Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11-003-0216
Sri K K Agrawal
Vs
National Insurance Co. Ltd.

Award Dated : 22-5-2006

Repudiation of Claim under Universal Health Policy on the grounds that Hospitalisation was not taken for minimum 24 hours. The Complainant was treated for Skin Diseases. During the course of Hearing, it was found that the Complainant was never hospitalised as an inpatient and the treatment was carried out on several days for 4/5 hours. Since no hospitalisation was undertaken as an inpatient, the decision of the Respondent to repudiate the claim was upheld.

Bhopal Ombudsman Centre
Case No. GI/NIA/0406/002
Mr. Raj Kumar Choudhary
V/s
The New India Assurance Co. Ltd.

Award dated 19.06.2006

As per the Complainant he had taken the policy No. 451300/48/03/03224 from 07.03.2004 to 06.03.2005 from the Respondent. He has also contended that he has not taken any Medi claim of a single rupee during his 34 years of Govt. Service. The Complainant stated that he went to M/S Apollo Hospital Chennai on 12.10.2004 for General Checkup. On behalf of him, his brother in law informed the doctor about the history of his health and said that last two years he was Diabetic and Hypertensive. His Angiography was done on 13.10.2004 and discharged from the hospital on 22.10.2004. The Complainant also stated that he was planning to go to New York in Nov./Dec. 2004, so as soon as before sufficient time of limitation of filing the claim form, he requested the Agent of the Respondent Mr. N. K. Bandi to prepare the claim form, so that he can sign the same. When the Agent prepared the same, he signed it in good faith and submitted in the office of the Respondent. Thereafter the Agent Mr. Bandi informed him that the claim form was misplaced and accordingly he again submitted the claim form on 31.03.2005. In view of the same it is quite clear that the mistake is on the part of the Respondent's Agent Mr. Bandi and his agency should be terminated so that bonafide consumers and senior citizens may not be harassed in future. Looking to the above situation the Respondent's TPA M/S Paramount Health Services Pvt. Ltd. has committed error in repudiating his claim on this count vide their letter dated 04.04.2005 & 06.05.2005. As per the Complainant he is not on fault for late submission of claim form and according to the Principal of natural Justice no person can be punished without his fault. The Complainant also stated that in the form of Medi claim Insurance policy, he had declared his good health, as he was not suffering from any disease, so he has not concealed any facts. After completing the age of 45 years, he started the general checkup where he found that his health is good. He also contended that according to the modern science "diabetic & Hypertensive" are not always the

direct cause of blockage of Arteries. At present time there are persons aged in between 30 to 40 years are also getting Blockage in Arteries, although they are not “diabetic & Hypertensive”. And as such the Respondent’s TPA has erred in writing in his letter dated 06.05.2005 that in his case “diabetic & Hypertensive” are directly related to CABG Surgery which is quite contrary to his documentary medical tests reports. Hence it is clear that as compare to the direct documentary medical evidence, the oral hearsay evidence has no value as written in Discharge Summary Report of the Apollo Hospital, Chennai that he was “diabetic & Hypertensive” for 20 years. It seems by typing “2” it is typed “20” so 2 years became 20 years the letter “20” are not written in words.

The Respondent stated that the Complainant was covered under medi claim policy No. 451300/48/03/04390 w.e.f. 07.03.2004 to 06.03.2005 covering the Complainant himself (age 62 years) and his wife (age 55 years). The Complainant was hospitalized w.e.f. 12.10.2004 to 22.10.2004 at M/S Apollo Hospital Chennai & he submitted the claim bill for Rs. 1,66,221/- (Sum Insured is only Rs. 1,00,000/-) to M/S Paramount Health Services Pvt. Ltd. whom the Respondent has appointed as Third Party Administrator for processing and settling the claim. The discharge Summary of M/S Apollo Hospitals details Symptom and History shows that “ This 63 years old gentleman, hypertensive and diabetic since 20 years was admitted with History of Class II angina since 1 week and with positive TMT for further cardiac evaluation……”. Besides the above, the certificate issued by Dr. D. Mitra, the family doctor of the Complainant, in column 6 of the certificate also stated that he is “Diabetic-20 years/Hypertensive –20 years”.

From the above documents, it is evident that the Complainant is “diabetic & Hypertensive” since long i.e. before first inception of medi claim insurance policy. Nexus between diabetes Mellitus and heart ailments is well established. The claim therefore falls under policy exclusion clause 4.1 and has been rightly repudiated.

It is observed that as per the guide lines of the Respondent sum insured is not to be increased after the age of 45 years but in exceptional circumstances sum insured can be increased after obtaining the health certificate from the Medical board and after obtaining the approval of the higher authorities of the Respondent. In this particular case nothing has been done. Complainant’s contention that they have also not increased the Sum Insured (as his sum insured is Rs. One lac since beginning) is not tenable in this particular case.

Further it is observed from the discharge Summary of M/S Apollo Hospitals details Symptom and History shows that “ This 63 years old gentleman, hypertensive and diabetic since 20 years was admitted with History of Class II angina since 1 week and with positive TMT for further cardiac evaluation……”

Besides the above, the certificate issued by Dr. D. Mitra, the family doctor of the Complainant, in column 6 of the certificate also stated that he is “Diabetic-20 years/Hypertensive –20 years”. Further in column No. 11 of the said certificate it is also mentioned that the disease is “acute”.

Hence the claim falls under policy exclusion clause 4.1 which state “Such diseases which have been in existence at the time of proposing this insurance, pre-existing condition means any injury which existed prior to the effective date of this insurance. Pre-existing condition also means any sickness or its symptoms, which existed prior to the effective date of insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing will be considered part of that pre-existing condition.”

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent to repudiate the claim is fair and justified therefore; I found no reason to interfere with the decision taken by the Respondent. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Case No. GI/NIA/0306/148
Smt. Sunita Bansal
V/s
The New India Assurance Co. Ltd.

Award dated 22.06.2006

As per the Complainant she had taken the policy No. 451701/48/04/75043 from the Respondent. She had not received any letter neither from the Respondent nor from the TPA of the respondent. When she contacted the TPA M/S Family Health Plan office at Bhopal and Hyderabad on phone, they never give her any satisfactory/proper reply. She also stated that she had sent the papers again, but the Respondent repudiated her claim on baseless ground.

The Respondent stated that their TPA M/S Family Health Plan Ltd. Bhopal had repudiated the claim on the ground of policy condition No. 4.1 as the present hospitalization is for the management of an ailment, which is related to pre-existing condition. The Respondent had also stated that the treating Doctor Dr. Shailendra Trivedi vide his certificate mentioned that " the duration of RHD is difficult to indicate as it is Chronic Disease but usually the disease is acquired in the age group of 8-15 years".

During the hearing the Complainant contended that she is a housewife and is living in a joint family. She had taken the Medi claim policy for herself in the year 2000 just before her marriage. She married in Dec. 2000. Her husband took the Medi claim policy for the first time in the year 2002. Other persons in her joint family such as Father-in-law or Mother-in-law or Husband's elder brothers had not taken ay Medi Claim policy. Complainant contended that after her 2nd delivery in August 2004 she was suffering with cough and cold and consulted doctor at Barwani and took the medicines. But there was no improvement hence she was consulted at M/S Bafna Hospital Indore on 19.11.2004. As per the Complainant Hospital authorities refer her to M/S CHL-Appollo Hospital Indore where she was admitted for 8 days and took the treatment. As per the Complainant still she is taking the medicines and has not operated as suggested by the doctors.

Respondent's contention that their TPA M/S Family Health Plan Ltd. Bhopal had repudiated the claim on the ground of policy condition No. 4.1 as the present hospitalization is for the management of an ailment, which is related to pre-existing condition. The Respondent had also stated that the treating Doctor Dr. Shailendra Trivedi vide his certificate mentioned that " the duration of RHD is difficult to indicate as it is Chronic Disease but usually the disease is acquired in the age group of 8-15 years".

It is observed that from the papers submitted by the Complainant wherein the Complainant's doctor Dr. Shailendra Trivedi vide his certificate mentioned that " the duration of RHD is difficult to indicate as it is Chronic Disease but usually the disease is acquired in the age group of 8-15 years". Hence the claim falls under policy exclusion clause 4.1 which state "Such diseases which have been in existence at the

time of proposing this insurance, pre-existing condition means any injury which existed prior to the effective date of this insurance. Pre-existing condition also means any sickness or its symptoms, which existed prior to the effective date of insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing will be considered part of that pre-existing condition." In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent to repudiate the claim is fair and justified therefore; I found no reason to interfere with the decision taken by the Respondent. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Case No. GI/OIC/0606/020
Mr. Sunil Sanghavi
V/s
Oriental Insurance Co. Ltd.

Award Dated 13.07.2006

As per the Complainant he had taken the medi claim policy no. 151111/48/06/00776 w.e.f. 30.09.2005 to 29.09.2006 from the Respondent for quite a long time. The Complainant also stated that he had submitted a Medi claim in respect of his son to the Respondent's TPA M/S Paramount Health Services Pvt. Ltd. but they vide their letter dated 11.04.2006 filed the claim as no claim. I was not aware about the disease of my son. The Respondent had repudiated his claim.

The Respondent stated that the Complainant's son Master Gaurav Sanghvi was hospitalized for operation of CONGENITAL HEART DISEASE. Their TPA M/S Paramount Health Services Pvt. Ltd. scrutinized the claim and on the basis of medical papers, the claim was repudiated. Since the congenital ailments falls under exclusion of policy and intimated to the Complainant vide their letter-dated 11.04.2006. Since the congenital ailments are not covered under the policy, the repudiation of the claim is in order.

During the hearing the Respondent stated they the Complainant's son Master Gaurav Sanghvi was hospitalized for operation of CONGENITAL HEART DISEASE. Their TPA M/S Paramount Health Services Pvt. Ltd. scrutinized the claim and on the basis of medical papers, the claim was repudiated. Since the congenital ailments falls under exclusion of policy and intimated to the Complainant vide their letter-dated 11.04.2006. Since the congenital ailments are not covered under the policy, hence they repudiated the claim.

It is observed that the Complainant's son was admitted in the hospital and he was diagnosis as " Congenital heart disease". As per policy condition 4.8 excludes such diseases, which is read as " Policy does not cover Convalescence, general debility, 'run down' condition or test cure, congenital external disease or defects or anomalies, sterility, venereal diseases..." and as such the said disease is not covered under the above mentioned policy.

