim The Compnay's Third Party Administrator M/s Raksha TPA had repudiated the claim invoking clause 4.1 and 4.10 of the mediclaim policy. Not satisfied with the decision Shri Sunil Labde represented to the Company which was also turned down. Hence aggrieved Shri Sunil B. Labde approached this Forum for redressal of his grievance. A deep study of the relevant records submitted to this Forum would reveal that the insured had a past history of jaundice, HBs +ve in 1999 and vaccinated with hepatitis B vaccine'. On going through the Indoor case papers it is noticed that the insured had history of enteric fever, Hepatitis 'A', Pyelonephritis in 1999. Ultrasonography of Abdomen was done on 18.11.03 and it was found that she was having mild hepatomegaly with icreased texture. The policy was issued to the insured in the year 2001. It would also appear that the insured was hospitalized mainly for the diagnosis purpose, claim for which is not payable in terms of policy condition 4.10.

Based on the above analysis and findings the decision of the Company to repudiate the claim is in order and this Forum has no valid ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI-396 of 2004-2005
Shri Gopal P. Yadav

Vs

United India Insurance Co. Ltd.

Award Dated 25.11.2005

Shri Gopal P. Yadav approached the Office of the Insurance Ombudsman with a complaint against rejection of his claim by United India Insurance Company Limited, Divisional Office - 18 on the ground that requirements were not received by the Company. Shri Yadav represented to the Company and not receiving any favourable response had approached this Forum. Records of the case have been perused and the parties to the dispute were called for hearing.

The reasons for rejection of the claim by United India Insurance Company was the aspect of non-cooperation by the Insured in not supplying them the information as to how long he was suffering from Inguinal pains. However, the Insured and the Complainant Shri Gopal Yadav in his letter had mentioned that he submitted hospital case papers as also certificate from Dr. Debashish Das, attending physician that Shri Gopal Yadav was suffering from pain since last 2 months before he was admitted to the hospital. Hence the charge of non-cooperation cannot be upheld at this Forum. Secondly the Insured submitted relevant documents and since it was hospitalisation and relevant records were submitted to the Insurance Company whetever queries they had they could have obtained from the hospital authorities as per Indoor case papers if they had any doubt. This was not done and therefore, the responsibility cannot be leveled at the Insured. Based on the above facts I decide that the policy amount being small amount and the compliance being completed from the Insured's side the claim should paid in full.

Mumbai Ombudsman Centre

Case No. GI-316 of 2004-2005

Smt. Rita Vaz

Vs

United India Insurance Co. Ltd.

Award Dated 28.11.2005

Smt. Rita vaz was insured for herself and her husband under Mediclaim policy of the United India Insurance Co. Ltd., since 09.10.2003. Her husband Shri Tony Vaz was hospitalized at P. D. Hinduja Hospital from 27.08.2003 to 28.08.2003 under care of Dr. Navneet Kumar for evaluation of cardiac problems. The claim arose under the Mediclaim policy no. 121201/48/02/01495 during the period 09.10.2002 to 08.10.2003. Smt. Rita Vaz preferred a claim to the Company after discharge of her husband. The Company referred the matter to Medico Legal Consultant, Dr. M. S. Kamath for his Expert opinion before settlement. Accordingly, the Company informed Smt. Rita Vaz about their inability to settle the claim as it fell under Exclusion Clause 4.10 of the mediclaim policy.

On going through the Discharge Card, it is observed that Shri Vaz was admitted to P. D. Hinduja Hospital on 27.08.2003 and the diagnosis was "for Evaluation of Coronary Artery Disease". It is noticed from the Discharge Card that the Insured had stress test positive which was observed during the health check up. The stress report suggested Coronary Angiography as the stress test was positive for inducible ischemia. However, no major abnormality was observed in the CAG Report except for advice for medical management. No treatment was mentioned to have been given to the patient and he was discharged after one day. Bills submitted by the insured does not pertain to any treatment given but only doctor's fees and test chrges.

During the deposition, the Complainant mentioned that CAG is an invasive investigation and nobody would do it for the sake of claiming from the Company. This is a valid point and when it was examined further it was noticed that Strees Test was strongly positive and the Insured being 53 yrs of age, the attending physician did not take any chance but referred for CAG for proper evaluation. The noting in the column for diagnosis was “Evaluation of CAD (TMT+)”. Until the test result came negative a risk factor was there and to ascertain that one has to undergo tests which in fact does not contradict the provision of the clause 4.10. That it was not followed up with treatment is a different issue altogether. Moreover, this Forum understands that in some company there is a practice of reimbursing cost of CAG once during the policy period provided the test was strongly suggested by the medical attendant on genuine grounds Under the present case, it seems even the CAG was advised only on second reference and that the test results were negative could not be held against the Insured.

In view of the above, the repudiaition of the claim by United India Insurance Co. Ltd. is hereby set aside and the claimant’s appeal is upheld to the extent of cost of CAG and other tests only.

Mumbai Ombudsman Centre
Case No. GI-385 of 2004-2005
Smt. Bharti M. Savla
Vs
The New India Assurance Co. Ltd.

Award Dated 28.11.2005

Smt. Bharti M. Savla was covered under Individual Mediclaim Policy NO. 140600/48/02/06250 issued by the New India Assurance Company Limited DO 140600, Vikhroli for the period 8.9.2002 to 7.9.2003. This was a renewal Policy and earlier she had policies with Oriental Insurance Company since 1996-97. She shifted her policy to New India in the year 2001. She was admitted to P. D. Hinduja National Hospital on 17.6.2003 to 19.6.2003 and was treated for Hypothyroidsm with DM and HTN. On discharge, when she claimed the amount from New India Assurance Co. Ltd. they rejected the claim on the ground that the disease contracted was pre-existing in nature which fell under Exclusion Clause No. 4.1 of the Mediclaim policy. She was aggrieved at the decision and even after making representation when the matter was not resolved, she approached Insurance Ombudsman with her grievance again at the Company.

The parties were called for hearing on 11th August, 2005. The above analysis leads to the conclusion that duration of 5-6 years mentioned in the hospital indoor case papers cannot be overlooked. The divergence in the noting of the duration of the diseases is too obvious to stand any scrutiny. As regards HTN, it was mentioned that the patient was on regular medicine and two such medicines were noted which are proven drugs. Similarly, for Hypothyroidism she was on Eltroxin all along. Having written this, the withdrawal to write the duration only for 6 to 8 months is no doubt an afterhought and hence rejected.

The insured did not disclose the existing ailment at the time of taking mediclaim policy in the year 2001 with New India Assurance Company. The insured also did not mention it in the proposal form about the claim he got settled by Oriental Insurance in 1997. This was an important information and health intervention which was suppressed. Based on the above findings, the repudiation of the claim by the Company is in order and I do not find any valid ground to interfere with the decision.

Mumbai Ombudsman Centre
Case No. GI-451 of 2004-2005
Shri Mahesh M. Gupta
Vs
The New India Assurance Co. Ltd.

Award Dated 28.11.2005

Shri Mahesh Mahadev Gupta and his wife took first mediclaim policy from the New India Assurance Co. Ltd. on 22.11.2002 for Sum Assured of Rs. 1 lakh each and added coverage for their child, Master Shubham on 26.05.2003. Mast. Shubham was hospitalised in Bombay Hospital for the treatment of Cerebral Palsy from 17.05.2004 to 22.05.2004. Shri Mahesh preferred a claim to the Company for reimbursement of hospitalisation expenses. He sent all necessary documents to M/s Paramount Healthcare Management Ltd. for processing the claim. After scrutinizing the discharge card it was decided by TPA to repudiate the claim by stating that the claim was not admissible as hospitalisation was primarily for investigation and there was no active line of treatment and the same was informed to the Insured. The examination of the case would be complete by scrutinising Dr. V. N. Tibrewala's certificate which was issued after the claim was rejected. It would also be necessary to consider the date of inclusion of child Mast. Subham Gupta under the mediclaim policy. The scrutiny reveals that initially Mast. Subham demonstrated signs of Cerebral Palsy disorder and after series of investigations it was detected to be Mucopolyaccharidosis for which active treatment was started. The conclusion was arrived without completing the comprehensive genetic disorder analysis and in that sense actual diagnosis was inconclusive.

However, Exclusion Clause 4.10 indicates that there should be a positive existence or presence of ailments/sickness, which was there and the final diagnosis of cerebral palsy with the attendent problems referred to the existence of illness. It should be admitted that cerebral palsy is a disorder which would require long term treatment and physiotheray, which was done in this case. Dr. Tiberewala confirmed that the diseases were of such a nature that hospitalisation was not necessary which supports the point raised by the TPA and the Insurance Company as per Exclusion Clause 4.10. If Clause 4.3 is also examined it would refer to congenital disease not being covered under first year policy operation but the Company has not taken this point particularly in repudiating the claim. The issue before us would be whether the child presented these problems before he was included in the scheme. To get the answer a further scrutiny would reveal that in the discharge summary of Bombay Hospital, it was mentioned that parents noticed delay in achieving milestones aferbirth. There was no head injury or convulsions or any ear discharge. For a small boy various milestones in each stage would be an evaluation standard for his normal health and delays proved that he was showing greater signs of abnormality after birth and no parents would miss those to report to the doctor.

Taking on balance the entire facts of the case and advice of a noted paediatrician to get the child admitted for proper examination and to get at the bottom of the disease in order to start appropriate treatment for which hospitalisation should be taken as extremely important and necessary. Along with hospitalisation the investigations done should also be taken as necessary In order to start treatment Taking therefore a balanced view that some treatment could very well be continued at house on the advice of the doctor including physiotherapy, and even some investigations could be done as an outpatient, I feel that in the present case there would be equity in deciding to pay at

least 50 % of the cost incurred only at the hospital out of the total expenses to resolve the case.

Mumbai Ombudsman Centre
Case No. GI-505 of 2004-2005
Shri Mahasukh K. Kamdar
Vs
The New India Assurance Co. Ltd.

Award Dated 28.11.2005

Shri Mahasukh K. Kambar alongwith his wife Smt. Manjula Kamdar was insured with the New India Assurance Company Ltd. D. O. 111800 under policy no. 111800/48/03/08441 with an exclusion of Health ailment and Hemiplegia. Smt. Manjula Kamdar was admitted in Medilink Hospital, Ahmedabad on 11.12.2003 for fracture of Public rami (R) hip jt & Osteoporosis c Cx. Spondylosis & VBI. Shri Kamdar preferred a claim to the Company for reimbursement of hospital expenses incurred for his Wife's treatment the company rejected the claim under Exclusion 4.1 of the mediclaim policy. Not getting any favourable reply from the Company to his representation, Shri Kamdar approached Insurace Ombudman with his grievance. The records of the case were perused and both the parties were called for hearing. The analysis of the case reveals that the Company tried to establish that the insured having suffered from stroke was vulnerable to fall as hemiplegic patients are prone to fall. They wanted to medically establish the co-relation between the two. On proper examination at this Forum it is felt that the co-relation cannot be doubted.

As the patient had a history of Cerebrovascular Accident (CVA) 27 years back and also she was affected by Hemiplegia she was all along vulnerable to decreased postural stability. The policy which was issued to her contained two specific exclusion namely viz heart ailment and hemiplegia. Here the question would be whether the fall was proximately caused either by hemiplegia or Vertebro Basilar Insufficiency. Yet a question would come as to how to conclusively conclude that the fall was due to the disease and not by accidental slip in a place like bathroom where it is commonly experienced and if it was so, how to deal with the claim. Again for a moment one can argue that IHD and Hemiplegia were excluded but all indirect consequences like vertigo, giddiness etc were also excluded would be far fetched to accept. The more balanced view therefore, would be to grant the benefit of the doubt to the insured with the contributory factors of VBA and Osteoporosis playing their part. Accordingly, the total rejection by New India is hereby set aside and the Company is asked to pay for 40 % of the admissible expenses.

Mumbai Ombudsman Centre
Case No. GI-372 of 2004-2005
Shri Rajith S. Menon
Vs
United India Insurance Co. Ltd.

Award Dated 29.11.2005

Shri Rajith S. Menon alongwith his parents were covered under mediclaim policy No. 21800/1007/2003 issued by United India Insurance Company Limited, D. O. 18 through Unique Mercantile Services Pvt. Ltd. Smt. Malathi S. Menon, mother of Shri Rajitha S. Menon was hospitalized at Vaidhyaratnam Nursing Home from 25.07.03 to 21.08.03 for Janusoola (Knee pain). When Shri Menon preferred a claim to the Company the Company repudiated the claim invoking exclusion clause 4.1 of the mediclaim policy.

Shri Menon represented to the Company and not receiving any reply from the Insurance Company he approached the Office of the Insurance Ombudsman. The records of the case have been perused and the parties to the dispute were called for hearing. From the records it is noted that the first policy was issued for the period 30.06.02 to 29.06.03 and the hospitalisation was from 25.7.03 to 21.8.03 for Arthritis and Varicose vein problems. The hospitalisation was done not with a critical emergency but to get cured from Arthritis and a varicose vein complication. By the very nature of these diease the on-set is prolonged and over a period. Arthritis is not of a day's problem and varicose vein takes years to develop into causing pain with stenosis in the veins to block blood supply. The purpose and objective of getting these cured through Ayurvedic system of medicine is obvious from the documents produced before this Forum. It would also appear that both the diseases could be treated at home with specific medicines quite commonly used plus physiotherapy and are bound to be long drawn in nature which obviously goes against the basic principle of mediclaim policy with the need for hospitalisation arising out of an extreme criticality.

In the facts and circumstances the claim of Shri Rajith Menon for the expenses incurred for his mother Smt. Malathi S. Menon's hospitalisation at Vaidyaratnam Nursing Home from 25.7.03 to 21.8.03 for Janusoola (Knee pain) is not sustainable.

Mumbai Ombudsman Centre
Case No. GI-322 of 2004-2005
Shri Kauntey M. Tanna
Vs
The Orienal Insurance Co. Ltd.

Award Dated 29.11.2005

Shri Kauntey M. Tanna and his family members were insured under mediclaim policy of the Oriental Insurance Co. Ltd. since May, 2001. Shri Tanna preferred a claim to the Company, after hospitalisation of his son his Mast. Mihir K. Tanna at Karuna Hospital for RT Testis Atrophy. The claim was processed by Raksha TPA Pvt. Ltd. (TPA) and they informed Shri Kauntey M. Tanna that the claim was not payable as it fell under Exclusion Clause 4.1 of the mediclaim policy which excludes pre-existing illness.

The analysis of the claim file reveals that the Insured Mast. Mihir K. Tanna was suffering from an undiagnosed pain off and on the Testis since last 2/3 years before hospitalisation. The diagnosis made at Karuna Hospital was Arthophy ® of testis due to torsion and the treatment was surgery "Orchidopexy". This is an operation to moblise "an undescended testis in the groin and fixing it in the scrotum". The Karuna Hospital papers clearly revealed these features of the claim and a further scrutiny reveals that the "operation should be performed well before puberty to allow the testis every chance of normal development". The expression "Torsion" means abnormal twisting of a testis within the scrotum. It clearly points out that this problem was there for quite sometime and surgery may have been delayed. The most important point would be that the Insured and his parents were fully aware of this by seeing the boy's body and the external shape of the organ with torsion is bound to be noticed and cause discomfort. Therefore, his rejection and denial that the problem surfaced only recently cannot be accepted from medical point of view and as duly corroborated by the hospital records. As the policy was from May 2001, the ailment would obviously exist before the inception, hence not payable in terms of the policy exclusion clause 4.1

Mumbai Ombudsman Centre
Case No. GI-589 of 2004-2005
Smt. Seema Sharma

Vs

The New India Assurance Co. Ltd.

Award Dated 29.11.2005

Smt. Seema Sharma and her family members were covered by mediclaim policy issued by The New India Assurance Co. Ltd. for the period from 16.03.2004 to 15.03.2005. Her mother-in-law, Smt. Chander Sharma was admitted in Dr. Balabhai Nanavati Hospital and was diagnosed as DM/HTN/IWMI CAG + TVD for which Angioplasty i.e. PTCA C Stenting to RCA & LAD was done. When Smt. Seema Sharma submitted the claim, M/s Paramount Health Services Pvt. Ltd. repudiated the same quoting exclusion clause 4.1 relating to pre-existing disease.

The patient was admitted with heaviness and burning sensation in the chest and the first thing would be to ask for details of past history and health status. It is natural that the reply of the relatives of the patient particularly by someone who stayed with her all through would be to mention spontaneously, the length of the primary illness like diabetes, hypertension etc. People normally speak in terms of years if it is not of recent origin and precisely that happened in this case. The issue surfaced when TPA did grant “cashless” facility which presupposed otherwise a clear, payable claim and also had a rider that if there was any contrary findings the “Cashless” facility would fall and the Insured would be asked to pay for deposits to the Hospital to be critically examined later by the TPA whether the claim would be settled by them. When the Insured’s inmates realized this, there was an attempt to re-state the duration and re-write the past history and the hectic activity which followed thereafter, made all kinds of efforts, starting from correcting hospital records, getting certificates from doctors who never earlier examined the patient, pointing out that the writer of the past history made a mistake in writing or even that while 13 “months” were told the writer heard ‘years’ and wrote as such. The Company did the right thing to give in for investigation and notably it was a specialist doctor Dr. P. R. Purandare. Dr. Purandare’s handwritten Report is a lengthy one along with the statement of the relative of the Insured who got her admitted and this Forum has very thoroughly examined the same.

Despite the fact that the first admission request note which was faxed to Paramount Health Care was not made available to the Investigator, he got the statement of Dr. Amit Rawal of Paramount who dealt with the issue of DM & HTN being of 13 years duration. Similarly, hospital records also noted initially that the DM/HTN was for 13 years and as per the certificate dated 19.07.2004 of the Registrar ICCU, it was a clearical error and that he was now given a history of 13 months past illness. This was further confirmed in the certificate dated 08.02.2005 long, after the rejection of the claim by TPA that the patient’s relatives who gave a history of “13 yrs” later corrected their statement to make it for “13 months” as the earlier one was given by “mistake”.

Factually and circumstantially the matter is established that there was an attempt to suppress the truth and actual duration of the disease. In fact the defective mechanism made the matter still worse as from totally effecting, deep cutting and writing the duration originally recorded to replace it by “recently detected” for both HTN/DM, all proved frantic effort to establish that there was no illness before. However, this was perhaps forgotten when the written denial came for HTN although the patient was on T. Stamlo, which proved beyond doubt that there was an incorrect statement. Finally, before the doctor, one gives instinctively the correct history and even normally one gives a history of illness in terms of years if it is longer rather than by months like 11 months, 13 months or 17 months. In the facts and circumstances, this Forum does not find any good to intervene and alter the decision of The New India Assurance Co. Ltd.

in rejecting the claim of Smt. Seema Sharma on the ground of Clause 4.1 of Mediclaim Policy for pre-existing illness at the inception of the policy.

Mumbai Ombudsman Centre
Case No. GI-360 of 2004-2005
Shri Mohan Mani
Vs
The New India Assurance Co. Ltd.

Award Dated 30.11.2005

Smt. Vardhini M. Mani alongwith her husband Shri Mohan Mani was covered under mediclaim policy No. 11900/48/03/06349 issued by The New India Assurance Company Limited. Shri Mohan Mani was hospitalized at Bharatiya Arogya Nidhi hospital for Angiography and Coronary Angioplsty. When a claim was preferred by Shri Mani to the Company for Rs. 1,10,000/- on the basis of original Sum Insured and Cumulative Bonus. Not satisfied with the decision of the Company, Shri mani represented to the Company which was also turned down and hence aggrieved, he approached this Forum. After perusal of the records parties to the dispute were heard. On a close scrutiny of the records it is observed that the insured took a mediclaim policy in 1998 for Sum Insured of Rs. 1 lac and then increased the Sum Insured in December, 2001 to Rs. 2 lakhs. There is a mention in the case paper that the insured was a known case of Hypertension and he was on medicine Tenismin (25) and he was on tab Aten for 4 years before hospitalisation for Hypertension. It is therefore, evident that the insured was sufering from Hypertension before increasing the Sum Insured and the records submitted by the Company have proved that the insured increased the Sum Insured to 2 lacs in the year 2001 without disclosing about the illness - Hypertention which he was suffering from. Considering the Angiography Report which revealed proximal LAD 95 %, Mid LAD 70 % and RCA 90 % and the hospital record together with the letter from Dr. Mahesh K. Shah, it is concluded that the onset of stenosis was for sometime and with Hypertension being there for more than 4 years must have contributed to the blockages.

In view of the above analysis I find the decision taken by the Company to settle the claim to the extent of Rs. 1 lac with Cumulative Bonus accrued on the policy before increase in Sum Insured is in order and this Forum therefore does not find any valid ground to interfere with the decision.

Mumbai Ombudsman Centre
Case No. GI-348 of 2004-2005
Mr. Shamrao J. Pawar
Vs
The Oriental Insurance Co. Ltd.

Award Dated 30.11.2005

Shri Shamrao J. Pawar along with his wife and son were covered under Mediclaim Policy 4820033993 issued by Oriental Insurance Co. Ltd., Ghatkopar D. O. for the period 4.10.2002 to 3.10.2003. Smt. Vaishali Pawar, wife of Shri Shamrao J. Pawar was hospitalized for Superior Sagittal Sinus Thrombosis with Venous Infarct in Rt. Basifrontal regional with Bilateral Maxillary and Rt. Ethmoid sinusitis with Secondary Seizures at Bharti Hospital from 21.6.2003 to 4.7.2003. When a claim was preferred by Shri Shamrao Pawar in the first year itself, to the Company, the Company rejected the claim vide their letter 27.7.2004 repudiating the claim invoking clause 4.3 of the mediclaim policy as a disease of the Company, Shri Pawar represented to the

Company and when the matter was not resolved, he approached the Office of the Ombudsman seeking intervention of the Ombudsman.

Facts are analysed on the basis of documets and papers submitted by the Insured/Hospital and the Company. From the above records, it is observed that the insured suffered from Sagittal Sinus Thrombosis with Venous Infarct. MRI of brain also suggested hyperacute to acute haemmorhage infarct, right basifrontal region a venous infact and thrombosis. It is thus clear that the ailment really was not sinusitis commonly known to occur in the nasal region and known as Paranansal Sinus but another major ailment. The Company failed to appreciate the difference between the most common form of disease which are excluded in the first year of the Policy as per Exclusion clause 4.3 of the Mediclaim Policy and the type of Sinus Thrombosis with Venous Infarct suffered by Smt. Vaishali Pawar for which they rejected the claim.

In the light of the above circumsances, I find that the rejection of the claim by the Company is not justified and the said decision of the Company is accordingly unsustainable on facts.

Mumbai Ombudsman Centre
Case No. GI-381 of 2004-2005
Shri Chetan M. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 30.11.2005

Shri Chetan M. Shah was covered under the mediclaim policy of The New India Assurance Co. Ltd. The claim arose after the hospitalisation of his son Mast. Dhrumil C. Shah in Sahil Surgical Hospital from 17.11.2003 to 18.11.2003 for Phimosis. M/s TTK Healthcare Services Pvt. Ltd. after scrutinising the documents they informed Shri Chetan Shah about their decision to repudiate the claim on the ground that Phimosis is a congenital external Disease and it comes under Exclusion Clause 4.8 of the mediclaim policy and it is not entertainable. Aggrieved by the decision of the Company, Shri Shah represented to the Company along with a certificate from treating Doctor, Dr. Sunil B. Bangera stating that the above ailment was not congenital. Not getting satisfactory reply from the Company, Shri Shah approached Ombudsman with his grievance that the reason given for repudiation of his claim is not agreeable to him.

On scrutiny of the hospital papers it is observed that the child was treated for Balanoposthitis following phiomosis. Balanoposthitis is an inflammation of foreskin and surface of the underlying glans penis. The affected areas becomes red and swollen which further narrows the opening of the foreskin and makes passing of urine difficult and painful. Initially doctors treat it with the administration of antibiotics but if the skin is elongated and the apparent defect is there since birth it cannot be medically managed. Hence, further attacks are prevented always with surgery i.e. circumcision.

There is no episode of external injury or disease to cause Balanoposthitis and it is evident that phimosis was caused by a basic defect or anomaly in the organ of the body. It was obvious from the age of the child that stenosis or narrowness of the preputial orifice was narrow since the beginning and the foreskin could not be pushed back over glan penis. This would have been visible to the parents. Accordingly, the ailment should be treated as a congenital external disease/defect and it was also pre-existing at the time of taking the insurance policy. Moreover, the mediclaim policy also excluded “Circumcision” in gereral unless necessitated due to any disease or accident,

which was not the case here (Clause 4.5). Consequently, the denial of the claim under Exclusion Clause 4.8 of the policy by the TPA and the Company is in order.

Mumbai Ombudsman Centre
Case No. GI-557 of 2004-2005
Shri Vipul Ramnik Mota
Vs
United India Insurance Co. Ltd.

Award Dated 30.11.2005

Shri Vipul R. Mota took a mediclaim policy from United India Insurance Co. Ltd., covering himself and family members for the period from 27.08.2003 to26.08.2004. Shri Mota consulted Dr. Nitin R. Malkan for his daughter Jaini Mota for the complaint of lack of vision and after examining her Dr. Malkan referred her to Dr. Anad N. Kumta of Kumta Eye & Retina Clinic & Laser Center who admitted her on 21.04.2004 and operation was carried out on the same day. Shri Mota submitted all necessary documents to Medicare (TPA) Services (I) Pvt. Ltd. for processing the claim. They informed him about their inability to consider his claim as it fell under Exclusion Clause 4.1 of the mediclaim policy.

Kum Jaini was diagnosed to have 'Both eyes peripheral lattice degeneration in retina with hole". The treatment that was given was a surgical procedure "Both eyes prophylactic laser photocoagulation around lattice degenerative and hole". From the diagnosis as per the Discharge Card it was evident that both eyes had changes of chorioretinal artophy. The certificate of Dr. Nitin Malkan confimed that Myopia was in very progressing stage with strong family history. In fact the family history was prominently mentioned in almost all medical records. The diagnosis of peripheral lattice degeneration in retina has been termed as Chorioretinal disorder i.e. pertaining to the choroid and the retina. Chorioretinal Atrophy would be a serious defect as would be seen from the meaning of Atrophy. Atrophy means the wasting away of normally developed organ or tissue due to degeneration of cells. Based on this analysis it would be concluded that the Insured, Shri Vipul Mota while taking the Mediclaim Policy was aware of his daughter's eye problems or even if it was not apparent it would be pre-existing as per diagnosis of Dr. Nitin Malkan that Kum. Jaini was high myopic even if the first examination was on 26.07.2003 i.e. 2nd year of the policy. The word 'degeneration' refers to deterioration or impairment of an organ or part in the structure of cells and the substances of which they are a component. Here retinal degeneration with hole at age 2 would always indicate an existing condition coming under exclusion clause 4.1 of the Mediclaim policy. Accordingly the decision of United India Insurance Co. Ltd to repudiate the claim of Shri Vipul Ramnik Mota in respect of his daughter Kum. Jaini Mota would be sutainable.

