Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. : 14-002-0120
Mr. J S Gandhi
Vs
The New India Assurance Co. Ltd.

Award Dated : 5-10-2006

Compensation for delay in settlement of Claim: The Insured was hospitalised upto 24-10-2005. He lodged Claim on 28-11-2005. A Discharge Voucher was sent to him on 29-12-2005. The Respondent submitted during the Hearing that since they had not received back the Discharge Voucher, a second DV was sent on 28-3-2006, which was executed by the Complainant in full and final discharge. The process culminated in issued of a Cheque on 7-4-2006. Judicial Pronouncements debar reopening of such cases. As such, the Complaint was disposed off without any relief.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0003
Mr. N D Oza
Vs
National Insurance Co. Ltd.

Award Dated : 6-10-2006

Partial Settlement of Mediclaim : While settling the Mediclaim, the Respondent had deducted Rs. 650/- towards Registration and Ambulance Charges, Rs.4000/- towards Anaesthesist's Fees and Rs. 10000/- towards Operation Charges. As per Policy Conditions, Registration and Ambulance Charges are not admissible. The other Fees were recovered since they were found to be unreasonable as per Gradation of Fees being followed by the Respondent. During the course of Hearing, it was revealed that such practice has not been called for by the Corporate Office. The Charges of the same treatment vary from Hospital to Hospital. Besides, the Insured is free to get treatment from a Hospital of his choice. As such, the Respondent was directed to pay Rs.14000/- recovered in the above case.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0368
Dr. A N Dixit
Vs
National Insurance Co. Ltd.

Award Dated : 6-10-2006

Partial Settlement of Mediclaim : While settling the Mediclaim, the Respondent had deducted Rs. 7000/- towards Operation Charges, since the Respondent felt that the same was unreasonable as per Gradation of Fees being followed by them. During the course of Hearing, it was revealed that such practice has not been called for by the

Corporate Office. The Charges of the same treatment vary from Hospital to Hospital. Besides, the Insured is free to get treatment from a Hospital of his choice. As such, the Respondent was directed to pay Rs. 7000/- recovered in the above case.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0151
Mr. D A Patil
Vs
New India Assurance Co. Ltd.

Award Dated : 20-10-2006

Repudiation of Mediclaim since treatment was taken for venereal diseases: The Insured was suffering from weak urinary stream and a sense of incomplete emptying of the bladder since one month. The Institute of Kidney Disease and Research Centre conducted a number of investigative tests. The RGU Report revealed bulbular urethral stricture. The Treating Doctor advised for Cytoscopy with end-to-end urethroplasty. Despite conduction of so many tests recordings thereof spanning 25 pages, the Doctors of the Premier Centre for Renal Disease could not ascertain the cause for the stricture. Claim was repudiated by the Respondent on the basis of the opinion of the Insurer's Medical Referee, since he felt the infection could have been caused for Venereal Diseases. Medical Dictionaries too call Urethral Stricture 'a rare phenomenon'. To sum up, the Respondent's reliance on the opinion of the Medical Referee is too weak to deny the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0146
Mr. M S Gujarati
Vs
New India Assurance Co. Ltd.

Award Dated : 20-10-2006

Repudiation of Mediclaim on the grounds that the Claim does not comply with the requirements of Hospitalisation: The Insured was operated for 'Impacted Wisdom Tooth Removal'. The subject Dental Surgery was done in a Dental Clinic, which as per the statement of the Dental Surgeon had only Dental Chairs. The Insured having been treated on an OPD basis, it does not get the cover of the benefit of a Mediclaim Policy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0117
Mr. B B Patel
Vs
United India Insurance Co. Ltd

Award Dated : 25-10-2006

Repudiation of Claim due to late submission of Claim documents: As per records the Insured was discharged from the Hospital on 15-7-2005. The Claim Form was received by the Insurer on 17-10-2005 i.e. after a delay of over 90 days. As per Policy conditions, the relevant documents must be filed with TPA within 30 days from the date of Discharge from the Hospital. The Complainant pleased that the filled in Claim Form

with the allied papers were handed over to the Agent of the Respondent. Since the delay was caused due to inaction on the part of the said Agent, the Complainant should not be penalised. The Respondent had enquired with its Agent and produced a letter from him confirming that the Claim form was received by him on 17-10-2005. Under these circumstances, the decision of the Respondent to Repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0107
Mr. N N Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 25-10-2006

Repudiation of Mediclaim since Hospitalisation was for diagnostic purposes: The Insured was admitted for 2 days in a Nursing Home for 'Vague Somatisations, Trembling of whole body and Dejection, Sadness of Mood' under the care of a Psychiatrist. The Respondent argued that of the total amount Claimed by the Complainant, the amount spent on Medicine was absolutely negligible. As such, the decision of the Respondent to repudiate the subject Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-004-0096
Mr. J R Mehta
Vs
United India Insurance Co. Ltd.

Award Dated : 25-10-2006

Repudiation of Mediclaim on the grounds of non submission of Claim Papers: The Complainant was admitted to a hospital. He sent the Claim Papers along with the documents to the TPA by Registered Post with AD. The Respondent denied receipt of the same. During the course of Hearing, the Complainant produced Courier slip to authenticate the despatch. He also produced copies of Hospital and Pharmacy vouchers sent to TPA. In view of the same, the Respondent was instructed to obtain an Affidavit from the Complainant that he has not received the Claim from any other Company and settle the full claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0182
Mr. H R Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 30-10-2006

Repudiation of Mediclaim on the grounds that Hospitalisation was done since the Insured was in a 'run down' state: The Insured was admitted to a hospital for 'acute anaemia and acute gastritis'. The treatment in the Hospital included Blood transfusion, IV Fluids and IV Injections. Claim was repudiated on the ground that the Insured was in a 'run down' state and he took treatment for general debility. From the papers it could be seen that the Policy had continued for 6 years without break and without Claim. Active Treatment for acute gastritis was administered in the Hospital. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre

Case No. : 11-002-0170
Mr. N J Soni
Vs
New India Assurance Co. Ltd.

Award Dated : 30-10-2006

Repudiation of Mediclaim on treatment arising from or traceable to pregnancy: The Insured was operated for 'Obstructed Incisional Hernia'. The Insured had earlier undergone a LSCS operation. The Respondent pleaded that the current operation was a complication which arose out of the previous LSCS Operation and as such the same is not admissible. The Medical Dictionaries also mentions that an Incisional Hernia occurs because a muscle had been weakened by a previous surgical operation. As such, the decision of the Respondent to repudiate the subject Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0148
Mrs. N N Karkera
Vs
New India Assurance Co. Ltd.

Award Dated : 30-10-2006

Repudiation of Mediclaim on the grounds that expenses for treatment of Fibroma is not covered in the First Policy Year: The Complainant was operated for treatment of Myonmectomy in the first year of the inception of the Policy. As per the Medical Dictionary, Myonmectomy stands for surgical removal of Fibroids from Uterus. Since the same is excluded as per Clause 4.3 of the Mediclaim Policy, the decision of the Insurer to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0150
Mr. J S Gandhi
Vs
The New India Assurance Co. Ltd.

Award Dated : 6-11-2006

Repudiation of Mediclaim since the disease was pre-existing: The Insured was suffering from drop in urinary output for which an Operation was done for Ureteric Stenosis for systoscopic ureter with dilation. The Case papers were referred to the Insurer's Medical Referee, who opined that the Disease must have been treated earlier as well. Hence details of medical history were called for. Since, 5 years had elapsed from the date of such earlier treatment, the Complainant could supply only three prescriptions which confirmed that the Insured was operated for Cystoscopy Urethral Dilation in June 2001. The Current Claim was repudiated on the ground that the earlier operation took place within 7 months of commencement of the Policy and as such the disease might have been pre-existing. However, the Respondent did not have any document to support the repudiation. As such, pre-existence could not be established and the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 14-002-0136
Mr. H B Jayswal
Vs

New India Assurance Co. Ltd.

Award Dated : 6-11-2006

Repudiation of Claim due to late submission of Claim documents: As per records, the Claim Form was received by the Insurer after a delay of 174 days from the date of discharge from the Hospital. As per Policy conditions, the relevant documents must be filed with TPA within 30 days from the date of Discharge from the Hospital. However, the Prospectus mentioned that the Claim Form should be submitted within 30 days from the date of completion of Treatment. The Complainant submitted documents to show that he was regularly treated upto 25-1-2006 and that he lodged the Claim on 10-2-2006. Since the two Clauses were inconsistent, the one which favours the Policyholder was applied and the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0140
Mr R H Soni
Vs
New India Assurance Co. Ltd.

Award Dated : 17-11-2006

Repudiation of Mediclaim on the grounds that Hospitalisation was done primarily for diagnostic purposes: The Insured was admitted to a Hospital to rule out Disease. Clinical Summary recorded by the Hospital noted that “all necessary investigations done and diagnosed as ?Tetany? A large number of Investigations like EEG, CT Scan of Brain, 2D Echo, RA Factor test etc. did not lead to any precise diagnosis. A significant portion of the amount claimed by the Insured was for cost for such Investigations. As such, the decision of the Respondent to repudiate the P.A. Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0156
Mr. N A Desai
Vs
United India Insurance Co. Ltd.

Award Dated : 17-11-2006

Repudiation of Mediclaim since the Disease was pre-existing: The Insured was operated for CABG Surgery in 2005 following triple vessel disease with impaired Left Ventricular function. The Mediclaim policy was issued in 1999 with an exclusion for reimbursement of ‘treatment pertaining to consequences and complications of Coronary Artery Disease, Myocardial Infarction, Diabetes Mellitus’. Since the current disease is a complications of the previous illness and the exclusions in the Policy, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0035
Mr. R Rajpara
Vs
National Insurance Company Limited

Award Dated: 17-11-2006

Repudiation of Mediclaim on the ground that the treatment was for Congenital External Disease: The Insured, a four year old child was operated for “inguinal Hernia” which according to the treating Surgeon was noticed for the first time 3 months back. The Respondent Insurer relied on the opinion of the Medical Referee that Inguinal Hernia in a 4 year old child is a Congenital Disorder. But it could not prove Externality. As a result, the decision of the Respondent to repudiate the Claim was set aside and the Complainant was awarded the full claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0183
Sri. N I Gohel
Vs
United India Insurance Co. Ltd.

Award Dated : 17-11-2006

Repudiation of Mediclaim on the ground that the disease was pre-existing: The Insured was hospitalised for ‘Rt. VU Junction stone with obstructive changes, Bil. Multiple small renal stones’ and Flush Therapy was administered. The Respondent submitted that Bilateral multiple Renal Stone cannot develop within 35 days. As such the same must have been existing prior to inception of the Policy. Medical presumption being a generalised opinion cannot be accepted in repudiation of a Claim bonafide of which hospitalisation/expenses are not contested by the Respondent. As such, the Respondent was directed to pay the full Claim

Ahmedabad Ombudsman Centre
Case No. : 11-005-0075
Mr. K V Dari
Vs
Oriental Insurance Co. Ltd.

Award Dated : 17-11-2006

Partial settlement of Claim under Marine Policy: The Complainant’s Boat was on the verge of sinking. He arranged for Four Boats for search and assistance of the Insured Boat. Due to such assistance, the Boat could be restored and persons could be saved. The Complainant maintained that in case 4 boats were not sent for search operations, the impact of Loss could have been much more. The Respondent’s Surveyor in his report had stated that the Insured had failed to show documentary evidence that they had informed the Customs and Port authorities that the 4 Boats were deployed for the search operations. However, the Surveyor had never negated the Claim of the Complainant that 4 Boats were arranged by him for search and assistance. The amount for Sue and Labour was assessed at Rs. 35000/-, which was awarded to the Complainant as full and final settlement of the subject claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0115
Mr. L V Rajyaguru
Vs
New India Assurance Co. Ltd.

Award Dated : 20-11-2006

Partial settlement of Mediclaim: An amount of Rs. 1825/- was deducted while making the payment for treatment of accidental injuries.

- Rs.1500/- towards Doctor's Fees for Home Visits, which the Respondent admitted was payable
- Rs. 225/- towards X-Ray Charges, which the Respondent conceded was payable
- Rs. 100/- towards Ambulance Charges which was not admissible under Mediclaim Policy

As such, the Respondent was directed to pay Rs. 1725/- towards full and final settlement of the subject Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0157
Mr. R H Modi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 20-11-2006

Repudiation of Mediclaim on the grounds that Dental Treatment was not taken in Hospital: The Insured underwent Root Canal Treatment in a Dental Clinic. The relevant Clauses note that reimbursement for Dental Treatment is admissible provided Hospitalisation has taken place, the minimum period of 24 hours is not to be applied here. In the instant case, the treating Dental Surgeon has stated that Hospitalisation was not necessary in the relevant case and was not done. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0169
Mr A D Pandya
Vs
New India Assurance Co. Ltd.

Award Dated : 20-11-2006

Repudiation of Mediclaim on the grounds that Hospitalisation was primarily for diagnostic purposes: The Insured fell down from a staircase, got severe pain with swelling and was not able to put weight on his left leg. On the advice of his consulting Orthopaedist, he was admitted to the Hospital, where he was diagnosed of 'Medial Meniscus tear left knee joint'. The Medical Referee opined that since only POP Slab was given and since injectibles or intravenous drips were not given, the same could have been done on an outpatient basis. However the treating Orthopaedist had noted that the Insured had Medical Meniscus tear post-horn Grade-II due to the fall and since he was in severe pain with swelling and instability, admission to the Hospital was essential. Besides, MRI was advised since the Insured was in severe pain with swelling and instability. Thus while the Respondent relied only on an opinion of its Medical Referee, the treatment was actually done on the advice of a qualified Orthopaedic Surgeon who undertook such medical interventions as were warranted in the case of Accidental Injury. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0147
Mr. D H Prajapati
Vs
New India Assurance Co. Ltd.

Award Dated : 22-11-2006

Partial Repudiation of Mediclaim : The Insured suffered an Accident and was admitted to a Hospital for treatment. An amount of Rs. 15310/- was deducted while settling Mediclaim. It was observed that after the accident, the Insured was admitted to one Hospital, then to another and back to the first Hospital. There was no Certificate from any of the Hospitals for shifting to the next. The Bills included that of a Hospital for a period which overlapped the period spent in another. There was no reasonable explanation as to the anamolous situation. Besides, bills for Medical Expenses incurred after 60 days of discharge from Hospital are not reimbursable as per the Mediclaim Policy. As such, the decision of the Respondent to deduct the said amount was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0174
Mr. H M Modi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 24-11-2006

Repudiation of Mediclaim: The Insured was admitted in a Hospital for 'Pelvic Pain and Dysmenorrhoea'. Investigations diagnosed 'Bilateral Endometristic Ovarian Cyst' for which surgery was conducted to remove the Cyst. Claim was repudiated citing grounds of Hospitalisation for treatment of Sterility and for treatment related to Pregnancy etc. The treatment papers included a History of Infertility 9 years back. But the subject Hospitalisation was not for infertility as was also certified by the Treating Doctor. The Doctor had prescribed Hormonal Drugs for correction of Menstrual Cycle. But the Hospitalisation was for treatment of Dysmenorrhoea. Hence it is not appropriate to consider the same to be associated with treatment for Pregnancy. Since none of the defences were found tenable, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0112
Mrs. B S Dave
Vs
National Insurance Co. Ltd.

Award Dated : 24-11-2006

Repudiation of Mediclaim on the grounds that Policy was taken by suppression of material facts: The Complainant was admitted to a hospital due to pain, swelling over volar side of left wrist, t/n left hand. Treatment was done by analgesic tablets only. On scrutiny of the Treatment papers contained an OPD Prescription of a Hospital which noted that the Complainant was operated for Spondilyosis by Laminectomy on left side which was not informed to the Insurer while proposing for Mediclaim. As such, non disclosure was established which snipes utmost good faith that forms the corner stone of the Insurance contract. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-011-0372
Mr. U K Gupta
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 24-11-2006

Repudiation of Claim under Health Guard Policy since the disease was pre-existing: The Insured was initially having Mediclaim cover from 1992 to 2004 with New India Assurance Co. Ltd. In 2004, the cover was transferred to the Respondent's Company. While proposing for Insurance with the Respondent Company, no previous history of medication/treatment etc were given. The present Claim was for treatment of UTI+Renal Stone. The Treatment papers noted Aortic Valve Replacement in 1996, Surgery for Renal Stone in 1997 and Recurrent UTI since 1½ years. This fact was not informed while proposing for insurance thus making the Claim inadmissible. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0215
Mr. S H Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 30-11-2006

Repudiation of Mediclaim on the grounds that Policy was taken by suppression of material facts: Mediclaim policy incepted with the servicing Office of the Respondent from 2005. Claim was repudiated on the grounds of Suppression of Material facts while taking the Policy. The Documents adduced showed that the Policy incepted from 2003 from a different servicing Office of the same Insurer who had also settled a Claim for the same disease earlier. Thus neither the ground of non-disclosure nor the ground of pre-existence is applicable for repudiating the Claim. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0160
Smt. R K Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30-11-2006

Repudiation of Mediclaim: The Insured delivered a Child in February 2006. She was again admitted in a Hospital in March 2006 for 'Bilateral Post Partum Breast Abscess'. Claim was repudiated citing grounds of Hospitalisation for treatment arising from or traceable to pregnancy, child birth etc. As per the Medical Books, Post-Partum means Post-Delivery. Breast Abscess refers to collection of pus in the mammary gland affecting mostly in post-delivery period when the mother lactates if Mastitis is not treated properly. Mastitis refers to inflammation of breast tissue usually occurring when Bacteria enters the nipple during Breast Feeding. Thus the nexus between Post Partum Abscess and post-child birth physical status of the patient got established. The Mediclaim Policy excludes reimbursement for all treatments arising from or traceable to Pregnancy/Child Birth including Caesarean Section. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-002-0206
Mr. L B Kayastha
Vs
New India Assurance Co. Ltd.

Award Dated : 30-11-2006

Repudiation of Mediclaim on the grounds that Policy was taken by suppression of material facts: The Insured was admitted to a Hospital. Treatment Papers noted history of Myocardial Infarction before 10-15 years and History of Hypertension since 10 years and that the he was on regular medication. The Policy commenced 4 years back. Since the above medical history was not mentioned in the Proposal, the Claim was repudiated on grounds that the Mediclaim Policy was taken be suppression of material facts. The Complainant produced a Certificate of the treating Doctor which indicated that the Insured had an History of Hypertension and IHD since 3 years only. However, since the Patient's History in the Hospital papers are facts not merely for Diagnostic opinion, it got difficult to differ with the decision of the Respondent. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0139
Mrs. P K Madhu
Vs
Oriental Insurance Co. Ltd.

Award Dated : 7-12-2006

Repudiation of Mediclaim since the disease was pre-existing: The Insured was admitted for Osteoarthritis of Left Knee within 15 months of inception of the Policy. The Case papers were referred to the Insurer's Medical Referee, who opined that the Disease takes 2-3 years to aggravate. Hence, the same must have been existing prior to the date of the Policy. The Complainant during Hearing strongly denied that the Insured had Osteorthritis prior to the date of the Policy. Since the Respondent could not produce any other acceptable indisputable evidence to the contrary, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0181
Mr. M D Thaker
Vs
New India Assurance Co. Ltd.

Award Dated : 11-12-2006

Repudiation of Mediclaim since Hospitalisation was not necessary: The Insured suffered a Vehicular Accident for which he was admitted to a Orthopaedic Hospital for 'Acromio Clavicular Dislocation of Lt. Shoulder'. The Respondent repudiated the Claim on the basis that no Anaesthesia was applied and the treatment could have been given on OPD basis. The Complainant submitted that Anaesthesia was not applied looking into the age of the Insured and his Diabetic History. It was not found acceptable that Claim could be denied only on the basis of a reference opinion. As such, the Respondent was directed to settle the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0153
Sri. S P Mahalia
Vs
New India Assurance Co. Ltd.

Award Dated : 11-12-2006

Repudiation of Mediclaim: The Insured was hospitalised for acute onset or Hemiplegia (Right Side) for which he was hospitalised in Dr. Tolia's Hospital from 3-8-2005 to 5-8-

2005. The treating Neuro-Physician noted that the patient has recovered well. After being discharged from Dr. Tolia's Hospital, the Insured was admitted to Suvidha Hospital for which treatment continued till 25-8-2005. The Complainant was denied the expenses incurred by him in Suvidha Hospital which prompted him to file the Complaint. The Respondent pointed out that the Insured has a neurological problem. It is not clear as to why he was admitted in Suvidha Hospital under the care of a General Surgeon. There was no medical advice preceding admission. Besides it was observed that the Complainant had accepted the Claim amount offered on execution of an unqualified execution of a Discharge Voucher in full and final settlement. As such, he is estopped from reopening the issue. As such, the decision of the Respondent to repudiate any further liability was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0028
Mr. C K Shah
Vs
National Insurance Co. Ltd.

Award Dated : 11-12-2006

Partial settlement of Mediclaim: The Amount Claimed was Rs. 3,03,183/-. The subject Policy was for a Sum Insured of Rs. 2,00,000/- + Cumulative Bonus of Rs. 55000/-. The Complainant submitted that the amount of Cumulative Bonus should be Rs. 65000/- In the course of Hearing, the Respondent gave a year-wise presentation of Sum Insured and Cumulative Bonus since 1999. The Respondent admitted to the error in calculation of Cumulative Bonus. As such, the Respondent was directed to pay the balance of Rs. 10000/- towards full and final settlement of the subject Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-011-0209
Mr. N K Patel
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 18-12-2006

Repudiation of Mediclaim: The Insured was admitted to a Hospital for excision of a Tumour in buccal mucosa being a case of Cancer of Gingivo Buccal Mucosa. Claim was repudiated on the grounds of an Exclusion Clause which excluded reimbursement for specific diseases like 'Tumours, Cysts, Nodules of any kind' within the first 2 years of the Policy. Since the Hospitalisation was within this time period, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0126
Sri P M Shah
Vs
National Insurance Co. Ltd.

Award Dated : 20-12-2006

Delay in settlement of Mediclaim: The Insured had not sent a formal intimation for Hospitalisation. On being discharged from the Hospital on 31-12-2006, he submitted his Claim form on 27-1-2006. A query was raised by the Respondent on 22-3-2006 which was complied within a week. The Respondent processed the payment on 13-4-

2006 but issued the Discharge Voucher only on 3-6-2006. The Complainant refused to accept the payment without interest for the delayed settlement. The Respondent admitted during the course of Hearing that they did not have any defence to offer and admitted that the claim could have been settled much earlier. It was also observed that the query raised two months after submission of the Claim form was on some details which was already contained at the back of the Hospital Receipt which was lodged by the Complainant alongwith the Claim forms. There being no contributory default on the part of the Complainant, the Respondent was directed to pay the Claim with interest at 8%.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0173
Mr. A J Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 20-12-2006

Repudiation of Claim under House Holder's Insurance Policy. The Complainant's Washing Machine and Television set were covered under House Holder's Insurance Policy. The loss to the domestic appliances took place due to Voltage Fluctuation as confirmed by the Surveyor. Claim was repudiated on the grounds that the Insured had failed to intimate the change in address of the premises. During the course of Hearing, the Respondent admitted that barring this lapse committed, there were no doubt into the bonafides of the Claimant. In fact there was no unsatisfactory experience with the Customer for the past so many years. As such, the Respondent was directed to pay the loss as assessed by the Surveyor in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0188
Mr. B M. Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 22-12-2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was admitted to a Hospital for treatment of Congestive Cardiac Failure with Atrial Firbrillation. The Mediclaim Policy continued without break from 1992 but there was a break in renewal of the Policy by seven days in 2002. As such, the Insurer took the cover to be incepting from 2002. Since, the Insured underwent CABG, HPT and DM earlier to this date, the Claim was repudiated on the ground that the Disease was pre-existing. It was however observed that while renewing the cover in 2002, a Fresh Proposal along with Annexure was not taken from the insured. The Cumulative Bonus was not reduced to NIL. Even though the Respondent stated that the mistake was committed through an oversight, in the absence of any communication to the Insured in this regard even on the face of Policy Schedule, he is absolutely justified in taking the gap of seven days to have been condoned/waived by the Insurer. In all fairness of things, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0188
Mr. B M Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 22-12-2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was admitted to a Hospital for treatment of Cardiovascular Stroke. The Mediclaim Policy continued without break from 1992 but there was a break in renewal of the Policy by seven days in 2002. As such, the Insurer took the cover to be incepting from 2002. Since, the Insured underwent CABG, HPT and DM earlier to this date, the Claim was repudiated on the ground that the Disease was pre-existing. It was however observed that while renewing the cover in 2002, a Fresh Proposal along with Annexure was not taken from the insured. The Cumulative Bonus was not reduced to NIL. Even though the Respondent stated that the mistake was committed through an oversight, in the absence of any communication to the Insured in this regard even on the face of Policy Schedule, he is absolutely justified in taking the gap of seven days to have been condoned/waived by the Insurer. In all fairness of things, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0158
Mr. B N Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated : 27-12-2006

Repudiation of Mediclaim on the grounds that the Hospitalisation took place within the first 30 days of inception of the Policy : The Insured is a child aged less than 2 years and had a sudden attack of Acute Watery Diarrhoea with Vomiting and Dehydration for which he had to be admitted in a Children Hospital under care of a Neonatologist & Child Specialist. Claim was repudiated on the grounds that the Hospitalisation took place within the first 30 days of inception of the Policy. The said Clause in the Mediclaim Policy however does not apply if in the opinion of the Panel of Medical Practitioners of the Insurer, the existence of the Disease was not known to the Insured at the time of the Policy. The Treating Doctor had noted that the Severe Dehydration led to the admission into the Hospital and that the duration of illness was only 2 days before admission. In the totality of consideration including age of the Insured, type of illness and severity of the same, denial of Claim was not found to be justified. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0191
Mr. D A Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 28-12-2006

Repudiation of Mediclaim since the disease was pre-existing: The Insured was admitted for Coronary Artery Bypass Surgery. The Hospital Discharge Summary noted that the Insured was a known case of Hypertension since 20 years. Thus, the disease was existing prior to the date of the Policy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-002-0045
Mr. B A Madan

Vs

New India Assurance Co. Ltd.

Award Dated : 28-12-2006

Delay in settlement of Mediclaim:

- Claim papers were submitted to the TPA on 22-11-2005.
- Discharge Voucher was issued on 4-1-2006 after 43 days (IRDA regulation provides the Insurer 30 days time)
- The Discharge Voucher was submitted by the Insured on 9-2-2006.
- Cheque dated 7-3-2006 was sent to the Insured on 14-3-2006 i.e. after delay of 36 days (IRDA regulation provides the Insurer 7 days time)
- However, the Complainant contested that the Cheque was not received by him. The Respondent could show the Records of the Courier Service that they had sent the cheque on 14-3-2006. Finally, a duplicate cheque for the identical amount was issued and was received by the Complainant on 18-5-2006.
- The Complainant prayed for interest for delayed settlement of the Claim.