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent to repudiate the claim on this ground

is fair and justified. I found no reason to interfere with the decision taken by the Respondent. Hence the complaint is dismissed without any relief.

Chandigarh Ombudsman Centre

Case No. GIC/293/NIA/11/06
Parshottam S Bhalla
Vs
New India Assurance Co. Ltd.

Award Dated: 16.6.06

Facts : Parshottam S Bhalla held a mediclaim policy for the period 30.1.05 to 29.1.06 for sum insured of Rs. 1.25 lakh. He developed some problem in his nose and was operated upon in CMC Ludhiana. He was advised to get himself admitted for a day. As no room was available he took permission to rest at home. After recovery he visited the office of the insurer to submit claim with photocopy of bills /prescriptions etc, but these were not accepted. He was asked to furnish discharge summary from the hospital. He stated that hospital provides discharge summary only if the patient gets admitted. Since he was not admitted discharge summary could not be provided. He sought intervention for getting the claim settled.

Findings : The complainant stated that he wished to be admitted, but this was denied due to non-availability of bed. Since he incurred expenditure on treatment of his nose, he should be reimbursed the same. On behalf of the insurer it was pointed out that as per terms and conditions of the policy, hospitalization for more than 24 hrs is a pre-condition for admissibility of claim.

Decision : Held that since the complainant was not admitted in the hospital, the claim is not admissible as per terms and conditions of the policy. In any case claim may not have been payable even if he was admitted, as the nature of ailment seems to be such that he could have been treated as an out patient, as had actually happened. Accordingly, the complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. GIC/338/NIC/11/06
Mahinder Kumar Goyal
Vs
National Insurance Co. Ltd.

Award Dated 13.6.06

Facts : Mahinder Kumar held a Mediclaim policy for the period 29.12.03 to 28.12.04. The policy was issued by BO Abohar for sum insured of Rs. one lakh each for self and his wife. He was admitted in Metro Heart Institute on 30.7.04 and discharged on 31.7.04 and again admitted on 14.8.04 and discharged on 15.8.04. After the treatment was over he filed the claim with BO for Rs. 29,776. Claim papers were sent to M/s Family Health Plan, the TPA. The claim was rejected on the ground that treatment could have been taken as an out patient and hospitalization was not necessary. He stated that he had swelling in the knee and was admitted on the advice of doctor. He urged that matter should be taken up with the insurer for settling the claim without any further delay.

Findings : The representative of insurer stated that there were two claims and part of claim pertains to only tests undergone by him for ascertaining the status of his heart. Tests conducted in this regard at Abohar, Faridabad and Sriganganagar revealed normal functioning of his heart. He contended that as per terms and conditions of the policy if investigations do not lead to positive existence of any disease, the claim is not payable. However, so far as treatment of knee is concerned, the matter was referred to TPA for reconsideration.

Decision : Held that the contention of insurer that claim relating to investigation for heart problem is not payable is correct. The claim regarding treatment for swollen knee was pretty old and it is not denied that complainant had knee problem of which he is still not fully cured. The question as to whether hospitalization was required or not is a matter of subjective judgement. I find weight in argument of the complainant that he got himself admitted as advised by the treating doctor. Having regard to the circumstances of the case and giving the benefit of doubt to the complainant, it was ordered that the claim in so far as relates to treatment for swollen knee be settled as per terms and conditions of the policy within a period of fifteen days of receipt of this order.

Chandigarh Ombudsman Centre
Case No. GIC/235/NIC/11/06
Davinder Kumar Jain
Vs
National Insurance Co. Ltd.

Award Dated 29.5.06

Facts : Davinder Kumar had taken a mediclaim policy from BO-V Ludhiana for the period 8.5.05 to 7.5.06 for sum insured of Rs. 80000 each for self and his wife and Rs. 30,000 each for his two sons. He was admitted in hospital from 2.5.05 to 4.5.05 and diagnosed to be suffering from depression with anxiety disorders. The claim filed by him was repudiated on the ground that the treatment could have been taken on OPD basis without the necessity of admission. He contended that he was admitted on the advice of attending doctor in view of seriousness of his condition. The admission was not any lame excuse as nobody desires to get admitted in a hospital. He urged that the claim be settled in his favour.

Findings : The complainant contented that on the day he was admitted, he was in serious condition and was feeling extremely uneasy. The treating doctor had advised admission. The hospital is 10 –15 km away from his house; he would not have wished to get himself admitted if not required. He still has complaint of pain in arm and has difficulty in breathing. He stated that his condition was so bad that he was admitted in ICU for evaluation and management He has been having policy since 2002, and no claim has been lodged before. The representative of insurer pointed out that claim papers were duly examined by TPA. As per documents, the insured was treated for evaluation and management. The claim in respect of hospitalization for evaluation is not payable. The ailments indicated viz. headache and anxiety are such that these do not warrant admission.

Decision : Held that the decision of the TPA and the insurer is flawed on many counts. In the first instance all claims in respect of hospitalization need not be brushed aside on the plea that hospitalization was not necessary. Only if prima facie, it is established that hospitalization was absolutely unwarranted being purely for investigation purposes, repudiation would be in order. But in a case where patient has some serious symptoms and the treating doctor opines that hospitalization is necessary, the claim should be viewed differently. He was admitted on the advice of attending doctor. As per record he also remained admitted in ICU for one night. That itself should be sufficient to establish that hospitalization was necessary. Secondly in his case admission was not purely for evaluation. It was also for management of an ailment. In the discharge summary it has been mentioned that hospitalization was for evaluation and management which implied that he had some serious problem which is corroborated by his admission in ICU. No further justification is required in a genuine case of

hospitalization like this. Besides, the claim amount is so petty for the insured has indeed been put to lot of inconvenience. Observed that ever since the introduction of TPAs, the insurers have abdicated the responsibility of reviewing the decisions of TPA. Held that claim is payable and settled accordingly.

Chandigarh Ombudsman Centre
Case No. GIC/186/UII/12/06
Surjit Singh
Vs
United India Insurance Co. Ltd.

Award Dated 27.04.06

Facts : Surjit Singh had taken a mediguard policy for the period 14.10.04 to 13.10.05 from BO Khanna. The policy was abruptly cancelled and the balance premium of Rs. 1905 was remitted on prorata basis for renewal of policy through a cheque. The complainant returned the cheque which was not accepted by the insurer. The complainant again sent cheque for renewal of policy, but it was not accepted. He urged that direction be issued to the insurer to revive and regularize the policy and settle the pending claim.

Findings : As per clause 3 of mediguard insurance policy, the policy can be cancelled at any time by giving 30 days' notice by registered letter at insured's last known address and in such an event company shall refund prorata premium for unexpired period of insurance. The notice regarding cancellation was served on 6.4.05 and policy was cancelled w.e.f. 3.5.05. The prorata premium of Rs. 1905 was refunded. On behalf of complainant it was stated that his father had been a policyholder for the last 8-10 years. The policy for 2004-2005 was cancelled during currency and balance premium amount was refunded. He represented to the insurer but cheque was not accepted. The policy became due for renewal and premium cheque was sent which was again returned. He stated that no claim was lodged for many years. It is only now that his father has been taken ill and he needs insurance cover which was being denied by the insurance company. The representative of insurer stated that contention of the complainant that no claim was filed in the past was not correct. Since 2001 onwards claims amounting to Rs. 1,85,107 have been reimbursed from time to time. He pointed out that decision to cancel the policy was taken after considering the claim experience. As per condition no. 13 renewal of a policy is on mutual consent and insurer is within his right to cancel it by giving 30 days' notice. Likewise the insured can also get the policy cancelled and premium is refunded on short period basis.

Chandigarh Ombudsman Centre
Case No. GIC/186/UII/12/06
Surjit Singh
Vs
United India Insurance Co. Ltd.

Award Dated 27.4.2006

Facts : Surjit Singh had taken a mediguard policy for the period 14.10.04 to 13.10.05 from BO Khanna. The policy was abruptly cancelled and the balance premium of Rs. 1905 was remitted on prorata basis for renewal of policy through a cheque. The complainant returned the cheque which was not accepted by the insurer. The

complainant again sent cheque for renewal of policy, but it was not accepted. He urged that direction be issued to the insurer to revive and regularize the policy and settle the pending claim.

Findings : As per clause 3 of mediguard insurance policy, the policy can be cancelled at any time by giving 30 days' notice by registered letter at insured's last known address and in such an event company shall refund prorata premium for unexpired period of insurance. The notice regarding cancellation was served on 6.4.05 and policy was cancelled w.e.f. 3.5.05. The prorata premium of Rs. 1905 was refunded. On behalf of complainant it was stated that his father had been a policyholder for the last 8-10 years. The policy for 2004-2005 was cancelled during currency and balance premium amount was refunded. He represented to the insurer but cheque was not accepted. The policy became due for renewal and premium cheque was sent which was again returned. He stated that no claim was lodged for many years. It is only now that his father has been taken ill and he needs insurance cover which was being denied by the insurance company. The representative of insurer stated that contention of the complainant that no claim was filed in the past was not correct. Since 2001 onwards claims amounting to Rs. 1,85,107 have been reimbursed from time to time. He pointed out that decision to cancel the policy was taken after considering the claim experience. As per condition no. 13 renewal of a policy is on mutual consent and insurer is within his right to cancel it by giving 30 days' notice. Likewise the insured can also get the policy cancelled and premium is refunded on short period basis.

Decision : Held that as per policy conditions, both the insurer and the insured can seek cancellation of the policy as per prescribed procedure. Likewise renewal of the policy is by mutual consent of the parties and can be effected only if both the parties agree and neither party can be forced to do so. In this case the insurer in its wisdom decided to cancel the policy. The complaint was, therefore, filed, being without merit.

Chandigarh Ombudsman Centre
Case No. GIC/342/UII/11/06
K.S. Majithia
Vs
United India Insurance Co. Ltd.

Award Dated 6.7.06

Facts : Kuldeep Singh Majithia had taken a Mediclaim policy for self and wife for sum insured of Rs. One lakh for the period 16.12.04 to 15.12.05 from DO XXVI, New Delhi. He developed a feeling of uneasiness and chest pain on 9.8.05. He consulted Dr. Romil Chhoda, who advised him to have himself checked up at Escorts Hospital where he remained admitted from 9.8.05 to 18.8.05. After the treatment was over, he filed a claim for Rs. 2 lakh. The claim was repudiated by M/s Family Health Plan on 9.11.05 on the ground that as hospitalization was for management of a pre-existing disease, the claim was not payable.