Mumbai Ombudsman Centre
Case No. GI-358 of 2004-2005
Shri Jawaharlal Kapoor
Vs
United India Insurance Co. Ltd.

Award Dated 01.12.2005

Shri Jawaharlal Kapoor and his wife were covered under Mediclaim Policy No. 020900/48/03/01091 issued by United India Insurance Company Limited, D. O. Shri

Jawaharlal Kapoor was hospitalized from 11.3.2004 to 05.4.2004 at Bhatia hospital for Osteoarthritis (R) knee and Total Knee Replacement (TKR). When Shri Kapoor preferred a claim for the said hospitalisation to the Company, Company repudiated the claim on the ground of pre-existing disease. Disatisfied with decision, Shri Kapoor represented to the Company but the Company reiterated their earlier stand of repudiation. Hence aggrieved Shri Jawaharlal Kapoor approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim for Rs. 4,50,000/-. After perusal of the records parties to the dispute were called for hearing. The relevant records submitted to this Forum have been studied in detail. On a closer scrutiny it clearly reveals that he was operated for left Total Hip Replacement together with the treatment of Oestoarthritis ILD with Diabetes Mellitus with Hypertension Interstitial Lung disease and was on regular medication. All these happened before the policy was taken from 26.6.2002 and it was absolutely clear that the Insured conciously decided to take the mediclaim policy. It is to be noted that when a policy is taken then all these diseases get automatically excluded from the scope of the policy regardless of the fact whether the policy mentioned them as specific exclusions or not. Accordingly this Forum would not like to intervene and alter the decision of the Company to repudiate the claim on the ground of clause 4.1 which is in order.

Mumbai Ombudsman Centre
Case No. GI-433 of 2004-2005
Kum. Savitri G. Daryanani
Vs
United India Insurance Co. Ltd.

Award Dated 02.12.2005

Kum. Savitri G. Daryanani who was covered under a Mediclaim policy No. 020500/48/03/06756 issued by United India Insurance Company Limited D. O. 5 had approached the Office of Insurance Ombudsman with a grievance against United India Insurance Company Limited for partial settlement of her claim amount. Kum. Savitri G. Daryanani was hospitalized for Polymyalgia Rheumatica and when she preferred a claim the Company repudiated the claim on the ground that hospitalisation was for evaluation and investigation and the treatment could have been done on an outpatient basis. Not satisfied with the decision of the Company, Kum. Daryanani represented and the TPA after taking a relook into the matter settled the claim for Rs. 32,956/- after deducting Rs. 14,490/- from the claim amount. The TPA also gave the reasons for disallowing the balance claim amount. Aggrieved by the deduction Kum. Daryanani represented to the Company and not receiving any reply from the Company approached this Forum. As all the necessary documents were made available to this Forum, there was no need to call the parties to the dispute for personal hearing. The relevant records submitted to this Forum have been scrutinized.

On going through the records it is observed that Company has rejected Rs. 1,850/- towards Echo charges Rs. 12,600/- for C. T. scan and RS. 40/- towards diet charges claimed by the Complainant. In fact myalgia is pain in the muscles and since the investigations were extensive the diagnosis was complete but from strict medical point of view some of these ivestigations were in excess. Nevertheless considering the fact that the claim has been admitted and CT scan helped in the process of final diagnosis a further amount of Rs. 6,300/- calculated at 50 % cost of CT Scan investigation may be allowed to the Complainant.

Mumbai Ombudsman Centre
Case No. GI-359 of 2004-2005
Shris Arzan M. Baria
Vs
The New India Assurance Co. Ltd.

Award Dated 06.12.2005

Shri Arzan M. Baria took a mediclaim policy since 18.01.2001 from The New India Assurance Co. Ltd. Shri Baria was hospitalised at Breach Candy Hospital from14.04.2004 to 17.04.2004 for Submental Non Specfic Lymphadenitis. He preferred a claim for reimbursement of mediclaim expenses of Rs. 82,769/- incurred for the hospitalisation at Breach Candy Hospital to the Company. For processing the claim, Shri Baria submitted necessary documents to M/s TTK Health Care Services Pvt. Ltd. and accordingly they settled the claim for Rs. 50,000/-. The Insured, Shri Baria had also submitted pre & post hospitalisation claim of Rs. 33,149/-, out of which TTK Health Care Services settled an amount of Rs. 2,880/- which was not accepted by him. He made a representation to the Company expressing his dissatisfaction over the settlement of the laim amount by M/s TTK Health Care Services.

The analysis of the claim would first of all reveal an administrative aspect of issuance of policy with certain benefits like cashless facility. This is an extended benefit under which the insured does not make any payment to the hospital within a certain limit and take his discharge without paying any charge. The system operates well as long as the limit is determined and adequate to cover the hospitalisation expenses. As per TPA, M/s TTK Health Care Services Pvt. Ltd., the type of treatment Shri Baria had and the nature of surgery performed, the limit of Rs. 50,000/- was adequate. This is a view which has emerged from comparative analysis of similar surgeries performed even in Class-I Hospitals. In effect however this was not the case and the limit was burst even by the doctor's fees which was Rs. 60,200/-. The TPA challenged this amount and held their view that the hospital has charged more under doctor's fees for surgery which they are not bound to pay as comparable surgeries even in Deluxe room of Class - I hospital should not be so expensive. Accordingly, they deducted a substantial amount to fit in to the limit of Rs. 50,000/-. The TPA has also offered a sum of Rs. 2,880/- as per and post-hospitalisation expenses which was also rejected by the Complainant.

In the facts and circumstances, The New India Assurance Co. Ltd. is directed to settle the claim for Rs. 60,000/- (Rs. 50,000/- cashless limit + Rs. 10,000/-) and pay hospitalisation, calculation may further be made and accordingly the exact amount arrived at be also relased. If it is above Rs. 2,880/- as offered, the exact amount be paid over and above Rs. 60,000/-. There is no order for any others relief.

Mumbai Ombudsman Centre
Case No. GI-83 of 2004-2005
Shri Anil Sitaram Talawdekar
Vs
National Insurance Co. Ltd.

Award Dated 09.12.2005

Shri Anil Sitaram Talawdekar along with his wife and son was covered under a fresh mediclaim policy no. 260400/48/03/8500435 for the period 10.10.2003 to 09.10.2004 issued by National Insurance Co. Ltd. Master Brijesh A. Talawdekar son of Shri Anil Sitaram Talawdekar was hospitalized for malaria and typhoid. When Shri Talawdekar preferred a claim to the Company for the said hospitalisation the Company repudiated the claim under Exclusion Clause 4.2 of the mediclaim policy. Aggrived by the decision

of the Company, he represented to the Divisional Manager of the Company but not getting any favourable reply, Shri Talawdekar approached Insurance Ombudsman for his intervention in the matter. As all the records and the written submissions were made available at this Forum by both the parties, it was felt that there was no need to call the parties to the dispute for any personal hearing.

On Scrutiny of the papers it is observed that Master Brijesh Talawdekar was admitted to Tunga Hospital for Malaria/Typhoid from 31.10.2003 and he was discharged on 3.11.2003. As per Redressal of Public Grievance Rules, 1998, this Forum can only adjudicate on the policy document actually issued and the terms and conditions binding this document which is applicable to both the Insured and the Insurer. In view of the facts and circumstances the company's decision to reject the claim cannot be faulted as the claim was lodged within the 30 day period.

Mumbai Ombudsman Centre
Case No. GI-476 of 2004-2005
Mr. Jethalal Chheda
Vs
National Insurance Co. Ltd.

Award Dated 12.12.2005

Shri Jethalal Chheda along with his wife was covered under Mediclaim Policy since 8th October 2001. Mrs. Manisha Chheda was admitted to Bombay Hospital from 21.7.2003 to 26.7.2003 for pain in abdomen in epigastric umbilical region with vomiting and weakness. Her claim was repudiated by the Company invoking clause 4.1 of the mediclaim policy. As the matter was not resloved, he approached the Office of the Ombudsman in the matter of settlement of his claim.

Facts were analysed on the basis of documents and papers submitted by the Insured/Hospital and the Company. Smt. Manisha Chheda was admitted to Bombay Hospital and Research Centre on 21.7.2003 for pain in abdomen epigastic umbilical region with vomiting and weakness. Indoor Case papers of the hospital reveals that the Insured had a history of weight loss, history of cervical LN biopsy done in Aug 2001, which ruled out T. B. She had Menorrhagia three years ago and Jaundice 20 years ago. She had Laparoscopic TL (Tubal Ligation) done willingly 8 years back. She had pain in upper abdomen on and off since 5 years and vomiting after food since then. There is also a mention that she was under active treatment for Cervical Lymphadenopathy and Endoscopy done on 23.7.2003 showed Hiatus Hernia. She underwent Laparoscopy and the reports revealed no abnormalities and also ruled out tuberculosis of abdomen. She was finally diagnosed as having Corrosive Gastroduodenitis, which is inflammation in the stomach and the duodenum with Hiatus Hernia. A certifcate from Dr. M. M. Begani, Surgeon, submitted by the insured to substantiate his stand stated that the patient was admitted to the hospital for abdominal pain, vomiting off and on for 3 - 5 months duration and a Laparoscopy was done to rule out Tuberculosis of abdomen. A scrutiny of the certificate would reveal that essentially the same diagnosis was arrived at through investigations and Dr. Begani's assertion that he wanted to rule out TB of abdomen contradicts hospital records. The duration of abdominal pain off and on as per indoor case papers is since 5 years and as per surgeon's certificate which was produced to the Company later, it was 3-5 months which cannot be accepted as per other medical history as noted above, we have first seen that there were number of diseases before the policy was taken out and most of them were related to the present illness. On this ground the claim does not merit any consideration and based on the

hospital records the rejection of the Company is justifiable as per clause 4.1 of the Mediclaim Policy.

Mumbai Ombudsman Centre
Case No. GI-494 of 2004-2005
Shri Bhagwan N. Wadhwani
Vs
United India Insurance Co. Ltd.

Award Dated 12.12.2005

Shri Bhagwan N. Wadhwani who alonghwith his wife was covered under a Mediclaim Policy issued by United India Insurance Company Limited, D. O. 5 had approached this Forum with a grievance that United India Insurance Company had rejected his claim of Rs. 6,950/- for Chronic Prolapsed Lumbar Disc at Brahmesh Orthopaedic and Trauma Centre. From the documents submitted by Shri Bhagwan Wadhwani and The New India Assurance Company it is observed that the TPA of the Company had rejected the claim on the ground that Brahmesh Orthopaedic and Trauma Centre doesn't fall under the definition of hospital. Shri Wadhwani's representation to the Company was not favourably answered hence he approached this Forum for redressal of his grievance. On going through the documents submitted to this Forum by both the parties it was found that since adequate records are available there was no need for holding any personal hearing. On examination it reveals that as per the relevant clause the Company has not been able to produce any certificate from the local authorities stating that it was not registered as a hospital or a nursing home. The other clause on which the claim was rejected was clause 2.3 of the mediclaim policy which required treatment to be taken from the hospital with minimum confinement of 24 hours. As regards this charge it is evident that it had not complied with minimum 24 hours hospitalisation. On further examination it is noted that the diagnosis was complete and only treatment was to be taken. In fact there is no need for hospitalisation and the patient would not require more than a few hours of attention which can be in OPD or at house. In the facts and circumstances while the ground of non-eligibility of the Orthopaedic Centre is not entirely proved with appropriate documents from the Authorities, this Forum finds no fault either for invoking clause 2.3 or 2.0 of the mediclaim policy as has been done, and therefore, the repudiation of the claim by United India is tenable.

Mumbai Ombudsman Centre
Case No. GI-518 of 2004-2005
Shri Chandrakant M. Khetan
Vs
United India Insurance Co. Ltd.

Award Dated 12.12.2005

Shri Chandrakant M. Khetan alongwith his family members were covered under Mediclaim Policy issued by United India Insurance Company Limited, D. O. 5. Shri Chandrakant M. Khetan was hospitalized for polysonography and when Shri Ketan preferred a claim for the said hospitalization to United India, the TPA of the Company settled the claim for Rs. 44,160/- after deducting Rs. 70,000/- towards the CPAP machine which as per the Insurance Company was not payable. Not satisfied with the decision of the company, Shri Khetan represented to the Company and approached the Office of the Insurance Ombudsman. The records have been perused and it was found that both the Company and the Complainant have given their written submissions and hence no useful purpose would be served by calling the parties for personal hearing. Instead Award is being issued through analysis of the issues involved. The main

dispute under this claim is the payment of cost of an apparatus which was required by Shri Khetan to ward off his sleep disorder. As per Shri Khetan he had availed this on the advice of his treating doctor. It is noted that the basic treatment received by him in the hospital was admitted by the Company under the terms of the policy. 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 domicillary treatment" under domicilliary hospitalisation benefits under specific circumstances. There has also been reference under clause 1 (d) that cost of pacemaker, artificial limbs and cost of organs would be reimbursed. However, the expenses for apparatus which are not on the body system as such but are external adjuncts fitted and used for a limited period at night for getting good sleep in this case, would fall outside the scope of Mediclaim policy for coverage.

Mumbai Ombudsman Centre
Case No. GI-359 of 2004-2005
Shri Kailash Chand Jain
Vs
National Insurance Co. Ltd.

Award Dated 12.12.2005

Shri Kailash Chand Jain alongwith his wife Smt. Santosh Jain was insured with National Insurance Company Limited under policy No. 250601/48/02/8503469 for the period 27.11.2002 to 26.11.2003 issued through Varishield Health Care Limited. Smt. Santosh Jain wife of Shri K. C. Jain was a cancer patient who was operated for right breast in 1994. She had developed some trouble in the intestine for which she was admitted in November, 2002 and again she was on continuous oral medicines for chemotherapy till August 2003. When Shri Jain preferred five claims for the expenses incurred during that period, the company settled two claims and did not settle the other claims as the Insured had undergone treatment in the form of oral tablets only at home. Hence as per the panel doctors of the Company, such treatment did not satisfy the definition of chemotherapy under hospitalisation and hence Company repudiated the claim. Not satisfied with the decision of the Company, Shri Jain represented to the Company and aggrieved by the decision of the Company, Shri Kailash Chand Jain approached the Insurance Ombudsman. Records have been perused and parties to the dispute were heard. Scrutiny of the relevant records submitted to this Forum revealed that the patient was not admitted to hospital for the chemotherapy taken by her, but the entire treatment was taken at home in the form of tablets as stated in the certificate of Bombay Hospital dated 23.9.2003. This treatment does not fall under Domiciliary Hospitalisation either, as per the Condition 2.4 of the Mediclaim Policy. The Complainants plea to treat this under Post-Hospitalisation also cannot be considered as post hospitalization expenses under the policy is limited upto 60 days only, from the date of discharge. As these expenses fall beyond the period of 60 days, it cannot be included under post-hospitalisation in view of the specific condition.

Under the circumstances, the Company's repudiation was as per terms of the policy as the oral chemotherapy was taken by the Insured at home and this Forum finds no valid ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI-156 of 2005-2006
Shri Bharat M. Pendse
Vs
The New India Assurance Co. Ltd.

Award Dated 13.12.2005

Shri Bharat M. Pendse was covered under the mediclaim policy issued by New India since last 10 years and had earned Cumulative Bonus @ 50 %. Shri Bharat M. Pendse was hospitalized for polysomnography and when Shri Pendse preferred a claim for the said hospitalization to New India, the Company finally offered to settle Rs. 32,333 after excluding Rs. 50,625 towards the cost of the CPAP machine. Shri Pendse as per his letter dated 21.10.2005 addressed to the Company and a copy endorsed to this Forum had stated that he was not inclined to accept this Offer. The records have been perused and it was felt that no useful purpose would be served by calling the parties for personal hearing. Instead an Award is being issued through analysis of the issues involved. The main dispute under this claim is the payment of an apparatus which was required by Shri Pendse to ward off his sleep disorder. 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 hosptalisation benefits under specific circumstances. There has also been reference under clause 1 (d) that cost of pacemaker, artificial limbs and cost of organs would be reimbursed. However, 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. 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 sustainable.

Mumbai Ombudsman Centre
Case No. GI-587 of 2004-2005
Shri Sankar Kumar Basak
Vs
National Insurance Co. Ltd.

Award Dated 13.12.2005

Shri Sankar Kumar Basak was covered under mediclaim policy issued by National Insurance Company Limited and it is reported that this policy was a fresh policy. Shri Sankar Kumar Basak was admitted in Lok Hospital, Thane for Diarrhoea and colonoscopy was done. When he preferred a claim TPA of the Company repudiated on the ground that hospitalisation was only for investigation. Not satisfied with the decision Shri Basak represented to the Company but as the same was upheld he approached this Forum. As all the records including medical records and the written submissions were made available at this Forum by both the parties i.e. from Shri Sankar Kumar Basak and the National Insurance Company, it was felt that there was no need to call the parties to the dispute for any personal hearing. The relevant records made available with this Forum have been studied in detail. On going through the medical records it is observed that there was no positive existence of any illness and no treatment was given during the hospitalisation, only certain medicines were prescribed. It is noticed that there was no emergency for hospitalisation as such as he was carrying on with loose motions for 15 days. Moreover, the number of motions was very minimal only one which must be there and which is very normal. There was no dehydration nor was he put on dextrose saline drops on admission. Hence the criticality was not there at all. Based on the above findings, it is found that the decision for repudiation by the National Insurance Company Limited under exclusion clause 4.10 is in order.

Mumbai Ombudsman Centre

Case No. GI-323 of 2004-2005
Shri Jayant Motilal Patel
Vs
The Oriental Insurance Co. Ltd.

Award Dated 13.12.2005

Shri Jayant Motilal Patel was insured under mediclaim policy of the Oriental Insurance Co. Ltd. from 31.07.1989 to 31.07.2002 i.e. for a period of 13 years. However, Shri Patel took a fresh policy from 31.01.2003 to 30.01.2004 after a break of nearly 6 ½ months. The fresh policy was issued with exclusions such as Aortic Aneurysm, Gall stones and Bilateral Refractive error etc. Shri Patel preferred a claim to the Company after his hospitalisation at Dr. Sadiwala's Clinic from 02.06.2003 to 14.06.2003 for complication of Incisional Hernia. The claim was processed by M/s Raksha TPA. On 08.10.2003 they informed Shri Patel about their inability to settle the claim as per the Mediclaim policy Exclusion Clause 4.1. Not satisfied with the decision of TPA, he represented to the Company but not getting any favourable reply from Company, Shri Patel approached the Insurance Ombudsman with his grievance.

On scrutiny of the records, it is observed that Shri Jayant Patel was covered under a Mediclaim Policy from July, 1989 to July, 2002 and since he had gone to USA, there was a break of coverage and thereafter when he renewed the policy from 31.01.2003 with the medical history, it excluded 'Aortic Aneurysm, Gall Stones and Bilateral Refractive Error'. He was back in India after hernia repair and was admitted to Dr. Sadiwala's Clinic on 02.06.2003 for infected haematoma. The diagnosis was infected pre-peritoneal haematoma in a case operated for Ventral Hernia Meshplasty (USA) and the operation done was "exploration of cavity with complete evacuation of haematoma followed by irrigation done under GA" In the case history it was written that he had Aortic valve repair, Cholecystectomy and Ventral Hernia Meshplasty all done in USA. The insured later forwarded some medical records for cholecystectomy done in June, 2002 to this Forum which have been studied. He has not forwarded papers relating to hernia repair. However, as the medical record of cholecystectomy is very clear the decision making would be easier.

Based on this analysis and as per medical records, either by exculsions under the policy or by Exclusion Clause of 4.1 which excludes all pre-existing illness at the inception, the claim for haematoma cannot be a stand alone disease but a fall out of abdominal surgery and as per operative notes, could be linked to cholecystectomy. Even otherwise as hernia was incisional it would be regarded as an immediate consequence forming a chain of event and consequently, the repudiation of the Company is sustainable.

Mumbai Ombudsman Centre
Case No. GI-460 of 2004-2005
Shri Vipesh Hirji Vira
Vs
The New India Insurance Co. Ltd.

Award Dated 14.12.2005

Shri Vipesh Hirji Vira who was covered under a Mediclaim policy No. 140500/48/03/07571 issued by The New India Assurance Company Limited, D. O. Vasai had approached the Office of Insurance Ombudsman with a grievance against the New India Assurance Company Limited for partial settlement of his claim amount of Rs. 1,02,331/- after deducting Rs. 15,085/-. Not satisfied with the decision of the company, Shri Vira represented to the Company which was also turned down. Hence

aggrieved he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim.

The records have been perused and it was found the basic treatment received by him in the hospital was admitted by the Company under the terms of the policy. Further, the Company has also admitted his pre and post hospitalization expenses which were paid vide cheque dated 4.9.2004 and 7.10.2004 respectively. However, the Insured made a strong plea for payment of pneumatic walker and felt the Company wrongly rejected it. He stated that it was not a walker in that sense and he produced a certificate from the Doctor to suggest that it was purchased on medical advice as a part of treatment. As regards reimbursement of cost of walker or similar orthopaedic or other appliances the policy is specific to exclude “such expenses” which are externally used and not within the body system like pacemaker, Artificial limbs and Cost of organs etc. Cost of hearing aids, spectacles, dentures etc are also excluded from the scope of the policy. The Insured used the pneumatic walker certainly on medical advice and it must have facilitated quick mobilization. However, the policy is designed to exclude costs of external appliances and the possible explanation would be that the apparatus which are not necessarily within the system and used as external adjuncts for a limited period of time would fall outside the scope of Mediclaim policy for coverage.

In the facts and circumstances the repudiation of the Company to that extent is in order.

Mumbai Ombudsman Centre
Case No. GI-179 of 2004-2005
Shri N. M. Mehta
Vs
The New India Assurance Co. Ltd.

Award Dated 15.12.2005

Shri N. M. Mehta was covered under Individual Mediclaim Policy No. 111900/48/01/08343 issued by New India 111900 for the priod 5.3.2002 to 4.3.2003. He was admitted to Nirmal Nursing Home for treatment of pain in abdomen. He was diagnosed as having Chronic Calcified Pancreatitis. On discharge when he claimed, New India settled the claim on non-standard basic of 75 % which was not acceptable to the Insured. In view of his representation, the Company referred the matter to their panel doctor, who recommended for rejection of the claim. The same was intimated to the insured. Not satisfied with the decision taken by the Co. the insured approached Insurance Omudsman for redressal.

Having studied the papers and obtained the respective view points, I felt that no useful purpose will be served in calling both parties for personal hearing and as per RPG Rules 1998, I therefore, decided to issue an award. The analysis of the medical records revealed that the provisional diagnosis was ‘drug-induced pancreatitis and the name of the probable drug was also mentioned Later on the doctors changed their opinion and diagnosed it to be ‘chronic calcified pancreatitis’. As regards drug-induced pancreatitis, the opinion given by Dr. P. Solanki of Dr. Thakur Hospital was that the level of drug was in theraputic range and could not have induced pancreatitis. Acute pancreatitis is a sudden illness in which the patient experiences severe pain in the upper abdomen and back, with shock; it may be associated with gallstones or alcoholism. Chronic Pancreatitis may be painful but sometimes may be painless. It leads to pancreatic failure causing malabsorption and diabetes mellitus. The pancreas often becomes calcified, producing visible shadowing on X-rays. (Quoted from Oxford Medical Dictionary, Indian Edition.)

In the present case the Insured had a history of diabetes which is also excluded from the scope of the policy. However, the analysis reveals that the doctors were not certain as to why it caused clacific pancreatitis. One points is emerging further that the USG of the Insured showed no Gallstones and about his being alcoholic, we have no data. Hence the cause may be something else and even genetic. Without going into the cause of Calcified Pancreatitis, the above narration leads to one conclusion that diabetes may have been caused by pancreatitis over a period of time. Therefore, instead of searching the cause for pancreatitis, it would be fair to grant some benefit of doubt to the Insured. New India did exactly the same thing by offering 75 % of the expenses to settle the claim as non-standard which was quite reasonable. I, therefore recommend non-standard basic settlement and set aside the repudiation made by new India Assurance Co. Ltd.

Mumbai Ombudsman Centre
Case No. GI-314 of 2004-2005
Shri Chandrakant C. Dalal
Vs
The Oriental Insurance Co. Ltd.

Award Dated 16.12.2005

Shri Chandrakant C. Dalal was covered under the mediclaim policy with the Oriental Insurance Company since 30.3.1990 without any break. Shri Dalal was hospitalized at Jaslok hospital from 22. 10.2002 to 27.10.2002 for “Obstructed Right Sided Inguinal Hernia”. and when Shri Dalal preferred a claim, the Company based on the opinion of their panel doctor, repudiated the claim on the grounds of pre-existing illness and non-disclosure of material facts. Aggrieved by the decision of the Company, Shri Dalal represented to the Company and not receiving any favourable reasponse from the Company, Shri Chandrakant Dalal approached this Forum with a complaint seeking justice. Records have been perused and hearing of the parties to the dispute was held on 25.8.2005. The analysis of the case reveals that the discharge card and the hospital case papers very clearly recorded past history of illnesses suffered by Shri Chandrakant C. Dalal. Chronologically it is constructed that he had right sides Inguinal Hernia operated in 1965, had Myocardial Infarction in 1980. Lt. Inguinal Hernia in 1999 from Breach Candy Hospital with appendicetomy also done. He was admitted with severe abdominal pain which on examination was found to be Obstructed Rt. sided Inguinal Hernia for which emergency reduction of Inguinal Hernia Rt. sided with Hernioplasty was done at Jaslok hospital. It should be noted that the past surgery was very well absorbed and the Insured maintained it well almost for 40 years when he got admitted for right sided obstructed inguinal hernia in October, 2002. The issue of linking it with abdominal weakness arising out of 1965 surgery would be farfetched although this Forum agrees that 1999 surgery plus an episode of appendicectomy for which no data is available could make abdominal wall weak enough to cause protrusion of the hernial sac. Nevertheless this issue cannot be squarely put against the insured and the charge of pre-existing illness cannot be levelled in that manner having settled expenses for left sided inguinal hernia in 1999. On balance therefore, I feel equity would be attained by granting only 50 % of the claim as a compromise settlement considering the fact that the Insured’s submission of proposal form in 1997 as documented before this Forum does not contain any declaration about the past illness/surgeries even granting that he might have declared the same in the proposal form of 1990.

Mumbai Ombudsman Centre
Case No. GI-435 of 2004-2005
Shri Pravin R. Haria
Vs
United India Insurance Co. Ltd.

Award Dated 16.12.2005

United India Insurance Co. Ltd. issued a mediclaim policy to Shri Pravin R. Haria covering his family members since 1994 which was being renewed without any break. Shri Haria was admitted in Chiranjiv Nursing Home on 23.07.2003 under the care of Dr. K. C. Parekh and diagnosed as TB Meningitis and was discharged on 25.07.2003. He submitted all necesary documents to M/s Medicare Services (TPA) for processing the claim. The TPA informed Shri Haria on 05.11.2003 about repudiation of the claim stating that the patient was a known case of Pulmonary Koch's for 5 years and TB Meningitis is a complication of Pulmonary Koch's hence the claim is not payable.