Under such circumstances, the Respondent was directed to pay Simple Interest at 8% for the delay of 32 days in disposal of the Complaint.

Ahmedabad Ombudsman Centre

Case No. : 11-002-0172

Mr. R B Shrimali

Vs

New India Assurance Co. Ltd.

Award Dated : 29-12-2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was admitted to a Hospital for treatment of non-healing ulcer in the Right Buccal Mucosa. Treatment Papers noted history of Tobacco chewing and submucosal fibrosis 10 years back. The Policy commenced 2 years back. The Complainant pleaded that since there was no malignancy in the Ulcer, the Claim should be admitted. However, since the Patient's History in the Hospital papers was prior to the date of the Policy, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre

Case No. : 11-002-0196

Mr. D D Trivedi

Vs

ICICI Lombard General Insurance Co. Ltd.

Award Dated : 29-12-2006

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was operated for "right eye sub-retinal neovascular membrane'. The treatment papers submitted by the Complainant contained Clinical History of High Myopia since the Insured was 10 years old, i.e. much prior to the date of inception of the Policy. The Treating Retino-Vitreous Surgeon had also stated in his certificate that the Insured suffered from the said disease because of myopic changes in retina, thus proving the causal relationship between Myopia and the said disease. The nexus between the intense Myopia existing prior to the inception of the Policy and the Disease suffered being so intimate, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0221
Mr. Y U Nair
Vs
New India Assurance Co. Ltd.

Award Dated : 5-1-2007

Repudiation of Mediclaim since the treatment was not covered under Mediclaim Policy: The Insured was admitted for treatment for Tonsilitis and Bronchitis by undergoing Naturopathy Treatment. The Case papers were referred to the Insurer's Medical Referee, who opined that Naturopathy treatment was not covered under Mediclaim and hence the Claim may be repudiated. However the Policy Document does not exclude any method of treatment. The Respondent during the course of Hearing also could not prove that Ayurvedic Treatment is excluded method of treatment under the Policy. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0370
Mr. N P Mehta
Vs

Ahmedabad Ombudsman Centre
Case No. : 11-002-0221
Mr. Y U Nair
Vs
New India Assurance Co. Ltd.

Award Dated : 5-1-2007

Repudiation of Mediclaim since the treatment was not covered under Mediclaim Policy: The Insured was admitted for treatment for Tonsilitis and Bronchitis by undergoing Naturopathy Treatment. The Case papers were referred to the Insurer's Medical Referee, who opined that Naturopathy treatment was not covered under Mediclaim and hence the Claim may be repudiated. However the Policy Document does not exclude any method of treatment. The Respondent during the course of Hearing also could not prove that Ayurvedic Treatment is excluded method of treatment under the Policy. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0370
Mr. N P Mehta
Vs
United India Insurance Co. Ltd.

Award Dated : 5-1-2007

Partial settlement of Mediclaim: The Claim for Hospitalisation and Treatment to the tune of Rs. 44394/- was already settled by the Insurer through Cashless settlement directly to the Hospital. The dispute was limited to Rs. 14728/- that was not paid to the Complainant, since the Claim forms for pre and post hospitalisation was filled up by the Hospital and not by the Insured himself, which was not proper. During the course of Hearing, both the parties were asked to discuss how much out of the total amount of Rs. 14728/- was payable on scrutiny. On scrutiny both parties agreed that an amount of Rs. 13308/- was payable which was awarded in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0235
Mr. S B Pandya
Vs
New India Assurance Co. Ltd.

Award Dated : 8-1-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was diagnosed as having 'Left Side Chocolate Cyst" for which she underwent Abdominal Hysterectomy. The Mediclaim Policy continued without break from December 2001. Since, the Insured had undergone Laparatomy for "Multiple Large Chocolate Cyst in Left Ovarian" in December 1993 and in October 2001, the Claim was repudiated on the ground that the Disease was pre-existing. The Insured had not disclosed these facts in the Proposal Form too. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0374
Mr. K B Ghael
Vs
New India Assurance Co. Ltd.

Award Dated : 18-1-2007

Delay in settlement of Mediclaim: The Claim was lodged on 23-2-2005. The TPA called for a requirement from the Insured on 18-4-2005, calling therein a letter from the Divisional Manager of the Insurer stating previous Claim Status. The TPA could have obtained the information on their own, rather than make the Insured comply. A discharge Voucher was issued on 10-1-2006 and the Cheque for payment issued on 13-2-2006. The delay reduced by the one month processing time allowed, comes to 9 months and 10 days for which simple interest at 8% p.a. was directed to be paid to the Complainant.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0095
Mr. U S Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 17-1-2007

Repudiation of Mediclaim: The Insured gave birth to a Child. A month later, she had to be admitted to a Hospital for treatment, which included Operation for Left Breast Abscess. Claim was repudiated as the Respondent alleged that the treatment had nexus with Child Birth. A reference to the relevant Clause in the Mediclaim Policy showed that treatments, which arise from or are traceable to Child birth are excluded. Breast Abscess is a post delivery infection in Breast Feeding. With a precedence of delivery only a month back, the subject Disease could be taken to have originated because the Insured was lactating following Child birth. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre

Case No. : 11-002-0058
Smt. J M Bardolia
Vs
New India Assurance Co. Ltd.

Award Dated : 17-1-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured underwent Coronary Angioplasty. The Mediclaim Policy continued without break from 2000. Since the Claim Forms noted previous Medical History for Hypertension for 10 years, which went prior to the date of inception of the cover, the Claim was repudiated on the ground that the Disease was pre-existing. The Insured had also not made the said disclosure in the Proposal Form. The non-disclosure being established, the contract gets vitiated and Claim becomes non-admissible as it snipes Utmost Good Faith which constitutes the corner stone of Insurance Contract. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-002-0064
Mr P C Gandhi
Vs
New India Assurance Co. Ltd.

Award Dated : 18-1-2007

Delay in settlement of Mediclaim: The Insured had executed the “Claim Payment cum Discharge Voucher” for the subject Hospitalisation on 30-1-2006. The Cheque was received by him 3 months later, due to which he urged upon the Forum to allow interest to be paid for the delay in settlement. IRDA Regulations stipulate that the Cheque should be issued within 7 days from the receipt of Discharge Voucher. As such, the Respondent was directed to pay simple interest at 8% p.a. for the delay of 3 months.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0244
Mr. R M Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 19-1-2007

Repudiation of Mediclaim due to late submission of Claim documents: As per records, the Claim Form was received by the Insurer after a delay of 6 months from the date of discharge from the Hospital. As per Policy conditions, the relevant documents must be filed with TPA within 30 days from the date of Discharge from the Hospital. However, the Prospectus mentioned that the Claim Form should be submitted within 30 days from the date of completion of Treatment. The Complainant submitted documents to show that he was regularly treated upto first week of February 2006 and that he had lodged the Claim within 30 days thereafter. Since the two Clauses were inconsistent, the one which favours the Policyholder was applied and the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-008-0248

Mr. A C Mehta
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 22-1-2007

Repudiation of Claim under Health Insurance Policy on the grounds that the disease was pre-existing: The Operating Surgeon noted Unstable Angina developing Myocardia Infarction and Double Vessel Coronary Artery Disease. The Insurer's Medical Referee opined that such a disease could not have developed over a period of the first 11 months from inception of the Policy. Hence the disease is pre-existing. The analysis was done on presumption of symptoms. The Respondent did not have any document to substantiate any pre-existing consultation of the Complainant. At the same time, the Operating Surgeon's Report noted that it was an acute ailment, not a complication of any pre-existing disease. The 'acute' in medical parlance is opposite to 'chronic', which is one more confirmation against pre-existence of the disease. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0193
Mr. K Ruparelia
Vs
United India Insurance Co. Ltd.

Award Dated : 23-1-2007

Repudiation of Mediclaim on the grounds of misstatements in the Proposal Form: The Insured while taking the Policy had not disclosed the fact that she had been operated for Cancer of Left Breast. The Complainant argued that she had six cycles of Chemotherapy along with Radiotherapy after which she was found to have been Clinically Disease free 8 years back. The history of Cancer is indisputable. It is also on record that the Insured was on regular follow-up on a medication in subsequent years. On her complaining about Left Hip Pain, the Cancer Institute decided 'second line of Chemotherapy and palliative Radiotherapy to involved bones as it was detected that she was having multiple bones metastasis. Misstatement in this regard sniped Utmost Good Faith which forms the cornerstone of Insurance Contract. As such, the decision of the Respondent to repudiate the Claim was upheld

Ahmedabad Ombudsman Centre
Case No. : 11-002-0179
Smt. K V Kothari
Vs
New India Assurance Co. Ltd.

Award Dated : 23-1-2007

Repudiation of Mediclaim since the disease was pre-existing: The Insured was hospitalised for Post-Hysterectomy Left Ureteric Stricture. The Complainant during the course of Hearing informed that the Insurer had paid the Claim for Hysterectomy 2 years back and that she had a history of Urethral Dilation 8 years ago. The Respondent stated that the History of Urethral Dilation being present, the Claim for the subject disease is not admissible.

- History : Urethral Dilation of Urethral Stricture

- Diagnosis of current disease : Left Ureteric Stricture.

Two tow terms medically refer to two different aspects. Urethra is the tube for passage of Urine from Bladder to exit point while Ureter is the tube that carries Urine from Kidney to Bladder. The disease in the present case seemingly did not coincide with the pre-existing one. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0220
Mr. A A Mehta
Vs
United India Insurance Co. Ltd.

Award Dated : 29-1-2007

Repudiation of Mediclaim since the disease was pre-existing: The Insured was hospitalised for Retrocalcaneal Bursitis. The treating Surgeon in his report has stated that the Insured had a history of forced planter flexion injury before 1½ years. The Policy having incepted later, due to break in cover due to delay in renewal, the pre-existence of the disease got proved. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0253
Mr. V U Amin
Vs
New India Assurance Co. Ltd.

Award Dated : 31-1-2007

Repudiation of Mediclaim since the disease was excluded from the scope of Mediclaim Cover: The Insured was admitted for removal of Ovarian Cyst and Uterus one year and four months after applying for the Mediclaim Cover. The Policy Conditions exclude the treatment expenses for Congenital Internal Disease/Defect within the first two years. The Medical Referee of the Respondent opined that the case was of Dermoid Cyst of Ovary and hence a Congenital Internal Disease. Since, the hospitalisation was done prior to this period, as per Policy Condition Mediclaim was repudiated. During the Course of Hearing, the Complainant referred to Literature on the subject provided to him by his treating Doctor, which clearly stated that Dermoid Cyst arise in patient between ages 20 and 30 and hence are not necessarily a Congenital Internal Disease. The Treating Doctor too in her report had stated that the Cyst was an accidental finding, which led to investigation and then surgery to rule out any possibility of Ovarian Cancer. As such, repudiation was set aside and the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0192
Mr. A A Patel
Vs
United India Insurance Co. Ltd.

Award Dated : 31-1-2007

Repudiation of Mediclaim since the disease was pre-existing: The Insured was hospitalised for Sub-Acute Intestinal Obstruction and was operated for Adhesiolysis and was administered Laprascopic release of the Intestinal Obstruction. The discharge summary of the Hospital ascribed that the Intestinal Obstruction had occurred due to inflammatory band and Adhesion. The Case history also noted that the Insured had previously undergone LSCS Surgery. The Respondent had referred the Claim papers to its Medical Referee who certified that the Intestinal obstruction was due to Adhesions following the previous LSCS Operation. Thus the nexus being proved, it got settled that the current treatment had a definite nexus with the history of the LSCS, which had occurred prior to the date of inception of the Mediclaim Policy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0280
Mr. S M Shah
Vs
National Insurance Co. Ltd.

Award Dated : 7-2-2007

Repudiation of Mediclaim on the grounds that hospitalisation period was less than 24 hours : The Insured was operated in a Hospital and was discharged within 22 hours. The Complainant agreed that the Operation was not so heavy that compulsory stay at hospital was necessary and hence, patient was relieved early. During the course of Hearing, the Complainant argued that Treatment is more important than duration of Hospitalisation and hence Claim should be paid. The Repudiation having been done by applying an explicit Clause of the Policy and it being an established principle of Law that where the provisions in wording is clear, no interpretative intervention is proper. As such, the decision of the Complainant to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0195
Mr. B R Sayani
Vs
New India Assurance Co. Ltd.

Award Dated : 7-2-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured experienced sudden chest pain. Coronary Angiography led to hospitalisation for Coronary Angioplasty with stenting of the LAD lesion. The Insurer's Medical Referee opined that such a disease could not have developed over a period of the first 10 months from inception of the Policy. Hence the disease is pre-existing. The analysis was done on presumption of symptoms. The Respondent did not have any document to substantiate any pre-existing consultation of the Complainant. At the same time, the Operating Surgeon's Report noted that it had an acute onset. As such, the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0210
Dr. P N Zaveri
Vs

New India Assurance Co. Ltd.

Award Dated: 6-2-2007

Repudiation of Mediclaim on the grounds that the Hospital did not have 15 in-patient beds: The Insured was admitted to a Hospital which had 9 in-patient beds. Claim was repudiated on the ground that the Hospital did not have 15 in-patient beds. The Insured insisted that there were 16 beds in the Hospital. He produced a number of certificates too to confirm the position. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0204
Sri. J M Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 6-2-2007

Repudiation of Mediclaim on the grounds that the Hospital did not have 15 in-patient beds: Claim was repudiated on the ground that the Hospital where the Insured was admitted did not have 15 in-patient beds. The Respondent submitted that since the Hospital was not registered and since it did not have the minimum of 15 in-patient beds, it did not qualify as a Service Provider under Mediclaim Policy and hence Claim is not admissible. The Complainant submitted a declaration from the treating Physician who pointed out that he owns 2 Hospitals in the same centre and the total number of beds taken together exceeds 15. The Respondent pointed out that it had filed a Written Statement in response to a Civil Suit filed by the same Physician in the Hon'ble Civil Court in respect of a different complaint on the same critical issue of aggregation of number of beds to qualify for the definition under Mediclaim Policy. As such, it was not considered appropriate to pronounce an Award in favour of either party since the only decisive aspect of the case would be adjudged by the Civil Suit. The Complainant is however free, if he so decides, to take up the matter against the Respondent to any Forum that may be considered appropriate.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0217
Mr. S K Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 12-2-2007

Repudiation of Mediclaim since Hospitalisation was not found to be justified. The Insured was hospitalised for complaints of 'Giddiness' for a day's investigation. Since, as per the conditions of Mediclaim Policy, charges incurred primarily for investigative examinations are specifically excluded, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0245
Mrs. R K Anklesaria
Vs
Oriental Insurance Co. Ltd.

Award Dated : 13-2-2007

Repudiation of Mediclaim: The Insured was operated for Total Knee Replacement. Claim was repudiated since the operation took place in the first year of the Good Health Policy. As per the Policy conditions, Claim for TKR is not payable if the operation takes place in the first two years of the Policy. This condition however does not apply if the Insured person is covered for an Individual Mediclaim Policy or a Group Mediclaim Policy with Oriental Insurance Co. Ltd. for a continuous period of the immediately preceding 24 months without any break. The Complainant was earlier covered with United India Insurance Co. Ltd. and hence is not eligible for the relaxation. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 21-001-0250
Mr. V T Parekh
Vs
New India Assurance Co. Ltd.

Award Dated : 13-2-2007

Partial Repudiation of Mediclaim. The Complainant was hospitalised for fracture which took place within the Policy period. Claim was admitted by the Insurer but an amount of Rs. 4742/- was deducted on specific items, which led to lodgement of the Complaint. On detailed discussions during the course of Hearing in which both the parties expressed their views and agreed that an amount of Rs. 2150/- could still be paid which the Respondent was directed to pay in full and final disposal of the Complaint.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0236
Ms. C L Ratanpara
Vs
National Insurance Co. Ltd.

Award Dated : 13-2-2007

Repudiation of Mediclaim on the ground that the operation was done for cosmetic purposes. The Insured had high chronic Myopia for which Lasik Laser Surgery was done on the advice of the Opthalmologist. The Insurer asked for duration of illness and past history of treatment which was not complied with by the Insured. The attending Doctors too noted Duration of the disease as ‘non known’. It is not unreasonable to visualise a situation wherein Myopia was detected and on the same day Surgery was undertaken to obviate the necessity of using Spectacles. So it is not unreasonable for the Insurer to ask for compliance in this regard. Although, the opinion of the Medical Referee of the Insurer do not categorically indicate that the subject surgery was necessarily cosmetic, non compliance of the basic data by the Complainant imparted reasonableness to the decision of the Respondent in this regard. As such, Repudation of the subject Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 14-002-0230
Mr S K Thakor
Vs
New India Assurance Co. Ltd.

Award Dated : 13-2-2007

Repudiation of Mediclaim: The Insured fell sick with acute 'Lt sided Chest Pain' requiring Hospitalisation. Several inconsistencies were found in the papers submitted viz. ECG was done well after 2 hours of admission, that too for severe Chest Pain. There is no record for advice for admission to ICCU. Even Echo-cardiography was done after a gap of 5 days. However this is not a sufficient reason to repudiate the Claim. As such, the Respondent was directed to pay the Claim amount after recovering the amounts for medicines taken for a period beyond the duration of post-hospitalisation period as per Policy Conditions.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0200
Mr. N K Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 12-2-2007

Partial Repudiation of Mediclaim. The Complainant underwent treatment of Pyrexia of Unknown origin with convulsions. The Respondent settled the same for Rs. 30000/-. The Insured pleaded for payment of the balance of Rs. 18231/-. It was observed from the records that the Policy commenced in 2004-2005 with a coverage of Rs. 30000/-. Its Sum Insured was increased to Rs. 50000/-in 2005-2006. The Complainant had preferred a Claim for the same disease in 2004-05, which was settled by the Insurer. The Respondent treated the current ailment to have been pre-existing and hence agreed to settle the Claim for Original Sum Insured of Rs. 30000/-. As per the Policy Conditions, whenever the Sum Insured was enhanced, the existing coverage gets renewed without any condition. However, the enhanced part of the Risk is notionally taken to be a new contract. As such, diseases pre-existing are to be excluded from the benefit of additional Sum Insured. As such, the decision of the Respondent to settle the Claim on the existing Sum Insured of Rs. 30000/- was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0246
Mr. B K Patel
Vs
National Insurance Co. Ltd.

Award Dated : 15-2-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured as operated for Choledocho-Duodenostomy required due to Large CBD Stone. Medical papers ere made available to state that the Insured was operated for Cholecystectomy 12 years back. The date of the disease counted back well prior to the inception of the Policy. Hence the disease is pre-existing since the current operation had a direct nexus with the disease 12 years back. The Insured had also not disclosed the history of the operation while filling up the Proposal Form for Mediclaim. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-003-0214
Ms. L S Shah

Vs

National Insurance Co. Ltd.

Award Dated : 15-2-2007

Repudiation of Mediclaim since Hospitalisation was not found to be justified. The Insured was operated for Stenosing Tenosynovites of Lt. Thumb. Since, the operation was done on the expert advice of an Orthopaedist and since an operation was actually done, the decision of the Respondent to repudiate the Claim on the ground that Hospitalisation was done primarily for investigative purposes was set aside and the Complainant was awarded the full claim amount.

Ahmedabad Ombudsman Centre

Case No. : 11-005-0284

Mr. D R Mehta

Vs

Oriental Insurance Co. Ltd.

Award Dated : 28-2-2007

Repudiation of Mediclaim due to late submission of Claim: From the records, it was observed that the Claim form was lodged by the Complainant after more than five months from the date of discharge from the Hospital. Claim was repudiated since the Claim forms were submitted beyond one month from the date of discharge. Since the important Policy condition was breached by a wide margin with no satisfactory explanation for the delay, the decision of the Respondent to Repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre

Case No. : 11-003-0177

Mrs. S G Patel

Vs

National Insurance Co. Ltd.

Award Dated : 28-2-2007

Repudiation of Mediclaim since the Policy excludes benefit of any disease contracted during the first 30 days of the Policy: The Mediclaim Policy incepted from December 2001 and continued without break till Dec 2003. Then there was a break in renewal by 5 days and the Policy was subsequently taken without any Cumulative Bonus etc. as a fresh coverage. Since, the Hospitalisation took place within 30 days of such Fresh Policy, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre

Case No. : 14-004-0154

Mr. M L Desai

Vs

United India Insurance Co. Ltd.

Award Dated : 6-3-2007

Repudiation of Mediclaim:: The Insured had severe abdominal pain requiring hospitalisation. Several queries were called for, by the Insurer from the Insured including copy of Indoor treatment record etc. The Hospital Discharge Summary noted that the patient had been operated for right renal cyst 3 years back. The Policy commenced prior to the date of the operation. Even in the course of Hearing, the Respondent couldn’t convincingly justify the reason for such queries without deciding

about the Case on the basis of the materials available. The file was closed a year later due to non compliance, which itself is deficiency of service. As such, the repudiation was set aside and the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0213
Mr. V A Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 6-3-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for 'Rt. Foot Cellulitis with non healing Ulcer'. The Discharge Summary of the Hospital noted that the Patient was a known case of Ischaemic Heart Disease, Myocardial Infarction and Diabetes since 10 years. The Policy commenced 9 years prior to the date of Hospitalisation. It is observed that Cellulitis is a bacterial infection of the Skin and the Tissues beneath it commonly observed to affect legs. Ulcer on the feet is one of the complications of DM. Hence the nexus with the disease which commenced prior to the date of the Policy and the current illness having been proved, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0313
Mr. P P Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 9-3-2007

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified. It was observed from the records that the Insured, a practicing Chartered Accountant observed severe back pain prompting him to be Hospitalised on the advice of an Orthopaedist. The Insurer repudiated liability on the basis of the opinion of their Medical Referee who opined that Hospitalisation was not justified since Orthocare and Physiotherapy could have been administered on an OPD basis. However, since the Insured had sought to avoid Hospitalisation by consulting a number of Doctors and undergoing investigative tests prior to his admission and since the subject Hospitalisation was done on actual examination of the patient by a qualified Specialist, the decision of the Insurer to repudiate the claim was set aside and they were directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0309
Mr. A H Padaria
Vs
New India Assurance Co. Ltd.

Award Dated : 12-3-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for Uncontrolled Hypertension with severe Tyroidism. The Complainant produced a Certificate of the treating Doctor, which noted that the Insured was suffering from Hypertension since 2 years. He also produced a Discharge

Summary of the Hospital also noted that the Patient was a known case of Hypertension for 2 years. The Respondent produced copies of Indoor Case papers of the Hospital which noted the past history of HT as 25 years. It also produced a Discharge Summary of the same hospital which noted history of HT of 10 years. The stand taken by the two parties rested mainly on Documents which contradict each other. The integrity of the Insurer cannot be doubted either. As such, the decision of the Respondent to repudiate the Claim was upheld. The Complainant is however free to take up his grievance to any other appropriate Forum for resolution of the Grievance.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0306
Mr. A S Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 14-3-2007

Partial settlement of Mediclaim. While settling the Mediclaim, the Respondent had deducted Rs. 15816/- towards treatment charges, since the Respondent felt that the same was unreasonable as per the package of Fees as agreed by Hospitals. It was observed that such practice has not been called for by the Corporate Office neither did the Prospectus or Policy Schedule contain any such information. The Charges of the same treatment vary from Hospital to Hospital. Such deductions were being done by one TPA of the Insurer. Besides, the Insured is free to get treatment from a Hospital of his choice. As such, the Respondent was directed to pay Rs. 15816/- recovered in the above case.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0286
Mrs. T C Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 15-3-2007

Repudiation of Mediclaim: The Insured had complaints of Chronic Backache and Chronic Shoulder pain along with drooping of shoulders. The treating Orthopaedist recommended for a Breast Reduction Surgery so that spine problems do not occur in future. The operation was done by a Plastic Surgeon. Claim was repudiated since the Plastic Surgery of the type administered on the Insured was excluded from the benefits of Mediclaim. The relevant Mediclaim clause excludes payment for Plastic Surgery other than as may be necessitated due to an accident or as a part of illness. Since, the operation was done as a part of an illness duly certified by more than one Surgeon, Repudiation was set aside and the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0266
Mr. B R Kedia
Vs
New India Assurance Co. Ltd.

Award Dated : 15-3-2007

Partial settlement of Mediclaim: The Insured was hospitalised for treatment of 'Brain Infarction'. Claim was settled on receipt of an unqualified Discharge Voucher from the Complainant in full and final settlement of the Claim. The deductions were effected for 'Post Hospitalisation expenses exceeding 60 days and SC/NC Charges. Hence as per precedents in law the Complainant was estopped from reopening the issue and the Complaint was dismissed without any relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0267
Mr. B R Kedia
Vs
New India Assurance Co. Ltd.

Award Dated : 15-3-2007

Partial Repudiation of Mediclaim. The Insured was hospitalised for 'Vaginal Hysterectomy'. The Insured did not execute the Discharge Voucher since the same offered settlement of the Claim for a much lesser amount. An amount of Rs. 6500/- was deducted for Room Charges and Rs. 2230/- towards Medicine and Investigations. The Respondent confirmed the deductions having been done on the grounds like excessive charges by the Hospital. However since no question had been raised about bonafide of the payment made by the Insured to the Hospital, the Respondent is under obligation to make full payment of the Claim under the circumstances when Claim is otherwise admitted. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0268
Mr. B R Kedia
Vs
New India Assurance Co. Ltd.

Award Dated : 15-3-2007

Partial Repudiation of Mediclaim. The Insured was hospitalised for 'Vaginal Hysterectomy'. The Insured did not execute the Discharge Voucher since the same offered settlement of the Claim for a much lesser amount. An amount of Rs. 6500/- was deducted for Room Charges and Rs. 2230/- towards Medicine and Investigations. The Respondent confirmed the deductions having been done on the grounds like excessive charges by the Hospital. However since no question had been raised about bonafide of the payment made by the Insured to the Hospital, the Respondent is under obligation to make full payment of the Claim under the circumstances when Claim is otherwise admitted. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0300
Mrs. J V Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 21-3-2007

Repudiation of Mediclaim since the disease was pre-existing. The Insured, a child of 3 years age was hospitalised due to High Fever and Convulsions. The Discharge Summary of the Hospital noted history of 'Clinical Epilepsy with history of

Convulsions'. The Record Sheets also noted that the child was pre term born and had to be then kept in a Neonatal ICU for 15 days with episodes of convulsions. There were several episodes of convulsions then onwards. Thus it gets established that the Child suffered from recurrent attacks. The Mediclaim coverage commenced only 5 months prior to the date of Hospitalisation. As such, the decision of the Respondent to repudiate the Claim since the disease pre-existed at the inception of the cover was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0207
Mr. J M Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 21-3-2007

Partial settlement of Mediclaim. The Insured was hospitalised for Pulmonary Lungs Fibrosis. While settling the Claim, the amount paid towards cost of purchasing 'Oxygen Instrument' and 'Glucometer Strips' was disallowed. Credible sources state that the said disease is incurable. Only its progress can be slowed down. As the sickness is basically inability of a person to draw Oxygen while breathing, domiciliary provisions of Oxygen through different means is considered in such cases as 'Life Saving Medication'. As such it is not fair to deny reimbursement of the said cost. As such, the Respondent was directed to pay the amount deducted as above.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0265
Mr. J M Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 21-3-2007

Partial settlement of Mediclaim. The Insured was hospitalised for Pulmonary Lungs Fibrosis. While settling the Claim, the amount paid towards cost of purchasing 'Oxygen Therapy Machine'. Credible sources state that the said disease is incurable. Only its progress can be slowed down. It was found that the American Lung Association recommends Oxygen Therapy by 'Oxygen Concentrator'. The device concentrates the Oxygen in the Air so that the Patient can be given supplemental oxygen intake to enable 'slow disease progression'. The device thus takes the form of a 'Life Saving Medication'. As such it is not fair to deny reimbursement of the said cost. As such, the Respondent was directed to pay the amount deducted as above.