Findings : The complainant got himself admitted within eight months of inception of policy. As per discharge summary he is 63 years old with history of chest pain off and on radiating to left arm, jaw and back associated with sweating and palpitation. As per clinical findings he was diagnosed to be a patient of CAD with triple vessel disease with left main disease, unstable angina and hypertension. He underwent heart bye pass grafting on 11.8.05. He had history of hypertension and was on regular treatment. The

present condition developed due to chronic ailment, as same would not develop within a short span.

The complainant stated that he purchased the policy in December'04. Prior to purchase of policy he was medically examined. In the policy issued to him, no exclusion was incorporated. He was taken ill and underwent surgery in 2005. While he was insured for Rs. one lakh, he incurred an expenditure of Rs. two lakh. As he had no heart problem at the time of purchase of policy, the claim was payable.

At the time of underwriting exclusion of heart disease and sugar was recorded in the proposal form, but inadvertently this was not incorporated in the policy. It was, however, admitted that ECG report at the time of inception of policy was normal. The representation filed by the complainant was referred to TPA. The TPA reiterated the view that insured was suffering from CAD and triple vessel blockade of 80%, which cannot develop within eight months and takes at least two years to assume serious proportions. It was stated that the insured is alcoholic, which is a contributory factor for heart disease. He also stated that in the discharge summary it is mentioned that he is hypertensive, which has nexus with heart ailment. The surgery was performed due to chronic nature of ailment which could not have developed within a period of eight months. It was not clear how exclusion of heart ailment and diabetes was incorporated in the proposal form, but it was not mentioned in the policy. Besides, admittedly the medical reports were normal. It was not clear whether there was any deficiency in the medical report and on what basis exclusion was incorporated in proposal form and why it was not endorsed in the policy.

Decision : That the contention of the complainant is that he had no heart problem at the time of purchase of policy. A 63 year old man is unlikely to suffer suddenly from CAD HT, triple vessel blockade within a short span of eight months of purchase of policy. It is well known that these diseases take their time to reach a stage requiring surgical intervention. It can be safely presumed that he would have been aware of it. The complaint, therefore, does not merit intervention and accordingly I dismiss it.

Chandigarh Ombudsman Centre
Case No. GIC/335/OIC/14/06
Som Nath Singla
Vs
Oriental Insurance Co.

Award Dated 14.7.06

Facts : Som Nath Singla had taken a Mediclaim policy from BO Panchkula for the period 30.9.04 to 29.9.05 for sum insured of Rs. 50,000 each for self and wife. He has been having policy for the last 3-4 years without any break. His wife was taken ill and admitted in the hospital in an emergent condition due to acute abdominal pain from 8.3.05 to 10.3.05 and again from 4.5.05 to 10.5.05. The medical bills in respect of expenditure incurred by him were filed with the insurer, but claim was not settled. He sought intervention for settlement of his claim amounting to Rs. 40,000 and demanded compensation for harassment suffered by him.

Findings : The claim papers were sent to TPA M/s Paramount Health Services. After scrutiny by panel of doctors, TPA informed that claim does not fall under the terms and conditions of the policy as it attracts exclusion under clause 4.1 of the policy. In the discharge summary relating to treatment taken by the wife of insured it was clearly mentioned that she was a known case of primary Hypothyroidism since 1984 and has

been under medical treatment. As per discharge summary she was diagnosed to be suffering from primary hypothyroidism since 1984, ulcerative colitis since 17 years and primary scleroring cholangitis for eleven years. She was also diagnosed to be suffering from acute pancreatitis (CT grade-C). The complainant admitted that his wife was suffering from various ailments for the periods specified in the discharge summary. However, he emphasized that treatment taken during admission was not related to these ailments, it was for acute pancreatitis, which was detected in March'05 only.

Decision : The only crucial issue in this case is whether acute pancreatitis can be considered as a stand alone disease, with no nexus with the past ailments and that these ailments are not a contributory cause for acute pancreatitis. The insurer was, therefore, directed to obtain opinion from PGI authorities and if it was established that there was no nexus, the claim shall become payable in respect of treatment for acute pancreatitis. In that case the claim bills can be split and only expenses in respect of treatment for pancreatitis be admitted.

Chandigarh Ombudsman Centre
Case No. GIC/52/NIA/11/07
Amarjeev Kaur
Vs
New India Assurance Co. Ltd.

Award Dated 31.7.06

Facts : Amarjeev Kaur had taken a Mediclaim policy for sum insured of Rs. 5 lakh for the period 15.7.05 to 14.7.06. She was admitted in Satguru Apollo Hospital, Ludhiana from 7.2.06 to 18.2.06 for knee surgery. She allegedly had an accidental fall from scooter which caused injury and necessitated replacement of right knee. She filed a claim for Rs. 1.6 lakh, which was repudiated by TPA on the ground that it was an old case of rheumatoid arthritis. She, however, contended that injury was on account of accident and it had nothing to do with her past illness.

Findings : The claim was repudiated on the basis of hospital record and non disclosure of material facts in the proposal form. The TPA informed on 29.5.06 that claim has arisen during the first year of policy and past history reveals that it was an old case of rheumatoid arthritis and the insured has been taking treatment for the past many years. These facts were not revealed at the time of taking the policy. The patient was admitted on 7.2.06 with diagnosis of ligamentous injury in the right knee. In the prescription slip dated 19.1.06, however, it was stated that she was a patient of rheumatoid arthritis with swelling and instability. But there was no mention of fall from scooter. It is only in the discharge summary that a mention has been made that injury was due to accident and further that the patient was admitted twenty days after fall from scooter. Besides, as per the complainant's version there was no serious external injury.

Decision : The plea on behalf of complainant that she did not suffer from rheumatoid arthritis in the face of diagnosis during treatment is unacceptable. Further the version regarding injury caused on account of accident appears to be quite dubious as it was not disclosed while giving intimation regarding admission to the insurer. Even if the contention of the complainant is taken to be true, ligamentous injury cannot be caused primarily be due to accident. On the contrary the trigger was rheumatoid arthritis. It seems highly improbable that a person would require total knee replacement merely after a fall from scooter unless she is suffering from serious ailment involving joints.

Besides proximity between purchase of policy and the alleged accident also puts a question mark on the bonafide of the claim. Therefore, the claim was not admissible on the grounds of non-disclosure of material information as well as it pertained to a pre-existing disease. The decision of the insurer to repudiate the claim was upheld and the complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. GIC/112/NIA/11/07
Satya Pal Bathla
Vs
New India Assurance Co. Ltd.

Award Dated 29.8.06

Facts : Satya Pal Bathla had taken a Mediclaim Policy for sum insured of Rs. 5 lakh from DO Ambala for the period 20.1.05 to 19.1.06. He remained admitted in Kottakal Arya Veda Shala Ayurvedic Research Centre, Kerela from 7.11.05 to 22.11.05. He had earlier taken treatment from the said Vaidyashala for lower backache which in medical term is kateegraham and kasam. The treatment comprised of specialized massages two to three times a day by specialists. Besides massage, patient is kept under observation. Previously also he was admitted in the same hospital and claim was filed for the period 4.1.05 to 31.1.05 which was entertained and paid by the insurer. The claim for the present treatment was filed on 23.11.05. Requisite documents like hospital certificate, bills etc were submitted. However Raksha TPA informed that claim is untenable on the ground that no special indication for admission had been given.

Findings : The complainant stated that he had some problem of cough and backache. He has been advised that surgery is the only cure. To avoid surgery, he visited the said Ayurvedic Centre earlier also and the claim was admitted by the insurer. He and his wife were advised to repeat the treatment after 8 months. The insurer pointed out that the treatment undertaken by the complainant and his wife is to be reckoned as post hospitalization treatment. There is no advise for admission. During the first hospitalization, they were advised to get themselves readmitted after 8 months. However, post hospitalization treatment is covered only for 60 days in terms of policy clause 3.2. Therefore, the claim is not payable. He further stated that the hospitalization was pre determined in this case as part of the same illness.

Decision : Held that the present hospitalization is a sequel to the treatment initiated during 4.1.05 to 31.1.05 and is thus in conjunction with and a continuation of the earlier treatment, for which the claim is allowable only for 60 days after hospitalization. The claim has, therefore, rightly been repudiated.

Chandigarh Ombudsman Centre
Case No. GIC/114/NIA/12/07
Surjit Kumar Jain
Vs
New India Assurance Co. Ltd.

Award Dated 29.8.06

Facts : Surjit Kumar Jain had taken a Mediclaim policy for the period 15.5.06 to 14.5.07. He contended that he is a regular policyholder since 15.5.98. He issued a cheque on 10.5.06 drawn on HDFC for getting the policy renewed w.e.f 15.5.06. After a month he was informed that cheque was mutilated. He stated that when he sent the

cheque, it was intact. On receipt of communication, he immediately sent a draft. But the company cancelled the policy and on receipt of demand draft issued a fresh policy without cumulative bonus. He sought intervention in getting the cumulative bonus restored on the ground that action of insurer was arbitrary and unjustified.

Findings : Development Officer had collected HDFC cheque no 283192 dated 10.5.06 for Rs. 17,341 and on receipt of the same BO renewed the policy on 10.5.06 w.e.f 15.5.06 to 14.5.07. The cheque was deposited in the Punjab National Bank, Dabwali on 11.5.06. On 6.6.06 the bank informed that the cheque had been dishonoured as instrument was mutilated. The BO cancelled the policy and informed the insured vide letter dated 6.6.06. Thereafter on receipt of Demand Draft on 14.6.06, BO issued a new policy w.e.f 14.6.06 to 13.6.06 and cumulative bonus was reduced to nil. It was pointed out that as the instrument was mutilated, the company had no alternate but to cancel the policy. Since there was break in policy the computer system did not provide the cumulative bonus. The complainant stated that on the date of presentation of the cheuqe there were sufficient funds in his account. He had not given a mutilated instrument, which was also acknowledged by the Branch Manager. He complained that he should not be penalized, if the cheque was mutilated in transit. The representative of the insurer admitted that the cheque was in good condition when it was delivered and that it was mutilated in transit, but stated that the system does not permit grant of cumulative bonus after break in policy.