On going through the documents, it is revealed that the insured was having policy since 1994 to 1998 with Branch No. 207 of United India and from 1999 onwards from Branch No. 020300. The first policy no. 207/60/1/72883/94 for the period 17.11.1994 to 16.11.1995 is available with this Forum. Branch No. 0203002 issued him a fresh Mediclaim Policy when he shifted his insurance with them even though he had clearly mentioned is his proposal form Q. No. 10 that he had earlier insurance with D. O. 207. This reveals that the insured was covered under Mediclaim Policy for the last 8 years and has been continuously renewing the policy without any break.

On the basis of above analysis, it is noticed that at the inception of policy in 1994, he was not having Koch's disease and hence find the stand taken by the Compnay to reject the claim on the basis of Exclusion Clause 4.1 is baseless. Moreover, the business was shifted from their own Branch which ought to have been checked at their level even at the time of entry. The mistake is theirs, which they must own. In view of the foregoing, it is felt that even though the insured had Pulmonary Koch's disease which he contracted in the 1998, it was not pre-existing when his policy incepted from the first time and therefore the claim is payable.

Mumbai Ombudsman Centre
Case No. GI-422 of 2004-2005
Shri Omkar O. Berde
Vs
The New India Assurance Co. Ltd.

Award Dated 19.12.2005

Shri Omkar P. Berde took a mediclaim policy for himself and his family members from the New India Assurance Co. Ltd., Divisional Office 112000. The policy was issued by the Company under an exclusion of diabetes and related problems to Smt. Savita P. Berde, mother of the insured. She was admitted to Breach Candy Hosptial on 07.11.2003 and was diagnosed to have Double Vessel Coronary Artery Disease and was discharged on 08.11.2003 with an advice to have PTCA (Angioplasty). Again on 30.11.2003 she was admitted to Asian Heart Institute under care of Dr. Ramakanta Panda to undergo Coronary Artery Bypass Surgery (CABG) on 01.12.2003. She was discharged on 09.12.2003. Shri Berde preferred a claim to the Company for reimbursement of hospitalisation expenses. The claim was processed by M/s TTK Healthcare Services Pvt. Ltd. and they informed him that the claim fell under Exclusion Clause 4.1 of the mediclaim policy, so the claim was not payable. The Company took a

Medical Opinion from their panel doctor, Dr. F. Dastur and accordingly the Company upheld the decision taken by the M/s TTK Health Services pvt. Ltd.

The analysis of the case along with the essential points of dispute would reveal that the Insured Smt. Savita Berde was covered under Mediclaim Policy for the first time from 06.02.2003 to 05.02.2004 at the age of 54 yrs. As per the underwriting practice of the Company she was evaluated through some pathological tests together with past medical history and for the purpose Sehat India was authorised by New India to send a suitable report together with pathological reports and results. It is closely observed from SehatIndia's report that the conclusion drawn was diabetes from post glucose blood sugar level. The history also noted Hysterectomy done some years ago. Based on this comment the policy was issued with a clear exclusion of diabetes and related problems. The Insured Smt. Berde got admitted first at Breach Candy Hospital where CAG was done and the advice was PTCA (Angioplasty) and with same disease she got admitted in Asian Heart Institute where CABG was done at the evaluation of doctor's at Asian Heart Institute. Summing up the entire history with the actual evaluation done before acceptance of the risk it would appear that the Insurance Company i.e. New India initially decided to exclude all the risks associated with the diabetes and the treatment of diabetes itself. This was noted in the policy and was accepted by the insured, Shri Omkar Berde without any question. It is medically established that the risk of IHD is increased in people with diabetes. This is partly due to high cholesterol and low HDL. The CAG revealed 'Proximal LAD 75 % and Distal RCA 95 % with Double Vessel Coronary Artery Disease' which also indicates the duration and progress of the disease. Considering the fact that the Insured preferred to include his mother for the first time in February, 2003 and that claim also took place in the same year itself coulped with the exclusion clearly noted under the policy and the cause of illness being triggered by diabetes and its associated complications, this Forum does not find any need to interfere with the decision of the Company to reject the claim.

Mumbai Ombudsman Centre
Case No. GI-605 of 2004-2005
Shri Gyanmal H. Porwal
Vs
The New India Assurance Co. Ltd.

Award Dated 19.12.2005

Shri Gyanmal H. Porwal alongwith his wife was covered under mediclaim policy of the New India Assurance Co. Ltd. He preferred a claim to the company, after cataract operation of left eye of his wife, Smt. Prabhavati G. Porwal on 02.12.2004. The claim was processed by M/s Paramount Health Services Pvt. Ltd. and they informed Shri Porwal that the claim was not payable as per exclusion for cataract for 24 months which is mentioned in the policy and the claim period was second year of the policy. Not being satisfied with the decision, Shri Porwal represented to the Company. The Company after reviving the case upheld the decision taken by M/s Paramount Health Services on 27.01.2005.

The facts of this claim have been analysed on the basis of Policy terms, claim papers and medical records available. It is observed that the Insured Shri Gyanmal H. Porwal was having Mediclaim Policy since 1995 (25.04.1995 to 24.04.1996) with Motimahal D. O. of New India and later when he shifted his residence, he renewed the policy with Vikhroli DO continuously. However, in the year 2003, he could not renew it on time and hence there was gap of about four months. The test reports of Smt. Porwal revealed IHD as pre-existing ailment. The Divisional Office while issuing the policy not only

excluded Heart Ailments and all circulatory diseases based on the test reports, but also imposed additional exclusions of Cataract, Hysterectomy, Renal Calculi, Hernia DNS (Devited Nasal Septum) for 24 months for Smt. Porwal and a different set of exclusions for Shri Porwal. A point may be raised whether this is in keeping with the usual underwriting policy or as per the usual condition imposed in the policy. This is apparently a harsh imposition of exclusions but there are two issues involved. The first is that the Company wanted to get away from a few common ailments and surgeries normally occuring on older people which are also excluded from the first year operation of the policy. The Company wanted to stay away for one more year perhaps to make the policy viable for old age bracket when the diminished vision sets in more number of aged people. The second point is that having renewed the policy with the above said exclusions it was for the Insured to approach, represent or reject the offer if he was dissatisfied. As remarked earlier the Company's attempt to play safe by excluding most of ailments specially to a person who was actually insured for a number of years with them looks pretty harsh and uncalled for. The Insured may separately take up this issue. However, based on the exclusions and the analysis made, the Company's decision to reject the claim upheld.

Mumbai Ombudsman Centre
Case No. GI/143 of 2005-2006
Shri. Naresh Bansal
Vs
New India Assurance Co. Ltd.

Award Dated 19.12.2005

The New India Assurance Co. Ltd. had issued a Master policy called Good Health Policy to Citibank Cardholders covering individual cardholders and their family members under Mediclaim and Personal Accident Insurance. Shri Naresh Bansal alongwith his family members were covered under the same policy. Shri Rameshwardas Bansal father of Shri Naresh Bansal was hospitalised for Benign Prostate Hypertrophy with Phimosis. When Shri Naresh Bansal preferred a claim of Rs.1,38,481/- for the above said hospitalisation expenses, the TPA of the Company settled the claim for Rs.1,04,939/- and disallowed a balance amount of Rs.33,542/-. Not satisfied with partial settlement of the claim, Shri Naresh Bansal represented to TPA but they upheld their decision. Not agreeing with the decision of the Company, Shri Naresh Bansal, approached the Insurance Ombudsman. The records have been perused and the relevant records submitted to this Forum have been scrutinized and it is observed that the Company has settled the claim strictly in terms of the policy condition.

In the light of the above the Company has settled the claim as per the limits.

Mumbai Ombudsman Centre
Case No. GI-483 of 2004-2005
Shri Chhaganlal P. Ranka (Jain)
Vs
The Orienstal Insurance Co. Ltd.

Award Dated 20.12.2005

Shri Chhaganlal P. Ranka and his family members were insured under mediclaim policy of the Oriental Insurance Company Ltd., M.C.D.O.3. The claim arose during the policy period 26.09.2003 to 25.09.2004 under policy no. 121200/48/04/2918. Shri Ranka preferred a claim of Rs. 15,844/- to the Oriental Insurance Company for his wife's

hospitalisation at Sir Hurkisondas Nurrotumdas Hospital & Research Centres for a period from 07.10.2003 to 09.10.2003 for Haematemesis - Reflux c Hiatus with Anaemia. The Insured submitted all case papers to Raksha TPA and they informed Shri Chaganlal Ranka that there was no emergency for hospitalisation and no specific treatment was given and repudiated the claim under Exclusion Clause 4.10 of the mediclaim policy which is on account of hospitalisation not required and admitted only for investigations.

Smt. Champibai Ranka was referred to Dr. Chetan B. Bhat of Sir Hurkisondas Nurrotumdas Hospital 06.10.2003 with complaints of burning and pain in epigastric region with a history of vomiting once “black coloured” eight days back. During investigation in the hospital, Upper GI scopy was done and as per the report the finding were “Duodenum revealed mild duodenitis. Oesophagus revealed lax hiatal opening with small linear hiatus hernia with moderate reflux with moderate esophagitis’. As per the Discharge Card, the diagnosis was Haematemesis Reflux with Hiatus with Anaemia. In medical terms ‘Haematemesis’ in vomiting of blood is generally dark and acidic. If the blood loss is severe enough, shock and collapse may occur. The patient should be down and be kept at absolute rest. Surgery may also be necessary depending on the status.

The Company held the view that the discharge card or the case history noted that blood vomiting was about a week back, hence there was no emergency to hospitalize and that all investigations could be done as an out patient. This is an extremely narrow view and non-medical approach for a Medical Insurance Policy coverage. It is surprising how the claim was processed at the Company level to ignore haematemesis with hiatus hernia which is possible protrusion of the stomach upward into the mediastinal cavity through esophagus and further diagnosis of duodenitis and reflux symtoms plus anaemia to be termed as non-existence of any positive illness or that the investigations were non-consistent with the findings. As the findings are clear and any person specially an elderly lady should recive proper treatment in a medically managed environment like hospital where ivestigations could be of various nature, often even invasive with sedation like Gastroscopy, Colonoscopy etc., the Company’s contention that it came under Exclusion Clause 4.10 is not accetable.

Mumbai Ombudsman Centre
Case No. GI-549 of 2004-2005
Smt. Shakuntala B. Salve
Vs
United India Insurance Co. Ltd.

Award Dated 21.12.2005

Shri Ratan B. Salve alongwith his mother Smt. Shakuntala B. Salve was insured with United India Insurance Company Limited D. O. 18 through Unique Mercantile Services Pvt Ltd. Smt. Shakuntala B. Salve was hospitalized at Noor Nursing Home for Vaginal Hysterectomy with AP repair. When a claim was preferred by Smt. Salve for the said hospitalisation the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Their contention was that as per the discharge card Smt. Shakuntala Salve was suffering from Uterine prolapse for 4-5 years. Dissatisfied with the decision of the Company, Smt. Salve represented to the Company. Not receiving any favourable reply from the Company, Smt. Salve approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of her claim. After perusal of the records parties to the dispute were called for hearing on 7th December, 2005. The analysis of the case reveals the dispute is centering around duration of complaints like diffuculty in passing urine and symptoms of uterine prolapse. It would

be seen that complaints like uterine prolapse and discomfort in passing urine was mentioned. The actual diagnosis was also “uterine prolapse” for which vaginal hysterectomy was done. The documents like histopathology report suggests “Uterine Endometrium in Proliferative phase with Focal cystic changes. Chronic Cervicitis”. In addition to the above findings, there has been an effort on the part of the Insured to rectify the record in a bid to get the claim. As mentioned above since the Reports are clearly indicative of age and since it was a 2nd degree uterine prolapse, the exact duration would be as per the original statement of the Insured made spontaneously and therefore, the later corrections would be taken as after thought. Moreover, there is a procedure to correct hospital records which cannot be done by merely a certificate.

Based on this analysis, I, do not find any merit in intervention to alter the decision of United India Insurance Company to reject the claim.

Mumbai Ombudsman Centre
Case No. GI-237 of 2004-2005
Shri Sunil B. Deshmukh
Vs
The New India Assurance Co. Ltd.

Award Dated 22.12.2005

Shri Sunil B. Deshmukh was covered under mediclaim policy No. 150800/48/02/01870 issued by the New India Assurance Company Limited, D. O. Nashik for a sum insured of Rs. 25,000/- for the period from 17.3.2003 to 16.3.2004, Shri Deshmukh had taken the policy in the year 2000 but the policy could not be renewed and hence a fresh policy was taken in the year 2003. Shri Deshmukh was admitted in Rajshree Sainath Hospital, Ahmednagar from 20.8.2003 to 28.8.2003 for excision of Right sided Gynaecomastia. When the claim was submitted to the Insurance Company under the mediclaim policy the TPA of the Company repudiated the claim invoking clause 4.5 of the mediclaim policy which excluded treatment for cosmetic surgery. Dissatisfied with the decision of the Company, Shri Deshmukh represented and his representation was also turned down by the Company, hence being aggrieved, he approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim alongwith interest. After perusal of the records parties to the dispute were called for hearing. It would be seen that the Company rejected the claim on the ground that the surgery done to remove the swelling on the right breast was only for cosmetic or aesthetic purpose without having any medical emergency. Unfortunately the Company and the TPA have overlooked one aspect of the problem. Gynecomastia occurs during the three distinct age period, transiently at birth, again beginning with puberty and declining during the later teenage years and finally in adults. The Insured was aged 33 years hence following the classical theory it should not have either occurred or continued till that age. It is thus an exceptional case as per the theory. Secondly there are instances of swelling continued with intense pain and when it becomes unbearable surgery is the only solution. There have been instances where ignoring this stage continuous swelling was later associated with intense pain. It would no doubt be impossible for the person to carry out with this discomfort for long and therefore, medical emergency and need is established by intensity of the disease. The hospital case papers clearly establish that the patient was having pain and swelling was increasing for which he had to consult a Doctor.

Based on the above view the Company’s repudiation is hereby set aside and the Complainant’s complaint is upheld.

Mumbai Ombudsman Centre

Case No. GI-310 of 2004-2005
Smt. Ishwari B. Gwalani
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27.12.2005

Smt. Ishwari B. Gwalani was insured under a Mediclaim Policy No. 121400/48/02/4224 issued by the Oriental Insurance Company Limited. When Smt. Gwalani preferred a claim for Rs.1,07,198/- to the Company the company settled the claim for Rs. 50,298/- after deducting Rs. 25,000/- towards Laparoscopic instrument and Rs. 28,000/- for Harmonic Scalpal. Not Satisfied with the decision of the Company, Smt. Gwalani represented to the Company which was turned down. Aggrieved for refusal to pay the cost of surgical appliances like Laparoscopic Instrument and Harmonic Scalpel Instrument she approached this Forum for full settlement of her claim. After perusal of the records parties to the dispute were called for hearing. Analysis of the relevant records made available with the Forum would reveal that Laparoscope is an endoscope designed to permit visual examination of the abdominal cavity. Thus the Laparoscopic instrument is made use of in several patients for examining the cavity of the abdomen. As regards scalpel, it is a small, straight surgical knife with a convex edge and thin keen blade. It is quite evident from the above that laparscopic instuments and harmonic scalpel are surgical instruments which are definitely not used only for one patient i.e. the Insured but quite usable in future laparoscopic surgeries.

On the basis of above analysis aided by a specialist Endoscopist and Laparoscopist opinion the Company's decision for disallowing Rs. 25,000/- towards laparoscopic instrument and Rs. 28,000/- towards harmonic scalpal cannot be faulted and this Forum does not find any valid ground to interfere with their decision for rejection of the above amount claimed by the Insured which has been paid by him.

Mumbai Ombudsman Centre
Case No. GI-320 of 2004-2005
Shri K. C. Vakharia
Vs
The New India Assurance Co. Ltd.

Award Dated 27.12.2005

Shri K. C. Vakharia alongwith his wife was covered under a mediclaim policy No. 110900/48/02/01400 issued by the New India Assurance Company Limited, DO - 110900 since 12 years. Initially they were covered under category A i.e. for Sum Insured of Rs. 96,500/- which was increased to Rs. 3,00,000/- from 1997-98. Smt. Rashmi K. Vakharia wife of Shri Vakharia was hospitalized and when Shri Vakharia preferred a claim for the said hospitalisation the company settled the claim for Rs. 1,35,100/- against his claim for Rs. 2,39,969.25. Not satisfied with the decision of the Company, Shri Vakharia represented to the Company which was also turned down. Hence aggrieved he approached this Forum for redressal of his grievance. After perusal of the records parties to the dispute were called for hearing. The relevant records produced to this Forum have been scrutinized and an analysis of the records would reveal that the Insured took policy from the New India Assurance Company originally for Sum Insured of Rs. 96,500 and approached the Company for increase in sum insured by Rs. 2,03,500/- on 3.5.97. From the records it is evident that this was a stage well beyond 1st and 2nd stage for which the Doctor decided to go for total knee

replacement which is not easily resorted to. Normally surgery is not done only when the remedial measures through medication and physiotherapy is not possible. Going by this analysis backed up by actual findings through Investigation reports it gives a direction to conclude that the ailment i.e. pain difficulty in sitting, squatting, climbing stairs were there for much longer duration than a year and a half and it was well within her knowledge. It would be safely inferred that the initial statement made before the Doctor that pain was of 8-10 years duration was correct even though it was not diagnosed as 'Oestoarthritis' right at that moment. It was expected of the Insured to disclose the ailment before increasing the Sum Insured with a long jump from Rs. 96,500/- to Rs 3 lacs. Since it was pre-existing and not disclosed at the time of increasing sum insured in 1997, the claim is payable for the original sum insured with Cumulative Bonus threon before the increase in Sum Insured.

In the facts and circumstnces I find the decision of the Company to restrict the claim to original Sum Insured with Cumulative Bonus is in order and this Forum has no valid ground to interere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI-472 of 2004-2005
Shri Kishore D. Doshi
Vs
The New India Assurance Co. Ltd.

Award Dated 29.12.2005

Shri Kishore D. Doshi was covered under the said mediclaim policy since 1994. When Shri Doshi preferred the claim for the said hospitalisation, the third party administrator of the Company repudiated the claim on the ground of pre-existing illness. On receiving Shri Doshi's representation the Company referred the file to their panel doctor and based on the opinion reiterated the stand of repudiation taken by their TPA. Hence being aggrieved he approached this Forum for full settlement of his claim. After perusing the records, the parties to the dispute were called for hearing. Facts have been analysed on the basis of documents and papers submitted by the Insured/hospital and the Comany. On thorough perusal of the entire claim file further duly supported by the documents produced by the Insured it is revealed that Shri Doshi was first hospitalized for Hypertension in 1995 at Bombay Hospital and Research Centre for which he had submitted a claim and the same was settled by New India on 5.2.1996. New India could not offer any comment against settlement of this claim nor could they produce any hospital records to prove the Insured's past medical history. The Insured has now preferred a claim for Non Q Anterior Wall Myocardial Infarction which has a direct bearing to his past history for Hypertension. The Company felt since the history is now revealed it should act as pre-existing illness and that way their earlier settlement was wrong. In absence of any records of medical history, hospital case papers and in fact even the claim file also could not be produced by New India, such a stand is untenable. Since there was some anomaly in the history noting in Rane's hospital with same notings possibly reveal some attempts of making a uniform statement for the purpose of Insurance claims with all these which is bordering on improper intention. The New India Assurance Company Limited is directed to settle the claim of Shri Kishore Doshi for his hospitalisations and pay only 50 % of the admissible expenses.

Mumbai Ombudsman Centre
Case No. GI-521 of 2004-2005
Shri Harendrakumar Thakor Desai

Vs

The New India Assurance Co. Ltd.

Award Dated 29.12.2005

Shri Harendrakumar Thakor Desai along with his wife took a mediclaim policy from the New India Assurance Company Ltd for Sum Insured of Rs. 3 lakhs each. Shri Desai took an Overseas Mediclaim Insurance Policy during the same year for 4 months. After coming back from abroad, Shri Desai renewed his Individual Mediclaim policy for a further period of one year. He was admitted to Brahma Kumaris' Global Hospital & Research Centre for Myocardial Infarction from 10.02.2004 to 12.02.2004 and on same date he was shifted to Asian Heart Institute for further management and Cardio Angiography was done on 14.02.2004 under care of Dr. Vaishnav and discharged on 18.02.2004. Shri Desai submitted all documents pertaining to his hospitalisation to M/s Paramount Health Services Pvt. Ltd., TPA who processed the claim. The Company took medical opinion from their panel doctor, Dr. Dhruman M. Desai and accordingly the Company informed Shri Desai their inability to settle the claim in view of the contradictory statements made by him in his letter dated 01.06.2004 and the inconsistency of medical facts seen from the hospital notes. It is noted that Shri Harendra T. Desai was hospitalised at Brahma Kumaris' Global Hospital & Research Centre for severe chest pain with sweating and choking sensation. He was diagnosed to have Anterior Wall Myocardial Infarction with hypertension and diabetes. Later he was admitted to Asian Heart Institute and was discharged with medical advice of low fat diet and physical activity with some medication.

A close scrutiny of the hospital records easily reveals the Insured's existing complaints and the past history. He was admitted with BP reading 160/110 and it was clearly mentioned that he was hypertensive and on regular medication with Atenolol since 1 yr. Amongst risk factors it was mentioned that he was heavy smoker and a known alcoholic as per the BSES MG Hospital notings. Hypertensive cannot be sporadically checked only when he came to India and on that basis decided that he was non-hypertensive. The Asian Heart Institute record also suggests that he was diabetic which was again remarked as final diagnosis. Secondly, if a person stays outside India and comes for a month also during which time if he is cheked by his physician with his medication intact the results are supposed to be negative. On the eontrary, if the results were positive it would appear that the medicines were not working. With the admission of Shri Desai before BSES Hospital that he was on Atenolol for his hypertension and with the clear diagnosis of both Hypertension and Diabetes mellitus and straightway being on diabetic diet with strong health hazard of smoking and alcoholism, it is medically and circumstantially established that the duration of disease would be longer than 1 year to be on medicine. In the facts and circumstnces, based on the analyses as made above also backed up by medical reports, I do not find any good ground to set aside the repudiation made by the New India Assurance Co. Ltd.

Mumbai Ombudsman Centre

Case No. GI-458 of 2004-2005

Shri Kiran H. Modi

Vs

United India Insurance Co. Ltd.

Award Dated 30.12.2005

Shri Kiran H. Modi alongwith his wife was continuously covered under the mediclaim policy from 31.8.1999. Smt. Shobhana Modi wife of Shri Kiran Modi was operated for severe dysmenorrohea at Dr. Trivedi's National Institute of Laser and Endoscopic

Surgery (NILES) on 5.10.2003 and when Shri Modi preferred a claim for the said hospitalisation the Company repudiated the claim and their contention was that the treatment undertaken was for infertility. Dissatisfied with the decision of the Company, Shri Modi represented to the Company and the Company reiteated their stand of repudiation Aggrieved by the said decision of the Company Shri Modi approached this Forum for redressal of his grievance. After perusal of the records parties to the dispute were called for hearing. The analysis of the claim reveals that whether Smt. Shobhana Modi was having the ailment which was necessary to be cured ? The answer would be obviously 'Yes' as she was having dysmenorrohea and severe abdominal pain. The investigations revealed that she had endometriotic cysts and adheniolysis The Histoscopy was done to eliminate any pathology in the uterus or pain in the abdomen. Again an important point is established that this ailment cured the patient from this disease and failure to do so would have been life threatening. In doing so, even if she was able to conceive later it would not be taken basically as a treatment for infertility for which the claim has been denied. The concened doctor has clearly confirmed in his letter that there was no specific treatment given for infertility. To our mind the treatment for sterility is a detailed long drawn treatment for which lot of researches are still on and that is excluded under the policy in a broader sense. In the facts and circumstances the repudiation of United India Insurance Company Limited is set aside as the claimant's complaint is found tenable.

Mumbai Ombudsman Centre
Case No. GI-495 of 2004-2005
Shri Anupkumar Manilal Chandarana
Vs
The Oriental Insurance Co. Ltd.

Award Dated 30.12.2005

Shri A. M. Chandarana was insured under mediclaim policy of the Oriental Insurance Co. Ltd., Thane Divisional Office. Shri A. M. Chandarana preferred a claim after hospitalisation at Lilavati Hospital for the treatment of Acute headache with neck pain with fever from 16.03.2004 to 17.03.2004. The claim was processed by Raksha TPA Pvt. Ltd. and after scrutiny of the claim papers, they opined that the hospitalisation was only for investigation and observation purpose due to which the claim becomes non-payable as per Exclusion Clause 4.10 of the mediclaim policy. The Company has also upheld the decision taken by TPA and informed the same to the Insured. Not satisfied with the decision taken by the Company, he approached the Insurance Ombudsman on 12.09.2004 seeking an intervention in the matter.

Dr. Conrad L. Furtado Physician, on 15.03.2004 had advised the insured for hospitalisation on observing symptoms like neck rigidity since 2 days and throat congestion along with fever and bodyache since 5 days. On going through the case papers from Lilavati Hospital, it is observed that the insured was admitted on 16.03.2004 and that there is a mention of 'Dr. no. reference' indicating thereby that there was no reference from any doctor for hspitalisation. As per the case papers the chief complaint was fever since 6 days, stiff neck since 1 day, history of headache since 1 day and no history of nausea/vomiting. From the case record it is also observed that the insured was a known case of hypertension since 3 years on tablet Losar and Tablet Ecossprin. Suspecting meningitis, Lumbar Puncture was done on 16.03.2004. The report of MRI Brain with contrast ruled out Subarachnoid Haemorrhage and meningitis.

It is observed that the insured first consulted the physician Dr. Conrad L. Furtado and subsequently he sought opinion from Dr. Shirish M. Hastak, a neurologist and as advised by him, Shri Chandarana decided to get admitted in Lilavati Hospital to rule out meningitis. As per the record of Lilavati hospital there was no reference from any doctor for the admission of the insured The way treatment was taken and progressed in stages, it clearly rules out the attack of meningitis which is a virulent form of ailment palpably different from the Insured's hopping between different doctors. Secondly, the series of investigations done would not have been done or agreed to by the Insured, if there was no insurance coverage. Clearly therefore there had been an attempt to utilise the Mediclaim Policy to the best advantage. Thirdly and most importantly, even if some investigations were necessary, they could have been done as outpatient only without getting admitted just for 24 hrs as per terms of the policy which is precisely the exclusion under clause 4.10 of the policy. Based on the above findings and analysis made, I find no fault in the decision of the Company to repudiate the claim under Clause 4.10 of the mediclaim policy.

Mumbai Ombudsman Centre
Case No. GI-478 of 2004-2005
Shri P. K. Gopalan
Vs
National Insurance Co. Ltd.