Ahmedabad Ombudsman Centre
Case No. : 11-005-0316
Mr. I A Vakil
Vs
Oriental Insurance Co. Ltd.

Award Dated : 22-3-2007

Repudiation of Mediclaim: The Insured was a Shareholder of Millenium Insurance Services Ltd. The subject Mediclaim Cover was a tailor made Group Insurance Scheme. As per the agreement of the Company with the Insurer, the Company would

collect the Proposal Form from individual Shareholders, prepare a Statement with full details and the Insurer would issue the Cover from the date as indicated by the Company to the Insurer. In the instant case, the premiums were paid by the Company to the Insurer on 5-1-2005 and the Risk Date was entered as 6-1-2005 in the abovementioned statement. Corresponding to this, the Insurer issued a Policy with period 6-1-05 to 5-1-06. The first Hospitalisation for 'Sigmoid Colon Diverticulitis' took place from 20-12-2004 to 28-12-2004 thus obviously prior to the inception of Mediclaim Cover and as such correctly repudiated. The second Hospitalisation was from 28-1-05 to 3-2-05 for 'Harman's Closure of Colostomy'. Even though, the second episode of Hospitalisation is within the covered period, it attracts Exclusion Clause 4.1 which deals with Pre-existing diseases since the second Hospitalisation was a direct consequence of the first operation. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0326
Sri S M Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 22-3-2007

Repudiation of Mediclaim since Hospitalisation done for diagnostic purposes. It was observed that the Complainant was Hospitalised on the advice of a Cardiologist for Investigations as to 'Cause of Leg Pain/Cramps'. From the Discharge Summary of the Hospital, it was seen that apart from several types of Diagnostic Investigations, only 5 types of Tablets were administered to the Insured. A review of the total Claim submitted also brought out that the treatment cost perse (Medicine etc.) were marginal. It seemed that the Hospitalisation was done primarily for Diagnostic purposes. As such, the Claim attracts Exclusion Clause and hence Repudiation is upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0311
Mr. R S Sharma
Vs
New India Assurance Co. Ltd.

Award Dated : 26-3-2007

Repudiation of Mediclaim on the grounds of pre-existing disease and non-disclosure of material facts. The Complainant was admitted to a Hospital for treatment of Rapidly progressive Glomerulo nephritis with renal failure. The disease was not an acute infection but a sequel of the patient's past health history which included Hypertension. The disease occurred in the first year of the Mediclaim coverage. The Clinical notes of the treating Doctor noted past history of Pregnancy induced hypertension. It further recorded that the treatment continued for years. The Insured had not declared this illness in the Proposal form. As such, it sniped at utmost good faith, that forms the corner stone of Insurance Contract. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-002-0056
Mr. K K Sancheti
Vs
New India Assurance Co. Ltd.

Award Dated : 26-3-2007

Partial settlement of Mediclaim: While settling the Mediclaim, the Respondent had deducted Rs. 13890/- Claim was settled on receipt of an unqualified Discharge Voucher from the Complainant in full and final settlement of the Claim. Hence as per precedents in law the Complainant was estopped from reopening the issue and the Complaint was dismissed without any relief to the Complainant

Ahmedabad Ombudsman Centre
Case No. : 11-002-0319
Mr. R R Jhunjhunwala
Vs
New India Assurance Co. Ltd.

Award Dated : 28-3-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was operated for 'Incisional Hernia'. The Discharge Summary of the Hospital noted that the Patient had a past history of Caesarian Section and Cholcystectomy operation 7 years back. The Policy commenced 5 years prior to the date of Hospitalisation. Incisional Hernia is one in which the intestine bulges through a scarred area of the abdominal wall because the muscle has been weakened by a previous surgical incision. The Discharge Summary of the Hospital had also noted that there was a scar of Cholecystectomy with a swelling of size 5 X 3 cms and that the hernia needs to be repaired. Hence the nexus with the disease which commenced prior to the date of the Policy and the current illness having been proved, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-004-0278
Mr. K N Surati
Vs
United India Insurance Co. Ltd.

Award Dated : 29-3-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for haemiparesis. The Discharge Summary of the Hospital noted that the Patient had a past history of Diabetes since 2 years and Hypertension since 7 years. The Policy commenced 5 years prior to the date of Hospitalisation. The subject illness has a direct nexus with hypertension. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. : 11-014-0224
Mr. G D Agrawal
Vs
Cholamandalam MS General Insurance Co. Ltd

Award Dated : 30-3-2007

Repudiation of Claim due to late submission of Claim documents: As per records the Insured was discharged from the Hospital on 23-11-2005. The Claim Form was received by the Insurer on 28-1-2006 i.e. after a delay of over 65 days. As per Policy

conditions, the relevant documents must be filed with TPA within 30 days from the date of completion of treatment, which in the instant case is 13-12-2005. The Complainant pleaded that family circumstances and some social reasons kept him busy. The Respondent found that the reasons were vague and unspecific and as such not enough to waive the delay. Since, there is no deficiency in service and since violation of Policy provisions got established, the decision of the Respondent to repudiate the Claim was upheld.

Bhopal Ombudsman Centre
Case No. : GI/UII/0906/057
Mrs. Hemlata Kulshrestha
V/s
United India Insurance Co. Ltd.

Award Dated : 17.10.2006

As per the Complainant (Mrs. Hemlata Kulshrestha) she had taken the Medi Claim Insurance policy No. 191100/48/04/00501 w.e.f.17.03.2005 to 16.03.2006 & the same was renewed vide policy No. 191100/48/05/00529 w.e.f.17.03.2006 to 16.03.2007 from the Respondent. She took the treatment in Apollo Hospital New Delhi for multiple Papilloma Nose/oral Cavities & incurred expenses for Rs. 74791/- for which she submitted the claim with M/S Medi Save Health Care, Bhopal the TPA of the Respondent. TPA rejected her claim and thereafter she represented to the Respondent's Regional Office who also rejected her claim.

The Respondent in its reply-dated 21.09.2006 had given the complete details of the case and has informed that they had reputed the claim under exclusion clause 4.1 of the policy (the disease is pre-existing i.e. prior to the inception of the policy) and on the following grounds: -

1. The Complainant was hospitalized in March 2006 twice on 01.03.2006 and from 21.03.2006 to 24.03.2006 for the complaints of Breathlessness, snoring hyper somnolence, hypertension, Multiple Papilloma in upper airway (nasal passage & oropharynx) muscle contraction, headache, late onset asthma with obstructive spirometry.
2. The Complainant is a known case of Hypertension and has been on medication since last 5 years.
3. The Complainant was operated at 5 years of age at Bhopal in 1961 for Papilloma of Oropharynx, nasal Cavity, multiple surgeries done at the age of 25 years.
4. Policy was taken for the first time in the year 2005 w.e.f. 17.03.2005 which was again renewed on 17.03.2006 for one year. The disease for which the treatment was received was already in existence at the time of taking the first policy and therefore will remain exclusion in the subsequent renewals also.
5. The case has been repudiated by their TPA M/S Medi Save Health Care, Bhopal as all pre-existing diseases are excluded vide exclusion clause 4.1 of the policy.

It is observed that the Complainant took the medi claim policy for the first time on 17.03.2005 while she was suffering from the said disease for quite a long time as is evident from the discharge card of the Indraprastha Apollo Hospital Delhi dated 01.03.2006 & 24.03.2006 and from the prescription of the Indraprastha Apollo Hospital Delhi dated 28.02.2006. Hence the claim falls under policy exclusion clause 4.1 which state as "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/NIC/0806/049
Mr. C.V.Velappan
V/s
National Insurance Co. Ltd.

Award Dated 08.11.2006

Mr. C. V. Velappan (hereinafter called Complainant) informed that he had taken Medi Claim Insurance Policy through M/S Golden Multi Services Club under Certificate No. 02/0121540 from National Insurance Co. Ltd., Kolkata (hereinafter called Respondent) under policy No. 100300/46/01/8500107/04/85/30004.As per the Complainant he met with an accident on 23.12.2004 and had fracture in his leg and hospitalized in Bhilai Nursing Home from 23.12.2004 to 25.12.2004 where Dr. Rajendra Pandey treated him and he recovered on 23.03.2005. The Complainant further submitted that he submitted his claim bill to M/S Golden Multi Services Club, but he did not get any response from the Respondent.

The complaint was registered on 17.08.2006 but Respondent has not replied in-spite of our writing letters on 17.08.2006, 05.09.2006, 18.09.2006 & 12.10.2006.For the sake of natural justice hearing was held on 07.11.2006 at Bhopal. The Complainant was present in person and the Respondent was absent despite sending notice on 12.10.2006 through letter as well as by fax which was received by them in time.

During the hearing the Complainant informed that he met with an accident on 23.12.2004 and had fracture in his leg and hospitalized in Bhilai Nursing Home from 23.12.2004 to 25.12.2004 where Dr. Rajendra Pandey treated him and he recovered on 23.03.2005. The Complainant further submitted that he submitted his claim bill to the Respondent through M/S Golden Multi Services Club on 16.03.2005 but the Respondent did not settled his claim. Complainant also contended that the Respondent had never demanded any additional documents from him for settlement of his claim.

It is observed that in this case the Respondent neither bothered to send us the reply nor have attending the hearing. Besides Respondent's Head Office, Chief Manager vide their letter No. HO:CSD:CRO-1:05-06:01:594 dated 19.01.2006 wrote a letter to the Complainant that they are referring the matter to the concerned Regional Office to take appropriate action, but till date no action appears to have been taken by them. In view of the same we have no other alternative but to believe contentions of the Complainant & to decide the case on merit and as per the document submitted by the Complainant. As per the attending doctor the Complainant met with an accident on 23.12.2004 and was hospitalized from 23.12.2004 to 25.12.2004. The Complainant incurred total expenses of Rs. 7971/- (Hospital bill of M/S Bhilai Nursing Home of Rs. 7075/- plus medicines for Rs.596/- & doctor's fee for Rs. 300/-) which is evident from the photocopies of the hospital bills and cash memos submitted by the Complainant.

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent not to settle the claim by the Respondent is unfair and

unjust. Respondent is directed to pay the claim amount of Rs. 7.971/- along with simple interest @ 6% w.e.f. 16.04.2005 (after 30 days from the date of submission of claim papers to the Respondent's on 16.03.2005) to the Complainant. The Respondent is also directed to pay the award amount with interest as mentioned above within 15 days from the receipt of the consent from the Complainant, failing which the Respondent shall be liable to pay the amount of award with additional interest @1% p.a. from the date of this order to the date of actual payment.

Bhopal Ombudsman Centre
Case No. : GI/UII/1005/066
Mr. Manoj Agarwal
V/s
United India Insurance Co. Ltd.

Award Dated 09.11.2006

Mr. Manoj Agarwal (hereinafter called Complainant) informed that he had obtained Medi Guard Insurance (Health plus Medical expenses) Policy No. 193000/48/05/00001263 from United India Insurance Co. Ltd., Indore (hereinafter called Respondent). As per the Complainant he had taken the Medi Guard Insurance (Health Plus Medical Expenses) policy no. 193000/48/05/00001263 w.e.f. 27.02.2006 to 26.02.2006. On 15.04.2006 his wife had fallen sick due to pain in chest and consulted Dr. Om Gupta but could not get relief and again consulted the same doctor who advised to go to specialist Dr. Dheeraj Gada. Accordingly the Complainant consulted the specialist doctor on 20.04.2006 who advised for an operation for removing the tumor as early as possible otherwise problem will increase and as such the operation was performed on 25.04.2006 for removing for the tumor and send the same to the pathology for Mammography test. During the test it was revealed that it is a Brest Cancer. Doctor advised for immediate operation otherwise the Cancer would be spread. Complainant also stated that, in view of the same, he took loan after pledging his mother's flat and arranged for the operation on 02.05.2006 at M/S Gokul Das Hospital where she was admitted from 01.05.2006 to 10.05.2006 and incurred 93,188/-. The Complainant submitted the entire claim papers to the Respondent, but the Respondent repudiated his claim. Since the Respondent had repudiated his claim, hence he has approached this office.

The Respondent in its reply-dated 13.10.2006 had given the complete details of the case and has informed that they had reputed the claim under clause 4.2 of the policy and on the following grounds: -

1. The policy is a fresh one and the risk is commencing from 27.02.2006 covering the wife of the Complainant Mrs. Naini Agarwal for Sum Insured of Rs.1,00,000/-.
2. Mrs. Naini Agarwal was hospitalized in Dr. Gada's hospital, Indore from 25.04.2006 to 27.04.2006 where a lump was detected by the doctor. The discharge card shows that lump was there since one month. Later on the cancer was diagnosed in lump.
3. A medical opinion was obtained from Dr. Dilip Kumar Achary who also corroborates that the lump was deducted during the first 30 days of the policy.
4. In view of the available medical papers and medical opinion it is established that the disease cancer was deducted during the first 30 days of the policy. Under the circumstances, according to the policy condition No. 4.2 the claim falls outside of the scope of the policy, hence the claim is liable to be repudiated.
5. A letter No. 549 dated 27.07.2006 has been issued to the Complainant, explaining there under the reasons for making subject claim as NO CLAIM.

It is observed from the discharge card dated 25.04.2006 submitted by the Complainant that the patient had breast lump for one month i.e the patient was suffering from this disease since 25.03.2006 while the Complainant took the policy for the first time w.e.f. 27.02.2006. Hence the claim falls under the policy exclusion clause 4.2 which states "policy excludes any disease other than those stated in clause 4.3 contracted by the insured person during the first 30 days from the commencement of the 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.

Bhopal Ombudsman Centre
Case No. : GI/UII/0906/058
Mr. S. K. Sharma
V/s
United India Insurance Co. Ltd.

Award Dated : 28.11.2006

Mr. S. K. Sharma (hereinafter called Complainant) informed that he had obtained Medi Claim Insurance Policy No. 190900/48/04/01228 from United India Insurance Co. Ltd., Jabalpur (hereinafter called Respondent). As per the Complainant he had taken the Medi Claim Insurance Policy No. 190900/48/04/01228 w.e.f. 24.11.2004 to 23.11.2005. He went to his son's house at Noida and fell sick and was hospitalized in M/S Metro Hospital & Research Centre Noida from 29.08.2005 to 30.08.2005 and intimated to the Respondent's TPA M/S Family Health Plan, Hyderabad and asked for cash less facility which was turned down by the Respondent's TPA. Complainant also stated that he incurred expenses for Rs. 7000/- & submitted the claim bill to the respondent at Jabalpur but till date his claim is not approved. Since the Respondent had not settled his claim, hence he has approached this office.

The Respondent in its reply-dated 24.10.2006 mentioned that power to settle the medi-claims have been given to TPA i.e. M/S Family Health Plan Ltd. The Complainant is required to send all the papers in respect of the claim to their TPA. In this case too the Complainant sent al the claim papers directly to the TPA. TPA vide their letter dated 12.04.2006 demanded certain papers from the Complainant. Thereafter the Complainant submitted the photocopy of Admission/Discharge slip, money receipt for Rs. 7000/- which the Respondent forwarded to TPA on10.07.2006. So far the Complainant has not submitted the required papers as demanded by their TPA.

It is observed that the Complainant submitted all the relevant claim papers to the Respondent vide his letter dated 27.10.2005 which the Respondent acknowledged on the same day. It is true that the Respondent's TPA has demanded certain documents from the Complainant which the Complainant informed the Respondent & his TPA his inability to submit the same. Had those documents been utmost necessary to settle the claim the Respondent may collect the same at their end from the Hospital authorities? I don't find any reasons not to settle the claim on this ground is justified.

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent not to settle the claim by the Respondent is unfair and unjust. Respondent is directed to pay the claim amount of Rs. 7,000/- along with simple interest @ 6% w.e.f. 27.11.2005 (after 30 days from the date of submission of claim papers to the Respondent's on 27.10.2005) to the Complainant. The Respondent is also directed to pay the award amount with interest as mentioned above within 15 days

from the receipt of the consent from the Complainant, failing which the Respondent shall be liable to pay the amount of award with additional interest @1% p.a. from the date of this order to the date of actual payment.

Bhopal Ombudsman Centre
Case No. : GI/NIA/1106/076
Mr. Virendra Singh Jadon
V/s
The New India Assurance Co. Ltd.

Award Dated 19.12.2007

Mr. Virendra Singh Jadon (hereinafter called Complainant) informed that he was covered under Medi claim policy No. 450800/48/05/75529 with The New India Assurance Co. Ltd., Indore (hereinafter called Respondent). As per the Complainant he was admitted in the hospital on the advise of Dr. S. R. Jain who admitted him in ICU and all test have been carried, but his claim has been repudiated on the plea that the treatment can be taken as on out patient. Since the claim was repudiated, hence he has approached this office.

The Respondent in its reply-dated 22.11.2006 & 29.11.2006 stated that the Complainant was covered under medi claim policy No. 450800/48/05/75529 w.e.f. 13.06.2005 to 12.06.2006 covering the Complainant himself & his family. The Complainant was admitted at Noble Hospital Indore on 30.12.2005 and had undergone various medical investigations viz. ECG, TMT (tread Mill Test), Blood examinations and X-ray chest (PA view). The Complainant submitted all the claim papers to their claim settling authority M/S Family Health Plan Ltd. (TPA) who after perusal of all claim papers rejected the claim on the ground that the instant hospitalization is for the investigation and evaluation of the ailment which is excluded under the terms and condition of policy clause No. 4.10. The treatment could have been taken as outpatient and as such there is no necessity of hospitalization for the same.

It is observed that the Complainant who was hospitalized only for different investigations/tests and during the hospitalization no treatment was given to him. During hospitalization only oral medicines were prescribed. It is also observed that the disease was not acute and no definite treatment was given to the patient and that these tests can also be conducted as OPD (out patient) basis and hospitalization was not needed. Therefore the expenses incurred clearly falls under exclusion No. 4.10 of the policy which state that “Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable.” 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/1006/070
Mr. Shyam Sunder Saini
V/s
The New India Assurance Co. Ltd.

Award Dated : 21.12.2006

Mr. Shyam Sunder Saini (hereinafter called Complainant) was covered under Medi claim policy No. 451300/48/05/20/70052213 with The New India Assurance Co. Ltd., Indore (hereinafter called Respondent). As per the Complainant his daughter felt uneasiness due to severe headache on 20.12.2005 in her class room and her teacher informed in his house. Subsequently she was referred doctor in OPD of Bombay Hospital who admitted her in the hospital and all tests were carried out and discharge from the hospital on 22.12.2005. Complainant also informed the TPA of the Respondent on 22.12.2005 and submitted all the claim papers to their TPA on 13.01.2006. Subsequently Respondent's TPA repudiated his claim on the plea that the treatment can be taken as on out patient. Complainant also informed that he admitted his daughter in the hospital on the advice of doctor and there is no fault from his side. Since the claim was repudiated, hence he has approached this office.

The Respondent in its reply-dated 15.11.2006 stated that the Complainant was covered under medi claim policy No. 451300/48/05/20/70052213 w.e.f. 21.12.2005 to 20.12.2006 covering the Complainant himself & his wife & two daughters. The Complainant's daughter Km. Kritika Saini was insured for Rs.30, 000/-. The medi-claim Insurance policy covers for reimbursement of expenses reasonably and necessarily incurred for the treatment of the insured person for sickness requiring hospitalization. The Policy is further subject to terms and conditions and exclusions contained in the policy. The complainant submitted the claim for reimbursement of expenses amounting to Rs. 5378/- allegedly incurred for treatment of Km. Kritika Saini. Exclusion 4.10 of the policy read as under: - the Company shall not be liable to make any payment under this policy "Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." Km. Kritika Saini the daughter of the Complainant was admitted in the hospital on 21.12.2005 and after conducting various Pathological/Laboratory test she was discharged on 22.12.2005. She was treated only with some oral medicines/drugs. The treatment papers submitted by the Complainant in support of his claim namely Discharge summary and more particularly various pathological/laboratory tests carried out at the hospital do not reveal positive existence of ailment/sickness requiring confinement for treatment at Hospital. For the aforesaid reasons the claim of the Complainant falls under exclusion clause No. 4.10 of Medi claim insurance policy.

It is observed that the Complainant who was hospitalized only for different investigations/tests and during the hospitalization no treatment was given to her. During hospitalization only oral medicines were prescribed. It is also observed that the disease was not acute and no definite treatment was given to the patient and that these tests can also be conducted as OPD (out patient) basis and hospitalization was not needed. Therefore the expenses incurred clearly falls under exclusion No. 4.10 of the policy which state that "Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examination not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home is not payable." 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.

Mr. Deepak Radgaonkar
V/s
ICICI Lombard General Insurance Co. Ltd.

Award Dated : 19.01.2007

Mr. Deepak Radgaonkar (hereinafter called Complainant) informed that he had obtained a Medi claim Insurance Policy under Policy No. 4034/FPR/00231121/00/000 from ICICI Lombard General Insurance Co. Ltd., Mumbai (hereinafter called Respondent). As per the Complainant he was suffering with low back pain. In view of the same he had gone to Apollo Speciality Hospital Chennai and consulted the doctors, who on 19.09.2005, advised him to under go some investigation and after investigation it was revealed that he is suffering from AVN (A Vascular Necrosis) of right femur and advised him to undergo BHR (Birmingham Hip Resurfacing) surgery at the earliest. Hence he approached the Respondent for cash less facility which was turned down and advised that the patient should make the payment and can come back for reimbursement. The Complainant also stated that some how he managed the money and arranged for the surgery and then submitted the claim bill to the Respondent for Rs. 2,04,234/- which was turned down vide their letter dated 21.04.2006 giving the reasons under the exclusion cause no. C-1 “claims arising on account of or in connection with pre-existing illness shall be excluded from the scope of the policy”. Since the claim was repudiated, hence he has approached this office.

The Respondent in its reply-dated 13.11.2006 stated that they had covered the Complainant under the above mentioned policy w.e.f. 20.10.2004 to 19.10.2005. The said policy was again renewed on 20.10.2005 under Policy No. 4034/FPR/00231121/00/000 for another period of one year. The Complainant approached their TPA i.e. TTK Health Care Private Limited for pre-authorization of cashless services. The provisional diagnosis of the patient was found to be Idiopathic Avascular Necrosis Right Hip with secondary arthritis. The said pre-authorization request was denied to the Complainant on 21.11.2005, because as per the papers submitted by the Complainant there was a possibility of ailment being pre-existing. The Complainant was admitted to the Apollo Speciality Hospital on 25.11.2005 and was discharged on 29.11.2005. The Complainant was diagnosed for Avascular Necrosis Right Femur and was operated for Birmingham Hip Resurfacing Right Hip with capital Valsus Realignment Technique. During the treatment, it was found that the complaint of pain in the right hip region was since 2-3 years. There was an insidious onset of pain and the same was severally affecting the pain. The Complainant filed a claim for reimbursement on 23.03.2006. On perusal of the papers, it was found that the Complainant availed the treatment of pain in the Right Hip Region. The Complainant was suffering from the pain prior to the inception of the policy; it was a clear case of pre-existing condition which is evident from the discharge summary. The condition of the patient was pre existing and therefore was excluded under the terms and condition of the policy. The exclusion under the policy is reproduced hereunder:

As per the policy condition, the company is not liable to make any payment for pre-existing condition. The policy wording is as follows:

“Any illness existing before the inception of the policy period. This exclusion shall cease to apply if the insured has maintained an ICICI Lombard Health Insurance Policy for a continuous period of full 4 years from the insured’s first ICICI Lombard Health Insurance Policy with the company”. The Respondent also stated that the insurance contract has to be read in its natural meaning and not otherwise. The policy terms should not be construed to give a wider meaning than that was intended by the

Respondent and the Complainant while the contract of insurance was entered into. In the instance case the Complainant was only in the second year of the policy coverage, therefore, the pre-existing clause was applicable to him. In the light of the above circumstances the claim is not payable hence the same was repudiated by them.

It is observed that the Complainant was suffering from the pain prior to the inception of the policy; it is a clear case of pre-existing condition which is evident from the discharge summary. Discharge summary shows that the complaint of pain in the right hip region was since 2-3 years. Hence claim falls under exclusion clause of the policy which states as “any illness existing before the inception of the policy period. This exclusion shall cease to apply if the insured has maintained an ICICI Lombard Health Insurance Policy for a continuous period of full 4 years from the insured’s first ICICI Lombard Health Insurance Policy with the company”.

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/1206/082
Mr. Prakash Rathi
V/s
The New India Assurance Co. Ltd.

Award Dated : 02.02.2007

Mr. Prakash Rathi (hereinafter called Complainant) informed that he was covered under Medi claim policy No. 450800/48/05/20/70051608 with The New India Assurance Co. Ltd., Indore (hereinafter called Respondent). As per the Complainant due to illness of his daughter & on the advice of his doctor, his daughter was admitted in the hospital at All India Institute of Medical Science, Delhi on 17.01.1006 and discharged on 19.01.2006 for the disease diagnosis as post 3rd Venticular (Tectal Plate glioma with Hydrocephalus)”. On 22.06.2006 Respondent’s TPA rejected his claim due to disease mentioned in the claim form is congenital on origin. The Complainant also contended that the decision of the Respondent’s TPA is baseless. As a proof he has taken a certificate from his treating doctor Dr. Subodh Jain of M/S CHL Apollo Hospital Indore that the disease is not congenital but of tumor in post 3rd Ventricular. The said certificate was also submitted to Respondent’s Regional office as well as to Respondent’s TPA, but till date his claim has not been approved.

The Respondent in its reply-dated 27.12.2006 stated that the Complainant was covered under medi claim policy No. 450800/48/05/20/70051608 w.e.f. 10.10.2005 to 09.10.2006 covering the Complainant himself & his family. The Complainant had lodged a claim for his daughter for the treatment of “post IIIrd Ventricular SOL (Tectal Plate glioma with Hydrocephalus)”. The Complainant submitted all the claim papers to their TPA M/S Family Health Plan Ltd. Their TPA, after going through the papers and after obtaining the opinion of their panel doctor, rejected the claim on account of the disease is congenital in origin. The Respondent also stated that they also agree with the decision of TPA since the disease falls under policy exclusion No. 4.8.