Decision : The cheque deposited with the insurer before due date of renewal was duly accepted. The complainant had sufficient funds in his account on the day the cheque was presented. If something went wrong with the instrument in transit, the complainant cannot be penalized. The insured deposited the premium in time to get the policy renewed. And if in transit, whether in the hands of insurer or the bank, the cheque is mutilated the insured cannot be blamed. He also cannot be visited by any adverse consequence on this account. Rather than trying to find a way out, the insurer lost no opportunity of cancelling the policy and renewing it prospectively, which was unjust and uncalled for. The insurer should have renewed the policy in continuity because break in insurance occurred for reasons beyond the control of both the parties. Therefore, ordered that the policy be renewed with effect from due date by the insurer.

Chandigarh Ombudsman Centre
Case No. GIC/101/UII/14/07
Surinder Singh
Vs
United India Insurance Co. Ltd.

Award Dated 25.8.06

Facts : Surinder Singh had taken an Individual Mediclaim policy for self and wife from DO-I Jalandhar for the period 17.8.05 to 16.8.06 for sum insured of Rs. 50,000. His wife got enteric fever and was admitted in Gill Hospital & Maternity Home. All claim papers were submitted in original to the insurer. These in turn were forwarded to Paramount Health Services. The TPA raised objection that claim papers should be attested by the doctor. The papers were resubmitted accordingly. Subsequently he received another reference on 20.5.06 stating that hospitalization for 11 days should be justified, which was already certified by doctor in the discharge summary. It was stated that hospitalization was as per advice of doctor. His wife was not got admitted for any entertainment or picnic. She was admitted and discharged as per the advice of doctor. It was stated that he was being harassed unnecessarily on flimsy grounds.

Findings : On behalf of insurer it was stated that OPD slip was not submitted nor justification from the treating doctor for hospitalization for eleven days given as it was a long duration.

Decision : The fact that the wife of the complainant remained admitted is not denied. Only issue raised by TPA is regarding hospitalization for eleven days for which justification is being sought. It is not proper for the TPA to put the treating doctors in the dock. A qualified doctor in his judgement may recommend admission for specified period and should ordinarily not be questioned. The TPA cannot transgress the jurisdiction and question the judgement of treating doctors and reject or hold up the claim on flimsy grounds. It is obvious that enteric fever does take time. So whether she was hospitalised for 5 days or 11 days is immaterial, so long as it is not in doubt that she was suffering from enteric fever. Hospital is not a place where anybody would like to stay by choice. Having regard to aforestated discussion, ordered that claim be settled.

Chandigarh Ombudsman Centre
Case No. GIC/81/UII/14/07
Vijay Kumar Nayyar
Vs
United India Insurance Co. Ltd.

Award Dated 24.8.06

Facts : Vijay Kumar Nayyar had taken a Mediclaim policy for sum insured of Rs. 1.3 lakh each for self and wife for the period 7.10.05 to 6.10.06 from DO-V Ludhiana. He and his wife were out of country for three months. On return, his wife was taken ill and doctor advised surgery. A claim for Rs. 34,579 was filed on 17.11.05, after the treatment was over. He followed it up with the insurer, but despite repeated enquiries no satisfactory response was given. He took up the matter with the Branch Manager with copies to the Divisional Manager and the Head Office. Six months passed, but still there was no response. Feeling aggrieved he filed a complaint in this office.

Findings : The complainant stated that he has been having Mediclaim policy from UII since 2003, except for the period from 9.7.05 to 6.10.05, for which he was covered under Overseas Mediclaim policy. His policy for 2005 was due to expire on 16.8.05, but he did not get it renewed because he was abroad and was covered under Overseas Mediclaim policy. On return he got the policy renewed from UII DO-V for the period 7.10.05 to 6.10.06. The representative of insurer stated that policy taken subsequently was treated as a fresh policy, as the period for which he had Overseas Mediclaim policy, cannot be considered as continuation of the earlier policy. The HO also advised that if insured has a Mediclaim policy and during the currency of policy he happens to travel abroad after taking an OMP policy, the mediclaim policy gets extended for the period covered by the Overseas Mediclaim policy. However, both the policies should be from the same insurer. Since, the complainant had taken Overseas Mediclaim policy from the Oriental Insurance Company, the claim was repudiated in the light of advice given by the Head Office.

Decision : The basic question in this case is whether it would be reasonable to deny the benefit of continuity of policy, if the Mediclaim and Overseas Mediclaim policy are taken from different insurers. The basis of repudiation of the claim is fallacious as mediclaim policy is not required for the period the person is abroad. Nor can any benefit accrue to the insured under mediclaim policy while he is abroad and is covered

under Overseas Mediclaim policy. Therefore, the period for which the complainant had taken the Overseas Mediclaim policy from OIC, has to be treated as extension of Mediclaim policy. This cannot be denied on the ground that OMP policy was issued by a different insurer. The interpretation given by HO is not in order, as it implies that the mediclaim policy will be extended for the period the insured takes an OMP Policy, only if both the policies are from them. This restriction is without rationale and is unreasonable. As per current practice, mediclaim policies taken from other insurers are reckoned as valid for the purpose of continuity, if the switch over is without break. The distinction sought to be made between Overseas Mediclaim policy and the mediclaim policy on this ground is invidious and hence unsustainable. Accordingly, ordered that the claim be settled.

Chandigarh Ombudsman Centre
Case No. GIC/136/UII/14/07
Dr. Sunita Rao
Vs
United India Insurance Co. Ltd.

Award Dated 20.09.06

Facts : Dr. Sunita Rao had taken a Mediclaim policy from BO-Goraya. She was hospitalized in Madan Hospital Amritsar for the period 22.8.04 to 23.8.04. The claim filed by her remained unsettled, despite follow up. She stated that she had submitted all the relevant papers except pre-operative X-ray report which was misplaced. M/s Paramount Health Services, the TPA has been insisting on submission of X-ray film. She stated that the insurer could confirm factual position from the hospital authorities and that she could provide post operative film showing plating done on the fracture.

Findings : She had met with an accident and claim for damage to car has since been settled. She received serious injuries and her jaw was fractured. The TPA demanded pre-operative X-ray film to determine admissibility of claim which was not possible as the film was misplaced. The representative of the insurer stated that TPA is yet to decide whether claim is payable or not. That can be determined only after examining pre-operative film. Madaan Hospital & Neuro Trauma Centre, Amritsar certified that complainant was operated upon for mandible fracture and plating was done. The representative of the insurer stated that post operative X-rays were referred to Dr. Dharmesh Nanda, Dental Surgeon. He confirmed in his report dated 14.9.06 that post operative X-rays suggest that patient was treated for mandibular fracture right side with bone plating.

Decision : Held that on the basis of facts of the case and circumstantial evidence there is no doubt that complainant was treated for dental fracture in Madaan Hospital. The report of Dr. Dharmesh Nanda, after scrutiny of post-operative X-ray films, and certification by hospital authorities fully establish that it was a case of fracture of mandible as a result of accident. For the same accident a motor claim has been settled by the insurer. In this background, insistence on pre-operative X-ray film and holding up the claim was unjustified. Therefore, ordered that claim be settled within three weeks of receipt of order.

Chandigarh Ombudsman Centre
Case No. GIC/128/NIC/11/07
H.C. Nair
Vs
National Insurance Co. Ltd.

Order dated: 22.09.06

Facts : HC Nair had taken a Mediclaim policy for sum insured of Rs. 50,000 for self and Rs. 20,000 for his wife for the period 30.9.05 to 29.9.06. He was admitted in Pushpanjali Hospital Delhi from 4.1.06 to 6.1.06. He has been a policyholder for the last six years and has never before lodged any claim. But the claim filed by him for hospitalization was repudiated on the ground that admission was for investigation purposes (policy clause 4.10). He sought intervention for reimbursement of claim amount.

Findings : The complainant stated that he felt pain in chest on 4.1.06 and had high BP. He collapsed in office and was taken by his colleagues to Singh Nursing Home where ECG was done which showed some abnormality. He was advised admission. He got himself admitted in Pushpanjali Medical Centre where he remained till 6.1.06. He had to undergo many tests. He admitted that no serious abnormality was detected, but initially it appeared that he had symptoms of heart ailment. The representative of the insurer stated that the hospitalization was primarily for investigation purposes, as the tests conducted did not reveal positive existence of any ailment. The investigations showed normal results.

Decision : Held that the claim is not payable as per exclusion clause 4.10. The case is, accordingly, closed.

Chandigarh Ombudsman Centre
Case No. GIC/119/NIC/14/07
Sushiksha Mitra
Vs
National Insurance Co. Ltd.

Award Dated 22.09.06

Facts : Susiksha Mitra had taken a mediclaim policy from BO Gurgaon. She was hospitalized for a day on 18.1.06. She submitted the claim for Rs. 7000. Since the claim was not settled, she filed a complaint seeking intervention.

Findings : The insurer sought justification for hospitalization. As there was no response from the complainant, the claim was treated as ‘no claim’. The file was sent to the panel Dr. Sharad Mathur for opinion. He expressed the view that there was no need for hospitalization as the patient is a known case of Atrial Fibrillation and Hypertension as per discharge summary and she was admitted for readjustment of continuing medication only. At the time of admission there was no emergency. The cause of gabrahat could have been evaluated by ECG only.

Decision : It is not disputed that insured had past history of some ailments and during the course of investigations some changes were detected. The basic question involved in this case is whether hospitalization was required or not. The categorical view of the panel doctor is that this was not required as investigations were undertaken for

readjustment of continuing medication only, which was possible on OPD basis. The plea of the complainant is that hospitalization was on the advise of treating doctor. However, keeping in view the past history and the degree of severity of the problem, hospitalization was not warranted. Therefore, having regard to the facts of the case, the claim is not payable. Accordingly, the complaint is dismissed.

Chennai Ombudsman Centre
Award No. 11.12.1294 / 2006 - 2007
Smt. Lalitha Ramaswamy
Vs
ICICI Lombard General Insurance Co. Ltd

Award Dated 24.04.2006

The Complainant stated that she had taken travel health/medical insurance with M/s ICICI Lombard for the period from 10.08.2005 to 12.12.2005 and visited USA during August 2005. On 22nd November suddenly she developed an infection with acute pain and was admitted in the Hospital as emergency. She also stated that her Diabetis was under control and the treatment was given to relieve her acute pain and it was covered under the policy. She also used special footwear and had not raised any foot problem from Dec. 2004 to Sep.2005. After a stay of 1 month in USA only she developed high fever and severe pain due to blister and was in Emergency for 12 to 14 hours approximately.