Award Dated 30.12.2005

Shri P. K. Gopalan alongwith his family members had taken a Mediclaim policy cover for the first time in the year 1999 from The New India Assurance Company Limited, D. O. 140300. Smt. Lata Gopalan wife of Shri P. K. Gopalan was admitted to Bombay Hospital and Medical Research Centre for Incisional Hernia and when Shri Gopalan preferred a claim for the said hspitalisation the Third Party Administrator of the Company repudiated the claim by invoking clause 4.1 of the mediclaim policy. Aggrieved by the decision of the Company Shri Gopalan approached this Forum for justice. After perusal of the records parties to the dispute were called for hearing. The analysis of the case reveals that Smt. Lata Goplan wife of the Complainant was admitted to Bombay hospital and research medical centre on 20th August, 2003 precisely for incisional hernioplasty with complaints of swelling of peri-umbilical region since last 5 years. It was mentioned that swelling became prominent on coughing and straining. The case papers further recorded that Smt. Gopalan had a history of 3 caesarian section deliveries and was also known to be a diabetic for which she was on medicine. The very expression of "Incision" would mean that herniation was due to the incision which occurs usually with abdominal exploration. In the instant case the very fact that there were 3 caesarian sections for delivery even if 2 years back, would easily mean that the abdominal wall was sufficiently weakened and thinned as a result of which there was a cavity which gave rise to protrusion or swelling in the umbilical region. The important point to note would be that three abdominal surgeries are significant health interventions which should be taken as a knowledge before the policy was taken and therefore, pre-existing as well.

In view of clear explanation in the hospital records about the nature, extent and cause of hernia due to past incisions coupled with the fact that since 5 years swelling was apparent the repudiation of the claim by the Company under clause 4.1 i.e. pre-existing disease is sutainable.

Mumbai Ombudsman Centre
Case No. GI-465 of 2004-2005

Shri Kishor Vithalani
Vs
National Insurance Co. Ltd.

Award Dated 30.12.2005

Shri Kishor Vithalani alongwith his family were covered under medicalim Policy issued by National Insurance Company Limited. Shri Vithalani had an intermittent chest pain for which he was initialy hospitalized at Suchak Hospital on 8.9.2003 and then he was shifted to Asian Heart Institute, Mumbai, from 15.9.2003 to 17.9.2003 for Angioplasty. When Shri Vithalani preferred a claim for the said hospitalisation the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Dissatisfied with the decision of the Company Shri Vithalani represented and not receiving and reply from the Company, he approached the Insurance Ombudsman for redressal of his grievance. After perusal of the records parties to the dispute were called for hearing. A critical analysis of the claim papers reveal that apparently the Insured had no past complications as per hospital case papers. The first admission was in Suchak Hospital on 8th September, 2003 in the ICU and certain investigations followed. He was later shifted to Asian Heart Institute on 15th September, 2005 where angioplasty was done. The analysis reveals that there would have been some positive existence of ailment which may not have been diagnosed as Coronary Syndrome as such but sufficient signals to be on guard with diet and physical activity to avoid heart disease, must have been there as a preponderance of probability factor.

Neverthless abrupt denial by the TPA without the past history and merely going by the blockages in the arteries would no doubt prove that they had totally closed their mind in respect of some patients who would be totally asymptomatic. Considering such a possibility and notwithstanding the findings in the ECG, Echo-D and CAG in absence of any documentary evidence, I feel the only solution would be to consider the claim on non-standard basis as a compromise to pay 60 % of the admissible expenses.

Mumbai Ombudsman Centre
Case No. GI-583 of 2004-2005
Shri Anil C. Hinduja
Vs
The New India Assurance Co. Ltd.

Award Dated 30.12.2005

Shri Anil C. Hinduja was insured with the New India Assurance Company Limited since 22.11.1999 and he had earned Cumulative Bonus of 35 %. When he lodged a claim with the New India Assurance Co. Ltd. for his hospitalisation at Ambulatory Surgery Clinic for internal piles - fissure, the Third Party Administrator of the Company sent a discharge voucher for Rs. 44,888/- which was not accepted by him. On Shri Hinduja's representation to the company, the TPA made an investigation and repudiated the claim on the basis that there was no indoor facility available in the hospital and the treatment was given on OPD basis. Hence, being aggrieved Shri Anil C. Hinduja approached this Forum for justice. Records have been perused and the parties to the dispute were held. A critical scrutiny of the case reveals that the insured was indeed under a terrible situation arising out of this bleeding piles which required immediate care and treatment. Mediclaim policy is designed to offer quick relief and care to the Insured who have availed this policy by paying premiums. Ambulatory surgery Clinic and hernia centre is registered with B.M.C. and has been functioning for quite some

time through enlistment of several reputed doctors. This Forum principally is concerned with the fact that the Insured under the policy has taken treatment from an authorized Nursing Home and at the hearing the deposition made by the Insured confirmed the services received by him for which he made actual payment to the Nursing Home and the surgeon. I therefore, feel that it would be equitable to admit the claim for surgery, cost of medicines etc without allowing overnight stay granting for the sake of established market view about the Nursing Home operating only as a day care unit where the patients are discharged on the same day following surgery and in the normal course it would have been done so in this case, going by the notation of the doctor to keep him overnight.

Mumbai Ombudsman Centre
Case No. GI-499 of 2004-2005
Shri Bosco Rodrigues
Vs
United India Insurance Co. Ltd.

Award Dated 30.12.2005

Shri Bosco Rodrigues who was to visit Toronto, Canda had taken an Overseas Mediclaim Policy (B & H) No. 020100/46/02/82052 from United India Insurance Company Limited, D. O. I. During his visit to Canada Shri Rodrigues slipped on ice and fractured his ankle. He was treated on OPD basis at Canada for a fracture to his ankle. When Shri rodrigues preferred a claim to the Company the claim setting Agents of the Company made partial settlement of the claim for which Shri Rodrigues was unsatisfied and hence approached this Forum for justice. After perusal of the records parties to the dispute were called for hearing. The analysis of the case reveals that basically the dispute continued because of Company's inability to properly explain the reason for disallowance of some amount claimed by Shri Rodrigues and also the Insured's lack of appreciation about the basic terms and conditions of mediclaim policy including the imposition of 'deductible; which is a very common expression in Insurance parlance. A deeper examination revealed that he claimed CAD $ 940.48 and the Company settled the claim in US $ after conversion of this CAD $ as per terms and conditions of settlement under the policy. As regards main claim United India settled US $ 377.95 to the Insured and US $ 136.48 directly to the hospital i.e. the providers. This did not include the cost of crutches and the policy excess/deductibe of 100 US $. The Company appreciated the point raised by the Insured and offered to settle US $ 136.48 directly with the hospital on receipt of proof that he had already paid to the hospital US $ 136.48 which would have virtually made a duoble payment to the hospital and therefore, recoverable from them by the Insurance Company. Since with all these terms and conditions the policy was issued which was accepted by the Insured and which compares favourably with the international market practice as well, this Forum does not have any good reason to interfere with the decision taken by United India Insurance Company Limited to repudiate the additional amounts claimed by the Insured.

Mumbai Ombudsman Centre
Case No. GI-445 of 2004-2005
Shri Bhavin G. Karia
Vs
The New India Assurance Co. Ltd.

Award Dated 02.01.2006

Smt. Nirmala Karia was covered under Mediclaim Policy of the New India Assurance Co. Ltd. since 1998 for Sum Insured of Rs. 5 lakhs. Smt. Nirmala Karia was hospitalised at Sai Baba Medical Services for pain and swelling in both lower limbs with tingling sensation and difficulty in walking. She was again admitted to the same hospital and was diagnosed as DVT & Pancytopenia c piles, Sacralisation of L5 gd. II anterolisthesis of L4, L5 c Spondylolysis at L4. Canal narrowing at L2-L3 to L4-L5, mild ant wedge collapse of D12 vertebral body. The insured preferred a claim for reimbursement of hospitalisation expenses for both the hospitalisation to M/s TTK Health Care Service Pvt. Ltd. but the same was rejected by them stating that the Insured was having the complaint of Deep Vein Thrombosis (DVT) since 10-12 yrs which is prior to the policy and comes under Exclusion 4.1 of the mediclaim policy. The Company after going through the records decided to uphold the decision taken by TPA and rejected the claim under Exclusion 4.1 of the mediclaim policy.

A critical alalysis would reveal that the problem could not be of sudden occurrence as it always takes a long time to cause veinous thrombosis. The recording of both lower limb pain and swelling since 10 to 12 yrs is the most likely scenario reflecting the true health status of the patient. In fact this history has been recorded in the Discharge Summary and Indoor Case papers as well. As far as medical facts are concerned the above analysis would reveal the truth. Even psychologically the fact would be established that when a person approaches the doctor to reverse the noting following the rejection by the Company, it would always be taken unfavourably. It would appear logical if the Insured objected to the discharge card recording even at the time of discharge or immediately thereafter but not later after the rejection of the claim to reduce ‘years’ to ‘months’ which comes handy because of policy coverage being inadequate to cover the period of complaints. In fact after the history is duly recorded by the hospital authorities, a certificate by an attending doctor or even by any other hospital doctor would not be an acceptable document in the matter of adjudication by any Forum unless it enjoys due legal sanctity of correction. Based on this analysis as above, it would be prudent to conclude that the main complications of DVT and associated ailments become non-payable to justify the rejection of the Company. However, taking a liberal view of the matter if it is possible to hold the direct consequences of DVT duly identified and then examine the independent occurrence of disease like Lumber Stenosis, Sacralisation, Hypertension and piles it would give some clue that perhaps not all would be the immediate fall out of DVT. But again when the sacral nerves got affected it would engage our attention to the cause. The physiology says these nerves “carry sensory and motor fibres from the upper and lower leg and from anal and genital regions” and sacralisation is “abnormal fusion of the fifth lumber vertebra with the sacrum”. Unfortunately, there is no specific treatment other than physiotherapy, conservative medical management and in extreme emergency surgiacal intervention. Hence, taking an extremely linient view. I order that 10 % of the admissible cost including proportionate hospital stay may be allowed and a lumpsum amount of Rs. 7,000/- as a compromise settlement may be made representing cost of treatment for some of the above mentioned diseases.

Mumbai Ombudsman Centre
Case No. GI-387 of 2004-2005
Shri Vijay Goel
Vs
United India Insurance Co. Ltd.

Award Dated 04.01.2006

Shri Vijay Goel alongwith his wife was covered under Mediclaim policy issued by United India Insurance Company Limited. Shri Vijay Goel was hospitalized at Breach Candy Hospital, Mumbai for Sarcoidosis atypical pneumonia. When a claim was preferred by Shri Goel for the said hospitalisation the Company repudiated the claim invoking pre-existing clause of the mediclaim policy. Dissatisfied with the decision of the Company. Shri Goel represented to the Company and approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. The records have been perused at this Forum and parties were called for personal hearing The analysis of the case brings certain important issues to the fore that the Insured was having multiple illness, which ultimately destroyed the immuno system may be hastened by high dose steroids and cyclosporin to combat the violent progress of the diseases. Based on the past history and findings it is evident that the first policy was taken with pre-existing illness which were not disclosed also, hence the repudiation by the Company is in order.

Mumbai Ombudsman Centre
Case No. GI-532 of 2004-2005
Shri Ramesh Chhaya
Vs
The New India Assurance Co. Ltd.

Award Dated 02.01.2006

Shri Ramesh Chhaya was covered under mediclaim policy No. 141600/48/03/05544 issued by the New India Assurance Company Limited, D. O. 141600 for Sum Insured of Rs. 65,000/- with 20 % Cumulative Bonus. Shri Ramesh Chhaya was hospitalized at Mangalam ICCU and General Hospital for Lt Cardio Vascular Embolism (Lt) Hemiplegia with IHD. When a claim was preferred by Shri Chhaya to the Company, 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 Chhaya represented to the Company and not satisfied, approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of his claim. After perusal of the records, parties to the dispute were called for hearing. It is also noted that while referring Shri Chhaya to Noble hospital by Mangalam hospital, the doctor has mentioned the Insured was a known case if IHD/old - 1994 and left hemiparesis - 1979. It also mentions Aspitrate/Rampress 10 mg/Dilzem SR 120 for 10 years. The concerned Doctor of Mangalam Hospital issued a specific letter to the TPA to admit their slip of pen in writing 1979 which should be 1999 and going by the concept of common number errors, it is acceptable and more so, when the Doctor has apologized for the slip. It was also acceptable from the actual C. T. Scan which recorded old infarct/lesion seen in the right basal ganglion. Since the Insured has admitted an episode in 1999, the corroboration on the C. T. Scan further confirms it and therefore, this Forum accepts the slip of pen as genuine. The Insured had a continuous policy since 1994 and he had received a claim due to Hypertension in 1994 from New India. The present history noting is also 10 years on medicine which goes back to 1994 from the date of hospitalisation and therefore, the pre-existing condition is borderline and cannot be accepted as New India already settled a claim for Hypertension on 1994. As New India has not been able to medically prove that Shri Chhaya was suffering from Hemiparesis prior to 1994, the contention of the TPA that the disease was pre-existing is not tenable. In the facts and circumstances the claim of Shri Ramesh Chhaya is sustainable.

Mumbai Ombudsman Centre

Case No. GI-250 of 2004-2005
Shri Bhupatrai Jethalal Parekh
Vs
The New India Assurance Co. Ltd.

Award Dated 06.01.2006

Shri Bhupatrai J. Parekh was holding a mediclaim policy No. 111400/48/02/13678 issued by the New India Assurance Company Limited for a Sum Insured of Rs. 5,00,000/-. Bhupatrai J. Parekh was hospitalized at Dr. Balabhai Nanavati Hospital from 28.10.2003 to 01.11.2003 for Ischemic Heart Disease where Percutaneous Transluminal Coronary Angiplasty (PTCA) was done. When a claim was preferred by Shri Parekh for Rs. 3,94,192/- to The New India Assurance Company Limited for the said hospitalisation the Company's Third Party Administrator (TPA), M/s TTK Healthcare Services sent a Discharge Voucher on 19.1.2004 for RS. 3,05,808/-. Shri Bhupatrai was not satisfied with the decision of the Company for not paying Rs. 30,607/- towards the cost of Coronary Angiography. His representation to the Company was also not considered. Hence aggrieved Shri Bhupatrai Parekh approached this Forum for settlement. The records were perused and the parties to the dispute were called for hearing. It is observed that the dispute is only regarding non-payment of cost incurred towards Coronary Angiography. It is also felt that the TPA failed to explain to the Insured the basis of settlement and the Company did not make an effort to clarify further. They merely mentioned that there is an administrative circular issued by New India instructing their Divisional Offices. An examination of this circular is important to find a solution to the dispute. The Mediclaim Policy has an Exclusion Clause 4.10 in terms of which claims consisting of only tests and investigations in a hospital without being treated in the hospital for an actual illness diagnosed as a result of the tests, would be disallowed. However, New India made an exception for CAG test to allow the cost of investigation even if it was not followed by treatment, in the hospital. Accordingly, New India made a payment of Rs. 30,408/- in September, 2002 under the claim lodged by the Insured. Hence, they disallowed the cost of CAG from the total cost of Angioplasty etc. as per their note.

In view of the above facts the Company's decision for non payment of claim amount to that extent is in order and this Forum has no reason to interfere in the decision taken by the New India Assurance Company Limited.

Mumbai Ombudsman Centre
Case No. GI-522 of 2004-2005
Shri Hemant R. Desai
Vs
The New India Assurance Co. Ltd.

Award Dated 09.01.2006

Shri Hemant R. Desai alongwith his family were covered under the mediclaim Policy No. 111800/48/02/12634 issued by the New India Assurance Company Limited, D. O. 111800 with an exclusion of Diabetes and any other complications thereof for Shri Hemant Desai. Shri Hemant Desai was admitted to Asian Heart Hospital on 15.10.03 to 18.10.03 for Single Vessel CAD, PTCA Stent to LAD and Diabetes Mellitus. When the claim was preferred by Shri Desai to New India the file was examined by their Third Party Administrator M/s TTK Healthcare Services Pvt. Ltd. and after scrutiny they informed Shri Desai that as Single Vessel Disease was a known complication of Diabetes Mellitus the claim fell under exclusion clause 4.1 and hence the claim was not payable. Not satisfied with the decision of the Company Shri Desai represented to the

Company and the Company reiterted the stand taken by their TPA. Being aggrieved, Shri Hemant Desai approached the Office of the Insurance Ombudsman with a complaint. The facts of the case have been gone through and the parties to the dispute were called for personal hearing. The issue of a parallel policy with National Insurance Company Limited has been resolved following insured's submission of the claim payment discharge voucher which was noted by parties at the hearing. A close scrutiny and analysis of the records submitted to this Forum would reveal that the insured was hospitalzed for chest pain with perspiration and the diagnosis was Diabetes Mellitus - Acute Anteroseptal Miocardial Infarction (Thrombolysis). While going through the Indoor case papers, it is noticed that the Insured had past history of Diabetes Mellitus since 11 years. While issuing policy New India Assurance Company had excluded diabetes and any complications therefrom from coverage. Diabetes has been identified as an independent and major risk factor for the development of Coronary Artery disease. Incidentally Shri Desai mentioned that he had a policy from National Insurance Company since 1989 for Rs. 15,000 with a Cumulative Bonus of 50 % and his claim was settled for Rs. 22,500/- by TPA M/s Paramount Health Care. In the facts and circumstanes of the case, the decision of the Company to repudiate the claim for the above hospitalisation cannot be faulted and this Forum finds no valid ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. GI-493 of 2004-2005
Shri Dilip Khimji Babla
Vs
National Insurance Co. Ltd.

Award Dated 10.01.2006

Shri Dilip K. Babla alongwith his wife Smt. Tara D. Babla was covered under the mediclaim policy No. 250300/48/03/8504744 issued by National Insurance Company Limited, D. O. III, Mumbai for the period 22.2.2004 to 21.2.2005 for a Sum Insured of Rs.1,00,000/- with Cumulative Bonus. Smt. Tara D. Babla was admitted to Wockhardt Hospital for Lt. MCA Infarct with Right hemiplegia. When Shri Babla lodged his claim for reimbursement, the TPA of the Company, M/s Heritage Health Services Pvt. Ltd. rejected the same invoking clause 4.1 of the mediclaim policy. Their contention was that as per documentary evidence Smt. Babla was suffering from hypertension since 15 years which was the proximate cause for Cerebrovascular accident. Aggrieved at the decision of the Company, Shri Babla represented to them and not receiving any favorable reply 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 relevant records produced to this Forum have been scrutinized thoroughly. An analysis of the records would reveal that as per the discharge summary of the hospital it is oserved that she was diagnosed to have 'Left MCA Infarct with Right Hemiplegia ? Her B. P. during admisson was on higher side showing 170/120. As regards past illness, "history of Hypertension since past 15 years on regular treatment" was mentioned in the Discharge Card. It is not merely that the Insured was on medicine off and on but the expression was "on regular treatment" which quite evidently confirms that history was given correctly and precisely to the Doctor and which is only normal procedure. The Complainant's contention that somebody else gave it would not hold water as whoever had given should have been responsible to do so as the hospitals have a clear policy in this regard. Moreover, the progress of the disease as evident from the Investigation reports with reduced power of

upper and lower limbs, high B. P. and the doses of a variety of medicines confirmed that the Insured was on treatment for quite sometime.

In view of the above analysis and based on the facts and circumstances, Company's decision to repudiate the claim is held sustainable.

Mumbai Ombudsman Centre
Case No. GI-154 of 2004-2005
Shri Shashikant A. Bhatkar
Vs
The New India Assurance Co. Ltd.

Award Dated 10.01.2006

Shri Vishnupant A. Bhatkar brother of Shri Shashikant A. Bhatkar was covered under a Good Health Group Policy issued to all City Bank Credit Card holders by the New India Assurance Company Limited, Chennai D. O. 712500 from November, 2002 for Sum Insured of Rs. 2 lacs. Shri Vishnupant Bhatkar was hospitalized at Doctor Eye hospital, Mumbai on 16.4.2005 for cataract an IOL implant surgery for his right eye. When he preferred a claim of Rs. 25,258/- to the Company, the Company's Third Party Administrator M/s TTK Health Care Services Private Limited after going through the file repudiated the claim stating that as per terms and conditions of the policy cataract surgery was excluded from the scope of the policy. They invoked certificate condition 4 comparable to clause 4.3 of the Group mediclaim policy issued to policyholders. Aggrieved by the decision, Shri Bhatkar represented to the Company stating that when he had taken the policy in the year, 2002 the exclusion was one year and the changes that had taken place to 5 years and then later on to 3 years period was not informed to him. He stated that he had renewed the policy based on the original terms and conditions. Not getting any favorable response, Shri Bhatkar, approached the Insurance Ombudsman, for his intervention in the matter. After perusal of records, parties to the dispute were called for hearing. 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 resorted 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. A copy of the Certificate issued to Shri Bhatkar has also been forwarded to this Forum. Under the above circumstances this Forum does not find any merit to interfere with the decision of the New India Assurance Company to limit their liability as per the policy conditions framed by the Insurance Company.

Mumbai Ombudsman Centre
Case No. GI-539 of 2004-2005
Smt. Aruna Sumanlal Mehta
Vs
The New India Assurance Co. Ltd.

Award Dated 10.01.2006

Shri Sumanlal J. Mehta took a Mediclaim policy from the New India Assurance Company Ltd., Mumbai covering himself and his wife Smt. Aruna S. Mehta for the period from 17.09.2002 to 16.09.2003. Smt. Aruna S. Mehta, preferred a claim under Domiciliary Hospitalisation for Rs. 11,535/- from the Company for the treatment which

her husband, Shri Sumanlal J. Mehta, took from Dr. D. D. Choudhary, Chief Intensivist (ICCU) of Parsee General Hospital. Thereafter, the Company repudiated the claim in 02.08.2004 on the groud of non-submission of relevant documents by the Insured. Smt. Aruna S. Mehta, represented to Regional Office, Grievance cell of the Company against the reoudiation of claim. In her letter, she mentioned that “No policy condition states anywhere that the patient should obtain letter from the hospital certifying that there is no bed available”.

In reply to her representation, the company regretted their inability to reconsider their decision of repudiation under exclusion clause 2.3 stating as under.

It is difficult to believe that in the city like Mumbai where facility is ample, no beds were available on that day.

The explanantion and the justification given in unjustifiable and unreasonable.

Aggrieved by the decision of the company, Smt. Aruna Mehta, approached the Ombudsman vide letter dated 20.1.2005.

It should be mentioned right here that the Company’s official rejection was dated 2.8.2004 and 27.12.2004 and, therefore, the stand taken at the hearing that the rejections also came under Condition 2.4 of the Mediclaim Policy would not be acceptable as this was an after-thought, which was never taken as a defence in the letters issued to the Insured which are available with this Forum as valid documents. Nevertheless, it would be examined in so far as it has relevance.

First of all, the company had all intentions to examine the claim in proper perspective and perhaps setting the same, which is demonstrated by their action to appoint an Investigator, Shri Yogesh Gaikwad, to go into only one aspect of the dispute viz. whether Shri A. S. Mehta was actually denied hospital accommodation. The Investigator has submitted his report dated 29th June, 2004 wherein, he mentioned that the concerned hospitals have confirmed that it was not their policy to issue such a certificate to anybody. Further, in June, they confirmed that their hospitals are running full capacity and normally, they give preference to patients requiring surgery on waiting list. The effort to get at the truth thus was not fulfilled in that sense to decide on the merits of the claim. The second issue as regards the treatment received at house was not much touched upon by the company as is evident from their letter dated 27.12.2004 which states that “It is difficult to believe that in a city like Mumbai, where facility is ample, no beds were available on that day”. In other words, therefore, the rejection only directs to this point but no other issue. However, this point also can be analysed in terms of actual situation.

Hypertension anyway was being controlled by various combination drugs but the issue came due to his past complications and heart surgery which would be life threatening and if a person is denied accommodation in ICCU, he has to be provided with medical relief for which the policy has been provided to him. This is more so when he had a record of past surgery coupled with the fact that he is a blind person and requiring attention of his family members in the hour of emergency.

Based on this argument, I feel the rejection of the company on the ground s mentioned in their letter plus the point which was raised at the hering would be unjustified and, therefore, I set aside the repudiation by the company.

Mumbai Ombudsman Centre
Case No. GI-233 of 2004-2005
Smt. Deepika P. Bagadia
Vs
National Insurance Co. Ltd.

Award Dated 16.01.2006

Smt. Deepika P. Bagadia was insured under a mediclaim Policy no. 250600/48/2001/8506777 issued by National Insurance Company Limited, D. O. 6 for the period from 29.3.2002 to 28.3.2002. Smt. Deepika Bagadia who was suffering from Oromandibular neck dystonia was admitted to Jaslok hospital under advice of Dr. Mohit Bhat from 2.8.2002 to 3.8.2002 and was given Botox injection. When Shri Pankaj Bagadia husband of Smt. Deepika Bagadia preferred a claim to the National Insurance Company for the said hospitalisation the Company after scrutiny of the relevant papers repudiated the claim stating that the hospitalisation was only for local injection and hence claim was not payable. Dissatisfied with the decision of the Company Shri Bagadia represented to the Company for reconsideration of his claim but National Company reiterated their earlier stand of repudiation. Hence being aggrieved Smt. Deepika Bagadia approached this Forum for redressal of her grievance. After perusal of the records parties to the dispute were called for a joint hearing. Dystonia is a muscle dysfunction characterized by spasms or abnormal muscle contraction. There may be spasm in the muscels of the face, shoulders, neck, trunk and limbs, the arm is often held in a rotated position and the head may be drawn back and to one side. Dystonic conditions including blepharospasm may be helped by the injection of botulinum toxin. Botulinum toxin is a powerful nerve toxin produced by the becteriumclostridium botulinum, that has proved effective, in minute dosage, for the treatment of various condition of muscle overaction and various dystonic conditions. It is administered by injection through eyes. From the above characteristics given for use of Botox injection it would appear that it was a specific purpose to serve and it is quite effective in quelling the effects of dystonia. Viewed in this context and the fact that the Company has already paid the claim of a similar illness in June 2001 for nerve disease, makes a good ground for some consideration. If hospitalisation expenses are deemed to be not properly called for the Company would be well advised to consider only the cost of medicine/injection and I feel a maximum of 25 % of cost may be deducted from otherwise admissible expenses to resolve the dispute.

National Insurance Company Limited is directed to settle the claim of Smt. Deepika Bagadia for her hospitalisation at Jaslok hospital for Oro-mandibular neck dystonia and pay 75 % of the total admissible expenses as a compromise settlement.

Mumbai Ombudsman Centre
Case No. GI-65 of 2004-2005
Shri Girish Hemant Inamdar
Vs
National Insurance Co. Ltd.

Award Dated 20.01.2006

Shri Girish Hemant Inamdar alongwith his family members were covered under a mediclaim policy issued by National Insurance Company Limited since 1997 and had earned Cumulative Bonus @ 35 %. Smt. Aparna G. Inamdar wife of Shri Girish H. Inamdar was hospitalized at Joglekar's hospital for Dental Implant surgery and when a claim was preferred by Shri Inamdar for the said hospitalisation, the TPA of the Company i.e. M/s Paramount health services Pvt. Ltd. repudiated the claim stating that treatment taken was related to cosmetic and prosthetic purpose hence claim was not payable. Aggrieved by the decision of the Company, Shri Inamdar represented to the Company and asked them to reconsider their decision taking into account the information given by Dr. Dilip S. Deshpande. Not receiving any reply from the Company, Shri Inamdar approached the Insurance Ombusman 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 Smt. Aparna Inamdar was suffering from periodontitis as was confirmed by her treating doctor as also on the basis of records submitted before this Forum. The history of surgery 6 years back lends credence to the fact that there was positive illness before the policy was operating since 1997-98 and therefore, the period of disease would be taken as pre-existing. As regards the other point of aesthetic or cosmetic treatment the Company's explanation is 'Cosmetic of any description' and therefore, should be taken to have larger dimension. Teeth being a very vital part of our body for mastication to digest food, any treatment which restores damaged teeth cannot be called 'aesthetic or cosmetic treatment" but necessarily required for gereral health. However, touching upon the first point of pre-existing illness this Forum has examined and it was found that the disease was there, diagnosis was complete and also the nature of treatment required, with only actual implantation was to be timed after restoration process was over.