It is observed that the Complainant’ patient was suffering from congenital disease as is evident from the papers submitted by him. Therefore the expenses incurred clearly falls under exclusion No. 4.8 of the policy which state that “ Convalescence, general

debility, rundown condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self injury and use of intoxicating drugs/alcohol." 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/NIC/1206/083
Mr. Yogesh Soni
V/s
The National Insurance Co. Ltd.

Award Dated : 27.02.2007

Mr. Yogesh Soni (hereinafter called Complainant) was covered under Medi claim policy No. 321701/48/05/8500082 with The National Insurance Co. Ltd., Indore (hereinafter called Respondent). As per the Complainant he and his family were covered under Medi Claim policy for the period from 09.06.2004 to 08.06.2005 and 09.06.2005 to 08.06.2006. He admitted his wife to M/S Lote Hospital Akola for Thr. ABORTION from 20.04.2006 to 23.04.2006 and submitted the claim bill for Rs. 8911/- but their TPA i.e. M/S Paramount Health Services Ltd., rejected his claim under policy exclusion clause 4.10. The Complainant also stated that the Respondent vide clause 4.12.1 excluded voluntary medical termination of pregnancy during the first 12 weeks from the date of conception, the said clause was deleted on 19.12.2001, w.e.f. 01.01.2002. Since his wife abortion was done due to some emergency hence his claim is payable.

The Respondent in its reply-dated nil received by us on 08.02.2007 stated that the Complainant was covered under medi claim policy No. 321701/48/05/8500082 w.e.f. 09.06.2005 to 08.06.2006 covering the Complainant himself & his wife & one son & one daughter. The Complainant's wife was insured for Rs.35,000/-. Their TPA rejected his claim under policy exclusion clause 4.12 (Treatment arising from or traceable to pregnancy are not payable). On the same ground, we also rejected the claim vide our letter dated 14.07.2006. The claim file was also referred to their Regional office who has also agreed with their TPA vide their letter dated 23.01.2007.

It is observed that the Complainant was hospitalized only for abortion which is also confirmed by the Complainant. As per terms and condition of the policy the same is excluded under the scope of the policy. Therefore the expenses incurred clearly falls under exclusion No. 4.12 of the policy which state that policy does not cover "Treatment arising from or traceable to pregnancy, child birth including caesarean section". 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/1206/085
Mr. Prakash Ghate
V/s
The Oriental Insurance Co. Ltd.

Award Dated : 27.02.2007

Mr. Prakash Ghate (hereinafter called Complainant) informed that he had taken Medi Claim Policy from Oriental Insurance Co. Ltd., Bhopal (hereinafter called Respondent). As per the Complainant he had taken the medi claim policy no. 152110/48/06/000306 w.e.f. 19.07.2005 to 18.07.2006 for Sum Insured of Rs. 75000/- along with cumulative bonus of Rs. 12,000/- for himself along with his family including his mother. On 01.04.2006 his mother was admitted in M/S Revival Bone & Joint Hospital at Thane for operation of "non-Union neck of Flmur i DHS insitu". He incurred expenses for Rs. 66,837.72 and submitted the claim bill on 23.05.2006 with the Respondent. Respondent's TPA send him pre-receipt voucher for Rs. 46250/- without assigning any reasons why the claim amount of Rs. 66837.72 is reduced to Rs. 46250/-. It is also not mentioned in the pre-receipt voucher how the total amount of claim is arrived for Rs. 62838/- instead of Rs. 66838/-.

The Respondent in its reply-dated 24.01.2007 stated that their TPA M/S E-Meditek Solution Indore approved the claim for Rs. 46250/- without mentioning the reasons why they have reduced the claim amount. Subsequently the Respondent again sent another letter dated 07.02.2007 wherein they have mentioned how the claim approved amount has been arrived with giving the reasons for reducing the claim amount. Subsequently Respondent vide his letter dated 21.02.2007 mentioned that correct claim amount is Rs. 66837.22 but the same is approved by their TPA for Rs. 46250/-. As per pre-existing condition they have restricted the claim amount up to Sum Insured of previous policy Rs. 40,000/- plus bonus @15%.

It is observed that the Complainant's Mother was admitted in M/S Revival Bone & Joint Hospital at Thane for operation of "non-Union neck of Flmur i DHS insitu". He incurred expenses for Rs. 66,837.72 and submitted the claim bill on 23.05.2006 for Rs. 66,837.72 and the Respondent as well as their Respondent's TPA rightly explained the reasons how they have arrived the approved claim amount for Rs. 46250/-. As per pre-existing condition they have restricted the claim amount up to Sum Insured of previous policy Rs. 40,000/- plus bonus.

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent to approve the claim for Rs. 46250/- 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.

Bhopal Ombudsman Centre
Case No. : GI/UII/0107/093
Mr. P. D. Jain
V/s
United India Insurance Co. Ltd.

Award Dated : 28.02.2007

Mr. P. D. Jain (hereinafter called Complainant) took the Medi Claim Insurance Policy from United India Insurance Co. Ltd.; Indore (hereinafter called Respondent). As per the Complainant he had taken the Medi Claim Insurance policy from the Respondent since 1988 with different branches of Govt. approved agencies. All the policies are very much in continuation without any break of insurance. The Complainant also stated that he had submitted all the papers available with him to the Respondent's TPA i.e. M/S Med Save Healthcare Ltd. Bhopal, but they still want each and every policy copy from him and on submission of the same they will review his file. Their TPA did not even write any letter to the Respondent to provide them with the policy copy or to certify the papers being submitted by him.

The Respondent in its reply-dated 01.02.2007 & 07.02.2007 had given the complete details of the case and has informed that they had reputed the claim under exclusion clause 4.1 of the policy (the disease is pre-existing i.e. prior to the inception of the policy) and on the following grounds: -

1. The Complainant has alleged in his complaint letter dated 21.12.2006 that he is taking the policy since 1988. Their nominated TPA requested the Complainant to provide the policy copies of all the year since 1988 till the date of admission of the insured person in the hospital on 19.08.2004. The burden of proof for submission of the policies lies with the Complainant since it is observed from the hospital records that the Complainant has history of CAD since 1990, diabetic since 10 years on insulin and hypertensive since 10 years on regular treatment. It is also evident from the discharge summary that the Complainant underwent coronary Angiography in the year 1992. The complainant failed to provide the copies of the policies which show that he was insured since 1988.
2. On the basis of hospital indoor papers submitted by the Complainant, they as well as their TPA observed from case summary dated 19.08.2004, that the patient was diagnosed as “Acute on Chronic Rental Failure”, known case of DM since 10 years on insulin, Hypertension since last 10 years on regular treatment, CAD since 1992 with unstable Angina, LVF/CRF. The Complainant was advised salt restricted diet and also the treatment of DM. The case history and the contents of the discharge summary prove the fact of “Positive existence of the illness before taking the policy”.
3. The Complainant could provide the continued policies for the last six years only to the concerned TPA. There was no Medi claim policy in the year 1997-1998, therefore in any case it may not be treated that the Complainant was having Medi claim policies continuously without any break. In view of the same there TPA has rightly repudiated the claim of the ground of pre-existence of the disease.
4. The Complainant took the medi claim policy No. 190300/48/03/20/1141 for the period from 24.03.2004 to 23.03.205 from them on the basis of fresh proposal submitted by the Complainant duly signed & agreeing the terms and conditions of our policy. It is in order for us to mention that the Complainant has concealed the material facts in the proposal form by not disclosing the positive existence of the illness since more than10 years. The policy was taken with the intention of claim by not disclosing the material fact in Col No. 12.1: 12.2: 13 C, J, K, N, O & 15 (date first treated for Angiography not clearly stated and also the insured has declared himself that he was cured fully but this was not a case of only Angiography, but the Complainant was required to be admitted in hospital for recurrent existing problems which is more particularly stated in the discharge card and the case history in the hospital of the Complainant.

It is observed that the Complainant took the medi claim policy since 1992 as per the documents submitted by the Complainant, but there is a gap of insurance as the Complainant could not produce the insurance policies for the year 1997-1998. In view of the same the policy was in continuously in existence since March 1998 while the Complainant was suffering since 1990 as is evident from the discharge card of the hospital.

It is also observed that the Complainant took the medi claim policy No. 190300/48/03/20/1141 for the period from 24.03.2004 to 23.03.2005 on the basis of fresh proposal submitted by the Complainant duly signed & agreeing the terms and conditions of the policy. Here the Complainant has concealed the material facts in the proposal form by not disclosing the positive existence of the illness since more than10 years which is evident from the discharge card of the hospital.

Hence the claim falls under policy exclusion clause 4.1 which states as “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.

Bhubaneshwar Ombudsman Centre
Case No. : 11 –002-0313
Sri Bishnu Prasad Panda
Vs
The New India Assurance Co. Ltd.

Award Dated : 25.01.07

Insured Complainant obtained a mediclaim policy from New India Assurance Co. Ltd since 1998 which has been regularly renewed from by the same insurer. Insured in his proposal form declared that he was suffering from Ischeamic heart disease which was duly treated and eliminated during 1993-94. Insurer issued the policy without any exclusion of disease . Insured complainant under went treatment of Coronary Artery diseases and PTCA was done and claim was lodged for Rs 435345/. Insurer repudiated the claim on the ground that the disease was pre existing prior to policy inception.

Being dissatisfied with the decision of the insurer complainant lodged this complaint.

During Hearing complainant stated that he was cured of disease which has been certified by consulting physician in the proposal form and he was not suffering from cardio logical problem at the time of mooting the proposal. More over he was provided with the policy condition stating the exclusion under clause 4.1

Insured stated that claim was repudiated due to preexisting of disease.

Hon’ble Ombudsman directed the insurer to pay RS 435345/ as insurer was failed to prove that condition containing 4.1 was supplied and policy document categorically states that it was issued subject to exclusion none.

Chandigarh Ombudsman Centre
Case No. : GIC/206/UII/14/07
Vivek K. Aggarwal
Vs
United India Insurance Co. Ltd.

Order dated: 7.12.06

FACTS : Shri Vivek Kumar Aggarwal has purchased a Mediguard policy for self and his family from DO-5 Ludhiana for the period 27.2.06 to 26.2.07 for sum insured of Rs. 45,000/-. His ten years old child was operated upon for Nasal Polyp on 3.8.06. The claim filed by him was not settled despite repeated follow up. Later the claim was repudiated on the ground that child was suffering from sinusitis.

FINDINGS : The complainant stated that his child was operated for FESS with Adenotonsillectomy. He lodged the claim with the insurer for reimbursement of an

amount of Rs. 32,181/-. However, the claim was repudiated by the insurer on the ground that child was suffering from sinusitis. He submitted a certificate from the treating doctor Dr. Narinder Verma to the effect that ailment in question was covered. The insurer clarified the reasons for repudiation by stating that as per the medical opinion given by one of the panel of doctors Dr. Pankaj Bhalla appointed by them, the child was suffering from sinusitis which was not covered under clause 4.3 of the terms and conditions of the policy.

DECISION : After going through the records and the certificate given by medical officer who had operated upon the child, held that it was a case of tonsillitis and not sinusitis. Since tonsillitis was not excluded under clause 4.3 of the terms and conditions of the policy, the claimant was entitled for reimbursement of medical expenses incurred by him on the surgery. Hence ordered to make payment to the claimant in full and final settlement of the claim.

Chandigarh Ombudsman Centre
Case No. : GIC189/NIC/14/07
Bal Mukand Rai Garg
Vs
National Insurance Co. Ltd.

Order dated: 19.12.06

FACTS : Bal Mukand Rai Garg had taken a Mediclaim Policy for the period 21.12.04 to 20.12.05 for self and wife for sum insured of Rs. 2,50,000 each and Rs. 50,000 each for his son and daughter from DO-III, Ludhiana. His wife was admitted in Maharaja Agarsen Hospital, Delhi from 5.10.05 to 7.10.05. After treatment he filed reimbursement of claim for Rs. 11,949/-, but the claim was not settled causing harassment to him.

FINDINGS : The insurer clarified the position by stating that hospitalization was primarily for carrying out medical tests, which did not confirm positive existence of any ailment. Such tests are not covered under the policy as per exclusion clause 4.10 of the Mediclaim Insurance Policy for individuals. He also mentioned that he had discussed the case with a panel of doctors of TPA who categorically mentioned that the tests conducted did not require hospitalization.

DECISION : Held that the repudiation of the claim by the insurer was in order. The case was dismissed.

Chandigarh Ombudsman Centre
Case No. : GIC/265/ICICI/11/07
Santvna Thadani
Vs
ICICI Lombard

Order dated: 5.2.07

FACTS : Mrs. Santvna Thadani had taken a Mediclaim policy from BO Gurgaon. Her son Arjun Thadani was also covered under the said policy. On 29.3.06 the school doctor diagnosed him to be suffering from conjunctivitis and stated that he would be well within 5-7 days. On 5.4.06 his swelling subsided and he went back to school. When he returned home his right eye was swollen again. He also had pain in his head, jaw, cheek and neck. He was taken to eye specialist Dr. Navin Sakhuja who after examining the child said that he was suffering from Cavernous Sinus Thrombosis

(which is life threatening) along with Periorbital Cellulitis (which is serious complication of an eye infection). The disease was not pre-existing. He was advised CT Scan and it showed that eye infection had caused lot of pus to collect in sinus sac in cheek, behind nose and below the eye. He was admitted in Max Balaji Hospital, New Delhi and endoscopy was done on 6.4.06 and 10.4.06 to remove the pus from eye orbit and sinus sacs. She applied for cashless facility which was refused by the insurer. The basis of rejection was clause 3.3 of the policy i.e. non cover of sinusitis and sinus related ailments. .

FINDINGS : The insurer informed that as per information available with them, the surgery was done within thirty days of the issue of the policy. When asked whether it was a renewed policy, he mentioned that he was not aware of the same. The complainant clarified that it was a renewed policy. Regarding the disease for which the patient was operated upon, the representative of insurer was asked whether he had studied the hospital record. He replied in the negative. The complainant showed the medical report to him wherein it was mentioned that surgery was for right eye and not for sinusitis.

DECISION : Held that the repudiation of the claim by the insurer was not in order. Ordered that the insurer would make payment of admissible amount of claim to the claimant.

Chandigarh Ombudsman Centre
Case No. : GIC/246/UII/11/07
O. N. Bansal
Vs
United India Insurance Co. Ltd.

Order dated: 5.2.07

FACTS : Shri O.N. Bansal had taken a SyndArogya medi-claim policy for which Paramount Health Services is the TPA. Under the policy, he was entitled to 25% of hospitalization expenses. He lodged a claim pertaining to his wife Mrs. Santosh Bansal who was admitted at Yashoda Hospital, Ghaziabad for eight days for treatment of nasal fungal infection and uncontrolled diabetes. He claimed 75% of expenditure from his bank and lodged the claim for balance 25% with the TPA.

FINDINGS : The insurer informed that as per the report received from TPA, Paramount Health Services and the discharge summary, it was clear that the patient was suffering from sinusitis. However, on going through the record of Yashoda Super Speciality Hospital Heart Institute, Ghaziabad wherein the patient was treated, it is seen that Mrs. Santosh Bansal was diagnosed to be a patient of nasal secretion for fungal and she was also advised to continue anti-fungal and other treatment.

DECISION : Held that fungal infection can be one of the causes of sinusitis. Also sinusitis attacks through a pair of sinuses. In this case, the treatment has been only for the left portion and Mrs. Santosh Bansal's treatment was for anti-fungal nasal and for diabetes which are not excluded in the first year of the policy. Hence ordered that the admissible amount of 25% of hospitalization expenses be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/239/UII/11/07
Jasbir Kaur
Vs
United India Insurance Co. Ltd.

Order dated: 13.2.07

FACTS : Smt. Jasbir Kaur was covered under Mediclaim Policy issued by DO Chandigarh. She fell sick and was admitted for treatment in Fortis Hospital, Mohali. She incurred an expenditure of Rs. 2,82,000/- on her treatment. After treatment the claim was preferred to Family Health Plan Ltd., TPA but the same was declined and no amount was paid to her. She contended that the claim was wrongly rejected.

FINDINGS : The insurer produced a letter from TPA giving reasons for the repudiation of the claim. The main reason appeared to be a certificate from Fortis Hospital that the person was suffering from diabetes from the last 4-5 months before the date of admission. It was also mentioned that it was being treated as pre-existing disease as the previous policy had expired and a new policy had commenced after seven days.

DECISION : Held that repudiation of claim by the TPA was not in order because of following reasons:

a) The complainant had stated that she was not suffering from diabetes at the time of admission in hospital.

b) As per records the treatment given to the complainant was for CAD and double vessel disease etc. No treatment was given for diabetes.

c) While the TPA has mentioned that it was new policy, there is no proposal form filled up by the complainant for new policy. The old proposal form was considered for giving the medical cover.

d) There is a circular from the insurer dated 30.12.99 in which it was clearly mentioned that a grace period of seven days is given to all Mediclaim policies for renewal. This period of seven days was covered under the instant policy and as renewal took place within seven days it cannot be treated as new policy but as a continuation/renewal of the previous policy.

e) Since it is treated as renewal of previous policy, there was no justification for treating diabetes as pre-existing disease at the time of taking the policy.

Hence ordered that the admissible amount of claim be paid by the insurer/TPA to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/271/UII/11/07
Som Nath Gupta
Vs
United India Insurance Co. Ltd.

Order dated: 9.3.07

FACTS : Shri Som Nath Gupta purchased a Mediguard policy for self and wife for sum insured of Rs. 1 lakh each for the period 30.8.05 to 29.8.06. They both got knee treatment from Sibia Medical Centre, Ludhiana. Both were admitted in the hospital on 1.5.06 and were discharged on 3.5.06. For three days treatment was given as indoor patient. After this the treatment continued upto 21.5.06 as an outdoor patient. After the treatment was over, the complainant and his wife both submitted separate bills along with the discharge summary, medical reports, receipts etc. amounting to Rs. 73,464.43. After more than 6 months i.e. 31.10.06, they got letter from the insurer that the claim was not payable because treatment could have been taken without necessity of admission.

FINDINGS : The insurer informed that the brochure given by the M/s Sibia Medical Centre where the complainant and his wife were admitted mentioned that hospitalization was not a must for such treatment as the patient required only half an hour of treatment everyday for 21 days and could go home after that. Moreover this was a chronic disease and could not have developed all of a sudden. Regarding need for hospitalization, Dr. Sibia was asked to give his views. He gave his technical opinion by stating that this was the latest technology for treatment of arthritis etc and a composite package is available in their centre for treatment / hospitalization. He also pointed out clauses 2.3(a) and (b) of terms and conditions of the Mediguard policy which states that (a) the treatment is such that it necessitates hospitalization and the procedure involves specialized infrastructure facilities available in the hospital. (b) due to technological advances, hospitalization is required for les than 24 hours. Since the equipment/infrastructure for treatment was available in Sibia Medical Centre, the treatment in Sibia Medical Centre is thus covered under clause 2.3 (a) and (b) of the terms and conditions of the policy.

DECISION : Ordered that the admissible amount of claim relating to Sytotron Therapy (RFQMR) to regenerate and repair cartilage of the knees undertaken by the complainant and his wife in Sibia Medical Centre be paid to the complainant by the insurer.

Chandigarh Ombudsman Centre
Case No. : GIC/291/NIA/11/07
Amit Bindlish
Vs
New India Assurance Co. Ltd.

Order dated: 13.3.07

FACTS : Amit Bindlish and his wife were insured under Mediclaim Policy for the period 29.3.05 to 28.3.06. He met with an accident on 11.12.05 and was admitted in the PGI. The following problems were detected due to the accident:

a) Black eye

b) Fracture in teeth

c) Nose deviated left side.

Respective surgeries were accordingly done. He was discharged from PGI on 17.12.05. On 12.01.06 the PGI doctor's suggested for dental opinion. He had applied for reimbursement of the PGI bills and expenditure vide letter dated 27.1.06 without dental treatment and had mentioned in the letter that treatment of teeth could not be carried out due to trauma and could be cured only after 3-4 months. He took dental opinion from Dr. Dhody's dental clinic, Chandigarh on 10.2.06 where after preliminary treatment he was advised to report after 21 days. Subsequently inter wiring was done and the treatment concluded in May 2006 which comprised Root Canal Treatment and crowning of fractured teeth. After receiving complete treatment, he filed claim on 25 May 2006 with all the relevant documents and bills which was not paid.

FINDINGS : The insurer informed that they had no intimation about the injury to dental structure while the earlier claim was submitted. Hence the claim was not covered under post hospitalization treatment. The complainant showed a copy of the letter by which he had forwarded the claim form earlier in which he had mentioned that the dental treatment would be done after two-three months.

DECISION : Held that the claim preferred by the complainant for his dental treatment was in order and insurer was liable to pay the claim. Ordered that the admissible amount of claim be paid to the complainant by the insurer.

Chandigarh Ombudsman Centre
Case No. : GIC/322/UII/13/07
Dev Raj Jain
Vs
United India Insurance Co. Ltd.

Order dated: 30.3.07

FACTS : Shri Dev Raj Jain had been insured for the last 6-7 years from DO II, Ludhiana under a Mediclaim policy for sum insured of Rs.3 lakhs and had been enjoying cumulative bonus of 25 %. In September 2006 he was admitted in the hospital for High Blood Sugar. After repeated attempts, the claim was settled by the company for Rs.13333/- in January 2007. However to his surprise he received a notice from the company canceling his policy.

FINDINGS : The insurer informed that they were apprehensive that further claims may be lodged and hence they cancelled the policy as per clause 5.9 of terms and conditions of the policy.

DECISION : Held that the policy has been cancelled by the insurer unilaterally. There is a recent judgment by the Hon'ble Delhi High Court, in which the High Court has given a ruling that the insurer cannot refuse to renew a policy on the ground that the insured had contracted a disease during the currency of the policy. The court has also ruled that the renewal of the policy is not a private contract between the insurer and the company. Hence the decision of the insurer to cancel the policy on the grounds of the insured having contracted a disease after 6 to 7 years of running of the policy was not in order, especially in view of the High Court judgment. Taking a fare and equitable view, it was ordered that the policy of the complainant should be re-instated ab-initio by revoking the earlier action of canceling the policy.

Chennai Ombudsman Centre
Case No.11.03.1080/2006-2007
Shri. K.V. Sivasankaran
Vs
The National Insurance Co. Ltd.,

Award Dated : 04.09.2006

The complainant represented that he and his spouse are covered under a Mediclaim policy issued by National Insurance Co. Ltd. His wife was hospitalised from 16.09.05 to 18.09.05 at Vikram Hospital due to a speech problem which necessiated a surgery and accordingly a 'K.T.P laser E.M.S. vocal cord Pathology polyp Right side under G.A' was done on her. Subsequently Sri Sivasankaran was also hospitalised in the same hospital from 25.09.05 to 27.09.05 for K.T.P. Laser Septoplasty/turbinoplasty + Bilaeral Extended Sphenoethmoidectomy under LA', which was necessiated due to a nasal obstruction and frequent attacks of cold. However, his claim for reimbursement was only partly paid by the insurer.

The insurer contended that as per the policy conditions, the Insuer could pay only reasonable and necessary hospitalisation expenses and justified that the amound paid

by the TPA was in order by producing quotations of various other hospitals in respect of the expenses for the same type of operation.

The forum stated that though the insurer has paid a reasonable amount, when the insured contacted the TPA of the insurer before hospitalisation, they failed to inform about the exhorbitant charges charged by Vikram Hospital therby giving an impression that there was nothing objectionable about Vikram Hospital hence, direction was given to the insurer to settle the pre-hospitalisation expenses and allowed the complainant on ex-gratia basis.

Chennai Ombudsman Centre
Case No.11.03.1060/2006-2007
Shri. V. Shanmugavelu
Vs
National Insurance Co. Ltd.,

Award Dated : 04.09.2006

The complainant was insured under Mediclaim policy with National Insurance Co. Ltd., for the period from 06.09.2004 and he was hospitalised from 25.09.2004 to 30.09.2004 for the treatment of hypertension, headache, burning micturition etc. The insurer repudiated the claim on the ground that the hospitalisation was purely for diagnostic purpose / healths check up and hence they repudiated as per exclusion clause 4.10 of the policy.

The insurer contended that they repudiated the claim as per the exclusion clause 4.10 and 8 of Mediclaim policy. Insurer also argued that there are more of diagnostic reports and all the reports & lab tests were normal and did not reveal any positive existence of ailment hence, their repudiation was in order.

After perusal of documents submitted by both the parties and based on hearing, the Forum observed that the patient was hospitalised for increased systolic BP, hypertension with angina, Micturion complaint that warranted hospitalization. Hence direction was given to the insurer to reimburse the charges relating to the same. The Ombudsman disallowed expenses, in respect of ENT problem related to age factor of the insured.

Chennai Ombudsman Centre
Case No.11.03.1079/2006-2007
Shri. M. Wilson
vs
The National Insurance Co. Ltd.,

Award Dated : 19.09.2006

The complainant represented that he already approached this forum, for the repudiation of the claim by the insurer, an award has been already passed to settle his claim, and however the insurer disallowed various parts claimed by him resulting into short settlement of the claim.

The Insurer represented that they allowed all the parts affected by flood damage except for Crankshaft since they have to go by the Survey Report which states that the reparier should check any damage to the crankshaft with M/s TVs and produce the certificate to that effect to enable him to asses the loss. Since the repairer never submitted the report, the crankshaft was not allowed.

Despite an award having been already passed by the Ombudsman, regarding admissibility of the claim, the insurer has arrived at the amount payable without application of the mind and disallowed a major part like the crankshaft without going

into the reasonableness of the issue. Hence, direction was given to the insurer to settle the claim for crankshaft and disallowed other parts, which were claimed but not affected by entry of floodwater.

Chennai Ombudsman Centre
Case No.11.04.1077/2006-2007
Shri. P.S. Sundaram
Vs
United India Insurance Co. Ltd.,

Award Dated : 22.08.2006

The complainant represented that he had taken a Mediclaim Policy for the period 01.11.2005 to 31.10.2006 under the Group Mediclaim Scheme offered by United India Assurance Co. Ltd. His wife was hospitalised on 02.12.2005 and she succumbed to her illness on 18.12.2005. He preferred a claim with the insurer, which was declined by them on the ground that his spouse was not covered under the policy.

The insurer contended that the proposal was submitted requesting for the coverage of Mr P S Sundaram only, the premium also paid only for Mr. P S Sundaram as per the premium schedule and no cover was sought and no premium was paid to cover his spouse, hence their repudiation was in order.

It has been observed that the complainant was trying to take advantage of pre printed form of the insurer i.e Income tax certificate issued for the purpose of tax benefit. It was established by the insurer that the proposal was submitted requesting for the coverage of Mr P S Sundaram and premium was also paid only to cover the complainant and it was not established by the complainant he had ever had an intention to cover his spouse under the policy, the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.04.1152/2006-2007
Shri. C.V. Parameshwaran
Vs
The United India Insurance Co. Ltd.,

Award Dated : 31.10.2006

The complainant stated that he was covered under Mediclaim with United India Ins. Co. Ltd., from 2001 onwards. He was hospitalised from 14.11.2005 to 16.12.2005 for the treatment of Melaney's Gangrene and preferred a claim with the insurer. His claim for reimbursement of medical expenses was repudiated by the insurer on the basis of exclusion clause 4.1 of the policy.