The insurer repudiated the claim stating that the Exclusion 3 of the clause clearly stated that any pre-existing condition would not be covered. He also stated that the complainant claimed that she was eligible for reimbursement as per condition no.8, which was incorrect. The condition no.8 stated that indemnification for the measures taken solely to relieve acute pain provided it was taken under emergency situation and the limit for the reimbursement would be for the measures taken until pain was relieved. Insurer stated that this claim was for a pre-existing condition and justified it by showing the medical records, which stated that the complainant, 63-year-old female was seen by Dr. Raftery, 3 years ago for a left foot callous and plantar blood blister, hence this cannot be treated as sudden and could be pre-existing.

The forum pointed out the wording mentioned in the policy which stated that any '...Life saving unforeseen emergency measures or measure solely designed to relieve acute pain..' . Any treatment underwent to relieve acute pain can be admitted as per the policy. But further treatment for the pre-existing condition cannot be reimbursed. The complainant also agreed for the same. The insurer was directed to review the matter after obtaining medical opinion and arrive at the amount admissible for the relieving of pain as per policy.

Chennai Ombudsman Centre
Award No. 11.08.1324 / 2005-2006
Smt. Padmini Rajagopalan
Vs
Royal Sundaram Allianz Co. Ltd.,

Award Dated 29.05.2006

The complainant contended that she has availed a Health Shield policy with Royal Sundaram from 2003. She was hospitalized from 2.11.05 to 7.11.06 with complaints of chest pain and was diagnosed to have Unstable Angina and Essential Systemic

Hypertension. She submitted the claim papers for the reimbursement of hospitalisation expenses, however the insurer repudiated the claim on the ground that the Echocardiogram revealed Concentric Hypertrophy of left Ventricle with Diastolic Dysfunction and the ECG report revealed LV strain, and these are indications that the patient should have had BP for a very long time and as per the case sheet of the hospital the insured was a known case of Ischaemic Heart Disease with Hypertension. She represented that M/s Royal Sundaram did not insist for medical checkup at the time of proposing and stated that she was never hospitalized before November 2005 and her claim was genuine.

This forum observed that the Doctor has mentioned “No-known case if HT/IHD”, normally the Doctors’ do not mention like “No-known case of”in their observations. In this case it was mentioned in the admission sheet as “no known case of IHD/HTN with treatment and follow-up.” Further Dr. V. Ramakrishna Rao, who was the complainant’s physician, stated that the complainant had been an Outpatient in the month of Sep 05 and taken treatment for Hypertension, and the Doctor instructed her to come for a review after a month. The Doctor had also confirmed that he inadvertently omitted to mention the past case of Hypertension in his observation.

This forum observed that Smt. Padmini did have a history of Hypertension and IHD prior to her hospitalisation in Novemebr 2005, however it was not established whether the same existed prior to December 2003 to establish that they were pre-existing diseases. It was also observed that the complainant was not transparent in her dealing with the Insurer and submitted doubtful and ambigous documents therby placing the insurer at a disadvantage. The Insurance is based on Good Faith both the insurer and insured are expected to be transparent. In this claim by not being transparent the insured lost her credibility in the issue, hence the forum grants relief upto 40% of the claim amount.

Chennai Ombudsman Centre
Award No. 11.02.1281 / 2005 - 2006
Shri.M. S. Velu
Vs
The New India Assurance Co. Ltd

Award Dated 30.05.2006

The complainant represented that he and his family members are covered under Good Health Policy with New India Assurance Co. Ltd., since 1995. As he was a Diners Card holder, Citi Bank automatically issued the policy and in the year 2000 the Citi Bank failed to remit the premium and renew the policy. There was a break of 6 to 7 months. During March 2000 he was asked to undergo Angeogram for which he voluntarily discharged from the hospital without undergoing Angeogram. Later in the year 2005 he was admitted in Vijaya Hospital where the block was confirmed and same was rectified. He also stated that he was not having heart problem for 7 years, so the insurer cannot repudiate on the ground of pre-existence.

The insurer repudiated the claim stating that there was a break in the policy for 7 months after 1.10.1998-30.9.1999. Any policy commencing after a break was considered as new policy and hence, they repudiated the claim on the basis of Exclusion clause 4.1 of the company.

The complainant failed to submit a copy of the discharge summary for the hospitalisation in March 2000. However the insurer submitted relevant documents and

medical reports for the same and it was observed that the complainant was advised for further Management of Coronay Angiogram in March 2000 itself. Since the complainant himself admitted there was a break in insurance from 01.10.1999 to 30.04.2000, the policy issued with effect from 01.05.2000 shall be treated as fresh policy and the insurer is right in rejecting the claim under the exclusion clause of pre-existing disease viz 4.1 of the policy exclusion.

Chennai Ombudsman Centre
Award No. 11.03.1362 / 2006 - 2007
Shri S.R.RadhaKrishnan
Vs
National Insurance Co Ltd

Award Dated 08.06.2006

The complainant represented that he had taken Mediclaim policy with National Insurance since 2003. The policy was renewed in2004 after a break of 27 days. During November 2005 he was hospitalised for heart treatment for 3 days at M/s Apollo hospital. He submitted necessary claim papers. However, the insurer repudiated his claim on the ground that the present hospitalisation is for the management of an ailment, which was pre-existing. He pleaded that his claim was for Heart Problem and not for BP, which was also under control and hence the repudiation of the claim was incorrect.

The insurer stated that there was a break in the insurance policy in the year 2004-05. Hence, they had taken 2004-05 as the first year policy and there was 3 years live policy. The TPA of the insurer were of the opinion that the complication of Heart Problem was due to pre-existing condition of Hypertension of the complainant, hence they repudiated. They felt that BP might be the contributory factor for the heart disease.

The forum pointed out that Hypertension need not be the sole cause for heart disease, there are other factors like Cholestrol level etc., which might contribute more to heart problem. Insurer also agreed that the Cholestrol was normal during 2003 and the complainant underwent a test, which stated that he had no heart problem. The Ombudsman enquired whether in the case of hypertension not being the contributory factor for heart disease what would be their stand. The insurer replied that they would consider the claim for angiogram and exclude expenses incurred for pre-exisiting disease of Hypertension. Ombudsman observed that it’s the duty of the insurer to arrange for an investigation prior to denial. They should establish nexus between the treatment and the pre-existing disease. The Ombudsman pointed out that there was no evidence to establish distinctively that the Hypertension has direct link with the heart disease.

The forum perused the documents and found that Hypertension was pre-existing but the same was under control with medication. Hypertension is one among the risk factors and not the only risk factor for Ischaemic heart disease. Ombudsman directed the insurer to settle the expenses related exclusively to the treatment of Ishcaemic Heart disease. Hence, the claim was parly allowed.

Chennai Ombudsman Centre
Award No. 11.08.1007 / 2006 - 2007

Smt. P. Meenakshi Ammal
Vs
The Royal Sundaram Alliance Ins Co. Ltd.,

Award Dated 14.06.2006

The complainant represented that she had taken Health Shield Policy for the period from 18.08.2005 to 17.08.2006. On 11.01.2006 she had a heart attack and was hospitalised for Myocardial Infarction and underwent coronary angiography followed by PTCA. The claim was repudiated by the TPA of the insurer stating that the present hospitalisation was for management of ailment, which was a pre-existing one. The complainant stated that at the time of taking the policy the insured was less than 60 years and no medical test was conducted. The complainant said that a renowned cardiologist attended her and issued a certificate in view of multiple risk factors for coronary artery disease like hypercholesterolemia, hypertensive and post menopausal-status existing in the insured. And also stated that it was difficult to pinpoint which was exactly responsible for the present coronery disease. Hence the insured contended that it was wrong on the part of the insurer to repudiate the claim on the ground that hypertension was the sole cause for his present ailment.

The insurer stated that the pre existing hypertension was not declared in the proposal form. The insurer read out the opinion of the panel doctor, which stated that the hypertension was one of the reasons for CAD and not the sole cause for the same.

The insurance Ombudsman pointed out that there are multiple risk factors like hypercholesterolemia, hypertensive and post menopausal-status present in the insured and the onus was shifted to the insurer to establish that the CAD was only due to pre existing disease of hypertension. The forum also pointed out that the patient was taking medicine for hypertension, which was of a minimal dosage. Ombudsman stated that the insured by not revealing the pre existence of hypertension in the proposal form did not maintain implicit transparency and good faith at the time of proposing for insurance, thereby putting the insurer at a disadvantage. On the basis of records and the hearing conducted, the Ombudsman allowed the claim upto an extent of 60% of the admissible expenses.

Chennai Ombudsman Centre
Award No. 11.05.1035 / 2006 - 2007
Shri. S. Lakshmanan
Vs
Oriental Insurance Co. Ltd.

Award Dated 15.06.2006

The complainant contended that he has taken Overseas Mediclaim Policy with Oriental Insurance Co. Ltd. He boarded the flight on 17.08.2005 and landed Nairobi on 19.08.2005, later he found out that his baggage had not reached Nairobi in the same flight. After 2 days the baggage was handed over to him on 19.08.2005 by Air India and he also received the compensation for the same from Air India. He preferred a claim with the Insurer and claimed for delayed baggage. But his claim was repudiated.

Insurer repudiated his claim on the ground that the bills produced by the insured pertains to food items and hence could not be considered as items of emergency.

During the hearing it was pointed out to the Insurer that the wordings in the policy pertaining to the scope of cover and exclusions must be clearly mentioned. Ombudsman perused the documents and stated that its very clear from the wordings

“necessary purchase of replacement items”, i.e purchase of items contained in the baggage which the insurer has been temporarily dispossessed of due to the delay in receipt of the baggage and has to be necessarily replaced for the conduct of his normal routine eg.clothes. But in this case the complainant claimed for Taxi expenses, telephone expenses and food expenses, which would not fall under the category of items, contained in the ‘baggage’.