Viewed in the context of the above analysis and based on the actual medical records the decision of the Company to reject the claim under exclusion clause 4.1 is sutainable.

Mumbai Ombudsman Centre
Case No. GI-138 of 2004-2005
Shri Ramesh Jayantilal Doshi
Vs
The New India Assurance Co. Ltd.

Award Dated 23.01.2006

Shri Ramesh Jayantilal Doshi and his mother Smt. Nirmala Doshi were covered under mediclaim policy issued by the New India Assurance Co. Ltd. Smt. Doshi was admitted in the Lilavati Hospital & Research Centre, Mumbai, from 24.06.2003 to 29.06.2003 for Slurring of speech with right-sided weakness. When Shri Ramesh Doshi submitted the claim, M/s TTK Healthcare Services Pvt. Ltd. repudiated the same that Thrombotic Stroke is caused due to hypertension and Smt. Nirmala Doshi was suffering from Hypertension since 15 years due to which the claim fell under Exclusion Clause 4.1 relating to pre-existing disease Shri Doshi represented to the Company on 12.02.2004 stating that his mother never took any medicine for hypertension and nor did she suffer from any heart ailment. He also stated that the history record in the hospital was wrongly written by junior doctor who instead of writing 15 days of hypertension wrote as 15 years of hypertension. The Company referred the matter to expert Medicolegal Consultant for his opinion and accordingly they upheld the decision of M/s TTK Healthcare.

The claim of Shri Ramesh Jayantilal Doshi for reimbursement of hospitalisation expenses incurred for his mother, Smt. Nirmala Doshi is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI-378 of 2004-2005
Shri Pyarali Rehemtulla Gilani
Vs
National Insurance Co. Ltd.

Award Dated 24.01.2006

Shri Pyarali Rehemtulla Gilani and his wife were covered under mediclaim policy issued by National Insurance Company Limited. Smt. Gulbanuben Pyarali Gilani wife of Shri Pyarali R. Gilani was hospitalized at National Hospital and had undergone

Cataract Operation. When Shri Gilani preferred a claim under the said policy, the Third Party Administrator of the Company M/s E-Meditek Solutions Limited asked Shri Gilani to submit relevant documents alongwith the claim form duly signed and also his past policy details and not receiving any document fom Shri Gilani, the TPA i.e. M/s E-Meditek Solutions Limited finally sent a repudiation letter denying their liability. Aggrieved by the decision of repudiation taken by the Company, Mr. Gilani approached this Forum for necessary intervention. After perusal of the records, parties to the dispute were called for hearing. A close scrutiny of the file reveals that the insured proposed to National Insurance and he had mentioned that he had continuous insurance upto 31.12.2003. However, he did not provide any further details when the Company and the TPA, M/s E-Meditek asked for the previous policy particulars by sending copies of those policies. Instead, he issued a letter dated 14th Dec. 2004 to this Forum as also to TPA stating that once he has submitted the previous Policy No. to the National Insurance Company and the policy was renewed on that basis, he would not submit any details. It is known that as per policy condition cataract is an exclusion in the first year of operation of the policy. Obvioulsy therefore, the past record of continuous policy would be an important issue. National Insurance Co. has levelled the charge that the insured was non-co-operative. At the same time the Insurance Company should have also checked the details from New India since the policy number was given to them and it was their responsibility to get the full details of previous policy even from New India, which they did not do. To that extent the onus should be on them also.

Taking a liberal view, I decide therefore, that the claim should be settled on 50 % basis, with both the parties sharing the burden of non-compliance as required, and taking the fact that the policy was operative before 2004-05 period and alteast for more than one year in a given block.

Mumbai Ombudsman Centre
Case No. GI-533 of 2004-2005
Smt. Padmavati L. Mehta
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27.01.2006

Smt. Padmavati L. Mehta was insured with The Oriental Insurance Company Limited, Mumbai D. O. 9 from 1998. Smt. Padmavati L. Mehta was hospitalized at Manisha Nursing Home and diagnosis was bulky cervix. When a claim was preferred by Smt. Padmavati Mehta for the said hospitalisation, the Third Party Administrator of the Company i.e. M/s Raksha TPA Pvt. Ltd. repudiated the claim invoking clause 4.8 and clause 4.10, hospitalisation being for general debility and investigation purpose respectively. On Smt. Mehta's representation the TPA once again reiterated their stand of repudiation. Hence being aggrieved Smt. Padmavati Mehta approached this Forum for justice. Relevant records were perused and the parties to the dispute were called for hearing. The relevant records submitted to this Forum have been studied in detail. On analysis it is observed that the insured consulted Dr. M. M. Patel who requested Manisha Nursing Home to admit the Insured urgently and mange her on emergency ground due to the reason that severe bleeding per rectum was not coming under control and her blood pressure had fallen to 90/60 mm. On going through the indoor case papers, it is quite evident that the history has been mentioned as 'Bleeding while passing stool occasionally 5-6 months and constipation' without any noting of severe bleeding. Other inestigations are "Urine-No abonormality detected (NAD), Blood Sugar

72 mg only, X-Ray chest - NAD, ECG-within normal limits, 2D Echo-normal, USG-Abd & Pelvis NAD". This is quite surprising as with severe bleeding PR history and passing blood stool, USG or scan should have shown some ulcer or even bleeding piles. Cervical biopsy had no malignancy, no dysplasia, CT Scan of abdomen and pelvis show the most important point is even granting that the Insured had to be admitted for detailed investigation to rule out any chronic illness, the Mediclaim policy has consciosly excluded the same that is, if investigations are done at random and the results are negative on all fronts it would be denied by the Insurer as per clause 4.10. The other point of generalized weakness and treatment received following the same also falls under 4.8 exclusion which is universally applicable in all Medical Insurance Policies. Viewed in this context the rejection of the claim by the Insurance Company following TPA's rejection is held sustainable.

Mumbai Ombudsman Centre
Case No. GI-96 of 2004-2005
Shri C. N. Shah
Vs
National Insurance Co. Ltd.

Award Dated 13.02.2006

Shri C. N. Shah alongwith his wife Smt. K. C. Shah was covered under mediclaim policy issued by National Insurance Company Limited, Unit 250880, D. O. VIII since 1994 for a Sum Insured of Rs. 1,00,000/- for self and Rs. 65,000/- for his wife. The said policy was renewed continuously and had hence earned Cumulative Bonus. As Shri Shah felt that the Sum Insured was less compared to the escalating medical cost, he took another policy from the year 2003 from National Insurance Company Unit 260301, D. O. IX covering himself and his wife both for a Sum Insured of Rs. 1 lac each. Smt. K. C. Shah wife of Shri C. N. Shah was admitted to Breach Candy Hospital for (R) Total Knee Arthroplasty and when Shri Shah preferred a claim for Rs. 2,48,574.95 for the said treatment under his two policies the National Insurance Company Limited, D. O. 250800 settled the claim for Rs. 94,250 being the Maximum Sum Insured alongwith Cumulative Bonus whereas the TPA after scrutiny of the claim under another policy repudiated the claim stating that as the claim has occurred in the 2nd year of the policy and Oestoarthritis cannot develop within a short span of time hence the claim was not payable. They invoked clause 4.1 of the policy treating the ailment to be pre-existing. Not satisfied with the decision of the Company, Shri Shah represented to the Company and not receiving any favourable response, he approached this Forum for settlement of his balance claim amount. After perusal of the records parties to the dispute were called for hearing. An examination of the entire material on record would reveal that the dispute is about non-payment of the balance amount by D. O. 260301. National Insurance Company did not settle the claim on the ground of pre-existing disease. The insured was hospitalized in the 2nd year of the policy issued by the Divisional Office 260301 of National Insurance Company while the other policy was since 1994 which was for Rs. 65,000/- only. As the ailment was pre-existing at the time of taking a fresh policy in 2003, the balance amount of the claim becomes suspect and non-payable. It would be of little consequence to say that the increase in Sum Insured with the same office would have cleared the claim as even increased Sum Insured with the same office would have the same merit as analysed.

In the facts and circumstances of the above case, I find the Company's decision in denying the balance claim amount on the ground of pre-existing disease is sustainable and does not require intervention by this Forum.

Mumbai Ombudsman Centre
Case No. GI-570 of 2004-2005
Shri Manje Erappa Gowda
Vs
United India Insurance Co. Ltd.

Award Dated 13.02.2006

Shri Manje Erappa Gowda had taken mediclaim insurance cover alongwith his family members under the Mediclaim policy issued by United India Insurance Company Limited, Divisional Office-160700 for the first time in the year 2003. Smt. Shanti Manje Gowda wife of Shri Manje Gowda was hospitalized at Bhatia Hospital for Adenomyosis and had undergone vaginal hysterectomy. When Shri Gowda preferred a claim for the said hospitalisation the Company based on their panel doctor's opinion repudiated the claim invoking clause 4.1 of the mediclaim policy. Aggrieved by the decision of the Company Shri Gowda represented to the Company but the company reiterated their earlier stand of repudiation. Hence being aggrieved, Shri Gowda 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.

On a deeper analysis it is observed that the insured was detected to have cervicitis with sqamous metaplasia which is an inflammation of the Cervix Uteri with conversion of tissue into a form that is not normal for that tissue. It is clear from the records that at the time of admission in the hospital the insured was suffering from menorrahagia due to adenomyosis. In adenomyosis the tissue inflitrates into the wall of the uterus (myometrium) and therefore, easily spells out a progressive invasion than sudden occurrence. The history of irregular PV bleeding since 2-3 years on and off and the medical reports give clear indication that ailment was a long standing to throw off symptoms well before the Insured was covered under the mediclaim policy. Thus, the ailment being pre-existing, the claim is not payable in terms of exclusion clause 4.1 of the policy.

In view of the above analysis I do not find fault with the decision of the Company to repudiate the claim.

Mumbai Ombudsman Centre
Case No. GI-571 of 2004-2005
Shri Nandkishor Ganesh Joshi
Vs
The New India Assurance Co. Ltd.

Award Dated 15.02.2006

Shri Nandkishore G. Joshi alongwith his wife and Mother had taken a mediclaim Insurance policy from The New India Assurance Company Limited D. O. Shri Joshi experienced chest pain and was at Lilavati Hospital and Research Centre for CABG. When a claim was preferred for Rs. 1,92,942/- by Shri Joshi the TPA settled the claim for Rs. 50,000/-. Not satisfied with the decision of the Company, Shri Joshi again represented to the Company asking them to reimburse the balance amount. Not receiving any reply from the Company Shri Joshi approached this Forum for seeking intervention of the Insurance Ombudsman for justice. After perusal of the records parties to the dispute were called for hearing. The analysis of the case reveals that it is primarily of a technical issue as to what whould be the eligibility amount under the mediclaim policy when the treatment is continuous and spills over the next policy period. Precisely therefore, admissibility of the claim is not a question which the

Company has already granted despite some gaps in Insurance cover taken as renewals of the original policies. The matter was examined in depth and it was found that the Company's approach was in order. First of all the mediclaim policy issued for a specific purpose is governed by specific terms with Sum Insured being the maximum liability of the Insurer. If there would be any Cumulative Bonus it should be added to the Sum Insured and the total liability could exceed the basic policy amount which is mentioned in the body of the policy. Under the present case The New India Assurane policy did not record any Cumulative Bonus and instead showed (0 %) as Cumulative Bonus meaning thereby that Rs. 50,000/- was the maximum admissible amount. Hence the approach of the New India Assurance Company Limited was in order to settle the Maximum Sum Insured of Rs. 50,000/- and therefore, the claim of the Complainant to the other amount of Rs. 50,000/- as per the next policy is not sustainable as the cause of claim is one which sets in under the expiring policy and was duly honured.

Mumbai Ombudsman Centre
Case No. GI-124 of 2005 - 2006
Dr. Jayant Shamrao Patil
Vs
The New India Assurance Co. Ltd.

Award Dated16.02.2006

Dr. Jayant Shamrao Patil alongwith his wife Smt. Meena J. Patil was covered under Mediclaim Policy issued by The New India Assurance Company Limited, D. O. 140300 for a Sum Insured of Rs. 1 lac each. Dr. Patil had the policy continuously from 1997 and had earned Cumulative Bonus of Rs. 25,000/-. Smt. Meena J Patil was hospitalized at P. D. Hinduja National hospital for Coronary Angiography where the diagnosis was Class II - III Angina. She was then admitted to Lilavati Hospital and Research Centre for Coronary Artery By-pass Graft. When a claim was preferred by Dr. Patil for the said hospitalisations the Company based on the panel doctor's opinion repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied by the decision Dr. Patil represented to the Company which was also turned down. Hence aggrieved, Dr. Patil approached this Forum for settlement of his claim. The evidence on record, both oral deposition made by the Company during the hearing and the written statements of the Company as well as the Complainant have been studied in detail. On scrutiny of the records it is observed that the Company repudiated the claim on the ground of diabetes being present before the policy was taken from May, 1997. This conclusion was reached by the process of analysis medically sustainable as opined by Dr. Dhruman Desai himself a consulting Cardiologist and according to him the noting in the hospital papers clearly indicated that Smt. Patil was a known case of diabetes and had cardiac problems with IHD. The historys of diabetes was noted as 3 years but the doctor's remark was "on regular medication". Based on this analysis, Dr. Desai was of the opinion that complete evaluation of the case would be possible if the entire consultation papers with cardiologist Dr. Ambardekar was forwarded to New India in support of the Complainant's contention that diabetes was not contracted before 1997. As this was not available, the Company resorted to circumstantial evidence to repudiate the claim. Considering all aspects of the matter and the documents that have been submitted to this Forum, the analysis made by the Cardiologist of New India cannot be ignored. It is also a fact that when complete medical records are not available particularly the past history, only a searching analysis would help to draw some conclusions as in this case which points to the progress of the disease and with

it the duration of the illness. It is evident that she was diabetic and was on regular medication but exact duration was not established. Having regard to both these positions, it is my considered view that in absence of conclusive proof of pre-existing ailment the application of clause 4.1 would be questionable. Taking a moderate view I feel the Insured cannot be denied of the benefit of the doubt and since the policy was taken from 1997 and the basic records prove that the Insured was suffering from April, 1998, equity would demand a 50 : 50 settlement with both sides bearing the burden of the loss. In the present case the Sum Insured of Rs. 1 lakh had 25 % Cumulative Bonus or Rs. 25,000/- as accrued bonus and settlement would be 50 % of the same irrespective of the total claim amount as per hospital bills.

Mumbai Ombudsman Centre
Case No. GI-527 of 2004-2005
Shri R. K. Nargund
Vs
The New India Assurance Co. Ltd.

Award Dated 16.02.2006

Shri R. K. Nargund along with his family members covered under the mediclaim policy of the New India Assurance Co. Ltd. Shri Nargund preferred a claim for his daughter, Smt. Arati Prasanna Tavargeri who was hospitalised at Asian Institute of Gastroenterology, Hyderabad, from 05.03.2003 to 06.03.2003 for Moderate Severe Ulcerative Colitis. After hospitalisation, Shri Nargund Submitted claim to the Company in May, 2003 on behalf of his daughter, Smt. Arati Prasanna Tavargeri for reimbursement of hospital expenses. On 07.10.2004, the Company informed Shri R. K. Nargund that due to non-availability of necessary documents they are not in a position to settle the claim and treating the matter as closed. Not satisfied with the decision of the Company, Shri Nargund represented to the Grievance cell of the Company by stating that he had submitted all necessary documents required for processing the claim. Not getting any favourable reply from the Company, Shri Nargund approached Insurance Ombudsman with his grievance and prayed that his genuine claim should be settled by the Company.

In the facts and circumstances it would be only logical for this Forum to direct the Divisional Office No. 111400 of New India to apply their mind on the basis of available documents and if some more material would be necessary, they should obtain the same and decide on the conclusion of complaint as per the merits. This complaint is therefore, reverted back to New India and closed at this Forum with a direction to resolve the matter as suggested.

Mumbai Ombudsman Centre
Case No. GI-565 of 2004-2005
Shri Jagdish P. Sunke
Vs
The Oriental Insurance Co. Ltd.

Award Dated 17.02.2006

Shri Jagdish Sunke along with his wife was covered under Individual Mediclaim Policy issued by the Oriental Insurance Co. Ltd. This was a continuous renewed Policy with accrued CB of 30 % and the Insured was covered under a policy with them since 6th June 1997. Shri Jagdish Sunke was admitted to Sahasrabudhe Hospital three times on various dates from 27.7.2003 to 2.8.2003; 15.8.2003 to 16.8.2003; and 29.10.2003 to 30.10.2003 as also in K.E.M Hospital from 8.1.2004 to 12.1.2004 for treatment of

Pancreatitis, Hepatitis and Liver Cirrhosis and Pleural Effusion. He was diagnosed as having Budd-Chhiari Syndrome. On discharge when he claimed the expenses from the Oriental Insurance Co. Ltd., they repudiated the claim as per excl. clause 4.8 as well as invoked clause 5.7 of the Mediclaim Policy for tampering the medical records. Let us examine the disease and the diagnosis made at the hospital for our purpose. The medical records gave the presenting symptoms as GI Bleed, Jaundice, Encephalopathy, Edema Feet, and Vomiting. He was diagnosed having Gall Bladder stone with Pancretitis. He had Right Plural Effusion and was on Antikoch's treatment. He was operated for Membranotomy. The Doppler Hepatoportal Test revealed Coarse Echotexture of Liver and abrupt narrowing of IVC in Suprahepatic IVC in terminal segment. This was askin to Budd-Chiari Syndrome- "which is a rare condition that follows obstruction of Hepatic vein by a blood clot or tumor. It is characterized by ascites and cirrhosis of the liver". [G. Budd (1808-82), British Physician; H. Chiari (1851-1916) German Pathologist.] (Quoted from Oxford Medical Dictionary, Indian Edition).

On final analysis it appears that the Insured had a congenital defect as mentioned in the classical theory associated with Budd-Chiari Syndrome. It is also possible that he neglected the symptoms and aggravated the condition along with Diabetes, HTN and Koch's Diseases. Notwithsanding this it is evidently clear that he was alcoholic as well as the chronicity was suppressed by a dubious method. There was tampering with the records which uniformly noted the history more than once and with the discharge card of KEM Hospital being simply altered by hand, points to a positive intention to defraud the Insurance Company and such an intention cannot be encouraged and therefore, I find no reason to interfere with the decision of Oriental Insurance Company to repudiate the claim as per condition no. 5.7 of the Mediclaim Policy as mentioned by the Company.

Mumbai Ombudsman Centre
Case No. GI-001 of 2005-2006
Shri Kanaiyalal Goradia
Vs
The New India Assurance Co. Ltd.

Award Dated 21.02.2006

Shri Kanaiyalal Goradia alongwith his wife Smt. Anasuya Goradia was covered under the Mediclaim policy issued by the New India Assurance Company Limited, D. O. 112500. The policy showed Cumulative Bonus of 50 % for Shri Goradia and 20 % for Smt. Anasuya Goradia. It is reported by Shri Goradia that he was covered under the mediclaim policy since last 10 years. Smt. Anasuya Goradia was admitted to Bay View Clinic for removal of abscess from her left thumb nail and proximal cellulitis. When Shri Goradia lodged his claim for reimbursement, the TPA rejected the same invoking clause 4.10 of the mediclaim policy. Their contention was that incision and drainage of left hand thumb abscess was done under local anaesthesia and the said line of treatment could be done on OPD basis. Moreover the ailment was not an emergency and did not require hospitalisation Dissatisfied with the decision of the Company Shri Goradia represented to New India and to the TPA. The file was reviewed by the Expert Medicolegal Consultancy and based on their opinion the Company reiterated the decision of repudiation to Shri K. L. Goradia. Hence being aggrieved at the decision of the company, Shri Goradia approached this Forum seeking intervention of the Ombudsman in the matter of settlement of his claim. The records have been perused and it is revealed that Smt. Goradia had a swelling on left thumbs which got infected

for whatever reasons and became cellulitis. The procedure is simple and the incision is done with local anaesthesia usually at home or at Doctor's clinic or even at OPD in a nursing Home or hospital. Truly it does not require any hospitalisation as nobody would normally like to be confined away from home comfort. Mediclaim policy is subject to certain terms and conditions and exclusions which have been drafted on the pattern of market practice and convention. Viewed in this context the provision of caluse 4.10 are to exclude non-emergency hospitalisation or for treatment which could otherwise be pursued in-house or as an outpatient. Since the line of treatment was antibiotics with analgesics and antacids after the incision it did not contain any criticality to be monitored only at the hospital. Similarly the infection was there for sometime to cause inflammation and therefore, the decision to get it operated was well planned without any emergency to hospitalize Smt. Goradia. Strictly from this point of view the decision of the Company cannot be opposed.

Mumbai Ombudsman Centre
Case No. GI-607 of 2004-2005
Shri Ronald Cecil Fernandes
Vs
National Insurance Co. Ltd.

Award Dated 22.02.2006

Shri Ronald Cecil Fernandes was insured under mediclaim policy of National Insurance Co. Ltd., Andheri Branch Office since 24.7.2001. The policy was issued to the Insured with an exclusion of Glaucoma. Shri Fernandes preferred a claim to the Company after his hospitalisation at Holy Family Hospital from 05.07.2004 to 16.07.2004 for Subdural Haematoma. He was under care of Dr. J. P. Jadwani. The claim was processed by M/s Varishield Healthcare Ltd. (TPA). Not getting any favourable reply from TPA, Shri Fernandes represented to the Company along with a cerficate from Dr. Ashish (RMO under Dr. Jadwani). On 25.10.2004 the Company informed Shri Fernandes about their inability to settle the claim as per the Mediclaim policy Exclusion Clause 4.1. Not satisfied with the decision of the Company, Shri Fernandes approached the Insurance Ombudsman with his grievance on 11.03.2005.

The National Insurance Co. Ltd. is directed to settle the claim of Shri Ronald Cecil Fernandes in respect of his hospitalisation at Holy Family Hospital for treatment of Subdural Haematoma for the period 05.07.2004 to 16.07.2004 for 50 % of the admissible amount as a compromise settlement. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI-459 of 2004-2005
Shri Yashwant Kagzi
Vs
The National Insurance Co. Ltd.

Award Dated 24.02.2006

Shri Yashwant Kagzi along with his daughter was covered under Mediclaim Policy since 1992-93 for SI of Rs. 82,500/- issued by the National Insurance Co. Limited. He had two separate mediclaim policies in force which was increased eventually. Shri Yashwant Kagzi was hospitalized at Baroda Heart Institute for Heart ailment, diabetes, hypertension, cholecystitis on 19.9.2004. He was again hospitalized at Bombay Hospital from 23.9.2004 and Coronary Angiography was done on 24.9.2004. He was

hospitlized the third time at Breach Candy Hospital from 29.9.2004 for Diabetes Mellitus, Skin Infection and Coronary By Pass Surgery and operated on 8.10.2004. He was discharged on 17.10.2004. He claimed a total expenses of Rs. 10,365,425/- out of which the Company settled an amount of Rs. 6,50,288/-. He approached the Office of the Ombudsman for the balance payment which was denied by the Company. The analysis of the claim reveals that National Insurance had settled the claim as per the terms and conditions of the Policy after adding Cumulative Bonus amount to the main SI. While issuing the policy National Insurance restricted the SI to Rs. 1.40 lakhs plus CB Rs. 49,000/- for Heart related ailments under the first policy and in another policy restricted the SI to Rs. 3.00 lakhs plus Rs. 1.35 lakhs CB for heart ailment. In other words any amount in excess of Rs. 6.24 lakhs would not be covered by them.

National justified their decision on the basis of hospital records and past history noted therein. It is observed that Shri Kagzi first claimed in April 1998 for heart attack for which he was hospitalized at Bombay Hospital and at that time he was having hypertension and diabetes since 5 years which when traced back, made it was from 1993 i.e. at the time when his policy first incepted. The above fact was not disclosed by the Insured, but the claim was admitted by the Company. Thereafter the policies were restricted for heart ailment for the original sum insured under both the policies for Rs. 1.40 lakhs and Rs. 3.00 lakhs respectively. On a close scrutiny it appears that, out of the three hospitalization, the bulk of the expenses were for CABG and related ailments. As per the SI limit and the limit for which heart ailment was to be restricted the Company's maximum liability works out to Rs. 6.24 lakhs. However, the Company appears to have made a payment of Rs. 6,50,288/-as per their actual calculations and this Forum is not supposed to look into all these aspects but give a broad direction. The Company made a commitment at the hearing to examine the sum of Rs. 5,700/- which was claimed by the Insured and therefore, the entire matter may be further examined by National Insurance CompanyDO VII in the context of total payment of Rs. 6,50,288/- made by them.

Mumbai Ombudsman Centre
Case No. GI-102 of 2005-2006
Shri Sunil Kumar Bhadury
Vs
The Oriental Insurance Co. Ltd.

Award Dated 24.02.2006

Shri Sunil Kumar Bhadury who was on his visit to USA had taken an Overseas Mediclaim Policy (B & H) No. 161100/2005/216 covering the travel world wide including USA and Canada, from the Oriental Insurance Company Limited, Pune D.O. I. The said policy was issued to Shri Bhadury with exclusions of Hernia, Prostate, Hypertension and heart and circulatory disorders. While Shri Sunil Kumar Bhadury was in USA he experienced chest pain and he was hospitalized at Community hospital of Los Gatos and the diagnosis was non-cardiac chest pain. When Shri Bhadury preferred a claim to the Company the Company stated that as he had a past medical history of cardiac ailment the claim was not payable due to pre-existing condition. Dissatisfied with the decision, Shri Bhadury approched this Forum for justice. After perusal of the records parties to the dispute were called for hearing. It is evident that the policy was issued with specific exclusions of Heart and Circulatory diseases and ailments relating to Hypertension etc. The Insured, Shri Bhadury had chest pain, which was thoroughly investigated. At age 78 any chest pain would be first taken to be relating to heart and circulatory disorders and to that extent the procedure followed was in order. The whole range of investigations which were done gave a clue to the diagnosis but through a

process of elimnation only. The expenses incurred in the process were all related to cardiac ailments, which were excluded from the scope. Hence the final diagnosis of non-cardiac pain was the result of all investigations done relating to cardiac disorders which were excluded by the policy. Consequently, the claim becomes non-payable as well. Moreover, the hospitalisation was utilized for doing tests while the patient was conservatively managed. In the end there was an advice for stress test to throughly rule out cardiac problems which was not done. Hence it cannot be said if the pain was not by any means a cardiac problem conclusively without the stress test. Secondly, the entire hospitalisation was utilized for tests only without any active treatment. On both these counts the claim is not sustainable and therefore the decision of the TPA and the Company to repudiate the claim is in order.