The insurer contended that in the pre-authorization form submitted by the attending doctor of the patient, it was clearly mentioned that the patient is a known case of Diabetes for 5 years. In the copy of the case sheet also it was mentioned that the patient was a known case of diabetes for 14 years. He stated that the insured had undergone treatment for gangrene, which was due to Diabetes, and it was obvious from the noting 'diabetic foot' and 'carbuncle' mentioned in the case records of the hospital. Insurer also stated that insured was suffering from diabetes for 14 years, which was not disclosed at the time of proposing for insurance. Hence they repudiated the claim as per exclusion clause 4.1.

The forum perused the documents. It was clearly established from the medical records that Diabetes Mellitus existed in the insured prior to 18.03.2001, i.e before policy inception. The insurer also clearly established by way of medical records that the patient was diagnosed as Diabetic foot. Hence the forum dismissed the complaint.

Chennai Ombudsman Centre
Case No.11.08.1129/2006-2007
Shri N. Seetharaman
Vs
The Royal Sundaram Alliance Insurance Co. Ltd.,

Award Dated : 11. 10.2006

The complainant represented that he was covered under Health Shield Policy issued by M/s Royal Sundaram Alliance Insurance Co. Ltd., for the period, from 11.01.2005 to 10.01.2006. On 05.08.2005 the complainant fell down from his two-wheeler and sustained internal injuries in vital areas viz. right knee, hip etc. He submitted the claim papers to the insurer for reimbursement of his hospitalisation expenses. However, his claim was rejected by the insurer on the ground that the treatment was primarily for Cervical Spondylosis and no external injury was sustained by the complainant and there was no proof for the accident. Hence the insurer stated that their repudiation was in order.

The insurer contended that according to their panel Doctor's opinion the ailment was a pre-existing one and also stated that there was no proof for accidental fall.

As per their policy conditions pre-existing condition 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. Hence they stated that their repudiation was in order.

Documents were perused and the forum referred the case to an Orthopaedic Surgeon and from the opinion of the Doctor, concluded that the meniscal tear does not seem to have been due to the fall of the insured from his vehicle and it was also noted that the line of treatment advised for the injury namely aspiration, Menisectomy and ACL reconstruction have not been administered during the hospitalisation. Hence the Ombudsman stated that the insurer does not incur any liability in this case and the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.02.1083/2006-2007
Shri. S. Dakshinamurthy
Vs
The New India Assurance Co. Ltd.,

Award Dated : 11.10.2006

The complainant represented that he was covered under Mediclaim policy with M/s New India Assurance Co. ltd for the period from 03.12.2004 to 02.12.2005. He was hospitalized for treatment of left vocal nodule at M/s Vikram Hospital and incurred hospital expenses of Rs.49,466/- . He submitted necessary claim papers to the TPA of the insurer. However, his claim was allowed only for an amount of Rs.25,000/-. Hence he approached this forum for short settlement.

The insurer contended that as per the policy conditions, the Insurer could pay only reasonable and necessary hospitalisation expenses and justified that the amount paid by the TPA was in order by producing quotations of various other hospitals in the same standard in respect of the expenses for the same type of operation.

The forum perused the documents and observed that M/s Vikram Hospital has charged exorbitant rates for the specific surgery and the reason for high rates was not substantiated. The forum stated that the Insurer couldn't be faulted for restricting their liability in this claim. However the helplessness of the insured in the aspect of the

hospital charging exorbitant rates should also be considered and therefore in order to meet the ends of justice, the forum allowed an exgratia amount of of Rs.10,000/- in addition to the amount already allowed by the insurer. Insurer was also advised to highlight to all the insured about the term of “reasonable expenses” alone being reimbursed under Mediclaim policy, especially for those who intent to take treatment in expensive hospitals.

Chennai Ombudsman Centre
Case No.11.03.1148/2006-2007
Shri. K.Kulandaiappan
Vs
The National Insurance Co. Ltd.,

Award Dated : 11.10.2006

The complainant represented that he and his wife are covered under Mediclaim Policy with The National Insurance Co. Ltd., from 10.10.2005 to 09.10.2006. Smt. Kalyani, wife of the complainant was suffering from severe headache and giddiness and was hospitalized from 07.2.2006 to 09.02.2006. The complainant approached the Insurer for reimbursement of hospitalization expenses. However, the insurer repudiated the claim on the ground that the ailment does not warrant hospitalization.

The insurer contended that under a mediclaim policy a claim becomes admissible only if the ailment suffered by the insured requires hospitalization as in-patient whereas in this case for the ailment some tests were done which could have been done without hospitalization, and hence the claim was not admissible. TPA of the insurer stated that as per the policy condition, Reimbursement would not be made for Investigation and Evaluation done and the ailment does not warrant hospitalization. He also said that it was clearly stated in the discharge summary that ‘No Significant Medication’ was given. Hence their repudiation was in order.

The forum perused the documents. Though it’s a prerequisite under the policy, the need for hospitalization is often decided by the attending doctor based on the overall condition of the patient considering the various health parameters of the patient. Subsequent to the various tests done to Smt. Kalyani, she has been advised to consult a psychiatrist, which implies that the patient did have problems of physical/mental health, which warranted medical attention. Hence, direction was given to the Insurer to reimburse the expenses limiting to the treatment of her headache viz. Room-rent, Bio-chemistry charges, Hematology and Radiology-CT scan. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No.11.04.1168/2006-2007
Shri. V. Sadasivam
Vs
The United India Insurance Co. Ltd.,

Award Dated : 10.11.2006

The Complainant Shri V Sadasivam stated that he and his spouse were covered under Mediclaim policy with M/s United India Insurance Co. Ltd. continuously from 1995 onwards. His wife was hospitalized on 11.09.2005 to 12.09.2005 for the complaint of chest discomfort with radiation to right hand for 1 day and was diagnosed to have systemic hypertension and a typical chest pain. He submitted the requisite documents to M/s MedSave Healthcare Ltd., TPA of the insurer. They rejected his claim on the ground that the treatment was taken for pre existing disease.

The complainant contended that by mistake it was mentioned in the discharge summary that his wife was suffering from Diabetes Mellitus and submitted a clarification letter from the attending doctor. Insurer stated that, they have sent a letter to this forum seeking advice on this matter. Ombudsman replied that if the insurer wants any clarification, they have to represent to the Regional Office or Head Office and not to the Ombudsman office since this is a redressal Forum.

The Forum observed from the documents submitted, that the hospitalization was for the complaints of chest discomfort with radiation to right hand for 1 day and the diagnosis was Systemic hypertension and a typical chest pain. The attending doctor has also certified that the patient was not suffering from Diabetes Mellitus whereas hypertension was diagnosed in the year 2000. The discharge summary for the hospitalization during the month of March 2002 also revealed that the patient was not suffering from Diabetes Mellitus. Since the insured is covered under mediclaim continuously from 1995 onwards and the Insurer has failed to submit any documentary evidence to establish that the patient was suffering from Diabetes Mellitus prior to inception of the policy, the Forum directed the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.02.1181/2006-2007
Shri. A. Ravichandra Gupta
Vs
New India Assurance Co. Ltd.

Award Dated : 16.11.2006

The complainant and his family members were covered under Mediclaim policy with M/s New India Assurance Co. His wife was hospitalised for hernia operation at M/s Kovai Medical Centre. He submitted necessary claim papers. However, the TPA repudiated the claim on the grounds of pre-existing since she underwent LSCS and Tubectomy in the year 1998. The complainant contended that according to their Doctor's opinion all persons who undergo LSCS would not be affected by Hernia.

The insurer stated that the complainant failed to mention about the caesarian operation done for the insured, thereby suppressed the material information. As per the medical opinion obtained from the Doctor, it was observed by them that the patient's present condition was due to repeated childbirth due to previous surgeries. Hence, they repudiated the claim on the ground that the surgical treatment given to the patient was for a pre-existing condition.

The Forum observed that the insured failed to disclose about the LSCS operation underwent and thereby suppressed the material fact. However, the insured explained that she did not consider childbirth and related treatment to be a disease; hence she did not find it necessary to mention the same in the proposal form. It was also noted that there was not specific query regarding details of Child birth. Hence the contention of the Insurer is not tenable. Direction was given to the Insurer to process and settle the claim as per policy regulations and other procedural aspects.

Chennai Ombudsman Centre
Case No.11.02.1165/2006-2007
Shri. C. N. Mohanraj
Vs
The New India Assurance Co. Ltd.

Award Dated : 21.11.06

The Complainant Shri. C.N. Mohan Raj was covered under Mediclaim policy issued by M/s New India Assurance Co. Ltd. for the period from 14.10.2005 to 13.10.2006. He fell sick and an angiogram was done. He was advised to undergo heart surgery and underwent the same on 12.10.2006. He submitted the claim papers to the Insurer for the reimbursement of hospitalization expenses, however the same was repudiated.

The Insurer contended that the insured failed to mention the ailments being suffered by him at the time of proposal. It was observed from the medical records obtained from the hospital authorities, that the patient was suffering from the said ailment for several years, hence repudiated the claim invoking exclusion clause 4.1 of the policy. The TPA of the Insurer also produced the medical records to substantiate their stand.

This Forum perused the relevant documents and the discharge summary of the M/s Madras Medical Mission, the Forum observed that the patient was a suffering from Dm for 20 years on OHA, HTN for 10 years on treatment. Hence it was evident from the discharge summaries of both the hospital that the patient was a known DM, HT patient for 20 and 10 years respectively. Hence, this Forum dismissed the complaint.

Chennai Ombudsman Centre
Case No.11.05.1164/2006-2007
Shri. A.R. Mohanram
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30.11.2006

The complainant Mr. Mohanram had already represented this forum for non-settlement of mediclaim by the Insurer. His claim was rejected by the Insurer on the grounds of pre-existing. This Forum has already passed an award and directed the Insurer to settle the claim. However, the Insurer has not settled the full amount preferred by the Insured, hence this complaint. The complainant said that he was residing at Kumbakonam a small city where they do not have a female physiotherapist, hence they utilize the services of trained nurse.

The Insurer stated that they have processed the claim on the basis of the prescription only. Since the physiotherapist bills were not pukka and certificate of the attending doctor or domiciliary hospitalization was not produced, they were unable to consider the entire amount.

The Forum perused the documents. It is observed from the documents that there was a need of domiciliary hospitalization for the patient. This forum already passed an order directing the Insurer to settle the claim on the above complainant. The insurer adopts various delaying tactics. In spite of the direction from the Ombudsman, the insurer had taken their own time and finally offered a paltry sum of Rs.7098/- that too after a lapse of 5 months. The Forum allowed the claim on ex-gratia basis, in order to avoid further delay and harassment to the complainant.

Chennai Ombudsman Centre
Case No.11.04.1212/2006-2007
Shri. B. Damodaran
Vs
The United India Insurance Co. Ltd.,

Award Dated : 30.11.2006

The complainant Shri. B. Damodaran was covered under Mediclaim policy with M/s United India Insurance Co. Ltd. from 18.02.06 to 17.02.07. On 11.05.2006 he got admitted to M/s Apollo hospital as an inpatient as per the advise of the doctor. His

cashless facility was denied by the TPA. The diagnosis was Allergic Rhinosinusitis, Diabetes Mellitus, Bilateral Chronic maxillary and let ehmoidal sisnusitis, Hypertension, Gastro Oesophageal reflux disease. His claim was rejected on the grounds of pre-existing disease. The complainant contended about the Discharge Summary of Apollo Hospital where it was mistakenly written that the he was having breathing problem for 20 years i.e once in year.

The representative of the Insurer stated that they have repudiated the claim on the grounds of pre-existing and pointed out that every insured should be aware of 1st year exclusion since there was a break of 42 days in the policy, which was mentioned in the proposal form itself. The insurer also contended that they have repudiated as per the Discharge Summary which states that the insured had history of Upper Respiratory Track Infection for past 20 years i.e once in a year.

The Forum perused the documents and first year exclusion clause of the policy, which clearly states that Sinusitis, and related disorders are not payable. Since, the claim made by the complaint falls under fist year exclusion, there is no liability under the policy, hence the complaint is dismissed. The forum also directed the Insurer to take appropriate remedial measures for changing the stance of the TPA i.e first repudiated under clause 4.1 and later changed to 4.3 of the policy, thereby misleading the complainant.

Chennai Ombudsman Centre
Case No.11.02.1207/2006-2007
Shri. M. Babu
Vs
New India Assurance Co. Ltd

Award Dated : 30.11.2006

The complainant Mr. Babu was covered under Mediclaim policy issued by M/s New India Assurance Co. ltd., for the period from 11.05.2005 to 10.05.2006. He was hospitalized for the treatment of jaundice. On submission of the claim papers to the Insurer, his claim was rejected by them on the ground of pre-existing ailment and stated that he was affected by jaundice 7 years back. The complainant represented that it was mistakenly mentioned as 7 years, by the hospital authorities.

The Insurer stated that their TPA has rejected the claim and based on their Panel doctor's report the insurer has repudiated the complaint. The representative of the TPA stated since the pre-authorization form contained information that the complainant was suffering from Hepatitis B with history of Hepatitis B 7 year ago and the complainant himself signed it. Since the complainant failed to reveal about his suffering of Hepatitis B in the proposal form, the insurer rejected the claim. The Insurer also stated that other than the pre-authorization form they did not have any other proof to substantiate his stand.

The Forum perused the document. It is observed from the discharge summary that the patient had contracted Hepatitis B 7 years back. The noting would not have taken place unless the insured had informed the doctor about the same. Having been infected by Hepatitis B once, the patient remains an all-time Hepatitis B potent person. Hence the complaint was dismissed by this Forum.

Chennai Ombudsman Centre
Case No.11.04.1243/2006-2007
Shri. M.A. Rajeev

Vs

United India Insurance Co. ltd.

Award Dated : 30.11.2006

The complainant represented that his spouse Smt. A.K. Vasantha was covered under Medi-guard policy issued by M/s United India Insurance Co. Ltd from 26.06.2006 to 25.06.2007. She had been covered under Mediclaim policy for 10 years and subsequently took medi-guard policy in the year 2004. At the time of renewal, the insurer imposed a condition that unless the complainant accepts for loading and exclusion of present ailment i.e. 'Cancer", his policy will not be renewed. In order to avoid discontinuation of the policy, the complainant accepted for the said condition. He represented to the Grievance Cell of the Insurer but the insurer upheld their stand, hence he has approached this forum for redressal of his grievance.

The representative of the Insurer contended that they have settled more than Rs.3 lac for the complainant during the previous year. Since the insured is a Cancer patient they may prefer further claims in case of renewal. Hence, they have renewed the policy subject to loading of premium by 200% and excluding Cancer from the scope of the policy, which was also agreed by the complainant.

This Forum pointed out to the Insurer that the insured is doubly penalized because of loading and exclusion. Since the policy is being renewed without break for more than 10 years , the Insurer should not exclude the disease because of adverse claim ratio which attracted after taking the policy. The insurer could impose conditions but such conditions are also intended to exclude the risk but not to avoid liability to loss, which has taken place, or to avoid risk, which is already turning into a loss. Hence, direction was given o the Insurer to rescind the particular exclusion.

Chennai Ombudsman Centre

Case No.11.08.1240/2006-2007

Shri. Radhid Hataria

Vs

Royal Sundaram All. Ins. Co. Ltd.

Award Dated : 30.11.2006

The complainant Shri. Rashid Hataria was covered under Health Shield Policy for the period from 06.06.2005 to 05.06.2006 with M/s Royal Sundaram All. Ins. Co. Ltd. He was hospitalized and diagnosed to have Cholelihiasis. He submitted the claim papers for reimbursement of hospitalization expenses, however, his claim was repudiated on the ground of pre-existing disease. He had stated that he was having the ailment only in Dec.2005 i.e. after the commencement of the policy. He also substantiated his stand by stating that he had taken simultaneously mediclaim insurance with New India Assurance Co. Ltd. and a Life policy where medical test were conducted which did not reveal any pre-existing disease.

The Insurer contended that the insured had Gall Bladder stone measuring about 22 mm. As per the Histopathology Report the impression was "Chronic Calculus Cholecystitis". The main contention of the Insurer was since it was mentioned 'chronic' and it measured about 22 mm, the same would have taken more than 6 months to develop. Hence they repudiated the claim on the ground of pre-existing.

This Forum observed that none of the medical documents states the pre-existence of the disease. It was evident that there was no documentary evidence to prove that Colelithiasis was diagnosed in the complainant prior to 06.06.05 and symptoms existed prior to 06.06.05, the insurer could not repudiate the claim by invoking the said

exclusion clause. Hence direction was given to the Insurer to settle the claim as per the terms and condition.of the policy.

Chennai Ombudsman Centre
Case No.11.08.1234/2006-2007
Shri. S. Chakkarapani
Vs
The Royal Sundaram All. Ins. Co. Ltd

Award Dated : 30.11.2006

The complainant Shri. S. Chakkarapani was a credit card holder of AMEX and SBI, hence he was covered under Hospital Cash Plan insurance policies offered by M/s Royal Sundaram All.Ins. Co. Ltd. He was hospitalized from 8.5.06 to 10.05.06 and diagnosed to have CAD. He submitted the claim papers to the insurer; however, his claim was repudiated on the ground of pre-existing. His main contention was that the present ailment had no connection with previous problems.

The Insurer contended that as per the Discharge Summary of the Malar hospital, the patient was a known HT, IHD since 13 years and the tablets mentioned were all related to HT and IHD. Since people with HT and DM are more prone to CAD, they have repudiated the claim on the grounds of pre-existing.

The Forum perused the medical records and found that IHD was present 13 years back and his medication would have kept the disease in check and it cannot be concluded that the complainant was totally cured of IHD which afflicted him in 1993. It was evident that IHD was pre-existing in the complainant and hence, the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.02.1208/2006-2007
Shri. V.R. Kumar
Vs
The New India Assurance Co. Ltd.,

Award Dated : 30.11.2006

The complainant Shri. V.R Kumar was covered under Mediclaim policy with M/s New India Assurance Co. Ltd. He was hospitalized for the complaint of Proteinuria and diagnosed to have systemic hypertension, Non-nephrotic range Proteinuria. On submission of claim papers, the Insurer repudiated the claim on the ground of pre-existing. Since the present treatment was for Proteinuria and the same was present in the year 2001, the Insurer had repudiated the claim. His main contention was that the treatment was not for the pre-existing disease i.e. hypertension.

The Insurer contended that the complainant was a known case of hypertension for 11 years and the same was specifically excluded from the policy coverage. As per the discharge summary he was a known case of hypertension and non-nephrotic range Proteinuria, hence repudiated the claim on the ground pre-existing disease.

This Forum observed that the Insurer has gone by the Pre-authorization request form to conclude that the Proteinuria is a pre-existing ailment. But the certification given by the attending doctor and the discharge summary does not contain any significant presence of Proteinuria before 2002. It was also found by this Forum that the insurer have not done any further investigation to establish the presence of Proteinuria before 2002 and the biopsy report was not submitted which only could prove that the hypertension was the cause of Proteinuria. Since, the Insurer had not conclusively

established that Proteinuria was pre-existing or that hypertension was the cause of Proteinuria, the claim was allowed.

Chennai Ombudsman Centre
Case No.11.02.1235/2006-2007
Shri. Vijayakrishnan
Vs
The New India Assurance Co. Ltd.

Award Dated : 30.11.2006

The complainant Shri. Vijayakrishnan and his spouse were covered under Mediclaim policy with M/s New India Assurance co. Ltd. through Unit Trust of India. His wife was hospitalized and diagnosed to have Pneumonia and he had incurred Rs. 30,476/-. He had approached the Forum for delay in settlement.

Meanwhile, the Insurer had settled the claim for Rs.30,143/- and disallowed a small an amount of Rs.333/ pertaining to pre and post-hospitalisation expenses which were not allowed under the scheme. The Insurer has further stated that this is a unique policy issued to UTI for their card holders. Hence they received documents through UTI and sent the voucher through the UTI.

This Forum perused the documents and found that the Insurer was not solely responsible for the delay nor the delay substantial enough to award the interest for the same. Hence the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.02.1239/2006-2007
Shri. R. Padmanabhanl
Vs
New India Assurance Co. Ltd.,

Award Dated : 26.12.2006

The complainant stated that he and his family members were covered under Mediclaim Policy with M/s New India Assurance Co. Ltd. His mother was hospitalized and the diagnosis was Artherosclerotic Coronary Artery Disease-Triple Vessel, DM, HT with unstable Angina. His submitted the claim papers to the Insurer and the same was repudiated on the ground pre-existing disease. The Complainant contention was that his mother was not suffering from DM for 17 years as stated by the Insurer but only for 5 to 7 years and not suffering from any other ailment. His representation was not considered, hence he had approached this Forum.

The Insurer contended that the patient himself agreed that his mother was a DM patient for 5 to 7 years and failed to disclose the same at the time of proposal. Insurer stated that DM might be the chief risk factor for heart disease. Hence, they have repudiated as per the report given by the Doctor.

This Forum perused the medical records and found that Diabetes and Hypothyroidism are pre-existing and the insurer have not proved conclusively that Diabetes was the proximate cause for the CAD of the insured. Hence the direction was given to the Insurer to process and settle the claim.

Chennai Ombudsman Centre
Case No.11.02.1242/2006-2007
Shri. V Rajagopal

Vs

New India Assurance Co. Ltd.,

Award Dated : 26.12.2006

The complainant stated that he was covered under Mediclaim policy with M/s New India Assurance Co. Ltd., since 2003 and the policy was renewed from 08.10.2004 to 07.10.2005. He was hospitalized at M/s Vadamalayan Hospital from 07.10.2005 to 09.10.2005 for the nasal bleeding. When he approached M/s Medi Assist India, TPA of the insurer for cash less facility, the same was rejected and subsequently when he submitted the claim papers, the claim was rejected on the grounds that the present hospitalization was for pre existing disease of HTN. His representation against the repudiation was also not considered and the insurer did not settle his claim, hence he filed this complaint.

The Insurer contended that the patient was hypertensive for the past 10 years and the present treatment was for nasal bleeding which could have been due to pre existing disease of hypertension, hence the claim is not admissible under the policy. The hospital records revealed that the patient had a complaint frequent episodes of bleeding, Small ulcer seen over the junction of Septum and Lateral wall of Nasal cavity, spots of blood seen. It was also revealed that ulcer which was bleeding, cauterized. Therefore, it was evident that the insured had ulcers in his nasal cavity, which the cause of the bleeding and the same was cauterized. Therefore, the insurer failed to establish by way of documentary evidence that the nasal bleeding was due to hypertension, hence complaint was allowed and direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre

Case No.11.03.1210/2006-2007

Shri. R Santhana Krishnan

Vs

National Insurance Co. Ltd.,

Award Dated : 26.12.2006

The complainant stated that he was covered under Mediclaim policy with M/s National Insurance Co. Ltd., T.Nagar Branch, Chennai for the past 3 years. He was hospitalized at M/s Vijaya Hospital from 16.01.2006 to 21.01.2006 for the treatment of stomach pain and diagnosis was Chronic calculus Cholecystitis, chronic appendicitis. He submitted the claim papers with M/s Medicare, TPA of the insurer, but his claim was rejected on the ground that the hospitalization was for pre existing disease. He represented to the insurer that he had not symptoms about the present ailment prior to taking the policy, hence the decision of rejecting his claim is not justifiable. However, his representation was not considered, hence he filed a complaint.

The Insurer represented that there was a break in insurance, hence they treated the policy issued in the year 2004-05 as a fresh policy and as per their panel doctor's opinion that the present hospitalization for pre existing disease. This forum perused the documents and understood that the present hospitalization was for chronic Calculus Cholecystitis, Chronic Appendicitis.

The Insurer relied on the prescription issued by Dr Nagasai in November 2005 mentioning that pain in the right iliac region since 2 years to support their stand. However, the diagnosis was Amoebiasis and medicines were also prescribed for the same. The insurer failed to establish by way of documentary evidence that the patient was diagnosed with Cholelythiasis and Appendicitis prior to inception of the policy or he was aware of the pre existing disease at the time of proposing for insurance.

Therefore, the insurer was not justified in their stand of repudiation, hence complaint was allowed and direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre
Case No.11.02.1233/2006-2007
Shri. V. Sarat
Vs
New India Assurance Co. Ltd.,

Award Dated : 26.12.2006

The complaint was filed by Mr V Sarat husband of Smt Rudrani. He stated that his wife was covered under Mediclaim policy with M/s New India Assurance Co. Ltd., Nungambakkam Branch. His wife was hospitalized from 09.05.2006 to 20.05.2006 for Primi IUI conception for observation and emergency LSCS was done on her. He claimed for reimbursement of hospitalization expenses, but the same was rejected by the insurer on the ground that the policy excludes treatment arising from or traceable to childbirth, miscarriage, abortion or complications of these including Caesarian, hence this claim is not admissible under the policy. He represented to the insurer that due to emergency and to save the mother and child the doctor conducted this surgery, hence the rejection of his claim was incorrect.

The Insurer contended that as per policy any testament related to maternity was not payable. During the hearing the complainant admitted that his wife underwent infertility treatment. From the hospital records it was evident that the hospitalization was for Ceaserian section. The Policy specifically excludes any treatment related to maternity including the emergency situation is excluded under the policy. The contract of insurance is based on certain mutually agreed terms and when it was perceived and exclude certain contingencies under the policy, this forum cannot overlook the said exclusion. Therefore, the complaint was dismissed.

Chennai Ombudsman Centre
Case No. : 11.02.1248/2006-2007
Smt. Leelamma Joseph
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.12.2006

The complainant Smt. Leelamma Joseph was covered under Mediclaim policy with M/s New India Assurance Co. Ltd. She met with a road accident on 03.11.05 and her first claim was settled but her subsequent claim made for her hospitalization with the diagnosis of Contusion Knee and IDK (LT), was declined by the TPA on the ground hospitalization not warranted.

The insurer contended that insured was diagnosed to have Contusion of knee and IDK and advised MRI Scan as per the discharge summary of the hospital. Insurer submitted the indoor case sheets to substantiate their stand and stated that the insured was advised only oral medication and Physiotherapy.

The Forum perused the medical records and observed that as per the policy it stipulates that the disease should require hospitalization for medical/surgical treatment as an inpatient. In this case the insured was examined as an op and advised for further treatment as OP and treatment given during hospitalization were in consonance with the treatment advised as an OP, hence the need for hospitalization had not been established. Hence, the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.02.1214/2006-2007
Shri. Shashikant Arya
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.12.2006

The complainant and his family members were covered under Mediclaim policy with M/s New India Assurance Co. ltd. His daughter Deepshi Arya was hospitalized for high fever. He had made a claim for an amount of Rs.22,722/- but his claim was short settled for Rs.7722/-. Since, the reasonable amount admissible under the policy was Rs.15,000/- the insurer had short settled the claim amount made.