The Ombudsman pointed out that the policy did not provide for reimbursement of any expense incurred due to the emergency situation created on account of the delay of baggage. Hence the said coverage was basically for items contained in the baggage and not for any incidental expenses. Hence the forum observed that the insurer cannot be faulted for repudiating the claim and dismissed the complaint.

Chennai Ombudsman Centre
Award No. 11.08.1064 / 2006 - 2007
Shri. K. S. Srinivasan
Vs
The Royal Sundaram Alliance Ins. Co. Ltd.

Award Dated 20.06.2006

The complainant stated that he and his wife were covered under Health Shield Policy with The Royal Sundaram Alliance Ins. Co. Ltd. for the period from 22.10.2005 to 21.10.2006. In December 2005 she underwent Mouth Flap Surgery. His claim was rejected on the ground that it was a pre-existing disease and the hospitalisation was done not more than 24 hours.

The insurer repudiated his claim on the ground that the ailment was pre-existing. Insurer contended that the policy was 2 months old but the treatment taken was for chronic periodonitis and the word ‘chronic’ indicates that the patient was suffering from this ailment for quite sometime. When the Ombudsman enquired what was the definition for ‘chronic’ in their terms, for which the insurer replied it is six months. The Ombudsman pointed out the chronic means it may be 3 months and not 6 months as stated by the Insurer.

Both the Insurer and the complainant were directed to submit the documents available with them to substantiate their stand. Insurer contacted the Doctor who did the surgery but he was not co-operative. Complainant did not submit the Radiograph and other documents to substantiate that the complainant was not suffering from this ailment prior to inception of the policy.

As per section B of the Health Shield Premeire Insurance policy it has been stiputated that a hospital to be accepted under the policy should either be registered as a hospital or should have at least 20 in-patient beds.

Section C of the policy states “.... For a claim to be admitted under this policy the Insured person should be hospitalised as an in-patient for a minimum period of 24 hrs.”

Insurer confirmed that the particular establishment i.e the Hospital did not have the stipulated 20 beds and the complainant had not been in the hospital for the stipulated period of 24 hours, so the forum felt that the complainant has not met the stipulations of the policy and hence the Forum dismissed the complaint.

Chennai Ombudsman Centre
Award No. 11.04.1001 / 2006 - 2007
Shri. S. Srinivasa Rajesh Kumar

Vs

United India Ins. Co. Ltd

Award Dated 21.06.2006

The Complainant represented that he and his family members were covered under Mediclaim Policy. His wife was admitted in the Hospital on 23.12.2005 and underwent surgery for Incisional Hernia and was discharged on 28.12.2005. He preferred a claim with M/s Family Health Plan Ltd, TPA of the Insurer towards the reimbursement of hospitalization expense. The TPA rejected his claim on the ground that the present hospitalization was for the management of an ailment which was related to a pre existing condition LSCS, hence the claims was not payable. The complainant represented that his wife underwent Caesarian operation in the year 2000 and was healthy without any post operative complication. At the time of inception of the first year policy in 2001 there was no symptom of Hernia.

The representative of the Insurer stated that the insured person delivered a child during the year 2000 by way of Caesarian Operation. The Incisional Hernia develops only from the scar of earlier operation/s. Hence this disease was considered as pre-existing. The hospitalization was for the management of the pre-existing condition and the claim was not payable as per exclusion 4.1 of the policy. Further Appendicectomy was a usual procedure in medical practice when any operation was done in abdomen as safety procedure to avoid later disturbances. Hence their TPA M/s. Family Health Plan Ltd., as per the opinion of their panel doctors, repudiated the claim.

Discharge summary was perused and the forum found that patient complaints of swelling in the abdomen region were one month prior to operation. This forum also observed that there was a mention in the discharge summary regarding LSCS done in 2000. There was no specific mention that the present ailment of Incisional hernia in Umbilical region is the complication of LSCS done in 2000 or that the incisional hernia was in existence prior to 4.5.2001 ie the date of inception of the policy.

The forum observed that both the TPA and the Insurer failed to submit any documentary evidence of doctor's opinion to prove that the present hospitalization was for Incisional hernia, which was present prior to 4.5.2001. It has to be noted that only the scar of the previous incision was pre-existing and not the Hernia. The mediclaim policy excludes pre-existing diseases and not pre-existing scars. Hence, the forum directed insurer to process and settle the claim as per terms and condition of the policy.

Chennai Ombudsman Centre

Award No. 11.04.1037 / 2006 - 2007

Shri. V. Muralidhar

Vs

United India Insurance Co. Ltd.,

Award Dated 21.06.2006

The complainant represented that he had taken the Mediclaim policy with United India Insurance Co Ltd., since 2002. During January 2005 he met with a Road accident and had a blood clot. He was hospitalised from 07.03.2005 to 12.03.2005 at M/s Vikram Hospital and treatment was given. He submitted his claim papers to the TPA. However, his claim was repudiated by the TPA's of the insurer on the ground that hospitalisation was for management of an ailment which was related to a pre-existing condition.

The insurer contended that the patient was diabetic and hypertensive for 20 years and the echo reveals hypertensive heart disease. The TPA of the insurer pointed out that the patient's sugar level was not under control and submitted records to substantiate his stand.

The forum on perusing the documents submitted by the complainant observed that the complainant was under regular medication to control the diabetes and hypertension. It was pointed out by the forum that it is incorrect on the part of the insurer to argue that Diabetes and Hypertension are the sole cause for the heart problem, when it was under control through medication and they may be one of the contributory factors amongs others. However in the present context it has not been conclusively established by the insurer that Diabetes and Hypertension were the proximate cause for the complainant's heart problem. Hence, the forum directed insurer to settle the claim as per policy terms and conditions.

Chennai Ombudsman Centre
Award No. 11.08.1058 / 2006 - 2007
Shri. G. S. Venkataraman
Vs
The Royal Sundaram Alliance Ins. Co. Ltd

Award Dated 21.07.2006

The complainant represented that he had taken a Health Sheild Policy with Royal Sundaram Alliance Co. Ltd, for the period from 05.04.05 to 04.04.06. He was hospitalised from 17.02.06 to 19.02.06 and subsequently from 06.03.06 to 08.03.06 for hemithyroidectomy and Completion thyroidectomy with nodal dissection respectively. His claim was repudiated on the ground of pre-existing disease.

The insurer contended that Histopathology report of the insured revealed that the complainant/insured had Papillary Carcinoma, infiltrating the perithyroidal soft tissue, right hemithyroid and this Papillary Carcinoma Thyroid could not have developed over a short span of time and it would have taken a long time and hence their repudiation on the grounds of pre existing exclusion is in order.

It was very clear from the definition of the term 'disease' that for a disease to exist there should be a manifestation by way of a set of symptoms and signs. Since there was no evidences of any manifestation of the disease by symptoms or signs prior to 05.04.2005 and the insurer also failed to establish that there was manifestation of symptoms existing in the insured at the time of proposing for insurance in April 2005, the Ombudsman directed the Insurer to settle the claim as per policy conditions and allowed the complaint.

Hyderabad Ombudsman Centre
Case No. G-030/2006-07
Sri Dinesh Kumar Jain
Vs
Oriental Insurance Co. Ltd.

Award Dated 31.07.2006

Complaint Dismissed : The complainant was covered under the individual Mediclaim policy for the period 21.07.2005 to 20.0.2006. He was admitted to eye hospital on 09.01.2006 and underwent Zyoptix surgery for both eyes. The insurer rejected the claim as the treatment fell under exclusion 4.5 of ht policy. The complainant contended

that the operation was needed, as he was intolerant to contact lenses. The insurers contended that the power of the lenses worn by the hospital produced by the insured do not refer to any abnormal increase in Refractive Error.

Held : This office obtained an independent opinion from an expert eye doctor. This doctor opined that the surgery undergone would fall under cosmetic or aesthetic treatment. In view of the evidence of the doctor and the independent opinion the decision of the insurer is upheld.

The complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/28/2006-07
Smt.Jayalakshmi
Vs
New India Assurance Co.Ltd.

Award Dated 12.9.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a medi claim by the insurer. The complainant, her husband and two children were covered under Medi claim Pol.No.761000/48 /05/75277 for Rs.30,000/- each. The complainant had undergone Ayurvedic treatment from 28.9.2005 to 24.10.2005. Although the complainant had availed of a medi claim policy from July 2003, there was a break in the policy for 2 days and the current policy was effected from 2.8.2005 wherefor the insurer had not taken a fresh proposal form. The amount for renewal having been entrusted with an agent, the complainant was reportedly unaware of the break. The insurer, therefore, repudiated the claim saying that the policy in question was a fresh one and therefore the disease was pre-existing. The fact, however, remains that all insurers have a discretion to condone the delay in renewal for 7 days and in this case, the benefit was not allowed. Besides, even if the policy in dispute is taken as a fresh one, the insurer should have obtained a fresh proposal from the complainant. Technically, the break in insurance being a fact, the claim was allowed in favour of the complainant only by 50% and the insurer was asked to bear 50% for not obtaining a fresh proposal for the fresh policy. Therefore, the claim was allowed by 50% and the complaint was disposed of.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/27/2006-07
Smt.Anu Manoj
Vs
United India Insurance Co.Ltd.

Award Dated 31.8.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 relates to repudiation of a medi claim by the insurer. The complainant's husband-Shri.Manoj and the complainant herself were under treatment of Dr.Valsaraj Balakrishnan of Krishna Hospital, Ernakulam from 17.3.06 to 27.3.06 and 31.3.2006 to 9.4.2006 respectively for chicken pox. It was a domiciliary treatment with intake of tablets since the Doctor had stated that there was no facility in the hospital for treatment of infected patients. The insurer repudiated the claim saying that the domiciliary treatment of the complainant and her husband did not satisfy the requirements laid down in the policy. On close

examination of the records, it was found that the treatment was genuine and the Doctor had also clarified that only Domiciliary treatment was possible in such cases for want of isolation facility for infected patients. The insurer was therefore directed to honour the claim subject to compulsory deductions, if any.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/24/2006-07
Smt.Valsala Rajan
Vs
United India Ins.Co.Ltd.