Mumbai Ombudsman Centre
Case No. GI-566 of 2004-2005
Shri Sanjay M. Gandhi
Vs
The New India Assurance Co. Ltd.

Award Dated 27.02.2006

Shri Sanjay M. Gandhi and his wife Smt. Bina S. Gandhi was insured under mediclaim policy of the New India Assurance Co. Ltd., Divisional Office 111900 since six years. The claim arose under policy No. 11900/48/01/08710 during the policy period 15.03.2002 to 14.03.2003. Shri Sanjay Gandhi preferred a claim of Rs. 12,340/- to the Company, after hospitalisation of his wife, Smt. Bina Gandhi in Dr. Balabhai Nanavati Hospital for the treatment of Left Ureteric Calculus from 10.11.2002 to 13.11.2002. After scrutiny of the claim papers, the Company referred the matter to their panel doctor, M/s Expert Medicolegal Consultancy for their expert opinion. They opined that in the indoor case papers of the hospital there was a remark that Smt. Gandhi was having similar complaint during her pregnancy and also asked the insured to submit details of the treatment taken in the past admission. Not getting any additional information the Company repudiated the claim under Exclusion Clause 4.10 of the mediclaim policy. Shri Sanjay Gandhi approached Insurance Ombudsman with his grievance stating that the ground on which the Company repudiated the claim was wrong.

However, on close scrutiny it is apparent that she had a severe pain in the abdomen which was detected to be stone and necessary treatment was received. It was also remarked in the case papers that she had a history of similar episode in the past where no refefence to pregnancy related pain or pain during pregnancy was mentioned as it was remarked in one case paper. It would therefore be taken that the patient had similar experience which she must have narrated. However, denial of the claim on that ground is also not justified as it might not have been detected to be kidney stone at that stage as it ought to have been mentioned in the subsequent hospitalisation. The company merely acted on the basis of a narration of a “similar pain” without proof. In absence of any conclusive proof, it is advisable to grant the benefit of doubt to the Insured as a special case and allow only the admissible expenses for the hospitalisation from 10.11.2002 to 13.11.2002.

The New India Assurance Co. Ltd., is directed to settle only the admissible expenses for the hospitalisation incurred by Shri Sanjay M. Gandhi in respect of his wife, Smt. Bina S. Gandhi’s hospitalisation at Dr. Balabhai Nanavati Hospital for the treatment of Left Ureteric Calculus from 10.11.2002 to 13.12.2002. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI-599 of 2004-2005
Shri Prasad Chandrakant Gurjal
Vs
The New India Assurance Co. Ltd.

Award Dated 27.02.2006

Shri Prasad Chanrakant Gurjal alongwith his family members were covered under the mediclaim policy issued by the New India Assurance Company Limited, Unit 153100 for the period. It is reported that Shri Gurjal was covered initially with the Oriental Insurance Company Limited and from August, 2002 he was covered with New India. Based on the proposal form filled in by Shri Prasad Gujral and Smt. Pooja Gujral, the Company issued policy to them with exclusions. Smt. Pooja Gujral was admitted to Bidaye Hospital, Pune on 14.4.2004 for Ectopic pregnancy (Lt. Tubal pregnancy) left salpingectomy done laparosopically. When Shri Gujral preferred a claim for the said hospitalisation, the Company's Third Party administrator i.e. M/s Medi Assist repudiated the claim invoking clause 4.12 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Gujral represented to the Company stating that his wife was operated for tubectomy during her second delivery in the year 1998 and in 2000 she was suffering from pregnancy in right fallopian tube and was advised salpingectomy and the claim was accepted by the then Insurance Company i.e. The Oriental Insurance. The New India Assurance Company who later insured Smt. Gurjal repudiated the claim based on the opinion of their medical consultant stating that since the failure of tubectomy has resulted in these ectopic pregnancies, the claim was not payable since tubectomy was a pre-existing condition. Hence being aggrieved by the decision of the Company, Shri Gujral approached the Office of the Insurance Ombudsman. After perusal of the records parties to the dispute were called for hearing. The analysis of this complaint reveals that when the insurance was shifted to New India, they accepted the same with specific exclusions of Caesarian Section and Laproscopic surgery. As the terms of acceptance of risk was quite clear and the Insured was informed about the same, no issue could be raised later following a claim which was precisely concerning the surgery of fallopian tube. The Insured's point that it was earlier right fallopian tube surgery (tubectomy) and therefore, the left fallopian tube surgery should be paid is not acceptable as the procedure which was done for Right Tube was known to the Company and they consciously excluded the same from the scope of the cover. The other point raised by the Company that Clause 4.12 was applicable is acceptable as it was a case of Ectopic pregnancy which was terminated through surgery. Accordigly, the repudiation of claim by New India cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI-21 of 2005-2006
Shri Salim Dawood Master
Vs
United India Insurance Co. Ltd.

Award Dated 27.02.2006

Shri Salim Dawood Master and his family was covered under a Tailor-made Group Annual Mediclaim Policy of The New India Assurance Co. Ltd. since 2002. Shri Salim Master subsequently renewed the policy with United India Insurance Co. Ltd. under Individual Mediclaim Policy on the basis of the renewal notice of 2002 - 2003 issued by New India Assurance Co. Ltd. The claim arose under policy no. 162481/48/03/000773

for the period 01.01.2004 to 31.12.2004. Shri Salim Master consulted his family physician on 20.11.2004 as he was feeling giddiness and uneasiness and as per doctor's advice he took some medicines as there was no improvement in the condition, he consulted Dr. N. R. Ichaporia at Jehangir Hospital for further treatment and he was admitted in the hospital on 26.11.2004 to 28.11.2004 and diagnosed as Positional Vertigo (Benign). After hospitalisation, Shri Salim Master preferred a claim to M/s Family Health Plan Ltd. TPA, for reimbursement of the hospital expenses. The TPA repudiated the claim stating that the treatment could have been taken on OPD basis so the claim was not payable. Not satisfied with the decision, Shri Salim represented to the Company. The Company took the medical opinion and accordingly, the claim was repudiated under Exclusion clauses 4.8 and 4.10 of the mediclaim policy.

The analysis of the case reveals that the Discharge Summary issued by Jehangir Hospital recorded the diagnosis as only "Vertigo-Benign Positional" The presenting symptom was giddiness since last 4-5 days in the form of rotation of objects persisting throughout the day. In the face of other vital functions remaining unaffected this problem would appear as a simple medical necessity not involving any seriousness or criticality in health condition to justify confinement in the hospital. The important point is that the behavior pattern of vertigo is often confusing but the present case patently appeared to be a disorder in the ear causing imbalance which may be due to many factors and very straight forward treatment is available for this symptom without any need for hospitalisation. The hospitalisation was also used to have some other investigaions which can always be rationalised by the Doctors as necessary but viewed in the context of the principles of insurance and the mediclaim policy's scope of cover it would be termed as falling under Clause 4.10 of the exclusion clause. The Company has also invoked Exclusion Clause 4.8.

Overall analysis points to the fact that hospitlsation was utilised for investigations and as mediclaim policy is designed to cover critical medical emergencies for treatment and the type of ailment being the most common symptom, even OPD treatment could have been taken. As it is a specific exclusion to stay away from avoidable hospitalisation expenses under an exclusion clause 4.10, I concur with the Compan's rejection.

Mumbai Ombudsman Centre
Case No. GI-584 of 2004-2005
Shri Digant Damoda Joshi
Vs
The Oriental Insurance Co. Ltd.

Award Dated 28.02.2006

Shri Digant Damodar Joshi alongwith his wife, children and mother were covered under the mediclaim Insurance policy issued by the Oriental Insurance Company Limited. The said policy was a fresh policy taken in the year 2003 and the Oriental Insurance Company had issued the said policy to Smt. Sushila Damodar Joshi, mother of Shri Digant Damodar Joshi with an exclusion of Diabetes Mellitus and Bilateral Refractory error. Smt. Sushila D. Joshi was hospitalized at Dr. L. H. Hiranandani hospital for unstable angina and thereafter she was shifted to Lilavati hospital for Coronary Artery Disease-Post Perculneous Transluminal Coronary Angioplasty (PTCA) to RCA and medicated stent was inserted. When a claim was preferred by Shri Joshi for the said hospitalisations, the Third Party Administrator of the Company i.e M/s Raksha TPA after scrutiny of the case papers repudiated the claim invoking clause 4.1 of the mediclaim policy. Their contention was that as per the discharge card Diabetes Mellitus was there since last 8 years and as it was the proximate cause for heart ailment the

illness was a pre-existing and moreover as Diabetes Mellitus was also an exclusion under the policy, the claim was not payble. Dissatisfied with the decision of the Company, Shri Joshi represented to the Company which was turned down and aggrieved at the decision of the Company, Shri Joshi approached this Forum Seeking intervention of the Insurance Ombudsman for justice. After perusal of the records parties to the dispute were called for hearing. The analysis of the claim reveals that the Complainant contested the repudiation on the ground that while diabetes was excluded from the scope of the policy, the treatment received was not for diabetes but for heart ailment which was not excluded, hence payable. Over a period of time diabetic perons develop arterial stenosis known as atherosclerosis and this causes narrowing of arteries which carry blood for which heart complications develop. Viewed from this point, the nexus between the two is established in Medical science and since diabetes was excluded, the subsequent heart problems and related treatment would also be excluded from the scope of the policy.

In the facts and circumstances the decision of The New India Assurance Company Limited to repudiate the claim is in order.

Mumbai Ombudsman Centre
Case No. GI-530 of 2004-2005
Shri Vinod P. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 28.02.2006

Smt. Shobhana V. Shah alongwith her husband Shri Vinod P. Shah was insured under a mediclaim policy issued by The New India Assurance Company Ltd. from the year 1986 for a Sum Insured of Rs. 96,500/- each. She increased the sum insured in piecemeal in the year 1993, 1996 and from 10.11.1999 to 09.11.2000 she increased their mediclaim cover by Rs. 2 lacs making their total cover of mediclaim as Rs. 5 lacs each with varied cumulative bonus for different Sum Insured. The Company at the time of issuing the policy for the period 10.11.99 to 9.11.2000 had put an exclusion of Rs. 5 lacs each with varied cumulative bonus for different Sum Insured. The Company at the time of issuing the policy of Shri Vinod P. Shah had put an exclusion of Rs. 2 lacs for heart ailment and complications thereof. The said policy was renewed every year thereafter and accordingly also had earned Cumulative Bonus. Shri Vinod P. Shah was hospitalised at Breach Candy hospital for which Angiography was done and for which he underwent CABG at Asian Heart Institute. When Smt. Shobhana V. Shah preferred a claim to the Company for her husband's hospitalisations for Rs. 3,68,883/- the TPA of the Company M/s Rakhsha TPA after processing the claim informed Smt. Shobhana V. Shah. However, on representation by the Insured and further with the settlement of the claim, Shri Vinod P. Shah approached the Insurance Ombudsman with his grievance that the Company should settle the full amount claimed by him. All records pertaining to the claim were perused and parties were given an opportunity to depose before the Ombudsman. On a close study of the records it is observed that the insured has been covered under mediclaim insurance since 10.11.1986 without any break. Although the records spell about Myocardial Infarction since 1986, no specific date or month has been mentioned and the claim was paid in 1986 even for M. I. Hence it cannot be concluded that at time of taking insurance policy, the insured was having this ailment atleast by the action of New India to settle the claim. However, at the time of increasing sum insured say in 1993 by Rs. 96,500, the Company ought to have taken note of the claims they had settled which they did not do. The Company paid a claim of Rs. 1,79,225/- for Shri Shah for PTCA during the policy period 1997 - 98 the Company

has demonstrated that there was no questions of non-availability of benefit for the increased amount of Sum Insured upto Rs. 3 lacs. However, when further increase came on next renewal on 10th November, 1999 from Rs. 3 lacs to Rs. 5 lacs the Compay restricted the policy to heart ailment and complications thereof to the existing Sum Insured only of Rs. 2 lacs and not making available another Rs. 2,00,000/- i.e. full Sum Insured of Rs. 5,00,000/-. Taking this restriction the Sum Insured available under the policy as on the date of hospitalisation was Rs. 3,00,000/- plus appropriate Cumulative Bonus on the basis of differential Sums Insured. As the representativ of TPA has already settled Rs. 38,402 towards the cost of angiography done at Lilavati hospital and Rs 87,408/- towards CABG during the same policy period, the balance amount of Sum Insured along with accrued Cumulative Bonus becomes payable the balance amount of Sum Insured along with accrued Cumulative Bonus becomes payable. Based on these arguments the calculations which have been made as per Sum Insured (original and increased) the partial rejection of the claim by the Company is hereby set aside.

Mumbai Ombudsman Centre
Case No. GI-611 of 2004-2005
Shri Balanna V. Sheregar
Vs
The New India Assurance Co. Ltd.

Award Dated 02.03.2006

Shri Babanna V. Sheregar took a mediclaim policy from The Oriental Insurance Company Ltd. Sum Insured of RS. 1,00,000/- and earned Cumulative Bonus due to continuous insurance without any claim. Later, he transferred the mediclaim policy to The New India Assurance Co. Ltd. and therefore renewed continuously without any break. He also increased the Sum Insured by Rs. 4,00,000/- to make it Rs. 5,00,000/- which was accepted by The New India Assurance Co. Ltd. after receiving medical report with an exclusion of diabetes and related diseases. Shri Sheregar was first admitted in Nityananad Nursing Home 26.11.2003 for Anterior Wall Myocardial Infarcition (AWMI) and on 27.12.2003 he was transfered to Hinduja Hospital for further management. On 28.12.2003 he was again shifted to Lilavati hospital and underwent Percutaneous Transluminal Coronary Angioplasty (PTCA) and got discharged on 02.01.2004. Shri Sheregar made a claim for 6.17,815/- to M/s TTK Healthcare Services Pvt. Ltd. (TPA) and they settled the claim for Rs. 1,50,000/-. After getting his representation, the Company referred the matter to Expert Medicolegal Consultancy for their opinion and accordingly the Company upheld the decision taken by the TPA, M/s TTK Healthcare Services.

The analysis of the case reveals that the dispute is only due to the TPA's restrictions of claim to Rs. 1,00,000/- + 50 % cumulative bonus on it and rejection of the claim for the balance amount, although Shri Sheregar got the policy from New India for Rs. 5 lakhs for the period 11.01.2003 to 10.01.2004. Shri Sheregar raised a point that he got a clearance from TPA that his claim will be settled for Rs. 5.5 lakhs (1 lakh + 50 % CB + 4 lakh) but since he made the payment upfront against the bill of more than Rs. 6 lakhs, the TPA withdrew the original offer and restricted it to Rs. 1.5 lakh only, which he contested. The scrutiny however reveals that when New India took the insurance they undertook a medical examination through their agency and the report submitted by Dr. Shailaja Masand mentioned specially that Shri Sheregar was suffering from Diabetes Mellitus which was excluded from the policy issued by New India.

First of all, we have to go by the policy as it is worded. The policy issued by New India did contain an exclusion of diabetes which was further clarified to expand its application as quoted above to include any disease/sickness/injury mentioned in the exclusion column, “attributable thereto or accelerated thereby or arising therefrom” would be excluded. This is indeed a very wide range of exclusions to cover all diseases attributable to diabetes and diabetes related ailments. It is a well known medical fact that diabetes mellitus is a chronic disorder of carbohydrate metabolism, marked by hyperglycemia and glycosuria and resulting from inadequate production or use of insulin. Cardiovasclular disease is the major disease arising out of diabetes. In addition, peripheral vascular disease may lead to Ischemia and gangrene of the lower limbs. As the Company had deliberately avoided these risks by putting a wide-ranging exclusion, it would be taken that they wanted to get out of the avoidable additional burden of incresed Sum Insured and restrict their liability to Rs. 1 lakh plus accrued Cumulative Bonus only in case of diabetes and allied diseases resulting from the same. Hence, on this basis no issue can be seriously raised as the decision of the Insured to raise the Sum Insured came much later and only during the renewal. In the facts and circumstnces, the decision of the Company to repudiate the full claim beyond Rs. 1.5 lakh is held tenable.

Mumbai Ombudsman Centre
Case No. GI-720 of 2004-2005
The Varachha Co-op. Bank Ltd.
Vs
The New India Assurance Co. Ltd.

Award Dated 03.03.2006

New India Assurance Co. Limited, Dadar Divi. Office 130600 issued a Long-term Group Janata Personal Accident Policy No. 130600/47/99/03384 to the Varachha Co-operative Bank Limited, Surat, as members of Winner Capital & Credit Pvt. Ltd. for the period 5.4.1999 to 4.4.2004 (5 years) covering 36,500 members unnamed shareholders and staff members for a Sum Insured of Rs. 1 lakh for employees and Rs. 25,000/- for other category. Between April 1999 to Jan 2004, 30 claims were lodged, out of which, 13 claims were settled and regarding 17 pending claims, there was an assurance from NIA that pending claims are being looked into and would be processed following receipt of certain documents. It appears from the records that the premium following receipt of certain documents. It appears from the records that the premium of Rs. 7.14 lakhs was paid through M/s. Winner Capital & Credit Pvt. Ltd. The New India Assrance subsequently cancelled the policy w.e.f. 1st May, 1999 as per condition no. 5 of the policy and brought the same to the knowledge of the general public by various notifications in the Newspapers. The issue before this Forum is to consider whether the cancellation notice by New India was served well in time and whether it was in accordance with the terms and conditions of the Policy. The answer to this would be found in the action taken by New India and also the status of cancellation. By setting 13 claims where the date of loss were varying from August 1999 to January 2001, New India has demonstrated that they have considered settlement of claims possibly for the transitional period and may not have cancelled the policy right from 1st May, 1999.

The Varachha Co-op. Bank has adduced that the cancellation of the Policy was not intimated to them even though the policy document was in their favour. Moreover, they alleged if New India was serious in cancelling the policy, they must have returned to them the premium on pro-rata basis. In the above situation when the matter has been examined by the authorities of New India, they obtained legal opinion, contested the case in Consumer Forum, possibly handling the complications arising out of policies

issued by the Agency 'Winner Capital' and also tackling the issues of irregularities through audit and other investigations, the issue of premature cancellation notice and its validity must have been squarely scanned and dealt with. In the same vein, the legal opinion having questioned the comprehensiveness of the cancellation, the repudiation of claims becomes suspect. The Company have also admitted that they are on the job of obtaining all relevant records including adjustment of premium etc. from the Agent for settling further 17 (seventeen) claims. In accordance with this status, the particular complaint along with similar other complaints if any, pending before this Forum are reverted back to the Company for due examination without allowing them to be further referred to this Forum.

Mumbai Ombudsman Centre
Case No. GI-591 of 2004-2005
Shri Surendra Jha
Vs
The New India Assurance Co. Ltd.

Award Dated 09.03.2006

Shri Surendra Jha was covered under the Mediclaim Policy No. 112500/48/04/76143 issued by The New India Assurance Co. Ltd. D. O. 112500, Mumbai for the period 20.05.2004 to 19.05.2005 for a S.I. of Rs. 35,000/- with 15 % CB.

Shri Jha was admitted to Sir Hurkisondas Hospital 27.10.2004 to 4.11.2004 following complainants of weakness and frequent micturation. When Shri Jha lodged his claim for reimbursement, the TPA of the Company, M/s. Raksha rejected the same vide their letter dated 19.1.2005 invoking Clause 4.10 of the Mediclaim Policy. Their contention was that the insured's complaints of giddiness, weakness, frequency of urination etc. were only since 2-3 months and that during hospitalization he was only kept on oral medications and was just investigated and which could be done on OPD basis.

The analysis of the case reveals that prior to hospitalization Shri Jha consulted Dr. Bharat P. Shah, M. D. on 25.10.2004 nd was prescribed a few medications. There was no indication of any emergency or advice for hospitalization from Dr. Bharat Shah. Instead there was an advice for follow up after every two months. But on the contrary, the Insured got himself admitted to hospital on 27.10.2004 under the care of Dr. Bharat Shah for the same complaints. During hospitalisation he was administered the same set of medicines and injections as prescribed on 25.10.2004 and a number of pathological tests and investigations were carried out, all of which were normal. The documents on record which were sufficient to decide the case were carefully examined and it was active line of treatment. Most of the medicines were already continuing and such cases could be easily handled being an outpatient without any critical emergency for hospitalization. On discharge the remark on the discharge card was "Patient was advised rest for 15 days". As regards the series of investigations done, the symptoms presented did not pose any clue to get those done as a must and most of these could be done even otherwise and actually being done by aged persons eg. USG of abdomen and pelvis, prostrate, hypertrophy evaluation, PSA level in blood, routine blood test, lipid profile test, ECG etc. as a regular heart check up. This is the reason why as a matter of policy, the exclusion clause 4.10 has been introduced in the Mediclaim Policy to stay away from avoidable expenses incurred without medical emergency.

In the facts and circumstances, the decision of New India Assurance Co. Ltd. to repudiate the claim of Shri Surendra Jha under Exclusion Clause 4.10 of the Mediclaim Policy is sustainable.

Mumbai Ombudsman Centre
Case No. GI-444 of 2004-2005
Smt. Frency Dadachanji
Vs
The New India Assurance Co. Ltd.

Award Dated 10.03.2006

Smt. Frency Dadachanji alongwith here husband Shri Rustom M. Dadachanji took a mediclaim policy The New India Assurance Co. Ltd. since 31.05.1994. She was admitted to Jehangir Hospital Medical Centre on 02.12.2002 to 03.12.2002 and again on 05.12.2002 to 14.12.2002 and was diagnosed as Carcinoma Ovary with Omental Mets. Smt. Freny Dadachanji preferred a claim to the Company. The Company referred the matter to EMC and after getting opinion from EMC, the company informed the insured that she was a known case of Carinoma Ovary and was operated for the same 17 yrs ago. This fact was not disclosed by the insured while availing mediclaim policy first time in 31.05.1994 and the company also asked her to repay an amount of Rs. 64,392/- which was paid by them in the year 2001 for her hospitalisation at Sadhu Vaswani Medical Complex for operation of Carcinoma Ovary.

The insured was admitted on 02.12.02 for some investigations and was readmitted on 05.12.02 for surgery and diagnosis was Carcinoma since one month. History of hysterectomy 17yrs, operated thoracotomy and known case of Hypertension on regular medicine. The New India acted on the basis of their Medical Consultant's report which has analysed the previous history which has clearly mentioned surgery hysterectomy 17 yrs ago. On the basis of the papers made available to this Forum it seems Cancer was detected much later and the first surgery 17yrs ago was only for removal of Uterus. It was been established that cancer itself may not have been detected 17 yrs ago to vitiate the claim already paid by New India. Hence, I decide that there is no question of refunding the amount paid to late Smt. Dadachanji. As regards, the claim made by late Smt. Dadachianji for her hospitalisation at Jehangir hospital for treatment of Carcinoma Ovary, the repudiation of New India is sustainable on ground of non-disclosure of earlier surgery and consequently under Clause 4.1 as well.

Mumbai Ombudsman Centre
Case No. GI-538 of 2004-2005
Shri Vasantlal Parmananddas Lakhni
Vs
The New India Assurance Co. Ltd.

Award Dated 10.03.2006

Shri Vasant P. Lakhani is a mediclaimholder of The New India Assurance Company Ltd. since 2001. The claim arose under policy No. 110800/48/03/06754 during the policy period 18.09.2003 to 17.09.2004. He was in Asian Heart Institute from 10.11.2003 to 19.11.2003 and diagnosed Triple Vessel CAD, Ischeamic Heart Disease and Coronary Artery Bypass Graft (CABG) was done. After his hospitalisation, he preferred a claim to the Company for Rs. 2,91,000/-. The claim was processed by M/s Raksha TPA and they informed the Insured by letter dated 11.06.2003 that from the indoor case papers of the hospital it was revealed that he is a known case of Hypertension since 13 years which is a proximate cause of Ischeamic Heart Disease (IHD) due to which the claim fell under Exclusion Clause 4.1 of the mediclaim policy and was not payable. Shri Lakshmi represented to the Company against the decision of the TPA. The Company referred the matter to Expert Medicolegal Consultancy (EMC) for an expert opinion on the claim file. Dr. A. V. Patil of EMC gave his opinion dated 01.09.2004 that

Ischaeamic Heart Disease is common to persons who are having hypertension and dyslipidaemia and therefore, his repsentation was also rejected. He approached the Insurance Ombudsman on 20.01.2005 for his intervention in the matter.

The analysis of the case reveals that as per the Insured's statement he was originally insured with New India from 1991 to 1995 later charged to National Insurance Co. Ltd. from 1996-1997 and again came to New India from 2001-2002. During tghis period, the Insured had admitted that he had no policy for 2yrs i.e. 1998-99 and 1999-2000. Further the policy with National Insurance Co. Ltd. was for Rs. 1 lakh and expired on 13.09.2001 while it was renewed with New India after 4 days break from 18.09.2001 with an increased Sum Insured of Rs. 4 lakhs to make the total insurance for Rs. 5 lakhs. New India issued the policy with an exclusion of cataract possibly as an underwriting policy and they failed to produce the past records to confirm whether standard medical examination was conducted to ascertain the health status of the Insured and accordingly took appropriate underwriting decision. However, it should be taken for granted that there was disclosure of existing ailments by the Insured as otherwise the policy document would have mentioned the same. The dispute is regarding pre-existing ailments i.e. Hypertension and dyslipidemia which Shri Lakhani was reported to be suffering from since 13 yrs as per hospital records. It is necessary for this Forum to examine how far the contention of the TPA and the Company would be valid to sustain the rejection.

Based on this analysis and the facts and circumstances of the case the contention of the New India and the TPA that the disease was pre-existing which contributed to cardiac ailments leading to CABG and therefore should be rejected under Clause 4.1, is sustainable.

Mumbai Ombudsman Centre
Case No. GI-559 of 2004-2005
Shri Rajesh B. Goel
Vs
United India Insurance Co. Ltd.

Award Dated 10.03.2006

Shri Rajesh B. Goel alongwith his mother Smt. Kantarani took a mediclaim policy for the first time in the year 2003 from United India Insurance Company Limited, D. O. 2. Smt. Kantarani was hospitalised at Dr. Mukherjee's Eye Clinic for Left Eye Cataract and when the claim was preferred by Shri Rajesh B. Goel in respect of the said hospitalisation, the Third Party Administrator of the Company, repudiated the claim on the ground of pre-existing disease by invoking clause 4.1 of the mediclaim policy. Not satisfied wit the decision of the Company, Shri Rajesh Goel repreented to the TPA and not receiving and favourable response from the Company Shri Goel approached the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim. The records pertaining to the claim were perused. The analysis of the case reveals that the Complainant Shri Rajesh Goel, son of the Insured Smt. Kantarani is claiming on the ground that cataract exclusion under the policy is applicable on the first year operation of the policy and not on the 2nd year after renewal. During the hearing he mentioned that under "Eyes" the doctor's remark on the Medical Examination Report form states that there was 'no evidence of cataract'. According to him this proved that cataract developed recently and therefore, should be paid without treating it as pre-existing illness. However, notwithstanding the above position the policy excludes 'refractive error' for Smt. Kantarani Goel. It is also a fact that the she took the mediclaim policy only in the 57th year and got operated the very

next year and within the same month of the first renewal. The Complainant specifically mentioned in his letter that no claim on the 2nd year can be rejected which evidently suggested that he was mindful of the exclusion clause he was mentioning in his letters to take the benefit out of the same. As this Forum is expected to render justice to both the parties in equal measure it would be equitable to grant 50 % settlement of the claim in the face of exclusion of 'refractive error' and also considering that technically the surgery was done in the 2nd year of the policy which point was consciously emphasised by the Complainant.