The Insurer contended that the patient was admitted for fever and the temperature of the patient was stabilized the next day itself. But 5 more days the patient was confined to the hospital , the reason for which was not substantiated. The room rent was exorbitant. The main contention of the Insurer was that the hospitalization for a period of 7 days was not warranted since the fever subsided the next day.

This Forum pointed out to the Insurer the tariff of hospitals varies from city to city hence, comparison of the cost is not appropriate. It was also observed from the discharge summary that the platelets counts increased substantially when comparing the same at the time of hospitalization with the platelets counts at the time of discharge. It was also pointed out that the attending doctor was the one who had recommended the span of hospitalization and the insured could not be blamed. Hence, direction was given to the Insurer to settle the balance claim amount subject to the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.02.1222/2006-2007
Shri. Suresh Kumar Bhatter
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.12.2006

The complainant Shri. Suresh Kumar Bhatter and his family members were covered under Mediclaim Policy with M/s New India Assurance Co. Ltd. His wife was hospitalized due to knee problem and diagnosed to have ligament tear. His claim was repudiated on the ground that the procedure could have been taken as an OPD. The complainant's contention was that the patient was admitted as per the advice of the doctor and they had advised for Arthroscopic surgery but they have postponed the surgery hence, the doctor had suggested with oral medication.

The Insurer contended that as per the discharge summary of the hospital, the patient had pain in her left knee since 2 weeks and in the prescription it was written as 'Scan Suggested' on its reverse side and argued that as per the prescription the insured would have taken MRI for which a hospitalization was not required. They also stated that no active treatment was done and at the time of discharge the insured was merely prescribed with Analgesics and to take rest. Since, there was no active treatment involved and hospitalization was only for diagnostic purpose, the insurer repudiated the claim on the ground hospitalization not warranted. It was pointed out by the TPA that the patient had not undergone any surgery till date as advised by the doctor.

The Forum perused the documents and found the severity of the ailment. since the doctor had advised to undergo surgery as early as possible. It was observed from the

discharge summary that the patient had a fall, diagnosed to have complete anterior ligament tear and Arthroscopic surgery was suggested. There was a positive existence of disease, which had made the hospitalization required, and the doctor had also advised hospitalization, hence direction was given to the insurer to settle the claim subject to the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.08.1232/2006-2007
Shri. A.V. Ramachandran
Vs
The Royal Sundaram Alliance Ins. Co. Ltd.,

Award Dated : 25.01.2007

The complainant was covered under Mediclaim policy with M/s Royal Sundaram Alliance Ins. Co. Ltd. for the period from 30.06.05 to 29.06.06. During his journey by train on 09.6.2006, he had chest discomfort and diagnosed to have Coronary Artery Disease, Triple Vessel Disease. His claim was repudiated on the ground of pre-existing disease. He had produced the Cardiologist certificate to substantiate his stand.

The Insurer contended that the policy was incepted in June 2005 and in the discharge summary of the hospital, it was mentioned that the patient was a known case of CAD and Acute MI, which revealed that the patient was a known case of CAD for a long time. Further, Insurer stated that the Angiogram revealed the Triple Vessel Disease and the problem would be in existence even though the patient may not be aware that the symptom is connected with the disease.

The Forum perused the documents and found that there was no recorded evidence to prove that the patient was suffering from CAD prior to 30.6.05. The Panel doctor considering the severity and nature of Triple Vessel Disease concluded that the disease would have pre-existing since the policy was incepted on 30.06.2005. The insurer had not produced conclusive evidence to show the onset of disease and the first onset of symptoms were only in June 2006, hence direction was given to the Insurer to process and settle the claim as per other terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.08.1256/2006-2007
Shri. V . Munisami
Vs
The Royal Sundaram Alliance Ins. Co. Ltd.,

Award Dated : 25.01.2007

The complainant, Shri. V. Munisami and his family members were covered under Health Shield Insurance with M/s Royal Sundaram Alliance Ins. Co. for the period from 29.08.05 to 28.08.06. His daughter was hospitalized from 7.3.06 to 13.03.06 and diagnosed with Ureteric Calculi. She underwent Cystoscopy and Lithotripsy. The Insurer repudiated his claim for reimbursement of hospitalization expenses stating that the patient had similar episode 2 years back as per the discharge summary hence, they repudiated on the ground of pre-existing.

The insurer contended that the symptoms of the disease were pre-existing and as per the internal case sheets which had stated that the patient had a history of passage of Stone after diuretic therapy 2 years back. The Insurer had also opined that Calculi of 7 to 9 mm would have taken more than a year to grow. But in this case the size of the calculi has not been recorded in the IVP.

The Forum perused the documents and observed that the insurer could not establish with concrete documentary evidence that the patient was not cured of the said problem 2 years ago and her problem was continuing even after diuretic treatment. Hence, it could not be construed as conclusive proof that that the patient was continuing with the said disease even at the time of proposing for insurance and the present ailment is the complication arising from the problem which took place 2 years back. The Insurer also fail to establish how long it would take for a stone measuring 7 to 9 mm in size to develop , hence in the light of the above facts, direction was given to the Insurer to process and settle the claim.

Chennai Ombudsman Centre
Case No.11.02.1276/2006-2007
Smt. Bhuvaneshwary Vasudevan
Vs
The New India Assurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Smt. Bhuvaneshwary Vasudevan was covered under Mediclaim policy with M/s New India Assurance Co. ltd. for the period 14.02.2005 to 13.02.2006 and she had included her daughter selvi. Sridevi under the policy on 23.02.05. She noticed on 01.09.07 that her child developed a swelling in the back of the neck and was hospitalized from 13.12.05 to 14.12.05 for surgery. Her claim was repudiated by the Insurer on the ground that the present hospitalization was for the treatment of a pre-existing disease. She contended that the hospitalization was not for pre-existing disease.

The Insurer contended that as per the Medical opinion obtained by their TPA the swelling though present soon after birth could exist and present during childhood or adolescence. The insurer suspected that since the child was not initially covered and later included, the ailment should have been congenital and on noticing the lump they would have included the child. The Insurer also stated that RO has repudiated the claim invoking 4.3 i.e 1st year exclusion.

The Forum perused the documents and it was observed that the RO repudiated the claim invoking 4.3. As per the medical records there was no indication of external or internal congenital disease or defect at the time of birth. The Insurer failed to establish by way of documentary evidence to substantiate that the present hospitalization was for congenital disease, hence repudiation invoking 4.3 was not tenable. The insurer was very well aware of the age of the child, and the complainant had furnished the necessary information in the proposal form, the insurer having accepted the risk with full knowledge casting aspersions at the time of a claim is not in good order. Hence direction was given to the Insurer to process and settle the claim as per terms and policy conditions.

Chennai Ombudsman Centre
Case No.11.04.1310/2006-2007
Shri. Govindarajan
Vs
M/s United India Insurance Co. Ltd

Award Dated : 27.02.2007

The complainant Shri. Govindarajan and his family members were covered under Mediclaim policy with M/s United India Insurance Co. Ltd form 2004. His wife was hospitalized and diagnosed with incisional hernia. The complainant submitted the claim

papers with the insurer and the same was rejected invoking exclusion clause 4.1 of the policy.

The insurer contended that they have repudiated the claim since the open Hysterectomy was done 14 years back which was prior to inception of the policy. Since, the same was the proximate cause for the present ailment, they have repudiated the claim invoking exclusion clause 4.1 of the policy.

This Forum perused the documents and observed that there was no adverse remark in the discharge summary regarding the open hysterectomy done 14 years back. The medical record showed that the Hernia problem started only 6 months back and Hernia was not a pre-existing disease. It was pointed out to the insurer that though it is a fact that incisional hernia takes place at the site of the scar and it was also noted that only the scar of the previous incision was pre-existing and not the hernia. Hence, direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.02.1314/2006-2007
Shri.J.Bhaskaran
Vs
The New India Assurance Co.Ltd.,

Award Dated : 27.02.2007

The complainant J.Bhaskaran has taken a Mediclaim policy with M/S New India Assurance Co.Ltd., from 1999. He fell down in his factory and was admitted in the hospital for the treatment from 25-02-06 to 01-03-06 and the diagnosis was systemic hypertension, V estibular neuronitis, left supra spinatus tendinits. He submitted the claim papers for reimbursement of hospitalization charges. But the same was rejected by the T.P.A. of the Insurer on the ground that the treatment did not warrant hospitalization and could have been treated as an outpatient.

The Insurer contended that that the complainant was admitted to Apollo Hospitals, Madurai with a history of vertigo and unconsciousness. As per the requisition form for cash less facility submitted by the doctor, duration of ailment was mentioned 4 days. AS per discharge summary, the patient was diagnosed to have SHTN, Vestibular Neuronitis, Left Spra Spinitus and Tendonitis. The complainant was treated with oral medicines and physiotherapy. The Insurer contended that patient was having only history of vertigo for the past 4 days prior to hospitalization, which could have been managed as out patient. The Insurer also argued that the hospitalization was only for diagnostic purpose and no treatment was given for positive existence of any ailment. Therefore the Insurer invoked policy exclusion and repudiated the claim.

This Forum perused the documents and found that there were no records to indicate that the patient was in such a condition so as to require the infrastructure of a hospital. The Mediclaim policy envisages reimbursement of the medical expenses if the disease and its treatment require the infrastructure of a hospital upon the advice of a qualified doctor. In this case the complainant failed to establish that the present treatment warranted the infrastructure of a hospital. Hence the forum dismissed the complaint.

Chennai Ombudsman Centre
Case No.11.02.1223/2006-2007
Shri. K. Thangavelu
Vs
The New India Assurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Shri. K. Thangavelu was covered under Mediclaim policy issued by M/s New India Assurance Co. ltd. since 1998. He was hospitalized since he had Cardiac Arrest and underwent Coronary Artery By Pass surgery. His claim was rejected on the grounds of pre-existing disease. He substantiated his contention by stating that he had taken Asha Deep Policy with LIC of India in 1999 after due medical examination and LIC has also settled the claim.. However, the Insurer did not consider it.

The Insurer contended that the complainant has three ailments namely DM, HT and elevated Cholesterol which are the major contributing factors for Myocardial Infarction. They also contended that renal failure would not occur within a short span. Hence DM would have been for 10-12 years which was stated by Insured himself to the hospital authorities and later altered as 2 years. The Insurer stated that they have not gone through the documents pertaining to his LIC policy and they have obtained only oral opinion from them which stated that the records were clear and hence LIC settled the same.

This Forum perused the documents. This Forum observed that though DM and HT both are risk factors but could not be the sole cause for CAD. It was also observed that medical records were contradicting in stating the history of Diabetes and later corrected. Hence, direction was given to the Insurer to pay the expenses relating to the treatment for CAD.alone.

Chennai Ombudsman Centre
Case No.11.14.1261/2006-2007
Smt. Manorama Arvind
Vs
M/s Cholamandalam MS Gen. Ins. Co. Ltd

Award Dated : 27.02.2007

The complainant Smt Manorama Arvid stated that she had taken Individual Health Policy with M/s Cholamandalam MS Gen. Ins. Co Ltd., in the year 2004 and disclosed her surgery conducted in the year 2002. The policy was renewed for the period from 26.03.2005 to 25.03.2006. She was hospitalized at M/s Apollo Hospital on 10.04.2006 for I-131 Ablation Therapy. Her claim was rejected by the insurer on the ground that present treatment was for Residual Functioning Thyroid Tissue, which is a complication of post Total Throidectomy status of Papillary Carcinoma of Thyroid which a was prior to the inception of the policy, hence the claim was not payable. She represented against the repudiation, but her claim was not settled.

It has been observed from the policy exclusion, the treatment for any pre existing condition is not payable under the policy, but would become payable if the insured had not taken any treatment or received medical advice in the past 24 months for the particular pre existing ailment. In this case , it was established by the complainant that she was cured of the disease after the surgery in January 2002 and subsequent problem leading to treatment has arisen only in April 2006. Hence, on the date of inception of the policy the insured has not had any treatment for the disease for a period of 26 months, hence as per the definition of the policy, the disease suffered by Smt Manorama Arvind in January 2002 is not be reckoned as ‘pre existing disease’. Therefore direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre
Case No.11.04.1278/2006-2007
Dr. P K Joy

Vs

M/s United India Insurance Co. Ltd

Award Dated : 27.02.2007

The complainant Dr P K Joy stated that his wife Mrs Saramma joy was covered under Mediclaim policy with M/s United India Insurance Co. Ltd., and she was hospitalized at M/s Apollo Hospital from 26.06.2006 to 04.07.2006 for the complaint of Pneumonia and she died in the hospital. He preferred a claim with M/s Family Health Plan Ltd., TPA of the insurer, but his claim was rejected on the ground of pre existence of Diabetes. He represented to the insurer that the primary cause of death was pneumonia and not diabetes. However, his claim was not settled.

The insurer / TPA has concluded on the basis of the pre existence of the disease on presenting complaints and provisional diagnosis mentioned in the admission request form. However, the Death Summary gave the actual diagnosis, which was 'pneumonia and pulmonary oedema'. The insurer relied only provisional diagnosis, but ultimate diagnosis and treatment as per the hospital records is that of a disease namely Pneumonia of which there was no indication of pre existence, hence insurer was not justified in rejecting the claim on the grounds of pre existing disease. The Insured also made a complaint that no claim form was issued to him, hence, insurer/TPA were directed to issue the claim form and settle the claim subject to other terms and conditions of the policy.

Chennai Ombudsman Centre

Case No.11.03.1294/2006-2007

Smt. P.A. Vijayan

Vs

National Insurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Shri. P.A. Vijayan stated that he had taken an Arokya Bima Policy for his family form 20.01.2003 to 20.01.2004 with National Insurance Co. Ltd. Subsequently he converted the policy as Universal Health Insurance Policy which was in force from 07.10.2003 to 06.10.2004. His wife was hospitalized for cataract operation from 02.10.2004 to 3.10.2004. His claim was repudiated on the ground of first year exclusion.

The Insurer stated that the complainant was covered under Jan Arogya Bima policy with one branch and under Universal Health Insurance policy with another DO, both the polices were overlapping. The contention of the Insurer was that the above said two policies were separate contracts of insurance. Since the claim was made under Universal Health insurance, the claim falls under 1st year exclusion. His claim for the treatment of Cerebro Vascular Attack was also repudiated under exclusion clause 4.1 of the policy.

The Forum perused the documents. It was observed that though the insured has been covered by Universal Health Insurance from Oct.2003, prior to that he has been covered by Jan Arokya Bima policy. Hence repudiating the claim invoking 1 st year exclusion is not unreasonable since the insured was covered under another health insurance policy. Subsequent to the hearing, it was found that the complainant was continuously covered under Jan Arokya Policy with Cuddalore Branch by his employer from 1999 to 2000 and with another branch from 2000 to 2004. Hence, direction was given to the insurer to process and settle the claim as per the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.05.1219/2006-2007
Shri. S. Chandrasekharan
Vs
Oriental Insurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Shri. S. Chandrasekaran was covered under Mediclaim policy with M/s Oriental Insurance Co. Ltd. since January 2004. He was hospitalized from 6.6.04 to 19.06.04 for which he had preferred 3 claims and diagnosed as Cirrhosis of Liver. However, his 1st and 2nd claim was short settled by the Insurer and the 3rd claim was totally rejected on the ground of pre-existing. The Insurer did not consider his representation.

The Insurer contended that the diagnosis was Cirrhosis of liver, which was chronic in nature hence, they have repudiated the claim invoking exclusion clause 4.1 of he policy. The TPA of the insurer stated that being chronic in nature the disease would be pre-existing and the complainant failed to disclose the same at the time of proposal.

This Forum observed from the panel doctors report that the patient might not be aware of the problem and the policy exclusion in respect of pre-existing disease stipulates that the pre-existing condition is not applicable when the opinion of the Medical practitioner appointed by TPA/Company, stating that the Insured person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of proposing insurance . In this case the panel of Doctors who have given opinion to the Insurer has not categorically stated that the patient was aware of the disease at the time of proposing for Insurance and the Insurer also failed to produce any documentary evidence to establish that the patient was aware of the disease at the time of proposing for insurance. hence, direction was given to the Insurer to settle the claim. Further, the first and second claims were also allowed since, the reasons for disallowing a partial amount were not substantiated properly by the Insurer.

Chennai Ombudsman Centre
Case No.11.04.1260/2006-2007
Smt. S. Sugunamma
Vs
The United India Insurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Smt. S. Sugunamma and her family members were covered under Mediclaim policy with M/s United India Insurance Co. Ltd. since 1999. The policy was renewed for the period from 27.03.05 to 26.03.06 but the premium cheque was dishonoured. The Insurance Co. cancelled the policy and had issued a fresh policy from 07.04.05 to 26.03.06. Subsequently, she was hospitalized for the treatment of Papillary Endocervicitis. However, the Insurer repudiated the claim on the ground that since the same falls under the first year exclusion of the policy. The main contention of the complainant was that she was not informed at the time of renewal that it was a fresh policy. She also contended that since the policy was renewed with a cumulative bonus of 5%, she was of the opinion that the Insurer had waived the lapse of 11 days break in insurance.

The Insurer contended that they have renewed the policy treating it as a fresh policy. Insurer also stated that they did not waive the 11 days break since it was violation of Sec.64 VB of insurance Act. Insurer also contended that Hysterectomy was not payable under the first year policy, hence they repudiated the claim.

The Forum perused the medical records and observed that the diagnosis was mild to moderate Dysplasia and there was no evidence for the Hysterectomy having been done due to Menorhagia or Fibromyoma. Insurer also failed to establish by way of evidence that the policy was treated as a fresh policy which are evident from the fact that no proposal form was obtained and cumulative bonus was also given which is generally given for no claim over a continuous period of renewal and it was observed form the act of the insurer that the policy was continuous one even though the premium was paid subsequently. Hence, direction was given to the Insurer to process and settle the claim as per the terms and condition of the policy.

Chennai Ombudsman Centre
Case No.11.03.1275/2006-2007
Mr Vasudev R Dave
Vs
M/s National Insurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Mr Vasudev R Dave stated that his wife Smt Asha Vasudev Dave was covered under Mediclaim policy with M/s National Insurance Co. Ltd., from 02.01.2005 and the policy was renewed for the further period 2006-07. His wife was hospitalized at M/s Ganga Hospital for degenerative lumbar canal stenosis (3-4, L4-5) with neurogenic, Claudication and functional restriction. He preferred a claim but the same was rejected by the insured on the grounds of pre existing disease. He represented that previously his wife was covered under Group Mediclaim policy and subsequently covered under Individual mediclaim policy for several years, his previous 2 claims were settled by the insurer and even though there was some break in insurance and technically the rejection may be correct, he requested that the claim may be considered on sympathetic grounds.

The Insurer established that the policy was taken from 02.01.2005 and as per hospital records that the patient was suffering from low back pain for 5-6 years. The previous claim in September 2005 was for Gastroenteritis, hence the same was settled. The Insurer claimed that the complainant was holding policy upto 30.03.2004 and there was a break in insurance from 01.04.2004 to 01.01.2005. . subsequently the insured had taken a fresh policy on 02.01.005 by submitting a fresh proposal. The discharge summary for the hospitalization in June 2006 revealed that the patient was having the complaints of pain in lower back and radiation to both lower limb 5-6 years. The discharge summary of July 2002 also revealed that the patient was diagnosed with degenerative Disc Disease with Radicular Pain. The discharge summary of hospitalization in October 2003 also revealed that the patient was diagnosed with chronic disc degeneration with disc prolapse at L3-L4 with compression of nerve roots. Therefore, it was evident that the patient had a complain of lower back pain and radiation for 5-6 years, earlier in 2 occasions she was hospitalized for the same ailment, the insured failed to disclose the said ailment in the proposal form submitted in the year 2005, hence the insurer is justified in rejecting the claim under the policy exclusion 4.1. The complaint is dismissed.

Chennai Ombudsman Centre
Case No.11.04.1312/2006-2007
Smt. P. Sellammal
Vs
United India Insurance Co. Ltd

Award Dated : 16.03.2007

The complainant Smt. P. Sellammal and her family members were covered under Mediclaim policy with M/s United India Insurance Co. from 24.11.05 to 23.11.2006. Her husband had a stomach pain and was hospitalized. Subsequently he has undergone surgery. The TPA repudiated the claim on the grounds of pre-existing illness.

The Insurer contended that there was a break in the insurance for 3 months and the insured failed to disclose at the time of proposal the illness suffered by him. The TPA contended that the present hospitalization was for management of a complication of earlier surgery done which is prior to the inception of the policy, hence they have repudiated the claim.

The Forum perused the documents. It was observed that the present hospitalization was due to a complication of the earlier surgery done and failed to disclose the same in the proposal form. Since, the present ailment though being an independent event is the same as suffered in 2004 and hence the insurer is not liable to settle the claim. The complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.05.1315/2006-2007
Shri. R. Gopalswamy
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 16.03.2007

The complainant Shri. R. Gopalswamy was covered under Mediclaim policy with M/s Oriental Insurance Co. ltd. since 1996. He was hospitalized for heart disease. The Insurer on the grounds of pre-existing disease of hypertension repudiated his claim.. He represented to the Insurer that he had no symptoms of heart disease. However, it was not considered.

The Insurer contended that they have repudiated as per their TPA's opinion. TPA stated that the insured was a known patient of HT, which was disclosed by the insured himself at the time of proposal and since the same being the contributing factor for CAD, they have repudiated the claim invoking exclusion 4.1 of the policy.

The Forum perused the documents. It was observed that the attending doctor had certified that the patient was not having any symptom of Ischemic heart disease. Since, the Insurer had failed to establish that Hypertension was the sole risk factor and proximate cause for CAD by way of documentary evidence, the direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.02.1360/2006-2007
Shri. S. Chokkalingam
Vs
New India Assurance Co. Ltd.

Award Dated : 21.03.2007

The complainant was covered under Mediclaim policy with M/s New India Assurance Co. ltd. from 25.02.06 to 24.2.2007. On 22.04.06 when his pushed his car, he developed pain and got hospitalized at M/s PSG Hospital. The diagnosis was proximal

weakness. The TPA has repudiated the claim on the grounds of hospitalization not warranted

The Insurer contended that only evaluation was done during his stay in the hospital, which includes MRI, USG abdomen and this could have been done as an OPD procedure itself. Hence, hospitalization was not warranted. The Insurer stated that the complainant was prescribed with few medicines, which are general vitamin tablets, and his medical reports were also normal, hence the Insurer reiterated their stand of repudiation. The Representative of the TPA stated that the complainant had a history of LBA, ear bloc and used to take electoral powder for past 6 years, which showed that the complainant was a hypothyroid patient. He stated that though the reason for which the complainant approached the hospial was correct , there was no active line of treatment given to him. MRI and USG were normal and advised with vitamin tablets and thyroid tablets. Hence, the TPA has repudiated the claim under clause 1.1 of the policy.

There was no indication that any active treatment was given which require infrastructure of a hospital. The Mediclaim policy envisages that the insurance company will reimburse hospitalization expenses only when the condition of the patient is such that he requires treatment, which requires the infrastructure of the hospital. The complainant failed to establish that the present treatment requires infrastructure of hospital and hence the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.12.1262/2006-2007
Shri. Sujit Jose
Vs
ICICI Lombard Gen. Ins. Co. Ltd.,

Award Dated : 23.03.2007

The complaint Mr Suchit Jose represented that he is a credit card holder of M/s ICICI Bank and covered under Mediclaim policy with M/s ICICI Lombard Gen. Ins. Co. Ltd., since 2003. During 2004-05, the premium was debited to his account on 09.08.2004, but the policy was renewed retrospectively from 20.04.2004 i.e. premium was collected by the insurer for the period they were not on risk, hence he sought the refund for this period. Further, he made a complaint that during the renewal in 2005-06, his request for the renewal of policy on par with the Credit card holders by collecting lesser premium in equal 24 months installment was also not considered by the insurer inter alia other general complaints against the insurer and also claimed for compensation & other relief.

The representative of the Insurer stated that for continuity of cover they offered the cover from April 2004. The insurer contended they got the discretion to issue the policy retrospectively eventhough there was no premium between April 2004 to August 2004 and they could have admitted and settled all the claims reported during this break in insurance. The Insurer also contended that even at this point of time, they are ready to renew the policy from April 2005 and will entertain all the claim during the break in insurance, provided the premium for the lapsed period being paid in lumpsum and the balance may be paid in equal EMI. Since, the insurer contention was not in consonance with the relevant provision of 64 VB of the Insurance Act , this forum communicated to the highest authority to confirm whether they are having corporate decision to issue the

policy retrospectively collecting the premium much after the commencement of the policy. However, the corporate office of the insurer failed to furnish their clarification.

Considering the facts and circumstances, following directions have been given to the insurer:

1. Refund of premium to be made for the period from 20.04.2004 to 08.08.2004.
2. Family Floater plan – Medical Insurance be offered to the complaint on EMI basis prospectively.
3. Break in insurance from July 2006 till date (within 30 days from the date of receipt of the award) shall be waived and all the other benefits viz. cumulative bonus, waiver of pre existing disease, first year exclusion etc., shall be allowed to the complainant.

No other relief was allowed to the insured.

Chennai Ombudsman Centre
Case No.11.03.1391/2006-2007
Shri. I. J. Balasamy
Vs
National Insurance Co. Ltd.,

Award Dated : 28.03.2007

A complaint was filed by Mr I J Balasamy stating that his wife Mrs Cecily was covered under mediclaim policy with M/s National Insurance Co. Ltd., Branch Office, Chennai. She had a swelling and pain in the abdomen and was hospitalized at M/s Vijaya Health Centre from 26.06.2005 to 03.07.2005 and the diagnosis was Incisional Hernia. His claim was rejected by M/s Family Health Plan Ltd., TPA of the insurer on the grounds that the hospitalization is related to previous surgeries, hence falls under pre existing exclusion.

It was established that the patient was having the complaint of swelling and pain in the abdomen region since 15 days prior to operation. There was no specific mention in the discharge summary that the present ailment Incisional Hernia in Umbilical area is the complications of LSCS done earlier or that the incisiional hernia was in existence prior to 13.12.2002 i.e. the date of inception of the policy. The present hernia would not doubt have arisen at the place of scar of the previous incision, however the scar of the previous incision was pre existing and not the Hernia. The mediclaim policy excludes pre existing disease and not pre existing scars. Direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.03.1313/2006-2007
Shri. A. Damodaran
Vs
National Insurance Co. Ltd.

Award Dated : 29.03.2007

The Complainant Shri A Damodharan was covered under Mediclaim policy for more than 15 years and he insured with M/s National Insurance Co. Ltd., since 5 years. The policy was renewed for the period from 10.10.2005 to 09.10.2006. He was hospitalized for the complaints of non-healing wound over left knee. He submitted the claim papers to M/s Family Health Plan Ltd., TPA of the insurer, but his claim was rejected on the grounds of pre existing disease of Haemophillia.