Award Dated 29.8.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a medi claim by the insurer under Pol.No.100204/ 48/03/01052 held by the complainant. The complainant had continuous medi claim insurance from 20.12.99 to 19.12.2003. However, the policy was not renewed in chain. The present policy was effected only from 5.3.2004. In the meantime, the complainant had a thyroid operation at AIMS Kochi in December 2004 and the case history cited the problem as existing for a period of 3 years which went far beyond the fresh policy that commenced on 5.3.2004. The complainant's argument was that since she had medi claim insurance from 1999 onwards, the benefits were payable. The insurer contested the claim on the ground that the due to a break in renewal, the policy issued on 5.3.2004 was a fresh one. The records of the case proved that the disease was pre-existing to the present policy. Since the stand of the insurer was justifiable as per the policy conditions, the repudiation of the claims under Exc.Cl.no.4.1 was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/22/2006-07
Ms.Raseetha P
Vs
Oriental Insurance Co. Ltd

Award Dated 23.8.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a medical insurance claim by the respondent under its Good Health Insurance policy. The complainant's current policy was for the period 22.3.2005 to 21.3.2006. She had earlier taken a medi-claim policy, which had a break in renewal, and therefore the current policy was treated as a fresh one. The insured had undergone inpatient treatment at Muthoot Medical Centre, Kozhencherry from 16.9.2005 to 20.9.2005 for Cervical spondylosis. The insurer had repudiated the claim citing exclusion under the "pre-existing diseases" clause. The insured stated before this Forum that she had, some time earlier, some pain on the hand for which she had consulted the Doctors at the same hospital and it was with the same OP ticket that she had gone to the hospital in Sept.2005 when only the disease was diagnosed as Cervical spondylosis. The insured contended that she was unaware of her problem as of Cervical spondylosis till the consultation in the hospital in Sept.2005. The insurer had based their decision on the opinion of a panel Doctor which stated that the

problem could have pre-existed in her atleast for a period of 175 days. In any case in the absence of a proper diagnosis till Sept.05, the insured could not be said to have been aware of it and hence the insurer was asked to settle the claim subject to proper verification of bills and all compulsory deductibles.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/21/2006-07
Sri.K.Sankaranarayana Pillai
Vs
Oriental Insurance Co.Ltd.

Award Dated 27.7.06

The complaint under Rule No.12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Medi claim by the insurer. The complainant – a retired LIC official – had undergone angioplasty for Coronary problems in January 2000. Again, in July 2003 he was admitted in the same hospital (AIMS Kochi) for chest pain and related problems. The TPA of the insurer had taken a stand that the tests conducted in July 2003 were only for diagnostic purposes and hence was not payable. This view was also endorsed by the Insurance Company. However, on evaluation of the records, it was found that the tests were for the purpose of continuous treatment in the background of the angioplasty done in 2000 and could not be therefore dismissed as diagnostic tests, which were not payable as per policy conditions. The insurer was also absent for the hearing before this Forum and they had not filed the circumstances of repudiation. Taking an over all view of the case, the contention of the insurer was found erroneous and hence the claim for Rs.11,777/- was ordered to be settled subject to compulsory deductions, if any.

Kolkata Ombudsman Centre
Case No. 387/13//002/NL/8/2005-06
Shri Satyendra Nath Datta
Vs.
The New India Assurance Co. Ltd

Award Dated 22.05.06

Facts & Submissions : The complaint was regarding dispute on the legal construction of the policy under Mediclaim Insurance Policy.

Shri Satyendra Nath Datta and his family members were covered under Mediclaim policy with the concerned insurance company since 17.03.1997. At the time of renewal for the period 17.03.2005 to 16.03.2006, the complainant proposed to increase the sum assured from Rs.40,000/- to Rs.1,00,000/- in respect of himself, his wife and son. Necessary test reports, viz., ECG, Blood sugar in respect of complainant and his wife were submitted to the insurance company. However, after receiving the premium and issuing receipt thereof on 14.03.2005, the insurance company demanded over telephone a TMT report for Smt. Datta on 22.03.2005. The complainant personally met the insurance company official the same day and requested him not to increase the sum insured, as proposed by him and to return the extra premium by him.

The medical opinion obtained by the insurance company was effected by insurance company dated 15.03.2005, i.e., after issuance of the premium receipt dated 14.03.2005 and the same was supplied to the complainant on 12.05.2005. Accordingly, the complainant submitted the original TMT report to the insurance company on

30.05.2005. The said TMT report did not show any adverse feature. The insurance company however, issued the policy unilaterally excluding heart disease from the scope of insurance in respect of Smt. Datta. Despite representation to various authorities, the insurance company did neither waive the heart disease exclusion nor did they refund the premium. Being aggrieved, the complainant has approached this forum for redressal of his grievances seeking relief is to set right the policy by making the sum assured in respect of the complainant's wife as Rs.1,00,000/- + Bonus already accrued, in order to avoid monetary loss to the extent of Rs.60,000/- in future.

The complainant submitted that the demand for TMT report, 8 days after acceptance of the premium, that too, over telephone at residence, was an after-thought and was not in conformity with the facts and circumstances of the case. The complainant requested for not increasing the sum insured, but the insurance company turned a deaf ear and issued the policy restricting cover for his wife's heart disease upto Rs.40,000/-. Issuance of such restricted policy without the consent of the complainant, was patently illegal.

The New India Assurance Company Ltd. stated that the Insured submitted ECG report at the time of enhancement of sum insured from Rs.40,000/- to Rs.1,00,000/-. As per opinion of Dr. J.N.Mitra, MD, dated 15.03.2005, the ECG of Ms. Datta dated 12.03.2005 showed 'Inferior Wall Ischemia'. On the basis of such opinion, heart disease was excluded for the increased sum insured of Rs.60,000/- and the policy was devised accordingly.

Decision : We find that the insurance company while collecting the renewal premium on enhanced sum insured did not mention any requirement and the premium receipt was issued unconditionally. As per the policy copy furnished to us, the same was signed on 14.03.2005, i.e., the date on which the renewal premium receipt was issued. The medical opinion obtained by the insurance company and the demand of TMT report were subsequent to the date of issue of premium receipt. The complainant therefore, was justified in alleging that action of the insurance company was the result of after thought. We also find that no written consent was obtained by the insurance company before restricting the cover in the policy as the same was different from the cover proposed for insurance. Since, the medical opinion dated 15.03.2005, indicating IHD, was already available with the insurance company before inception of the cover on 17.03.2005, they should have obtained the complainant's consent for restricting the cover. From the subsequent correspondence, it is apparent that the complainant was not agreeable to restricted insurance coverage. Therefore, the contract document was concluded unilaterally by the insurance company without obtaining consent of the Insured to the restriction of the cover. Even afterwards, the insurance company did not consider it necessary to respond to any of the several representations filed by the complainant, as per documents furnished to us. Moreover, the insurance company charged full premium for the complainant's wife, but did not allow her to enjoy the maximum benefit otherwise available under the policy. They even did not respond to the complaint's request for not enhancing the sum insured for all the Insured persons and issued the policy as per their own whims.

In view of the above, it was held that imposition of restriction in the policy in the manner followed by the insurance company was irregular and defied equity and natural justice. The order was, accordingly, reversed and the insurance company were directed to set right the policy by withdrawing the restriction imposed on account of heart

disease for the enhanced sum insured of Rs.60,000/- in respect of Smt. Datta under the policy in question.

Mumbai Ombudsman Centre
Complaint No.GI-036 of 2005-2006
Shri Pradeep Chibber
V/s.
The New India Assurance Company

Award Dated 05.06.06

Smt. Vimla Vedprakash Bhai had taken an Overseas Mediclaim Policy for her overseas trip to Auckland, New Zealand to visit her daughter. At the time of taking the policy Smt Vimla Vedprakash Bhai disclosed about her diabetes and blood pressure and also submitted ECG report to New India. On 10.12.2004 while she was in Auckland she developed fever and was admitted to Auckland District Health Board, Infectious hospital from 10.12.2004 to 29.12.2004 for Haemophilis Parainfluenza Endocarditis . When she preferred a claim with Coris, Paris they rejected the claim due to pre-existing condition. Aggrieved by the said decision Shri Pradeep Chibber son of Smt Vimla Vedprakash Bhai approached this Forum for justice.After perusal of the records parties to the dispute were called for hearing .Going by the medical records it is apparent that lot of tests were conducted to finally arrive at a conclusion and diagnosis that Smt Bhai had an attack of Haemophilus parainfluenza endocarditis for which she was given intravenous amoxicillin and gentamycin. It is also confirmed as per her admission note that Smt Bhai had a Transient Ischaemic Attack causing left arm and right face weakness and C.T. head was performed which showed some old Ischaemic changes consistent with her age. We have noted that Diabetes is one of the most important pre-disposing factors as also referred by some other researchers.

This analysis make it clear that pre-disposing factors were intertwined in a complicated manner of which some of the existing illnesses played a major part. At the same time a pointed reference made by the specialists at Auckland District Health Board identified bacterial infection after only a series of tests. It would therefore, be relevant to consider atleast 50% of the admissible claim amount being payable for a possible independent genesis of this disease which could be diagnosed through tests followed by a package of treatment .

Mumbai Ombudsman Centre
Complaint No.GI-196 of 2005-2006
Shri Dayanand Sachdev
V/s.
The New India Assurance Co. Ltd.

Award Dated 27.07.06

The New India Assurance Co.Ltd. 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 Dayanand Sachdev and his wife Smt.Rashmi D.Sachdev was covered under the same policy since 2001. Smt. Rashmi Sachdev was covered for a SI Rs.1,10,000/- in the year 2001 and it was increased to Rs.3,00,000/- in the year 2004. Smt.Sachdev was hospitalised in Breach Candy Hospital and underwent Coronary Angioplasty and has claimed an amount of Rs.1,07,051/- for hospitalisation expenses. The claim was processed by M/s TTK

Healthcare Services Pvt. Ltd. (TPA) and they paid Rs.99,953/- to the hospital and balance amount of Rs.10,047/- was reimbursed to the Insured. Not satisfied with the settlement of the claim, Shri Sachdev represented to TPA stating that they should settle his claim for Rs.1,80 lakhs as per the pre-authorisation letter . Upon the representation from the Complainant, the TPA again re-examined the case and informed the insured that since the date of admission to the hospital was 29.07.2004 and the date of commencement of the policy was 01.07.2004 and the ailment Unstable Angina was first diagnosed in November 2003 i.e. during the policy period 2003-2004 wherein the Sum Insured was Rs.1,10,000/- hence the settlement amount is restricted to Rs.1,10,000/-. The enhanced sum insured benefit is not available to heart ailments. Hence the claim fell under Exclusion Clause 5.6 of the policy. Shri Sachdev approached the Insurance Ombudsman with his grievance.