Mumbai Ombudsman Centre
Case No. GI-520 of 2004-2005
Shri Jimmy F. Daruwalla
Vs
United India Insurance Co. Ltd.

Award Dated 13.03.2006

Shri Jimmy F. Daruwalla and his mother Smt. Francisca F. Daruwalla took a mediclaim policy for the first time from United Insurance Company Limited, D. O. 3 for the period 22.04.2002. The said policy was renewed had earned Cumulative Bonus @ 5 %. Smt. Fransica was hospitalised at Bombay Hospital for IHD and the claim was preferred by Shri Jimmy Daruwalla in respect of the said hospitalisation to the Company. Not receiving any reply despite several reminders to the Company regarding his claim, he approached the office of the United India Insurance Company from where he received a copy of the letter stating that his claim was rejected on the ground that his mother was having Hypertension. Aggrieved by the decision of the Company on this filimsy ground, Shri Jimmy Daruwalla approached the Insurance Ombudsman for justice. The records pertaining to the claim were perused and the parties to the dispute were called for a hearing. The analysis of the case reveals that the TPA of the Company M/s Medicare Services Pvt. Ltd. Kolkata has repudiated the claim on the ground that the Concentric Left Ventricular Hypertrophy could not have taken place in such a short time when the policy was in the 2nd year to constitute a valid claim under the policy and therefore, the disease must be pre-existing. Obviously the moot point would be to establish first of all that Smt. Daruwalla had Hypertension before taking the policy. Unfortunately without establishing the same the Company decided to repudiate the claim on the assumption that in the first place Hypertension was there, secondly it was long standing to cause Concentric LVH and therefore, the claim was not payable. The Company did not apply their mind even after the rejection of the claim and merely defended the decision of the TPA without any conclusive support. It is important to note here itself that the statement of the Insured that she had severe chest pain in the evening for which she was rushed to the hospital stands out from the ECG report which talks about 'Impending MI' and therefore, it is established that prompt attention was given to her. The Discharge Summary and the Indoor case papers do not write any other past history of Hypertension of Diabetes Mellitus or any other illness and the patient did not have even breathlessness or palpitation or even suffered from chest pain. The patient is a lady and passed 50 years. She was 52 plus when she was admitted to the hospital. Some of the blockages could be even age related which is faster in women after menopause period. The medicines suggested were minimum including vitamins and antacids and there was no nothing as to the medicines she was already taking at the time of admission of the hospital which is indeed a point of contention. Usually the patient's exisiting medication is noted and more so, in case of HTN/DM and those are not charged by the Hospital. From all these nothings backed up with actual treatment methodology there does not appera to be a strong indication that

the patient was already suffering from Hypertension since long time and therefore, the conclusion made by the TPA in their repudiation letter is unsubstantiated by facts and documents.

In the facts and circumstances the decision of the Company to reject the claim is not sustainable as the hospital records did not have any past history of illness and the TPA and the Company also have failed to substantiate their viewpoints to justify pre-existence of illness as per clause 4.1.

Mumbai Ombudsman Centre
Case No. GI-504 of 2004-2005
Shri Nemjee Popatalal Savla
Vs
The New India Assurance Co. Ltd.

Award Dated 17.03.2006

Shri Nemjee Popatalal Savla had taken a mediclaim policy from The New India Assurance Co. Ltd. covering self and his wife Smt. Liza Nemjee Savla for sum insured of Rs. 3,00,000/- respectively. On 26.11.2002 Smt. Liza N. Savla was admitted in Dr. Balabhai Nanavati Hospital, Mumbai for Myocardial Infarction under the care of Dr. V. Mehan and was discharged on 06.12.2002. After hospitalisation, Shri Nemjee Savla, husband of Smt. Liza Savla preferred a claim of Rs. 4,19,648/- to the Insurance Company. The Company referred the case to Expert Medicolegal Consultancy (EMC) for opinion. Dr. A. V. Patil from EMC opinion that the Insured was a known case of IHD, suffering from Hypertension and Diabetes Mellitus and he was on treatment for the same. To clarify this, he asked the insured to submit papers pertaining to hypertension and diabetes mellitus to confirm the exact date when hypertension and diabetes mellitus respectively was first detected. The Company later informed the insured about its decision to repudiate the claim under Exclusion Clause 5.5 of the mediclaim policy due to non-cooperation and non-submission of the required documents.

The risk factors have been analysed from out of the available material. The progress of the disease is also available from out of the Investigation Reports. The issue would be to determine the duration and taken a decision as regards pre-existing illness. To this extent, it is necessary for the Insured to provide adequate information and by sending a letter that since there was no history, there was no question of providing any records would be taken as running away from reality on the basis of the material which has been provided to this Forum. In the facts and circumstances, the claim of Shri Nemjee Popatalal savla in repect of his wife, Smt. Liza N. Savla's hospitalisation at Dr. Balabhai Nanavati Hospital for Myocardial Infarction is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. GI-17 of 2004-2005
Mr. Prakash T. Bajaj
Vs
The New India Assurance Co. Ltd.

Award Dated 17.03.2006

Shri P. T. Bajaj was covered under Mediclaim Policy since 13.8.1999. He had claimed in the past for cataract under 1999 policy, for left eye cataract under 2000 policy for left eye vitroctomy under 2001 policy and for left eye silicon removal under 2002 policy. The present claim is for Steroid induced dueodenal ulcer under 2003 policy no. 111900/48/03389. The insured was admitted to Jaslok hospital on 6.5.2004 and was

discharged on 13.5.2004. When he lodged a claim with the Company for Rs. 1,00,083/- , the company settled his claim for Rs. 92,683/- and disallowed Rs. 7,400/- (Rs. 6,800/- for Olympus injector and Rs. 600/- for one time fee of doctor since there was no mention of Doctor's name. The analysis of the file as per the records made available to this Forum would reveal the following :

The final disallowed items thus stands at Rs. 7,400/- (Rs. 6,800/- for Olympus Injector and Rs. 600/- Doctors one time fee.). The Doctor's fees have already been billed and recovered. The main dispute is therefore, regarding non-payment of Rs. 6,800/- for Olympus Injector which as per Stores Code CORD 1710143 dated 10.5.2004 has been noted as Needle 2 Quantity. The issue would be whether the needle would be reusable or disposable. This point was specifically checked with the surgeons of top hospitals in Mumbai by a Medico-legal Consultatn and he has obtained the following clarification :

the Olympus Gastroscope Injector Needle is a disposable item

the needle is normally not reused because of its low cost viz. Rs. 800/- to Rs. 1,000/- per piece

the cost of the needle are included in the 'Operation theatre Equipment Costs' and/or in 'Materials used in the Theatre' expenses by the Hospital.

It is a fact that Operation Therefore Cost includes these expenses as cost of material and since that amount was supported to have been made by the TPA and the Company, no further payment should be necessary. Unfortunately, there is no confirmation to this effect nor does the O. T. Cost mention specifically. Hence to resolve the longstanding dispute, I recommend that a lumpsum amount of Rs. 2,000/- being maximum amount of cost of two needles be allowed to the complainant.

Mumbai Ombudsman Centre
Case No. GI-590 of 2004-2005
Shri Dilip Sunderdas Rajpal
Vs
United India Insurance Co. Ltd.

Award Dated 20.03.2006

Shri Dilip Sunderdas Rajpal took a mediclaim policy covering himself and his family members from United India Insurance Co. Ltd. Mumbai Divisional Office - 14 since 2001. The claim arose under the policy no. 021400/48/03/00840 for a period from 06.07.2003 to 05.07.2004. Master Sanjay D. Rajpal was admitted at Joy hospital on 08.04.2004 and diagnosed as (R) Inguinal Hernia and Herniotomy was done on same day by Dr. Roy Patankar. Shri Dilip S. Rajpal, father of the Insured preferred a claim to the Company for reimbursement of medical expenses incurred by him at Joy Hospital. The claim was processed by M/s Medicare Services (TPA) and on 21.07.2004, they informed the Insured that Inguinal Hernia at such a young age develops through a patent process vaginalis developmental defect and it is a result of a congenital defect and therefore the claim is not payable.

The analysis of the case reveals that the rejection of the claim by the TPA was due to their obtaining a medical opinion that 'inguinal hernia' at such a tender age would be the result of an existing problem of herniation, probably congenital and they offered the Complainant the opportunity to prove it otherwise by appropriate medical opinion. Unfortunately, the Complainant did not respond and at the hearing the Complainant maintained that it was noticed in March, 2004. If it was so, it was open to him to contradict the medical opinion by means of an appropriate independent medical opinion or even from the treating sugeon to confirm that the problem was of this type of hernia becoming a latent disorder which would have been palpable at coughing or squeezing

in particular. The classical theory mentioned by the TPA's medical consultants as a patent processes vaginalli developmental defect cannot be overlooked unless opposed through a rebuttal by a competent medical person. Amongst all forms of hernia there is a possibility of protrusion of abdominal organs into the umbilical cord, due to a fault in embryonic development. It is present at birth and can be trated surgically. The Company has also mentioned in their note to this Forum that the discharge card summary does not mention about the past ailments or symptoms at all. Similarly the first prescription of the attending physician who must have suggested surgery was not forwarded to them despite advising the Complainant and when a further oppertunity came at the time of hearing. This is quite important and really surprising that if Shri Dilip Rajpal was so confident about the disease occurring suddenly in Mach, 2004, he should have forwarded past medical records for consideration. Master Sanjay was 6 yrs old when the surgery took place and the above etiology does suggest that during the developmental stage it happened which was noticeable and therefore pre-existing at the time of insurance.

In the facts and circumstances, the decision of the TPA and Company to reject the claim on the ground of pre-existing illness coulped with non-submission of past medical records is sustainable.

Mumbai Ombudsman Centre
Case No. GI-024 of 2004-2005
Shri Ramkishan S. Agrawal
Vs
The New India Assurance Co. Ltd.

Award Dated 20.03.2006

Shri Ramkishan S. Agrawal alongwith his wife and son was covered under the mediclaim policy issued by the New India Assurance Company Limited, Unit 111800. Shri Ramkishan S. Agarwal initially was admitted to Desai Hospital Pvt. Ltd., following some discomfort like chest pain, giddiness and headache. He was then later taken to Asian Heart Institute for Coronary Artery disease where PTCA/Stent to LAD and to OM (Drug coasted) was done. When Shri Agrawal preferred a claim for the said hospitalisations, the Company's Third party administrator i.e. M/s TTK Health Services Pvt. Ltd. repudiated the claim invoking clause 4.1 of the mediclaim policy. Shri Agrawal had approached this Forum for settlement of his claim as he had not received any communication from the Company or from the TTK after he preferred a claim. After perusal of the records parties to the dispute were called for hearing. The analysis of the record reveals that Shri Agrawal had a policy from 13th December, 1995 to 12th December, 1996 and had a break in cover as he failed to renew the policy. He later took it from February, 1997 which was rightly treated as a fresh policy by New India for all practical purposes.

The Discharge Card of Desai Hospital gave a clear idea about the partient being hypertensive and on medication like Atten, ASA, Monotrite etc. Pulse was irregular and BP 180/100. He was immediately put on pacemaker to stabilize and later shifted to Asian Heart Institute. The history is clear, symptoms are suggestive of Ischaemic heart disease with history of irregular heart rhythm. Shri Agarwal had Tachycardia and Bradycardia which are really quite a disturbing health feature. These are of longstanding nature and he was on regular medications and himself admitted at the hearing that he was a patient of hypertension and was taking medicines. Based on these clear evidences and an official recording of Shri Agarwal's having Hypertension

since 15 years, there is no question that the disease was pre-existing before policy was issued by The New India Assurance Company Limited.

Accordingly the decision of the Company to reject the claim on grounds of pre-existing illness not been disclosed as per clause 4.1 is sustainable.

Mumbai Ombudsman Centre
Case No. GI-004 of 2004-2005
Shri C. H. Ahuja
Vs
United India Insurance Co. Ltd.

Award Dated 22.03.2006

Shri C. H. Ahuja along with his wife had taken a cover under Mediclaim Policy from 29.12.1997 from United India Insurance Company Limited. Shri Ahuja underwent cataract surgery of left eye on 8.1.1998. During August 2004 his vision in the left eye was getting blurred and distorted and as per advice of Eye Specialist of Wockhardt Hospital, he underwent Photo Therapeutic Keratectomy on 26.8.2004. When he preferred a claim under policy with United India, their TPA, Family Health Plan Ltd. rejected the claim invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company Shri Ahuja represented to the Company and also pointed out to them that the policy was continuous and he had earned Cumulative Bonus. On receipt of the same the Company based on their Medico-legal Consultant Dr. M. S. Kamath's opinion repudiated the claim on the ground that there was no necessity of admission to the hospital and it was a cosmetic surgery. Aggrieved by this decision Shri Ahuja approached this Forum for justice. All the relevant records were perused and parties to the dispute were called for hearing Shri Ahuja mentioned during the hearing as also in his submissions that he experienced severe difficulty over a period of time culminating during the last 3-4 months of terrible problems of vision in left eye and not in right eye. It could be raised as a point that he did not try other avenues of vision correction meaning by proper lens and he was keen to get LASIK treatment as a permanent solution. Similarly the probelm can be attributed due to improper surgery in 1998 on the left eye. Since the policy is from 1997 it cannot be treated as pre-existing illness which occurred during the covering of the policy. Hence irrespective of the fact whether it was covered by the employer or the Insurance Company i.e. United India, the fact remains that it was a problem which was corrected much later and therefore, should get accommodated under the policy which was continuous since 1997. It could be taken as correction surgery or an extension of Cataract surgery made earlier for which United India Insurance Company may take some load on their policy. Finally taking a view that normally cataract surgery is covered even as a non-admitted person in the hospital no serious offence can be taken by the Insured getting the outpatient bills and preferring the same. Taking a balance view of the entire matter and also the fact that it could be ascribed to past only 50 % of the claim amount may be settled by United India to resolve the dispute raised in may Forum as a compromise solution.

Mumbai Ombudsman Centre
Case No. GI-35 of 2004-2005
Shri Govardhan Das Bangard
Vs
United India Insurance Co. Ltd.

Award Dated 27.03.2006

Shri Govardhan Das Bangard along with his wife was covered under Mediclaim Policy since February 1992 with New India and later on from 1998 with United India and had been continuouslyh renewing his policy. Shri Bangard's wife was operated at Tata memorial Hospital for Cancer of Right Breast on 25.3.2004. She had received three cycles of Chemotherapy before surgery and had been operated on 25.3.2004. Post surgery she had been advised to take Hormone Therapy (Oral Medication to be taken at Home) Tab. Armidex 1 mg. OD x 6 months after completion of radiation therapy and to discontinue chemotherapy. He lodged a claim or reimbursement of medical expenses for the full treatment including radiation therapy and Hormone treatment taken for 3 months since he purchased the said medicines only for 3 months initially as it was not affordable to him in view of the high cost of the medicine, after radiation therapy i.e. upto 25.8.2004. The TPA allowed the maximum amount payable under the policy treating the hospitalization period from the date of surgery i.e. 25.3.2004 till the end of Radiation Therapy i.e. 25.5.2004. The Company has calculated the Post Hospitalisation Expenses till July 2004 and paid the cost of Hormone Treatment proportionlly as admissible within the post hospitalization period. However, since the Hormone treatment was of a continuous nature, the Insured felt that the continuous expenses of the hormone treatment also should be paid by the Company.

It is admitted that the treatment of Cancer and similar other critical ailments require coninued medical treatment but to grant the same under Mediclaim Policy would be a discrimination against other buyers of the policy who whould be advsersely affected by the conditions. It is also admitted that such type of diseases require special attention but again doing that the terms of the policy should not be affected. However, to resolve the dispute, I decide as under :

United India should calculate the exact admissible amount upto July 2004 inclusive of Hormone therapy cost.

Whatever be the package of total Hormone treatment of 6 months, I advise even after icluding the cost of Armix till 20.7.2004, the Company may grant one more hormone therapy dose as a special case and as a maintenance drug before she presented herself for further check up. The remaning portion of the expenses should be borne by the Insured.

Mumbai Ombudsman Centre
Case No. GI-81 of 2004-2005
Shri Bhupendra Sheth
Vs
The New India Assurance Co. Ltd.

Award Dated 27.03.2006

Shri Bhupendra Sheth had taken a mediclaim policy from The New India Assurance Co. Ltd. covering himself and his wife Smt. Hansa B. Sheth for sum insured Rs. 2 lakh respectively. In the year 2000-2001, he increased the sum insured from Rs. 2 lakhs to Rs. 3 lakhs under policy No. 142000/48/00/03166. On 22.04.2002, he was admitted to Smt. S. R. Mehta & Sir Kikabhai Premchand Cardiac Institute, for chest pain and choking sensation restrosternal on walking. He was advised CAG and the same was done on 22.04.2002. He was again admitted on 25.09.2002 for Angioplasty and was discharged on 27.09.202. He submitted his claim to the Insurance Company for Rs. 31,457/- & Angioplsty was settled for Rs. 2,18,494/- as against Rs. 3,43,052/- Rs. 1,24,558/-. The analysis of the case reveals that the Company restricted their liability uoto Rs. 2 lakhs sum insured plus appropriate CB on the same, on the ground that Rs. 1 lakh incease to the existing sum insured by Shri Sheth was suspect in so far as as

cardiac problems were concerned. This argument is based on the fact that the earlier hospital notings in Dec. 2001 recorded “HT +, DM + with family history” and a noting of Betacard 50 mg. from the medical details of OPD case paper of the Hospital. In fact from the underwriting point of view, all increases are fresh contracts to the extent the amount increased and is liable to be examined thoroughly in the light of existing diseases. The hospital notings in the OPD case paper reveals that he has HT and diabetes and was already on medicine which indicates that Shri Seth was having these problems for quite some time. Again he was advised to bring the paper for further visit, which he did on 13.4.2002 and Thallium Perfusion Scan revealed symptoms of IHD + and he was advised angiography and Two medicines Loprin and Monotrate were recommended furher by the concerned doctor. This proved a point that he was vulnerable for Coronary Artery Diseases.

As documentary evidence had proved this point, this Forum is of the opinion that the Company’s restriction to the sum insured to Rs. 2 lakhs plus CB cannot be questioned. In the facts and circumstances the decision of the Company to settle the claim of Angiography for Rs. 31,457/- and Angioplasty claim for Rs. 2,18,494/- for which the Insured gave a full and final discharge would be acceptable and this Forum would not interfere. Moreover, the Insured lodged his claim apparently after three months which was accepted by the Company following the complaints’ representation. The Company having considered this claim has demonstrated their positive approach.

Mumbai Ombudsman Centre
Case No. GI-031 of 2004-2005
Shri Jethalal V. Nandu
Vs
United India Insurance Co. Ltd.

Award Dated 27.03.2006

Shri Jethalal V. Nandu was insured under mediclaim poliy of the United India Insurance Co. Ltd., Divisional Office I alongwith his wife Smt. Bhavna Nandu and son Mast. Rahul Nandu. The claim No. 0703113 arose under policy No. 020100/48/02/06720 during policy period 20.11.2002 to 19.11.2003. Mast. Rahul Nandu was hospitalised at Swastik Nursing Home on 03.04.2003 to 04.04.2003 for Bilateral Breast abscesses under care of Dr. Shivkumar V. Dalvi. Shri Jethalal V. Nandu preferred a claim to the Company for reimbursement of hospitalisation expenses incurred for his son’s hospitalisation. The claim was processed by M/s Medicare Services TPA. They had informed Shri Nandu about its decision to repudiae the claim on the basis that the USG of breasts done a day prior to the admission showed no abscess, yet the patient was admitted for incision and drainge of breast abscess was done. According to them the patient concealed all these facts and hence the claim is not payable. Not satisfied with the decision, Shri Jethalal Nandu repesented to the TPA but not getting any favourable reply, he approached Insurance Ombusman with his grievance.

The analysis of the case revals that the Complainant, Shri Jethalal Nandu lodged a claim for Bilateral Breast abscesses for his 15 yr old son Mast. Rahul Nandu who was admitted on 03.04.2003 and discharged on 04.04.2003. He was operated for Bilateral Breast abscesses under General Anaesthetia. The TPA M/s medicare Services raised certain issues in their letter dated 01.08.2003 as they felt that the USG done on both breasts showed no mass lesion or abcess and yet Bilateral Abscess drainage was done. The Complainant mentiond that they replied the letter under his letter dated 10.08.003 (unfortunately the copy is not avalable with this Forum) which should have

clarified the issues. A close scrutiny of the USG reveals that on 02.04.2003 Mast. Rahul was examined and following are the comments “Both breasts show a normal pattern, however show c/o increased fat deposition”. “Opinion: Fatty Proliferation of the male breasts, No. E/O Mass Lesion”. It is felt from the USG report that there was fatty prolifation of breasts although no lesion was noticed. It would be reasonably presumed that USG was done for some other invasive examiantion but not or apparently noticeable abscess which were removed by surgery. The TPA’s point that the USG was done earlier cannot be taken against hospitalisation as USG may be advised by the treating doctor to detect other problems and many a time we carry out the advice of doctor to aid his diagnosis. This cannot be taken as preempting hospitalisation. The further point is that pre-hospitalisation expenses are payable and the USG charges would not be paid if done by the hospital again. The name of the Anesthetist together with the surgical procedure of Bilateral Breast Abscess was put down by concerned surgeon Dr. V. M. Kini. His professional fees and the medical expenses were available on record. The TPA raised a further issue that the number of tests were conducted some of which appeared to be not consistent with the findings. In fact, in respect of surgery some routine tests would be always necessary but it is admitted that some of the investigations could be in excess. However, the TPA’s charge that there was concealment of the fact by the claimant was totally unfounded by means of any positive documents for either the diagnosis made earlier of treatment received for the same. On the contrary, it clearly shows their lack of application of mind to make out from the course of treatment that there was a positive ailment and the surgical intervention under General Anaesthetia required hospitalization. Since the alleged malafide intention has not been proved and the documents produced are evidently to confirm the presence of the illness, I have to accept the statement of the Complainant and allow the claim to be passed by the Company and to their rejection uncalled for. However, considering the fact that some of the investigations could have been avoided, I grant a net amount of Rs. 12,000/- as against Rs. 16,295/- as claimed by Complainant.

Mumbai Ombudsman Centre
Case No. GI-014 of 2004-2005
Shri Padbidri Vasudev Shanbhag
Vs
The New India Assurance Co. Ltd.

Award Dated 27.03.2006

Shri Padbidri Vasudev Shanbhag along with his wife Smt. Bharati V. Shanbhag was covered under Mediclaim Policy from 1995. Initially the Sum Insured under the policy for both of them was 50,000/- which was increased by Rs. 25,000/- for both in the year 2000. On 20.02.2004 Smt. Bharati Shanbhag experienced retrosternal pain and choking sensation in the throat for which she consulted Dr. S. R. Mahale who advised her to get admitted to Hospital. The diagnosis at Singhi hospital was unstable angina and at Jaslok hospital it was IHD, DM, HTN, Normal Coronaries. When Shri Shanbhag preferred a claim for the said hospitalisations the Third Party Administrator of the Company M/s TTK Healthcare Services rejected the claim by invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the TPA, Shri Shanbhag represented his case and not receiving favourable response he approached this Forum. Records have been perused and the parties to the dispute were called for hearing It appears from the indoor case papers that there were two different notings 6-7 years and 10-15 years which is a very long duration and normally we should accept such

statements as gap between 15 years and 10 years is high i.e. 5 years. The Company has gone by the duration of 15 years since the policy was taken in 1995 and if if was taken to be 10 years Hypertension it would have been covered under the policy even as a border-line case. As regards the duration of Diabetes Mellitus 3-4 Months the hospital records clearly mentioned that the patient was on some medicines like Aten, Sorbitrate, Glyconet etc which were clearly medicines for both Hypertension and Diabetes Mellitus. Since she was on glycomet for diabetes as back as from October, 1999 (it should be even before) it would be evident that diabetes, was there for more than 5 years from the date of hospitalisation in 2000 and therefore clearly it was a flase statement made before the Singhi hospital and Jaslok hospital to record her Diabetes Mellitus as 3-4 months only.

In the facts and circumstances since there has been an attempt to tamper with the medical records and make the statement which did not reflect the exact health status, it would be incorrect to make any payment to the Insured. In this background it would be logical to hold the hypertension of 15 years duration rather than 10 years and take it as an existing illness.

Accordingly, the decision of The New India Assurance Company Limited to reject the claim for CAG on the ground of pre-existing illness coupled with incorrect statements made before the hospital authorities cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI-609 of 2004-2005
Shri Pravin Chenmal Oswal
Vs
The New India Assurance Co. Ltd.

Award Dated 28.03.2006

Shri Pravin Chenmal Oswal who alongwith his wife was covered under mediclaim policy issued by The New India Assurance Company Limited, D. O. 151200 had approached the Office of the Insurance Ombudsman by a letter dated 6.3.2005 seeking intervention of the Ombudsman in settlement of his wife's claim which was rejected by New India. Smt. Rekha P. Oswal, wife of Shri Pravin Oswal was hospitalized at Kamakshi hospital, Kolhapur for Vaginal total plication c entero rectocele repair with Uterosacrals done ↓G.A. When Shri Pravin Oswal preferred a claim for the said hospitalisation, the Third Party Administrator of the Company repudiated the claim invoking clause 4.1 and 4.3 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Oswal represented to the Company and not receiving any favourable response, he approached this Forum for settlement of his claim. After perusal of the records parties to the dispute were called for hearing. A scrutiny of the documents submitted at this Forum reveals that the policy was taken for the first time on 31.3.2003 it would constitute both pre-existing and non-disclosure and come under 4.1 policy exclusion. Further the surgeon doctor has confirmed that it was a case of "recurred prolapse" which meant that it was earlier there and hence pre-existing. The surgery was total plication of uterosacrals with enterectocele repair which means stitching of folds or trucks within the organs with repairs for an incision already done. This has badly exposed the Insured that he did not state the facts before and also at the hearing when he was specifically asked about past surgery.

Apart from the above analysis, the first year excluded disease includes any hysterectomy for menorrahagia or Fibroma which is not payable. Although it was not a case of hysterectomy yet since it was related to uterus prolapse and of recurring type the Company could resort to it indirectly but not with any force or sustaination. Hence I am not inclined to accept this exclusion as a defendable point.

In the facts and circumstances the claim of Shri Pravin Oswal for the expenses incurred for his wife Smt. Rekha P. Oswal's is not sustainable.