The representative of the insurer stated that the policy commencing from 29th September 2004 was taken from his office. In the proposal dated 29th September 2004, he did not disclose the diabetes and hypertension in the proposal form. After submission of the claim, they investigated since the complainant was admitted with Haemophilia with 7 weeks old internally fixed fracture patella left with Haemotoma. It was observed that the complainant had undergone a surgery for Scrotal Haemotoma in 1979. He had also undergone blood transfusion. He was a diabetic for 6 years and had hypertension for 16 years. The same was not disclosed in the proposal form. The complainant had a history of Haemophilia. Since the claim was made for a pre-existing condition they have repudiated the claim.

The patient himself and his relatives are the only source of this information and the significance of this information cannot be undermined. In the light of the above, the denial of the insured regarding the detection and awareness of his Hemophillia condition prior to his hospitalization in Apollo First Med Hospital does not carry conviction. It is also noted that had the Insurer been informed of the Hemophilia condition of the insured, the insurer would have been enabled to underwrite the risk appropriately, and by withholding this information, the Insurer has been put at a disadvantage. The forum observed that invoking of exclusion clause 4.1 is not tenable. However since with the available evidence, the issue of the insured being unaware of the existence of Hemophilia is debatable. Hence direction was given to the Insurer to pay 50% of the claim amount only.

Chennai Ombudsman Centre
Case No.11.02.1370/2006-2007
Shri. K S Babjee Gopinath
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Shri K S Babjee Gopinath stating that his wife K S B Chitrawas was covered under mediclaim policy since 2002 with M/s New India Assurance Co. Ltd., Divisional Office, Madurai. The Policy was renewed for the period from 03.04.2005 to 02.04.2006. His wife was hospitalized at M/s 04.12.2005 to 10.12.2005 for the complaints of pain on knees and underwent surgery. He submitted the claim papers to M/s Medi Assist, TPA of the insurer for the reimbursement of hospitalization expenses. They rejected his claim on the grounds that the hospitalization was for congenital external disease/defect/anomalies, which is excluded under the policy. His contention was that the hospitalization was not for congenital external disease and also submitted a certificate from his doctor.

It has been observed that neither the TPA nor the insurer established by way of documentary evidence that the present hospitalization was for congenital external disease. The panel doctor who had given an opinion to the insurer has not categorically certified that the present hospitalization was for congenital external disease or defect, but opined that the disease with deformity could have been there at least for more than 5 to 8 years. As per the Medical term ‘Congenital’ means ‘existing at, and usually before, birth’ (referring to a conditions that are present at birth). In this case, the insurer has failed to establish that the present problem is due to congenital external disease/defect/anomalies as meant by the term congenital. Further, the insurer also contended that the claim falls within the exclusion clause 4.1 viz., pre existing disease. However, the insurer failed to substantiate their stand by way of documentary evidence that (i) the ailment was present prior to the inception of the policy (ii) the insured was aware of the same and was taking treatment prior to

inception of the first policy etc. Hence complaint was allowed and direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.03.1334/2006-2007
Shri. G.Gopinathan
Vs
National Insurance Co. Ltd.,

Award Dated : 29.03.2007

The complainant Mr G Gopinathan made a complaint that he had a mediclaim policy with M/s National Insurance Co. Ltd., Divisional Office VII, Chennai since 2003. The policy was renewed from 09.10.2005 to 08.10.2006. He was hospitalized at M/s Ramachandra Medical Centre for the complaint of chest pain from 09.11.2005 and underwent coronary angiogram on 14.11.2005. He preferred a claim with the M/s Medicare, TPA of the insurer and it was initially approved by them, but subsequently it was rejected on the ground that the hospitalization was for pre existing disease.

The TPA has stated that the policy was in force with effect from 09.11.2003. The patient was a known case of Hypertension and Diabetic for last 2 years. Hence, HTN and Diabetes are major risk factor for the Coronary Artery Disease; The present disease is considered as pre existing disease, hence it is not admissible under the policy.

As per the documents produced by both the parties, it was clearly established that the policy was in existence since 09.10.2003. Even taking into consideration of the argument of the TPA, that the diabetes and hypertension for the past 2 years prior to hospitalization i.e. prior to 09.11.2005, the commencement date of ailment was 09.11.2003. However, the policy was taken one month prior to the commencement date of the ailment. Therefore, the insurer/TPA failed to establish that the insured was suffering from hypertension and Diabetes prior to inception of the policy.

During the hearing, the representative of the TPA furnished false information regarding the discharge voucher issued towards the settlement of claim and Suitable Instruction was given to the TPA to be more professional and transparent in their dealings. Direction was also given to the insurer to process and settle the claim as per other terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.04.1369/2006-2007
Shri. S Nagarajan
Vs
United India Ins. Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Mr S Nagarajan stating that he was insured under mediclaim policy since 2004 with M/s United India Insurance Co. Ltd., Coimbatore. The policy was renewed for the period from 07.10.2005 to 06.10.2006. He was hospitalized at M/s P S G Hospitals from 14.06.2006 to 16.06.2006 for the complaint of chest pain and the diagnosis was Ischemic heart disease. The TPA of the insurer M/s Family Health Plan Ltd., rejected his claim on the grounds that the present hospitalization was for the management of an ailment which is related to a pre existing disease (viz chest pain in 2000),. His main contention was that he was not having or aware of any heart problem prior to inception of the policy in 2000 and the present hospitalization was not for pre

existing disease. He also produced a copy of the certificate issued by the attending doctor to support his stand.

As per the documents produced before this forum, there was a remark of 'IHD since 2000' in the admission request. The certificate issued by M/s PSG Hospitals dt.17.08.2006 revealed that as per their records it was observed that there was some variation in the ECG taken on 23.12.2000, however, the patient produced a letter from M/s GKM Hospital that there was no significant change in ECG, and that it can be considered that he had no ischemia in 2000. Dr. S Rajasekhar of M/s G Kuppuswamy Naidu Memorial Hospital stated that as per the opinion of Dr R Chokalingam, there was no significant change in ECG taken on 23.12.2000 and he enclosed a copy of the prescription dt.23.12.2000.

The Insurer/TPA failed to establish that these medicines prescribed to the patient were for heart ailment. Therefore due to the discrepancies in the available documents it is not clearly established how long the insured was having IHD and whether he was aware of the same or not. The insurer also failed to produce any other documentary evidence to establish that the patient was having IHD since 2000, that he was aware of the said ailment and was under active treatment so as to establish their stand that the present hospitalization was for a pre existing disease. In the light of the above discussion, the repudiation of the claim is not maintainable, the complaint was allowed. Direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.02.1400/2006-2007
Shri. V Ramadurai
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Capt. V Ramadurai representing that a policy called Good Health has been taken by him since 1999 with M/s New India Assurance Co. Ltd., Divisional Office, Chennai and policy was also renewed for the period from 01.02.06 to 31.01.07. On 11.04.2006 he had a jaw pain, radiating to left arm with swelling and he was hospitalized at M/s Apollo Hospitals, Chennai from 11.04.2006 to 26.04.2006. The diagnosis was Coronary Artery Disease. His claim was rejected by M/s TTK Health Services P Ltd., since the present hospitalization was for the pre existing disease of heart disease 20 years back. He contended that the present hospitalization was not because of any other pre existing diseases.. His main contention was that the present hospitalization was not pre existing disease and also submitted a doctor certificate to support his stand. He claimed for the medical expenses and compensation of Rs.50000/-

It was established by the documents that the doctor who had filled in the data in pre authorization clarified that the patient had intimated chest pain 20 years back and no definite history of heart attack . Eventhough there is a remark in the discharge summary that the patient had silent inferior wall MI 25 years ago, but there are not other indication that the patient was having this problem for such a long time and was under treatment for the same. The insurer also failed to establish by way of documentary evidence that the patient had Coronary Artery Disease prior to inception of the policy, he was aware of the disease and under active treatment. The Insurer also contended that the insured failed to disclose his heart problem in the proposal form.

When there was an isolated episode of chest pain 25 years back and there was no definite history of heart attack, no record to support that the insured being aware of any heart ailment or taking treatment for the same, it was held it was not justifiable on the part of the insurer to invoke exclusion clause 4.1. Hence, Claim is allowed and direction was given to the insurer to process and settle the claim as per terms and conditions of the policy. No other relief was allowed towards compensation as claimed by the complainant.

Chennai Ombudsman Centre
Case No.11.02.1383/2006-2007
Shri. Shashikant Arya
Vs
New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Shri Shashikant Arya stating that his family is covered under Mediclaim policy since 1999 with M/s New India Assurance Co. Ltd., Divisional Office Coimbatore. The Policy was renewed for the period from 23.07.2006 to 22.07.2007. His wife Smt Nisha Arya was hospitalized from 05.07.2006 to 05.08.2006 for the treatment of Vathapittha complaints (Arthritis and skin lesions). He submitted the claim papers with M/s Medi Assist, TPA of the insurer, who rejected the claim on the grounds of pre existing disease. His main contention was that the insurer settled his previous claims hence this claim should also be settled and the insurer is wrong in treating this claim made for pre existing disease.

There was a directive from the GIC in the year 1998 to all the Public Sector Insurance Companies that in case of break insurance the insurance may obtain fresh proposal and issue the policy subject to any pre existing disease. In the said case, there has been a break in 1999 and the Discharge summary of 2003 carries the wording “General Joint pain – since 6 years’. The Insurer has accordingly excluded Complaints due to ‘Vatha’ from the year 2003 onwards. The Insurer was justified in denying the claim for “Vatha’ however, it is also noted that the Discharge summary mentions ailments arising due to ‘Pittha’. Since there is no specific exclusion for the treatment of ‘Pittha’, direction is given to the insurer to obtain necessary details from the hospital authorities for the treatment given for ‘Pittha’ and reimburse the same. Direction is also given to the insured to cooperate with the insurer to obtain these details from the hospital authorities so as to enable them to finalize the claim. Complaint is partially allowed.

Chennai Ombudsman Centre
Case No.11.02.1351/2006-2007
Shri. N Balan
Vs
New India Assurance Co. Ltd.,

Award Dated : 30.03.2007

A complaint was filed by Mr N Balan, stating that his family is covered under mediclaim policy with M/s New India Assurance Co. Ltd., Branch Office, Coimbatore since 2000 and the policy was renewed from 22.09.2005 to 21.09.2006. His mother was hospitalized at M/s PSG Hospital, Coimbatore from 17.06.2006 to 20.06.2006 and was diagnosed for mild depressive illness, Atrial Fibrillation secondary to IHD and Systemic Hypertension. His claim was rejected by the insurer on the grounds of policy exclusion

4.1 (pre existing disease) and 4.10 (hospitalization was not warranted). His main contention was that the hospitalization was not for any pre existing disease and due to bad health condition of her mother, she was hospitalized.

The documents revealed that the patient was having complaint of hyper salivation (persisting) with loss of appetite, nausea, occasional vomiting, constipation for 6 days and treatment was given accordingly. Hence the patient was not in health state at the time of admission and was affected psychologically in connection with her health condition. The attending doctor who can best decide the necessity for hospitalization taking into account the holistic picture of the patient physiologically and psychologically. The opinion of the insurer/TPA is only a post facto assessment of the situation without having seen the condition of the patient at the time of admission in the hospital. The Insurer also failed to establish by way of documentary evidence how the HT for the past years contributed for the present ailment to support their stand of pre existing exclusion. Direction is given to the insurer to settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No.11.08.1279/2006-2007
Shri. C F Thomas
Vs
Royal Sundaram All. Ins. Co. Ltd.,

Award Dated : 30.03.2007

The complainant Mr C.F. Thomas preferred a complaint stating that he was covered under Hospital Cash plan policy with M/s Royal Sundaram Alliance Ins. Co. Ltd., for the period from 15.03.2006 to 14.03.2007and the benefit under the policy was Rs.1000/- per day during hospitalization. He was hospitalized at M/s Sri Ramakrishna Hospital from 21.07.2006 to 23.07.2006 for coronary angiogram and was on leave for 21 days. He submitted his claim for the reimbursement of Rs.19000/- for 19 days, eventhough he was on leave for 21 days. However, the insurer rejected his claim on the grounds of pre existing disease of Diabetic and Hypertension. He contended that as per his doctor's opinion that Diabetes and hypertension might not be the primary factor for Coronary artery disease and the present hospitalization was not for pre existing disease. He claimed for compensation of Rs.19,000/- plus Rs.100000/- towards tension and mental agony.

There is no recorded evidence to establish that the patient was suffering from Coronary artery problem prior to 06.03.2006 and there is no mention about the past history of coronary artery problem in the claim form. The insurer's panel doctor opined that the Single Vessel Disease would have developed over a long period of time and there were no documentary evidence that the patient was having known of the disease prior to July 2006, hence the insurer was not justified in repudiating the claim. However, the policy provides benefits of Rs.1000/- for every 24 hours of hospital confinement viz admission in an hospital/nursing home and since the insured was hospitalized only for 2 days, direction was given to the insurer to settle the claim for Rs.2000/- towards 2 days hospitalization. No other relief was allowed.

Chennai Ombudsman Centre
Case No.11.08.1356/2006-2007
Shri. Prema @ Savithri Veeraraghavan
Vs
Royal Sundaram All. Ins. Co. Ltd.,

Award Dated : 30.03.2007

Smt. Prema @ Savithri Veeraraghavan filed a complaint against M/s Royal Sundaran Alliannce Ins. Co. Ltd., stating that she had taken mediclaim policy with them for the period commencing from 26.05.2003. She was hospitalized for the complaint of continuous haematuria with clots at M/s K J Hospital (P) Ltd., from 05.10.2006 to 28.10.2006. The claim was rejected by the insurer on the grounds of pre existing disease. She contended that previously there was heamaturia in urine, cystoscopy was done, she was treated by the urologist for urinary infection and was cured, hence she was not having any pre existence of the problem.

As per the documents placed before this forum it has been observed that it was evidence that patient was having problem of Haematura and there was a provisional diagnosis of CA Urinary bladders in Ultra Sound Report dt.25.08.2005. The treating doctor also given a certificate that the patient was under his treatment for superficial bladder cancer for the past 6 months which is prior to inception of the policy. There seems to be a hospitalization just prior to the present hospitalization in October 2006 which was not recorded in the discharge summary. The complainant also failed to disclose any information regarding this as well as the TURBT to this forum. Further the fax message of M/s K J Hospital dt.09.10.2006 indicates the diagnosis as Carcinoma. The complainant was not transparent to this forum. Further, the opinion of the doctor indicates that the last episode of massive Haematura was possible due to Radiation cystitis and bleed from the cancer site. In the light of the doctor's opinion, overwhelming evidences and the suppression of the information by the complainant, the complaint was dismissed.

Chennai Ombudsman Centre
Case No.11.04.1371/2006-2007
Shri. Ravi Kumar
Vs
United India Ins. Co. Ltd.,

Award Dated : 30.03.2007

A complaint was filed by Shri Ravi Kumar representing that he has taken a householders policy 170501/48/05/00261 for the period from 22.07.2005 to 21.07.2006 and a Special Contingency policy 170501/46/05/00074 covering the Laptop for the period from 05.07.2005 to 04.07.2006 with M/s United India Insurance Co. Ltd., Conoor. He arrived at Chennai by train on 14.10.2005 and his belongings were lost in the Railway Station. He preferred a complaint with the Railway police and the case was registered. He preferred a claim with the insurer for the loss of his Toshiba Laptop, Nikon Camera and baggage. The Insurer called for the non traceable certificate and he also submitted the same. However, the insurer insisted that he has to submit the court order in respect of Closure of FIR by the Magistrate Court. He informed the insurer that the Railway Police booked this case under Non cognizable offence and hence they were not in a position to issue this certificate. However his claim was not settled. His

main contention was that even after submission of necessary documents, his claim was not settled by the insurer.

The Insurer issued Householders Insurance policy no.170501/48/05/00261, extended to cover Baggage insurance (Personal Baggage, Personal effects & other articles) for the sum insured of Rs.5000/-. However, the complainant failed to establish whether his camera was also covered under any other section of the Householders Insurance policy. The Insurer failed to submit a copy of the All Risks Policy condition attached along with the said policy. Going by the usual wordings of an All Risks policy , it covers, inter alia , loss or damage due to accident or misfortune . The missing of the baggage is a misfortune and hence the same stands covered under the policy.

The policy wording stipulates that in case of a claim the insured shall give an intimation to the insurer along with evidence to substantiate his claim. The insured submitted evidence by way of a police certificate that his property was lost and 'un-detectable.' It is also observed that the insurer arranged for Investigation, but the investigation report appears inconclusive. Hence claim is allowed for Laptop under special contingency policy subject to market value basis. The complainant failed to establish under which policy the Camera was covered, hence claim was allowed under Baggage section subject to the sum insured of Rs.5000/- towards loss of camera, flash, zoom and clothes. No further relief on any other grounds is allowed.

Chennai Ombudsman Centre
Case No.11.08.1352/2006-2007
Shri. T. Sathiah
Vs
Royal Sundaram Alliance Ins. Co. Ltd.

Award Dated : 29.03.2007

The Complainant Shri T. Sathiah was covered under Health Shield policy issued by M/S Royal Sundaram for the period from 15.05.2006 to 14.05.2007. He was hospitalized for the complaint of chest pain with sweating and diagnosed to have CAD and advised for Angiography.

The Insurer contended that the policy was just 2 months old. As per the doctor's opinion obtained, it is stated that the insured's ECG report showed Bradycardia, which meant that the patient might be under medication. They also stated that the insured was a smoker and had multiple risk factors to develop CAD. Insurer argued that CAD could not develop within 2 months; hence they have repudiated the claim on the grounds of pre-existing.

The Forum perused the medical records and observed that none of the documents submitted gave any indication of pre-existing of Coronary Artery Disease prior to inception of the policy. The Insurer failed to produce by way of documentary evidence to substantiate that CAD existed in the insured before taking the policy and symptoms existed in the insured prior to 15.05.06 i.e. prior to inception of the policy. Hence the Insurer is direct to settle the claim as per other terms and conditions of the policy.

Delhi Ombudsman Centre
Case No. : GI/197/UII/05
Ms. Shikha jain
Vs
United India Insurance Company Limited

Award Dated : 25.10.2006

Ms. Shikha Jain lodged a complaint with this Forum on 27.06.2005 that she was having pain in her stomach(abdomen) and was admitted in the City Clinic on 19.11.2003 and discharged on 23.11.2003 after operation. On 28.06.2004, she had taken mediclaim policy of Rs.1,00,000/- from United India Insurance Company Limited. After taking the policy, she had severe pain at left side of lower abdomen, therefore, she was admitted in Shri Mool Chand Kharaiti Hospital and Ayurvedic Research Institute, New Delhi on 18.10.2004 and discharged on 21.10.2004 after operation. On 19.10.2004, the TPA, Family Health Plan Limited denied the cashless service to hospital. She had filed the claim papers after discharge from the hospital with the Insurance Company. She had received a letter from Family Health Plan Limited asking her to file previous surgical papers which she submitted with them on 05.01.2005. After one month, she received a phone call from the claim office that her claim has been rejected on the ground previous operation. No letter has been issued by the TPA rejecting her claim.

The Insurance Company, vide their letter dated 29.08.2005, informed that while going through the papers submitted by Ms. Shikha Jain in support of her claim, it is observed that she was admitted in City Clinic, New Delhi on 19.11.2003 and discharged on 23.11.2003 with complaint of pain in Lower abdomen and operated.

Again she was admitted in Moolchand Hospital on 18.10.2004 with the same problem, whereas as per the proposal form in Column No.13(a to o) which related to old diseases/illness/operations showed as NIL. As per standard mediclaim policy condition No.4.1 “All diseases/injuries which are pre-existing when the cover incepts for the first time. The Insurance Company shall not liable to make any payment under this policy in respect of any expenses incurred. Hence, the claim has rightly been rejected.

At the time of hearing, Shri Ramesh Chand Jain, father of the complainant, contested that his daughter was admitted in City Clinic on 19.11.2003. She had pain in lower abdomen for which she was operated. However, at Moolchand Hospital, she had pain at left hand side of lower abdomen. As such the place of operation was different and, therefore, the claim should be paid. Shri Sharma was shown the proposal form filled in by Ms. Shikha Jain wherein against Item No.13(h and j), she has replied as NO which means that she had no problem, disorder of stomach nor any complaint requiring surgical/hospital treatment. He was unable to give any reply to the question asked by this Forum. The Insurance Company contested that Ms.Shikha Jain was admitted in City Clinic and underwent surgical operation. She has not disclosed this fact in the proposal form and, therefore, has concealed material fact from the Insurance Company. Also on examination of the Discharge Certificate of the City Clinic, it is clearly mentioned that Ms. Shikha Jain was a case of pain in lower abdomen. The same case history is also mentioned in Moolchand Hospital Discharge Certificate.

Keeping in view that Ms. Shikha Jain had not disclosed to the Insurance Company that she had suffered from any stomach disorder as well as surgical treatment in the hospital which was material for the Insurance Company to underwrite the proposal and as per the terms and conditions of the policy issued, the United India Insurance Company Limited has rightly rejected the claim of Ms.Shikha Jain.

I uphold the decision taken by the United India Insurance Company Limited in repudiating the claim of Ms.Shikha Jain.

The complaint is disposed of finally.

Delhi Ombudsman Centre
Case No. : GI/252/NIA/05
Shri N.M.Rathi
Vs

New India Assurance Company Limited

Award Dated : 30.10.2006

Shri Navneet Rathi, on behalf of his father, Shri N.M.Rathi, has lodged a complaint with this Forum on 19.07.2005 wherein he has mentioned that his father Shri N.M.Rathi along with his mother, Smt. Shanta Rathi were covered under mediclaim policy for the last 10 years with the New India Assurance Company Limited. Shri N.M.Rathi visited the Insurance Company's office on 18.07.2005 and 19.07.2005 for renewal of the policy but the concerned Development Officer refused to renew the same and misbehaved with him. The cheque along with the covering letter was forwarded to their office by Speed Post but the same was returned back. Due to the arbitrary approach of Shri Atul Sharma, the policy could not be renewed on 19.07.2005.

The Insurance Company, vide their letter dated 08.08.2005, informed this Forum that the policy No.323200/48/04/75349 had expired on midnight of 19.07.2005. Shri N.M.Rathi sent them the premium cheque through speed post on 20.07.2005 which was received by this office on 21.07.2005, that is, two days after expiry of the policy. Since there was a gap in renewing of the policy, they returned the cheque to Shri N.M.Rathi stating their inability to renew the policy due to the gap vide their letter dated 21.07.2005. As far as the allegation of Shri Rathi regarding misbehavior of the officer concerned, it is baseless as no complaint was lodged with the Divisional Manager who was present in the office for the last so many days.

At the time of the hearing, this Forum enquired from Shri Navneet Rathi that when Shri Atul Sharma has not renewed his policy and misbehaved with him why he did not approach the concerned superiors of the Office for renewal of his father's policy, Shri Navneet Rathi informed that he did not think it prudent to approach the higher authorities. The representative of the Insurance Company disclosed to the Forum that the policy which was to be renewed, there was a claim preferred by Smt. Shanta Rathi which was paid to her. Further the Insurance Company probably thought it wise not to renew the policy since both Smt. and Shri N.M.Rathi are senior citizens and claim was already preferred, it was not advisable to renew the policy. Further, at the time of hearing, the representative of the Insurance Company contested that there was a gap in the policy as such the premium cheque was returned back. On enquiry by this Forum from the representative of the Insurance Company that there was a gap of one day in the policy and since the Insurance Companies' can renew the policy from the date of dispatch of the cheque which was, in this case, of 20.07.2005, the Divisional Manager is competent enough to waive the gap up to 15 days. Why, in this case, he did not consider waiving the gap since as per the renewal notice sent to Shri Rathi, there was a cumulative bonus of 50% on one lakh and 20% on one lakh for himself and 20% for his wife Smt. Shanta Rathi after the payment of the claim. The Divisional Manager informed that there is no noting on the file why the premium cheque was returned except as mentioned in their letter as there was a gap. On further enquiry by this Forum that in case the Insurance Company was not prepared to waive the gap then they could renew the policy after getting the medical done of the insured since Shri N.M.Rathi was being insured by the Insurance Company for the last 10 years. Why one of the courses were not resorted to ? The Divisional Manager who was present at the time of hearing, was not able to throw any light on the various steps mentioned by this Forum. He only informed that he was not the Divisional Manager when the premium cheque was returned.

On examination of the papers submitted as well as after hearing both the parties, I do not agree with the decision of the Insurance Company returning the premium cheque since there is no official recording why the cheque was returned except a letter

addressed to this Forum on 08.08.2005 that there was a gap. The Divisional Managers' have been given the authority to waive gap in the renewal up to 15 days and here the gap being only one day, it is presumed that the insured has not approached the Insurance Company. It was not a vital factor to decline the proposal specially when Shri N.M.Rathi was earning a cumulative bonus of 50% and Smt. Shanta Rathi was earning a cumulative bonus of 20% at the time of renewal of the policy. Smt. Shanta Rathi was earning a cumulative bonus of 30% on the earlier policy which was to be reduced to 20% because of the claim filed in the current policy. The risk should not have been declined.

I, therefore, pass the Award that the New India Assurance Company Limited should renew the policy from the current year without any medical examination nor subject to any exclusion clause. I am not giving the benefit of cumulative bonus to Smt. and Shri N.M.Rathi since I have agreed to renew the policy without any pre-medical examination as well as without any exclusion on the policy.

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

Delhi Ombudsman Centre
Case No. : GI/212/UII/05
Shri Vishal Aggarwal
Vs
United India Insurance Company Limited

Award Dated : 31.10.2006

Shri Vishal Aggarwal lodged a complaint with this Office on 25.07.2005 stating therein that he was hospitalized at Vinayak Hospital, Delhi on 09.08.2004 with the complaints of pain in upper abdomen, vomiting and fever and they had started the treatment. Simultaneously they got the consent from Family Health Plan Limited on 10.08.2004 since he was covered under cashless facility given by the Insurance Company and on completion of treatment, he was discharged on 14th August,2004. Hospital sent all the documents and all other material to Family Health Plan Limited, TPA for United India Insurance Company Limited, to release expenses/payment for the treatment taken by him. In the month of March, 2005, he was told by Vinayak Hospital regarding the rejection of his claim vide letter No.Claim ID:del 16639 dated 04.03.2005, that is, after 7 months sent by Family Health Plan Limited stating that as per their medical opinion the present hospitalization is related to the management of an ailment which is as a result of alcohol intake. This is not covered as per the mediclaim policy, hence the claim is repudiated by them. He was stunned by the rejection of his claim because he used to drink occasionally on some functions and parties in very small quantity. Therefore, it was very illogical and unjustified and shows the autocrat behavior of Family Health Plan Limited.