It is evident that dispute is only regarding the total amount of cashless limit as per pre-authorisation letter issued by TPA and actual settlement made by them. Our examination reveals that it was a matter of unfortunate slip up by the TPA not to have obtained the exact policy details with increase of Sum Insured made only in July,2004 from Rs.1,10,000/- to Rs.3,00,000/-, which caused TPA giving a wrong intimation to the Insured. It would appear that the Insured's policy Sum Insured was Rs.1,10,000/- from July,2001 till 31.06.2004 and only thereafter in July,2004 she increased to Rs.3,00,000/-. Whenever an increase takes place, the increased amount is subject to pre-existing illness clause if not disclosed by the Insured. It appears that Smt. Sachdev was diagnosed for Unstable Angina before the policy sum increased to Rs.3,00,000/- as per hospital records. Accordingly, when the Coronary Angioplasty was done she was not eligible to receive the claim with a maximum limit of Rs.3,00,000/- but only upto the limit of Rs.1,10,000/-. Seen in this context, the settlement of the claim by the TPA and confirmation by the New India is in order. The decision of The New India Assurance Co.Ltd. to repudiate the claim of Shri Dayanand Sachdev in respect of his wife, Smt. Rashmi D.Sachdev's hospitalisation at Breach Candy hospital is sustainable and the claim of Smt.Rashmi Sachdev for balance payment is not tenable.

Mumbai Ombudsman Centre
Complaint No. GI-146 of 2005-2006
Dr. Amol Ashok Pawar
V/s
ICICI Lombard General Insurance Co. Ltd.,

Award Dated 31.07.06

Facts giving rise to the dispute are briefly as under: ICICI Lombard General Insurance Co. Ltd. issued a Family First Health Insurance policy to the credit cardholders of ABN AMRO Bank NV. Dr.Amol A.Pawar insured himself and his wife Dr.Jyoti under the Policy No.4034/ABN/1004480 for Sum Insured of Rs.4,00,000/- for the period 19.06.2004 to 18.06.2005. He preferred a claim in respect of his two hospitalizations for low back pain which was repudiated for which he appealed to the Ombudsman for settlement of his claim.

Analysis of the case reveals that Dr. Amol A. Pawar and his wife were covered under Family First Plan ICICI Lombard Health Care for the first time from 19th June 2004. Dr. Amol was hospitalized at Shree Hospital on 5/5/2005 for low back ache, tingling, numbness in both lower Limbs since 4-5 months and tingling sensation, numbness increased on walking. MRI L.S. Spine done on 1st May, 2005 revealed Intraspinal Soft

tissue swelling causing cord compression at L4-L5 level. His provisional diagnosis was ?? Infective etiology, ?? Neoplasm, ?? Koch's and was advised CT guided Biopsy at Hinduja Hospital which commented "Though no well defined epithelioid granulomas the possibility of tuberculosis cannot be ruled out. Co-relation with clinical and laboratory findings is essential.". He was treated and discharged on 9/5/2005.

He was again hospitalized at Aditya Nursing Home on 24/5/2005 with history and presenting complaints of L.B. Pain and he was diagnosed to have epidural soft tissue neoplasm with cord compression/early neuro deficit. Total L4-L5 –S1 Laminectomy with excision biopsy of epidural soft tissue was done under G.A. Histopathology Report of Tata Memorial Hospital revealed reactive inflammatory myofibroblastic tumour (inflammatory pseudotumour).

The Company declined the claim for the reason that pseudotumour is a type of a tumour which is excluded from the scope of the policy for two years. The Insured's contention was that there was a subtle difference between a pseudotumor and a tumor which the Company failed to appreciate despite his submission of inputs quoted from Merriam Webster Medical Dictionary and Stedman Medical Dictionary on the issue. He also submitted at the hearing that his earlier claim for disc prolapse sometime in July 2004 and Dec. 2004 was settled by the Company for which he had submitted a copy of covering letter issued by the Company for claim settlement.

The main dispute is relating to the applicability of the exclusion under the policy in the particular case. It has been medically confirmed by the entire process of investigations for which the doctors toiled hard to find out the exact cause of the infective swelling and unfortunately the Company mistook it to be a case of tumour as the expression 'pseudotumour' appeared in one of the investigation reports. Apart from the very connotation of 'Pseudo' which means "not genuine" and "resembling or imitating", nowhere in the discharge summary the diagnosis was 'pseudotumour' and was even referred as an early neuro deficit. It therefore, clearly betrays lack of analysis by the consultants of TPA. Effectively, therefore, it was an infective inflammation which caused the soft tissue swelling which was not properly picked up at the first MRI and the Insured's claim was accepted and settled by the Company. The same complaint continued which got detected in the subsequent MRI to be the same cause giving rise to greater complications for which the claim should be acceptable.

Mumbai Ombudsman Centre
Complaint No. GI-268 of 2005-2006
Shri Rajnikant Ravilal Doshi
V/s
Oriental Insurance Company Limited

Award Dated 31.07.06

Shri Rajnikant Ravilal Doshi was covered under the Mediclaim policy issued by The Oriental Insurance Company Limited, D.O. 4 since 1988-89.Shri Rajnikant R Doshi was admitted to P.D.Hinduja for Superior Sagittal sinus thrombosis c venous infarct Rt. Parietal region. When Shri Rajnikant Doshi preferred a claim for the said hospitalisation to The Oriental Insurance Company, the third party administrator of the Company M/s Raksha TPA repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Doshi represented to

Oriental for reconsideration of his claim but the Company based on their panel doctor's opinion reiterated the stand taken by their TPA in repudiating the claim. Hence being aggrieved at the decision of the Company, Shri Rajnikant R Doshi approached this Forum seeking intervention of the Ombudsman for justice.

The relevant records produced to this Forum have been scrutinized. The analysis of the rejection of the claim by The Oriental Insurance Company Limited would reveal that the Company has gone by their medical opinion which confirmed that Shri Rajnikant Doshi was hospitalized at P.D.Hinduja Hospital for Superior Sagittal sinus with venous infarct Rt Parietal region in 1990 and the present episode was MCA infarct with Diabetes Mellitus which became the same cause essentially and therefore, pre-existing ailment which was an exclusion under the policy (4.1). This was the stand point of Raksha TPA who drew a conclusion from the present MRI which revealed old infarct and since the policy was from 1998 the TPA repudiated the claim. The dispute assumes significance since the Insured pointed out that his policy was in effect from 1989. The Company failed to produce the old records and the Insured insisted that he was insured with them since 1988-89. In support of his statement Shri Rajnikant Doshi produced an Income-Tax statement which recorded a payment of Rs. 4050 in the accounting year ended 31st March, 1992 and an Amount of Rs. 1500 for the accounting year ended 31st March, 1991, Assessment Year being 91-92. This has been corroborated by bank account statement which recorded a payment of Rs. 1500 and Rs. 4050 towards The Oriental Insurance Company Limited. Atleast the Insured is able to produce a record of 1991-92 as against the Company's claim that policy was issued from 1998. However, an important point to be noted is a fact that the Insured has not been able to prove that he had the policy document from 1988-89 nor the Company has been able to disapprove that the policy issued by them as claimed by the Insured. In absence of the confirmation of the policy records the only course open to this Forum is to go by atleast the Income-Tax records produced by Shri Doshi valid for the period 1991-92. The moot question would be whether the Insured was covered before 1990 and whether the claim was paid by The Oriental Insurance Company under the tie up arrangement. Having shared the information it would be the responsibility of the Company to settle or reject which was not done despite a clear letter to the Regional Manager, The Oriental Insurance Company Limited dated 18.4.2005 by Shri Rajnikant R Doshi. On the contrary, a thought would come that if Shri Doshi was able to produce records upto 1991, why could he not produce the records for 1989-90 to confirm that he was under the policy of Oriental since 1988 as claimed by him ? In the absence of the same it would remain a matter of doubt as to whether he was really covered under the policy issued by Oriental Insurance in 1988-89. The Company, on the contrary, has written in their letter dated 10.2.2006 that the Insured has been rotating his policy from one Office to another even in the same Company of Oriental Insurance, but he was granted Cumulative Bonus at the same time to give him the benefit. Going by the percentage of Cumulative Bonus they feel that the Insurance was continuous since 1998 and not 1988. The Insured has again not been able to produce the claim reportedly received by him from The Oriental Insurance Company though direct payment to the hospital was made as claimed by him nor any certificate from the hospital has been produced to this effect. It may be argued that such old records are

destroyed even by the hospital. This Forum therefore, has no other alternative but to give benefit of doubt based on 50:50 basis to both the parties.

The analysis of 1998 episode revealed clearly that the Insured had Superior Sagittal sinus thrombosis c venous infarct Rt. Parietal region Superior Sagittal means " A large venous sinus along the attached border of the falx cerebri from the crista galli to the internal occipital protuberance where it joins either the right or left transverse sinuses or both." (Taber's Cyclopedic Medical dictionary 18th edition), This means that at the age of 40 years of the Insured had a serious ailment and a thought could come that after this disease the Insured might have taken the mediclaim policy from 1991-92 period and this should be acceptable as an argument although not proved. As regards the present claim which was MCA Infarct in the parietal region, the patient was a known case of Diabetes Mellitus and had Oral Hypoglycemic Agents (OHA) as per the hospital records. In the hospital case papers of 1990 it was written that the patient was hypertensive as well while in September, 2004 hospital papers did not mention him to be a case of Hypertension but his Diabetes was confirmed. It would appear therefore, that the Insured had history of similar episode and therefore the linkage is established. However, on the grounds of lack of proof and confirmation by the Company to convincingly establish that the Insured was not covered under their earlier policy and considering the fact that the Insured was continuously insured with the same Company for atleast 13 years, I decide that he should get the benefit of doubt with only 50% payment of admissible hospital expenses as a special case.

Order : The Oriental Insurance Company Limited is hereby directed to settle the claim of Shri Rajnikant R Doshi for the expenses incurred by him for his hospitalisation at P.D.Hinduja Hospital from 5.9.2004 to 10.9.2004 for Superior Sagittal sinus thrombosis c venous infarct Rt. Parietal region and pay only 50% of the admissible expenses. There is no order for further relief. The case is disposed of accordingly.