Mumbai Ombudsman Centre
Case No. GI-526 of 2004-2005
Shri Dinesh Kapadia
Vs
National Insurance Co. Ltd.

Award Dated 29.03.2006

Shri Dinesh Kapadia and his wife were covered under a Group Mediclaim Policy since 1.7.2001 issued by Life line Global Ltd. under National Co. Ltd. DO 13. Shri Kapadia lodged a claim with Lifeline under policy No. 251301/48/02/35/0279 issued for the period (30.6.2003 to 29.6.2004) in respect of his Angioplasty done at Asian Heart Hospital on 30.1.2004. Shri Kapadia's complaint was that the said claim was neither repudiated nor settled nor any correspondence was received. Shri Kapadia had on the date of his enrolment informed Life Line that he was suffering from Diabetes as per referral form filled and signed by him. He had also given a duly signed declaration that he understood that hospitalization benefits would not be applicable for pre-existing ailments under the Life Line Scheme and that he is applying for Lifeline services accepting all the terms and conditions. In January, 2004 Shri Kapadia was hospitalized for angioplasty at Asian Heart Institute. The history of present illness in the discharge card was noted as "known hypertensive and diabetic - on regular treatment had been having chest pain and breathlesness since 3 month. ECG shows Ischemic changes. Also suffering from pulmonary Koch's since Nov. 2003 - of AKT. Recently had right pleural effusion which was tapped at Breach Candy Hospital. Admitted for CAG". On examination of the relevant documents it appears that he made a disclosure about his diabetes followed by a declaration that he knew that any treatment for diabetes and related diseases would not be payable.

As regards diabetes, it was mentioned that not only he was on required medicine and he was also taking insulin but his diabetes was generally under control. After long delays S. Ajmera, who opined that Cardio Vascular diseases would be a direct consequence of Hypertension and Diabetes. Based on this opinion National Insurance have repudiated the claim by invoking Clause 4.1 of Mediclaim Policy.

Going by the progress of the disease and the proven medical theory of long standing diabetes causing arterial stenosis, it would be logical to accept that the presence of HT and diabetes would be a great risk factor for heart diseases. The Insured had diabetes but no hypertension. This however, does not lessen the risk as diabetic persons are prone to develop cardio vascular diseases with peripheral vascular diseases which may lead to ischaemic and gangrene of the lower limbs. It would be logical to conclude that his diabetes was not under control as on 30.1.2004 it showed 312 mg %. He had TB for which he was on long treatment and had to do tapping of pleural effusion. Based on these evidences the decision of the Lifeline Global to recommend rejection and the acceptance of the same by National Insurance Co. Ltd. cannot be questioned.

Mumbai Ombudsman Centre
Case No. GI-10 of 2005-2006
Smt. Maya Cirvante
Vs
The New India Assurance Co. Ltd.

Award Dated 29.03.2006

Smt. Maya Cirvante was having mediclaim policy of The New India Asurance Co. Ltd. since 2000 for a Sum Insured of Rs. 3 lakhs with exclusion of diabetes. Smt. Maya Cirvante was admitted to Lilavati Hospital for renal artery stenosis under care of Dr. M. G. Pillai from 22.11.2004 to 24.11.2004. The Insured preferred a claim under policy no. 141600/48/03/04524 for the policy period 01.02.2004 to 31.01.2005 for Rs. 2,56,000/-. The claim was precessed by M/s Paramount Health Services Pvt. Ltd. (TPA) and they informed the Insured Smt. Maya that the claim is not payable as renal artery stenosis is a complication of pre-existing disease which is diabetes and it is excluded in the policy. After getting the rejection letter from TPA, on January 2005, Smt. Maya Cirvante represented to the Regional Manager of the Company stating that Renal artery stenosis is a thickening or narrowing of lining of the mainstream artery that supplies blood to kidneys, and it has nothing to do with pre-existing ailment that is diabetes and it can occur to anybody without the history of diabetes and it can sometimes occur as a result of ageing process. The Company referred the matter to their panel doctor, Dr. Agam C. Vora for his opinion and accordingly they upheld the decision of the TPA to repudiate the claim. Not satisfied with the decision of the Company and TPA, Smt. Maya Cirvante represented to the Ombudsman vide her letter dated 09.04.2005 seeking his interference in the matter.

The policy had an exclusion of diabetes and related diseases all through. The Insured, Smt. Maya Cirvante decided to take a Mediclaim Policy when she was over 62yrs old and thus it would be taken as an anti-selection against the Insurance Company. It is quite natural that aged persons would be susceptible to some illnesses and in fact this has been confirmed by Dr. Pillai in his certificate dated 23.11.2004. He has mentioned that renal artery stenosis would be an ageing disease and has no direct relation with diabetes. The point would be that in an ageing process apart from normal stenosis the aggravation would be caused more by diabetes which is existing since long and would always be a dominant factor. Diabetes is a chronic disorder of carbohydrate metabolism, marked by hyperglycaemia and glycouria resulting from inadequate production or use of insulin. Diabetic persons are prone to developing retinopathy, glaucoma and various types of neuropathy apart from cardiovasular diseases. Cardiovascular disease is recknoned as the major cause in diabetics and since this increases 5 times more the risk of arterial stenosis, the nexus between the two is established in medical science. Dr. Pillai in his certificate has mentioned that diabetes does not have any direct relationship of diabetes with the arterial stenosis which is being advocated here. Based on this analysis and the documents produced before the Forum coupled with the consultant Dr. Agam C. Vora's opinion, the decision of the New India to reject the claim on the ground of already excluded pre-existing illness of diabetes, canot be questioned as it was their conscious underwriting decision.

Mumbai Ombudsman Centre
Case No. GI- 15 of 2004-2005
Shri Merwan Rashid Gourabian
Vs
United India Insurance Co. Ltd.

Award Dated 29.03.2006

Shri Merwan Rashid Gourabian was covered under Mediclaim Policy of United India Insurance Co. Ltd. since 2001 along with his family members. The claim arose under policy period 03.12.2003 to 02.12.2003. Shri Merwan Rashid Gourabian was hospitalised at Breach Candy Hospital from 27.10.2003 to 11.11.2003 for Acute Anterior Wall Myocardial Infarction and Coronary Angiography (CAG) c PTCA was done on 04.11.2003. The insured preferred a claim for reimbursement of hospitalisation

expenses of Rs. 93,750/- to M/s Medicare Service (TPA) along with a certificate from Dr. Farokh E. Udwadia, treating doctor of Breach Candy Hospital but the same was rejected by TPA stating that in the discharge card it has been clearly mentioned that the Insured was suffering from hypertension since long time and hypertension is a known factor for coronary artery disease. They also mentioned that there is complete contradiction in the statement of discharge certificate and Dr. Udwadia's Certificate. Hence the claim is not payable.

The analysis of this case to find a solution would depend on a few fundamental issues getting cleared first. The Policy was issued from 03.12.20033 to 02.12.2003 and the hospitalisation took place on 27.10.2003 for Myocardial Infarction for which angioplasty was done. The Company i.e. United India has written in their note of 21.03.2006 submitted along with their deposition that the policy was from 03.12.2002 without mentioning the Cumulative Bonus accrued on it to give a correct idea about the inception of the policy. It attached 25 % Cumulative Bonus which meant that policy was from 1997 at past, i.e. it was in the sixth year of operation without any claim before. In fact this would not leave any doubt to contradict that the duration of the disease BP was in existence since long time which would be more than 6 yrs even without specifying the exact date. The Company took the insurance business of a nearly 70 yr old person without proper underwriting care and the policy was issued without any exclusion. Even the usual exclusion about cataract etc. were not imposed. Hence perhaps the issues raised by the Company later would sound out of place. However,the documents have to be relied upon and going by the progress of the disease and in keeping with the advanced age of the insured it would be natural to conclude that the arterial blockage was the cause of long standing hypertension. Moreover, the hospital papers have written that Shri Gourabian was on regular medicines for hypertension which he or his relatives must have mentioned else how the hospital would record the same. Yet the Insured denied all these and in fact wanted to get a certificate from Dr. Udwadia to say he had no hypertension which proved the wrong intention. Dr. Udwadia was the doctor of Breach Candy hospital and not the Insured's family physician. Shri Gourabian also denied having taken any medicines in his life hence should not have consulted any physician for his ailments. How then Dr. Udwadia could certify that he had no hypertension before as he never treated him earlier. Hence the denial by the Insured also denied arthritis although it was recorded in the history sheet as long standing. hence, both on pre-existing i.e. 4.1 clause and for fraudulent intention to change the history recorded in the hospital, the claim would be inadmissible and the decision of United India to reject the claim would be sustainable.

Mumbai Ombudsman Centre
Case No. GI-11 of 2004-2005
Shri Shamkant Bhalchandra Wagh
Vs
The New India Assurance Co. Ltd.

Award Dated 29.03.2006

Shri Shamant Bhalchandra Wagh took a Mediclaim Poilcy from The New India Assurance Co. Ltd. covering his family members for a sum insured of Rs. 50,000/- each. After getting all requirements from Shri Wagh, the Company issued a mediclaim policy with an exclusion of B. P., Diabetes & Cardiac Problems. The claim arose under policy no. 142000/48/03/00731 during policy period 14.05.2003 to 13.05.2004. On 19.04.2004, Shri Shamkant Bhalchandra Wagh was admitted to Suchak Hospital, Malad and diagnosed as Lt. sided Hemiplegia c Rt. sided facial weakness. He was shifted to

Hinduja Hospital on same day i.e. on 19.04.2004 for further management and diagnosed as (R) lentiform Hypertensive bleed and discharged on 29.04.2004. After hospitalisation, the insured preferred a claim for reimbursement of hospitalisation expenses incurred at both the hospitals. The claim was processed by M/s Paramount Health Service Ltd. (TPA). On 27.08.2004, TPA informed Shri Wagh about its decision to repudiate the claim on the basis that the he was suffering from hypertension since 10 years and hemiplegia a complication of hypertension. Moreover, hypertension and related complications are excluded from the policy. Hence the claim is not payable.

The repudiation of the claim is based on purely a technical medical issue of the exact impact of hypertension to cause intracerebral bleed resulting into paralysis which is called as 'paralytic stroke' or 'simply stroke'. On 19th April, 2004, he suffered a stroke and was initially admitted to Suchak Hospital and later was shifted to P. D. Hinduja Hospital where the diagnosis was clearly made as "Lantiform Hypertensive bleed". The expression hypertensive bleed is very focussed to guide any reader to the disease 'hypertension' and the bleeding has been qualified by hypertension to confirm that the rupture is caused by hypertension. There is no ambiguity in this expression and lentiform means lenticular which is lens shaped obviously suggesting a little oval shaped with a high elevation in one side (5.2 × 2.2 cm). In this case right sided infarct has given left sided weakness in the body and it uniformly affected the left side which is a condition known as 'hemianopia'.

It is indeed surprising how Dr. Tungare issued the certificate but the only point which could take away the force from the certificate was his reference to Shri Wagh's regular medication to control BP. and therefore he possibly asked for shifting of focus by calling the bleed to be 'an unfortunate' incident.

In the facts and circumstances, the decision of the TPA and New India to reject the claim is sustainable.

Mumbai Ombudsman Centre
Case No. GI-20 of 2004-2005
Shri Pravin Bhanushali
Vs
The Oriental Insurance Co. Ltd.

Award Dated 29.03.2006

Shri Pravin Bhanushali who was covered under a Mediclaim Policy No. 121501/48/04/1131 with The Oriental Insurance Company Limited was hospitalized at Mukund hospital for right knee joint ligament injury. When Shri Bhanushali preferred a claim the TPA repudiated the claim invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Bhanushali represented to the TPA for reconsideration of his claim along with the certificate of the consulting doctor, Dr. Ram Prabhoo which was also turned down by the Company. Hence being aggrieved by the said decision, Shri Bhanushali 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.

A scrutiny of the case reveals that Shri Pravin Bhanushali reportedly had a fall from the scooter and he was brought to Mukund hospital by his son for investigation and treatment. The diagnosis was Right knee ligament injury and during the admission oral medication was given and the rest was number of investigations. In fact 2 day confinement in the hospital included only investigation's including MRI of right knee joint. MRI did reveal the post traumatic features. The Company has rejected the claim on the ground that despite having apparent ligament injury no active treatment was

taken by the Insured and instead he preferred to have oral medication with knee bracing following discharge. The Company's contention was that this line of treatment should have been pursued as an out patient only and therefore, they rejected on the grounds of needless hospitalisation for only investigations under clause 4.10 of the mediclaim policy. It is also true that no body would take lightly a fall from the scooter since it may have an impact on other organs of the body and therefore, invasive examination could be undertaken. Yet there would be a point that some of the investigations were done in excess and the hospital stay was also more than necessary since the injury was focused. Straight away X-rays and MRI's would have done the trick.

In the facts and circumstances, I set aside the rejection of the Company and direct them to settle the claim for net amount of Rs. 10,000/- as a lump sum payment with a token amount rejected for additional investigation costs to resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI-412 of 2004-2005
Shri M. P. Khanvilkar
Vs
United India Insurance Co. Ltd.

Award Dated 31.03.2006

Shri M. P. Khanvilkar along with his wife Smt. Madhura Khanvilkar were covered under Mediclaim Policy since November 1992 with United India Insurance Co. Ltd. He lodged a claim under Policy No. 020100/48/02/06828 issued for the period 25.11.2002 to 24.11.2003 in respect of Smt. Madhura M. Khanvilkar, who was hospitalized at Lilavati Hospital in two phases for acute Multiple Scelerosis (relapsing type). First hospitlization was from 18.12.2002 to 25.12.2002, for which his claim was settled. The second hospitalization for the recurrence of the same disease was from 30.6.2003 uptil 2.7.2003. Among the medicines advised to be taken, one of the medicines prescribed by the doctor was an Injection Avonex 1 vial to be taken once a week for one year as per his letter dated 21.2.2003. The said life saving drug was not available in India and hence the Insured obtained a one time custom duty exemption for the entire import of 144 injections to be taken for a period of 3 years and imported 12 number of injections at the first instance. The said medicine was administered from 2nd June 2003 as per advice of Dr. Chauhan. The Insured lodged the claim for second hospitalization on 7.7.2003 for an amount of Rs. 73,938/- which included cost of only 4 vials of Avonex out of the 12. The cost of remaining 8 vials of vonex amounting to Rs. 1,05,813/- was claimed by the Insured under post hospitalization claim which was submitted by him on 21.8.2003. The main claim as well as the post - hospitalisation claim of the second hospitalization was pending for payment by the Company. Let us examine what exactly is the disease with its prognosis. "Multiple Sclerosis (MS, disseminated sclerosis) is a chronic disease of the nervouse system affecting young and middle-aged adults. The myelin sheaths surrounding nerves in the brain and spinal cord are damaged, which affects the function of the nerves involved. The course of the illness is usually characterized by recurrent relapses followed by remissions. Steroid treatment may be used in acute relapse, and beta nterferon therapy reduced the relapse rate in some patients". (quoted from Oxford Medical Dictionary) It is estabished that the treatment of Multiple Scelerosis and similar other critical ailments require continued medical treatment but to grant the same under the Mediclaim Policy would be a discrimination against other buyers of the policy. Since the nature of treatment would be continuous and long standing, the Insured cannot assume that the entire expenses even beyond the period covered by the Policy. To this extent the company's point of view is well

taken. This Forum can guide both parties, what should be the basis of a settlement and a decision on payment of cost of Avonex which was essentially the matter of dispute. Accordingly while noting the company's approach to pay cost of 12-13 Avonex, it is strongly recommended that the Company may calculate upto the post hospitalization period and to grant one more avonex Injection as a special case.

Mumbai Ombudsman Centre
Case No. GI-31 of 2005-2006
Shri Sandeep Likhite
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

Shri Sandeep Likhite who was insured with New India had preferred a claim with New India for the expenses incurred for his wife's hospitalisation at Suyash Nursing Home for Umbilical Hernia and Incisional Hernia. On receipt of the claim form alongwith other relevant papers from Shri Likhite, the Third Party Administrator of the Company, M/s TTK Healthcare Services Pvt. Ltd. rejected the claim invoking clause 4.12 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Likhite represented to the Company but the Company reiterated the stand taken by their TPA. Hence being aggrieved Shri Likhite approached this Forum for justice. The records have been perused and it was found that Smt. Likhite had a child birth through caesarian section in March, 2003 which is well within the policy period. The point which would be important to consider here is the fact that incisional hernia by its very name would suggest that there was an incision and hernia developed through the surgical scar at the same site of surgery. The Insured repeatedly mentioned in his letter that umbilical hernia has nothing to do with caesarian section which his wife had undergone. The surgery was Omphalectomy with Mesh Plasty in which Umbilicus was exicised. In the present case the surgery was done only in March, 2003 and as per doctor's confirmation Hernia was detected in October, 2003 itself. Going by the nature of the surgery and the total confinment period in hospital it seems there were some complications triggered by the past surgery which were medically managed through repair and correction. The analysis would reveal that there are quite a few fall outs of pregnancy and child birth like severe infections, eclampsia, absence or delayed lactation etc which would be excluded as arising out of same generic disease which would not include hernia or adhesions as directly caused. Moreover, there has been an interruption in the chain of events as more than 6 months elapsed after the caesarian Surgery. Additionally it was not only incisional but umbilical hernia as well.

Accordingly, I decide that The New India Assurance Company Limited's total rejection should be set aside and they should be called upon to pay 50 % of the admissible claim amount to meet the ends of justice.

Mumbai Ombudsman Centre
Case No. GI-264 of 2004-2005
Shri R. H. Bhasin
Vs
The Oriental Insurance Co. Ltd.

Award Dated 31.03.2006

Shri H. B. Basin who was covered under policy no. 161701/2005/1436 was admitted to Sanjeevani Criticare and Research Centre Pvt. Ltd. on 16th June, 2005 for acute on chronic liver disease (alcoholic) but unfortunately passed away on 1st July, 2005.

When the claim was lodged by Shri R. H. Bhasin son of Shri H. B. Bhasin the claim was rejected by the Company through their TPA M/s Paramount health care vide their letter dated 4.8.05 on the grounds of exclusion clause 4.8 of the mediclaim policy. The Complainant Shri R. H. Bhasin approached this Forum. The analysis of the case would reveal that the Insured late Shri H. B. Bhasin was admitted on 16.6.2005 at Sanjeevani Criticare and Research Centre Pvt. Ltd., Nashik apparently for hepatic failure. The treating doctor Dr. Nitin Borse has mentioned in his case papers as “chronic alcoholic abuse” and acute on chronic liver disease (alcoholic). The cause of death was also mentioned as “Cardiorespiratory Arrest due to fulminant hepatic failure due to hepatorenal syndrome”. Among the causes affecting liver are types A to E as also inducted by drugs and alcohol. Alcohol is regarded as a dominant caue of liver infection leading to cirrhosis and liver failure. The scrutiny of the entire claim would make it apparent that when Shri H. B. Bhasin was admitted in May, 2005 at Dr. Sanjay Ganorkar’s hospital Shri Bhasin had jaundice even at that stage which is mentioned in his certificate. Having considered all these statements and the submissions backed up by medical records it is evident from the hospital case papers of Sanjeevani Criticare and Research Centre that Late Shri H. B. Bhasin’s was a case of chronic Alcoholic abuse as was diagnostative with features of alcoholic liver disease which has been categorically mentioned by the doctors. There is sufficient material to confirm the status and the treatment received by Shri Bhasin and finally it caused cardio respiratory arrest due to hepatic failure causing hepatorenal syndrome which is a logical conclusion of severe hepatitis affecting liver and causing failure of liver and kidneys.

In the facts and circumstances the decision of the Company to reject the claim on the basis of exclusion clause 4.8 is sustainable.

Mumbai Ombudsman Centre
Case No. GI-16 of 2004-2005
Shri Dilip M. Choksey
Vs
The Oriental Insurance Co. Ltd.

Award Dated 31.03.2006

Shri Dilip M. Choksey was insured under a mediclaim policy alongwith his wife, with The Oriental Insurance Co. Ltd. Borivali Divisional Office, for the policy no. 124300/48/99/125 for a period 29.04.1998 to 28.04.1999 for a sum insured of Rs. 1,00,000/-. Shri Choksey preferred a claim to the Company for his wife’s hospitalisation at Bombay Hospital. The claim was made under policy no. 1243090/48/04/279 during the policy period 29.04.2003 to 28.04.2004 for Rs. 1,39,906/-. Smt. Saryu D. Choksey was hospitalised at Bombay Hospital for pain in the left knee due to osteoartheritis from 09.02.2004 to 13.02.2004 and was operated for a total replacement of left knee on 09.02.2004. The claim was referred to M/s Raksha TPA and they informed vide their letter dated 11.07.2004 about its decision to repudiate the claim by stating that the patient was suffering from Left Knee pain for past 8 yrs i.e. since 1996 which is prior to the inception of the policy in the year 1998. Hence the claim is not payable under Exclusion Clause 4.1 of the mediclaim policy.

The noting of past history of ailments is an important step to make correct diagnosis of the disease the patient is suffering from. It is in the interest of the Insured patient that the exact ailment with symptoms and duration etc. should be narrated before the doctor. Accordingly, the staff notes down (may be a Junior Doctor or Nurse) but

obviously he or she gets the details only from the patient and therefore, cannot be his/her own statement. Chances of wrong writing would be less and unless he or she corrects the same by suitably acknowledging his or her mistake before the Resident Director by an acceptable legal process. The Complainant later approached Dr. Nilen Shah who gave a certificate dated 07.08.2004 i.e. after the rejection of the claim which would appear to be based on the approach made by the Complainant. As he is not the treating doctor, he could have neither confirmed nor denied the duration of the disease. Hence, his certification that arthritis was for 3 yrs would not hold valid as it would be based on the statement made by the Insured only. Smt. Choksey had difficulty in walking. She had spondylosis Ls - L_1 as well. She developed degenerative changes in left knee for which the doctor decided to have total knee replacement. Accordingly, the very fact that the knee was replaced would indicate the long stating problem and the history of 3 yrs is difficult to accept as it would not require replacement in such a short time and total knee replacement would be the last resort of the treatment by an orthopedic surgeon. If a claim is repudiated the immediate reaction of the beneficiary is bound to be bad and more so, if it is due to the history narrated at the time of admission. Accordingly, the Insured reacted to correct the noting hoping that it would be then acceptable. Psychologically, therefore, the analysis would be that such reaction is always an after thought. The case is circumstantially also favouring the duration to be of 8 yrs going by the progress of the disease and also the fact that insurance was taken by Smt. Choksey when she was over 50 yrs old and not before. Some of the age related disease of which arthritis for ladies is quite common manifests usually after the menopausal period.

In the facts and circumstances the decision of the Oriental Company to reject the claim on ground of pre-existing illness i.e. Clause 4.1 of the Mediclaim Policy, is sustainable in my view.

Mumbai Ombudsman Centre
Case No. GI-30 of 2005-2006
Shri Shamsunder B. Khetwani
Vs
New India surance Co. Ltd.

Award Dated 31.03.2006

Shri Shamsunder B. Khetwani along with his wife Smt. Anita Khetwani were covered under Mediclaim Policy since June 1997 with New India Assurance Co. Ltd. He lodged a claim under Policy No. 111800/48/03/02376 issued by New India for the Period 6.6.2003 to 5.6.2004 with 30 % cumulative bonus for his hospitalization for HTN with DM - acute.

On going through the claim papers submitted by the complainant, the TPA noticed that the Discharge Card mentioned k/c/o HTN and DM. In order the get the duration of the pre-existing illness they wrote to the Complainant to submit the Indoor Case Papers of Tandon Hospital or a certificate from the treating doctor stating the duration of HTN and DM. The Complainant/Insured did not comply. When the TPA approached Tandon Hospital for the same, they sent the Indoor Case papers through Fax to the TPA. The fax copy of the Indoor Case Papers showed some overwriting in the duration of HTN & DM. (ten years changed to two years). TPA rejected the claim of Shri Khetwani under exclusion 4.1 of the Mediclaim. Analysis of the case reveals that the Indoor case

papers does indicate some overwriting done in the duration of HTN and DM without any authentication and the same is also confirmed by Dr. Tandon in his certificate dated 29.11.2004, but the TPA's conclusion that original duration was for ten years and it has been overwritten / changed to two years cannot be confirmed for want of any documentary proof submitted by TPA. Let us examine the medical analysis of the case out of the hospital records available with us. First of all the ECG indicates acute ASMI, Strees Test way strongly positive with Anterior Chest Lead. The 2D Echo suggested LV Enlarged and only 37 % ejection. It is clear that the policy period of 7 years and therefore the history initially noted to be of 10 years as per statement made to the Hospital Staff appears more plausible. However, since the tampering specifically by the Insured has not been proved, nor was there any written report by the Hospital to that effect but perhaps, there was an attempt to do so, it would be equitable to grant the benefit of doubt to the Insured and settle the claim for 50 % on grounds of insufficient proof to confirm that there was non-disclosure or pre-existing illness to vitiate the claim altogether.

Mumbai Ombudsman Centre
Case No. GI-41 of 2004-2005
Shri Deeraj L. Parmar
Vs
The New India Insurance Co. Ltd.

Award Dated 31.03.2006

Shri Deeraj L Parmar had taken a long term Hospitalisation/Domicilary hospitalisation Insurance policy from The New India Assurance Company Limited, D. O. 110902. The policy had exclusion for Acute Pancreatitis c cholethiasis laproscopic. The policy covered pre-existing illness if it was claim free for four policy periods and no treatment for atleast two preceding years for the pre-existing condition. Shri Deepraj Parmar was admitted to Jaslok hospital from 19.12.03 to 28.12.03 for chronic pancreatitis with acute attack and when he lodged a claim to the Company it was also turned down and hence being aggrieved Shri Parmar approached this Forum for justice. The records have been perused and the analysis of the claim solely rests on the understanding and interpretation of clause 5.11 of Long term Hospitalisation/Domicilary Hospitalisation Insurance policy issued by New India which is designed to grant cover for pre-existing illnesses on certain pre-conditions. A close look at the medical records with actual tretment received by Shri Parmar would leave no doubt that the policy was taken with a pre-existing condition by the Insured only with the hope that the policy should remain claim free for 4 years to enable him to get the benefit as per clause 5.11. However, the hospitalisation record confirms that he had received some treatment in 2000 which obviously he did not claim as it would not have been reimbursed as per the terms of the policy and would not also have made it uninterrupted to be claim free for four years. Based on this, it is quite clear that he did not enjoy four claim free years from 1999 to 2003 as it was intervened by the treatment he received in June 200 as confirmed by Dr. Shah.

Based on the above analysis the rejection of the claim by the Company would be sustainable on the ground that the Insured availed treatment in between the policy inception and four-claim free periods. Secondly four claim free years was not straight away available because there was hospitalisation in the year June 2000 itself and the fact that he did not claim would not be material as it was potentially claimable and the

spirit of the exclusion with its due application was vital for consideration. Thirdly the past hospitalisation being from 1996 virtually a continuous treatment since then was availed with periodical evaluations which made the disease not only pre-existing but continuing as well with the intake of maintenance drugs.