In response to this rejection of claim Vinayak Hospital, vide their letter No.vh:03:05:18 dated 15.03.2005 stated that prior to day of admission there is no H/O consumption of alcohol. The patient is not a regular alcoholic and takes small amount of alcohol only on occasions. In no way this history of alcohol can be held responsible for the illness he had on 09.08.2004. Their diagnosis of Acute Pancreatitis of viral/idiopathic cannot be ruled out. Further it is supported by CT scan reports showing acute focal pancreatitis involving neck and proxipnal body region. There is no evidence of any chronic pancreatitis in scan to level it as Alcoholic pancreatitis. Secondly LFT done in no way suggest any effect of alcohol. Hence, occasional intake of alcohol by the patient cannot be blamed for attack of acute pancreatitis. The Insurance Company has

not quoted any exclusion clause and Shri Vishal Aggarwal has also gone through the terms and conditions of the policy and found that this disease is not under of any exclusions of policy. He has requested this Forum to pay his claim.

The Insurance Company, vide their letter dated 12.12.2005, informed this Forum that as per the medical opinion, the present hospitalization is related to management of the ailment which is as a result of Alcohol intake which is not covered as per the mediclaim policy. Therefore, they have rightly repudiated the claim.

At the time of hearing, Shri Vishal Aggarwal informed the Forum that on 09.08.2004, he had the complaint of vomiting, fever and pain in upper abdomen. He got himself admitted in Vinayak Hospital. He is a social drinker. However, the disease he had suffered with has not occurred due to alcohol consumption as per Vinayak Hospital letter dated 15.03.2005. The disease has not occurred as a result of alcohol consumption as per the CT scan and his claim has been wrongly repudiated by the Insurance Company after the TPA had already considered the disease being covered for which they had granted permission to the hospital authorities.

The representative of the Insurance Company drew the attention of this Forum to the Condition No.4.8 of the policy where alcohol is excluded. On enquiry by this Forum whether the proposal form of the insurance policy has any column where the proposer has to declare that he consumes alcohol. The representative of the Insurance Company informed that there was no such question in the proposal form. On further enquiry by this Forum why the TPA had given permission for cashless service when according to them, the claim was not admissible? The representative of the Insurance Company had no reply to this query.

On examination of the papers submitted and after hearing both the parties, the grounds of rejection of the present case being result of alcohol intake. As per the history recorded insured had been mentioned to be taking alcohol. It has not been mentioned that insured had consumed excessive alcohol prior to the present episode. It maybe possible that insured was a social drinker as evident from his blood test reports-liver function tests, which are absolutely within normal limits. Acute pancreatitis, the disease from which insured had suffered from, only in 2% of cases alcohol is the causative factor. Mostly in 55% biliary tract disease and in 35% of case the cause cannot be found out. Alcohol is a cause is when a person consumes very large amount of alcohol on daily basis, which does not appears to be in present case. Usually it is chronic pancreatitis in such type of case. I am also guided my opinion by the observations made by Vinayak Hospital in their clarification dated 15.03.2005 addressed to Family Health Plan Limited where it is opined that CT scan reports showing acute focal pancreatitis involving neck and proxipnal body region. On examination of the Hospital bills, it is observed that medicines to the tune of Rs.8405/- has also been supplied by Hospital authorities which proves that it was not a case of management of the ailment. As such, I am not in agreement with the decision of Family Health Plan Limited, TPA for the United India Insurance Company Limited and, therefore, pass the Award that Shri Vishal Aggarwal be paid for his hospitalization from 09.08.20004 to 14.08.2004 at Vinayak Hospital, Delhi along with 8% interest from Ist July,2005 till the time the payment is made.

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

Copies of the Award to both the parties.

Shri Ravi Vaish
Vs
National Insurance Company Limited

Award Dated : 07.11.06

Shri Ravi Vaish had lodged a complaint with this Forum on 07.09.2005 that he had received rejection of his claim from Alankit Health Care Limited on 06.08.2006 and he has sent his written representation on 07.08.2005 to the National Insurance Company Limited and again a reminder was sent on18.08.2005. Even after 30 days, he had not received any reply from the Insurance Company. Shri Ravi Vaish had written to the National Insurance Company Limited on 20.07.2005 that his daughter baby Shreya Vaish was discharged from hospital on 30.05.2005 and claim was put to Alankit Health Care Limited, TPA for the National Insurance Company Limited, on the next day, that is, on 31.05.2005. He received a letter from Alankit Halth Care Limited on 19.06.2005 asking him to clarify some queries which was complied on the next day, that is, on 20.06.2005. They again sent him another letter on 12.07.2005 asking him to submit details of previous illness along with Birth record of the hospital. It was not at all ethical to demand two year old medical records to approve this claim. Fortunately, he had those papers in his record and he had complied their request. What happens if he forgot to maintain old medical records of his daughter which has no significance to this claim ? He had sent those documents to Alankit Health Care Limited on 20.07.2005. On enquiry from the office of Alankit Health Care Limited, he was informed that the case was under progress. He received a letter from Alankit Health Care Limited repudiating his claim on the basis of pre-existing exclusion Clause No.4.1. It is regretted that Alankit Health Care Limited took 70 days to repudiate this claim. He has further mentioned in his letter that how pneumonitis/respiratory tract infections can be declared as congenital diseases ?

Dr.Sanjeev Bagai who had treated the baby on 30.04.2003 for bilateral pneunonitis at North Point hospital was fortunately available n the panel of Rockland Hospital. The baby was admitted on 19.05.2005, the baby was absolutely fine and no minor illness is even reported. There is no congenital/pre-existing disease in the baby and the baby is fully immunized till age. Since he had not concealed/misrepresented any facts, he has requested this Forum to settle his claim.

The Insurance Company, vide their letter dated 03.10.2005, informed this Forum that Baby Shreya, 3 years old girl was admitted in the Rockland Hospital on 19.05.2005 with a history of cough Dry and Non-productive since 3 weeks and was discharged on 30.05.2005. In the Discharge Summary it has been categorically and specifically stated that She is a known case of TR with PAH and has been having frequently episodes of LRTT's in the past. Fully immunized till age. She was also admitted in the Northpoint Hospital from 23.04.2003 to 30.04.2003 and as per the discharge summary, patient already known of the disease which she has suffered from and revealed after investigation done by ECHO which showed TR + PAH and the insurance policy was taken on 28.08.2003 which makes the disease come under pre-existing. Hence, the claim is inadmissible and comes under the Exclusion Clause 4.1. Hence, it is clear that the patient was earlier having the disease which was proved from Investigation results, that is, TR + PAH and again she was admitted in the Hospital for the same illness. This was admitted by the patient's father in his complaint. The only point of conflict is that the complainant states "that Dr.Bagai who has treated the papers certified that Routine Tests done then had no correlation with any other medical condition. Also the ECHO was repeated in the hospital stay in May,2005 and was normal. There was no pre-existing cardiac/or any other medical or congenital issue in this case". But as per the

observation of the Insurance Company and as per Alankit Health Care Limited, the present disease was due to TR + PAH and the policy commences from 28.08.2003, that is, after the disease. Alankit Health Care Limited re-examined the case and once again came to the conclusion that the claim was not payable under Condition No.4.1 of the policy.

At the time of hearing, the representative of Shri Ravi Vaish contested that the baby had suffered congestion, as such was admitted in Rockland Hospital. As per Dr.Sanjeev Bagai, the hospitalization on 19.05.2005 did not have any relevance with her earlier hospitalization at North Point Hospital in the year 2003. The Insurance Company has wrongly repudiated the claim on the grounds of pre-existing disease.

The Insurance Company contested that at the time of hospitalization on 19.05.2005, baby Shreya had the disease due to TR + PAH which was in existence in the year 2003 when she was hospitalized at North Point hospital and the policy has been taken subsequently on 28.08.2003. As such the disease was pre-existing and they have rightly repudiated the claim.

On examination of the papers submitted and after hearing both the parties, the present claim has been repudiated by the Insurance Company on the grounds that the disease is pre-existing as it is related to TR + PAH. Insured has sustained pneumonia after a period of more than 2 years of previous episode and after about 1-3/4 years of commencement of present policy. Her episode of pneumonia is fresh illness and not related to her heart condition, that is, tricuspid regurgitation and PAH. Moreover, her heart condition, that is, tricuspid regurgitation had resolved on its own with passage of time. I am, therefore, not in agreement with the repudiation of the claim by the National Insurance Company Limited and, therefore, pass the Award that Shri Ravi Vaish be paid the claim for the hospitalization of her baby daughter, Shreya Vaish, on 19.05.2005.

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

Delhi Ombudsman Centre
Case No. : GI/311/UII/05
Shri Brij Mohan Bhardwaj
Vs
United India Insurance Company Limited

Award Dated : 7.11.06

Late Shri Brij Mohan Bhardwaj lodged a complaint with this Forum on 22.08.2005 that he had submitted medical bills for reimbursement on 20.05.2005 amounting to Rs.70914.88 through Family Health Plan Limited, incurred for the treatment of plasmacytoma (brain tumor) which was diagnosed in the month of April,2005 and later on continuing treatment for multiple myloma from All India Institute of Medical Sciences(AIIMS). Prior to undergo surgery on May,2005, he had taken permission from Family Health Plan Limited, TPA for United India Insurance Company Limited and Andhra Bank who has rejected the claim on 10.06.2005 with the condition that the present hospitalization is for the management of an ailment which is related to a pre existing condition. He had further requested to the Insurance Company for reconsideration of the case as the surgery of the brain tumor (plasmacytome) was neither pre-existing for him nor was he aware of anything about the existence of Brain Tumor(Plasmacytoma) disease. As he was unable to move personally after major surgery of brain tumor, he had perused the case through his brother, who had paid a number of visits to Family Health Plan Limited and United India Insurance Company

Limited but did not get any satisfactory reply and was forced to make personal visits to the office the TPA and the Insurance Company but no action was taken by them for reopening and reconsideration of reimbursement of his hard earned money which has caused him financial hardship and physical and mental agony to which it has shattered his faith on the Insurance Company. He has requested this Forum to direct the Insurance Company and Family Health Plan Limited to reimburse the claim amount.

The Insurance Company, vide their letter dated 18.11.2005, has mentioned that they have rejected the claim on the grounds that the Diagnosis :Right Temp Intra and Oribitalplasmacytoma with DM. “the present hospitalization is for the management of an ailment, which is related to a pre existing condition clause 4.1 due to which the claim is repudiated”

The representative of the deceased contested that late Shri B.M.Bhardwaj was hale and hearty and has represented the country in a number of international sporting events and it was only in the month of April,2005, he developed some pain in the eye. He was shown in the All India Institute of Medical Sciences and was operated on 08.05.2005 for his brain and was discharged on 12.05.2005. He did not have any pre existing disease. As such, the claim maybe paid to them.

The Insurance Company contested that as per the discharge certificate issued by All India Institute of Medical Sciences which states that Shri B.M.Bhardwaj had proptosis of right eye for the last 6 months , Headache for more than 6 months and the policy was taken from 09.08.2004 which means that he was already suffering from the diseases of right eye proptosis before the policy commenced and they have rightly repudiated the claim under Clause 4.1 of the policy.

On examination of the papers submitted and after hearing both the parties, it is observed that late Shri Brij Mohan Bhardwaj had proptosis of right eye for the last 6 months , Headache for more than 6 months and the policy was taken from 09.08.2004. He was admitted in the hospital on 08.05.2006, that is, after 9 months of taking the insurance policy. Going by the Discharge summary, Shri Bhardwaj was not suffering from the disease of proptosis of right eye prior to his taking the mediclaim policy. The United India Insurance Company Limited has wrongly repudiated the claim as a pre-existing disease.

I, therefore, pass the Award that the nominee of Shri Brij Mohan Bhardwaj be paid the hospitalization expenses when he was admitted in All India Institute of Medical Sciences along with 8% interest from 01.07.2005 till the date of payment is released.

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

Delhi Ombudsman Centre
Case No. : GI/360/NIC/05
Smt. Anjali Banerji
Vs
National Insurance Company Limited

Award Dated : 17.11.06

Smt. Anjali Banerji lodged a complaint with the Ombudsman, Kolkata which was transferred to this Office vide their letter dated 31.10.2005. Smt. Anjali Banerji, vide her letter dated 02.03.2005, informed that her daughter Ms. Anita Banerji had taken a group medical policy through a special scheme started by Bank of Baroda for credit card holders.Medicare Service Club and National Insurance Company Limited were the names engraved on the card issued to her. No formal policy document was ever issued

to them. After her surgery Medicare Services Club, New Delhi were sent all the required documents. They forwarded the documents to their Kolkata office who acknowledged the documents and subsequently she has been in contact with them till they stopped corresponding in spite of repeated reminders. Subsequently, she was advised to contact the Grievance Cell of National Insurance Company Limited, Kolkata which she did. The correspondence was acknowledged and they asked Medicare Service Club to respond which they did not. Reminders to the office of Grievance Cell of National Insurance Company Limited, Kolkata did not elicit any response. She requested the Forum at Kolkata for an early decision in the pending matter.

Ms. Anjali Banerji was admitted in Sitaram Bhartia Institute of Science and Research on 15.06.2003 and discharged on 22.06.2003 for Bilateral Osteoarthritis termed as Total Knee Replacement. She had submitted a claim bill for Rs.3,25,000/-. She has claimed a sum of Rs.1,75,000/- and a sum of Rs.1,50,000/- was not claimed since it was paid by M.R.Enterprises. She was holding a mediclaim policy with the National Insurance Company Limited vide policy No.251802/48/00/8506130 for the period 28.03.2001 to 27.03.2002. Prior to this, she holds a policy with the Oriental Insurance Company Limited in continuity.

The National Insurance Company Limited, vide their letter dated 13.10.2006, informed that they have referred the matter to their TPA, Medicare Service Club to review the claim and have received their detailed reply vide their letter dated 25.09.2006 that they have again produced the claim before the panel of doctors, who have also given the same opinion, “it is unlikely that advance degenerative changes needing surgery would develop over just 1 year and 4 months from the policy inception. Hence the ailment was definitely pre-existing and the said claim stands inadmissible and not payable. Hence the claim is rightly repudiated as it falls under the exclusion clause 4.1 of the mediclaim policy.

At the time of hearing, Dr.A.K.Banerji, husband of the complainant, contested that he was holding a mediclaim policy with the Oriental Insurance Company Limited and subsequently with the National Insurance Company Limited for the period 28.03.2001 to 27.03.2002. Smt. Anjali Banerji was covered by her daughter from 01.02.2002 under the Group Mediclaim Plan for Bank of Baroda Credit Card Holders. She did not suffer from any disease of the knee and as per the discharge certificate of Sitaram Bhartia Institute of Science and Research, the discharge summary mentions of pain in both knees for 7 to 8 days. Even if the policy of the National Insurance Company Limited are taken into consideration, the first policy was taken by her on 28.03.2001 and she was continuously covered till the time she was admitted in the hospital and is even covered now under the same plan of Credit Card Holders of Bank of Baroda. She had a mediclaim cover for more than approximately 27 months before she was admitted in the hospital which proves that she did not have any disease of Osteoarthritis of knees. As such the claim was admissible.

The representative of the Insurance Company contested that it was unlikely that advance degenerative changes needing surgery would develop over just 1 years and 4 months from the policy inception. Hence the ailment was pre-existing and the said claim has been rightly repudiated.

After hearing both the parties and on examination of the documents, it is observed that as per the discharge summary of Sitaram Bhartia Institute of Science and Research, Smt.Anjali Banerji had complaints of pain in both knees with restriction of activities of daily living for 7 to 8 months. She was having a mediclaim policy with the National Insurance Company Limited from 28.03.2001 does not amount to pre-existing disease

on the basis of which the Insurance Company has repudiated the claim. I am not in agreement with the decision of the Insurance Company.

I, therefore, pass the Award that Smt. Anjali Banerji be paid expenses of Rs.1,75,000/- for her hospitalization at Sitaram Bhartia Institute of Science and Research along with Rs.6000/- for physio Therapy treatment from Aarvee Physiotherapy Clinic, New Delhi which is within 60 days of the hospitalization.

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

Delhi Ombudsman Centre
Case No. : GI/75/NIC/06
Shri K.D.Nayar
Vs
National Insurance Company Limited

Award Dated : 17.11.06

The National Insurance Company Limited had paid a claim of Rs.5825/- to Shri K.D.Nayar and a reduction of Rs.1099/- from the claim amount for which Shri Nayar lodged a complaint with this Forum on 04.08.2006 stating therein that his claim No.DEL 56090 for Rs.6974/-and pending claim No.DEL56090 for Rs.1890/- be paid. At the time of hearing on 04.10.2006, the representative of the Insurance Company agreed that the claim would be settled of Shri K.D.Nayar and would communicate to this Forum about the payment made.

The Insurance Company, vide their letter dated 30.10.2006, addressed to Shri K.D.Nayar, has released the payment of Rs. 505/- on 19.10.2006 in full and final settlement of claim as the balance sum insured after payment of earlier claims is Rs.505/- Further, they informed that an amount of Rs.1149/- deducted earlier (Rs. 50/- for admission charges, Rs.198/- Leukoband, Rs.551/- Patient plate disposable, and Rs.350/- for warmer charges totaling to Rs.1140/-) were not payable under policy conditions.

Shri K.D.Nayar, vide their letter dated 01.11.2006, has written to this Forum that as per the assurance of the Insurance Company on the date of hearing on 04.10.2006, the Insurance Company has not fully reimbursed the outstanding amount and a sum of Rs. 1099/- is still pending which is contrary to the assurance given to this Forum.

This Forum has taken a serious view and contempt of the assurance given by the representative of the Insurance Company that the full amount of Rs.2299/- would be paid to Shri K.D.Nayar. The Chief Regional Manager of the Insurance Company is advised to take appropriate action against the concerned officer in this regard. Further, Chief Regional Manager is advised that he should depute officer who is able to take the decision on behalf of the Insurance Company and not commit to this Forum if they do not have requisite authority. In case, there is no sufficient balance available under the policy a detailed break up of the claims made under the policy and the amount paid be sent to Shri K.D.Nayar and what other amount available against the claim for balance Rs.1099/-be paid to Shri K.D.Nayar. Further this Forum Orders that all the original records may be returned to Shri K.D.Nayar since his wife Smt. Swarn Lata Nayar has been suffering from Breast Cancer which may be required by her doctors for further advise.

Delhi Ombudsman Centre
Case No. : GI/241/NIA/05

Shri Narender Kumar
Vs
New India Assurance Company Limited

Award Dated : 29.11.06

Shri Narender Kumar had lodged a complaint with this Forum on 15.07.2005 that he had taken a mediclaim policy with the New India Assurance Company Limited and was paying regular premium for the last eight years. His wife, Smt. Alka Kumar, was hospitalized during last year and he had filed a claim with the Insurance Company. But the Insurance Company has not been settling the claim of Rs.80,000/- saying that as per the discharge slip, the disease was pre-existing, as such, the claim was not payable. He has requested the Forum to refund the premium in case the Insurance Company is not paying his claim.

The Insurance Company, vide their letter dated 23.08.2005, informed the Forum that the claim was dealt by their TPA, M/S.Vipul MedCorp. Private Limited and it was repudiated by the on 03.03.2005 on the following grounds :

"That Smt. Alka Kumar was treated for complaints of vaginal discharge accompanies by occasional abdominal and back pain from last 10 to 12 years. She had history of two MTPs in the year 1993 and 2000. Smt. Alka Kumar had also undergone Cervical Cautery and Biopsy in the past for cervix Erosion. She was diagnosed for chronic cervicitis with Adenomysis of Uterus and Endometriosis of the Ovary after investigations/examinations. For the disease she was operated for Total Abdominal Hysterectomy on 25.10.2004 followed by supportive medical treatment. The ailment/complications for which the patient was treated in this case had been continuing for 10 to 12 years (and the policy is with their Company for the last 8 years). In all probability the disease was pre-existing and the claim is repudiated as falling under exclusion No.4.1 of Standard Mediclaim Policy.

At the time of hearing, Shri Narender Kumar contested that his wife was normal and was not suffering from any disease as can be seen from the policy issued to her by the New India Assurance Company Limited for the last 8 years since his wife is earning cumulative bonus of 35%. They have never made any claim with the Insurance Company and the disease for which she was operated, therefore, was not pre-existing as claimed by the Insurance Company. The Insurance Company has wrongly repudiated the claim. He should be paid the amount claimed by him.

The representative of the Insurance Company contested that as per the discharge summary of the hospital "The Cradle", Smt. Alka Kumar was suffering vaginal discharge, pain in lower abdomen for the last 10 to 12 years and the disease was pre-existing before the policy was taken 8 years back. Therefore, they have rightly repudiated the claim under 4.1 of the policy condition.

After hearing both the parties and after careful consideration of the facts of the case, it is observed that Smt. Alka Kumar had vaginal discharge with pain in abdomen since 10 -12 years off and on. This is a very common symptom in a fertile lady because of so many factors, for example, hormonal, stress, infections, or condom related erosion etc. and gets corrected after treatment of symptoms. She was not having any specific disease. No lady will intentionally wait for 12 years to get the treatment of any organic problem. She had delivered two children normally. It was only in 2000 when after cervical biopsy and pap'smear when she was found to be having cervical erosion for which cautry was done. Uterus was normal in Ultrasound done on 25.09.2000. It was only during 2004 Ultrasound when multiple fibroids with bulky uterus was detected with degeneration with cervicitis. She was managed with hysterectomy for same.

From the above, I come to conclusion that since the insured is covered from 1997 and actual disease was diagnosed during 2000 and 2004, the claim of Smt. Alka Kumar is admissible and payable under the terms of the policy.

I, therefore, pass the Award that Shri Narender Kumar be paid by The New India Assurance Company Limited for the expenses incurred by him on the hospitalization of his wife, Smt. Alka Kumar.

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

Delhi Ombudsman Centre
Case No. : GI/217/NIA/05
Shri Achir Goel
Vs
New India Assurance Company Limited

Award Dated : 29.11.06

The complaint was heard on 22.11.2006. The complainant, Shri Achir Goel, was absent. He was also absent on the earlier hearing on 06.10.2006. The Insurance Company was represented by Shri B.D.Aggarwal, Administrative Officer.

Shri Achir Goel lodged a complaint with this Forum on 19.06.2005 wherein he has mentioned that he had taken a mediclaim policy with the New India Assurance Company Limited and he was suffering from common cold for the last 5-6 months for which he was under the treatment of Dr.P.P.Saharia. Despite proper treatment, his cold was not cured and he was advised to undergo Septoplasty Surgery, which was done on 25.02.2005 for which he was admitted to Max Health Care Hospital on 24.02.2005 and was discharged on 25.02.2005. He had preferred a claim of Rs.16640/- spent in the above said surgery and the claim was lodged with the TPA, Vipul Medcorp Private Limited. Subsequent to lodging the claim form with Vipul Medcorp Private Limited, they had raised a query directing him to submit first prescription/OPD card regarding the disease and details of the treatment taken in the last 6 months. In response to the query, he has sent the medical prescription of Dr.P.P.Saharia. Vipul Medcorp Private Limited, vide their letter dated 31.03.2005, informed him that his claim has been declined as from the documents it was found that Shri Achir Goel was suffering from the said disease prior to December,2002. In order to clarify the doubt and findings that Shri Achir Goel was suffering from the said disease prior to December,2002, a certificate was issued by Dr.P.P.Saharia declaring that Shri Goel was under his treatment for common cold and Shri Goel was having the problem for which he went surgery, for the last one year. Subsequently, a legal notice dated 19.04.2005 was sent to the insurer which was duly received by the insurer and in reply the insurer asked Shri Goel to contact the underwriting office. He has sent reminder dated 07.05.2005 but till date he has not received any reply.

The Insurance Company, vide their letter dated 25th July,2005 informed the Forum that Shri Achir Goel has taken a mediclaim policy for the first time for the period 30.12.2003 to 29.12.2004 which was subsequently renewed on which the present claim was preferred. Shri Goel was admitted in max Health Care Hospital on 24.02.2005 for Septoplasty surgery and discharged on 25.02.2005. He had preferred a claim for Rs.16640/- for the said hospitalization. His claim was repudiated on the grounds of pre-existing disease Clause No.4.1 of the policy. This was based on Shri Goel having the history of present disease prior to 30.12.2003, that is, before commencement of the

risk for the first time as per prescription of his treating doctor, Dr.P.P.Saharia dated 04.12.2002 in which he mentioned that Shri Goel have cold since very long. Further, Shri Achir Goel has submitted a declaration that he has been taking the treatment for the same disease for the last few years. Based on this the claim was repudiated.

On examination of the papers submitted, it is observed that as per the letter dated 04.12.2002 of Dr.P.P.Saharia, Shri Achir Goel was suffering from cold since very long – mouth breathing. As per the discharge summary issued by Max Health Care, it has been mentioned that Shri Achir Goel was admitted with nasal blocking and mouth breathing since 6 months. Since the consultant has mentioned in the certificate of Dr.Saharia's letter dated 04.12.2002, the common cold since very long appears to be the date since Shri Achir Goel has been suffering with the disease. Shri Achir Goel has taken the policy for the first time on 30.12.2003. As such, the Insurance Company has rightly repudiated the claim, since the disease was pre-existing, that is, prior to commencement of the policy.

I, therefore, uphold the decision taken by the New India Assurance Company Limited repudiating the claim of Shri Achir Goel

There is no further relief to be granted to the complainant.

Complaint is disposed of finally.

Delhi Ombudsman Centre
Case No. : GI/255/NIC/05
Smt Kamlesh Devi
Vs
National Insurance Company Ltd.

Award Dated : 12.01.2007

Smt. Kamlesh Devi had taken a Household Policy with National Insurance Company Ltd. from 1.10.2004. She had covered the local Asscubled Air Conditioner under section 5, along with other household's items. Suddenly the A.C stopped working and was put for repair with M/s Cool Tech, Shakarpur, Delhi. The intimation of the same was given to the Insurers. The Insurance Company had appointed Shri Gupta for Survey and Loss assessment. Shri Gupta first inspected the A.C at the workshop, which did not belong to her and opinioned the claim is not payable. And conveyed the same to her husband through the phone, when Shri Goyal found out the fact that her A.C had not been inspected, he then approached Shri Gupta and asked the Insurance Company again for inspection of correct A.C. Shri Gupta, who was to re-inspect the A.C, argued for additional expenses for Commutation and when he was asked for re-imbursement then only he will inspect the A.C again, and he again opinioned that the claim was not payable. Smt Kamlesh Devi further pointed out that, Shri Gupta had no technical background and is from Commerce Stream. Despite convincing the repairer about the exact cause of Break Down is the Voltage Fluctuation, Shri Gupta did not agree and submitted his report of claim as not payable. Based on the recommendation of the surveyor, Insurance Company has not paid the claim.

National Insurance Company vide their letter dated 31.8.2005, informed the forum that till date no claim has been lodged in the office in respect of Machinery Breakdown of refrigerator as mentioned by the complainant in her letter. Smt. Kamlesh Devi vide her letter dated 11.8.2005 informed the forum that by mistake she had mentioned Refrigerator in her letter dated 20.7.2005, actually the claim is for A.C.

At the time of hearing, the Insurance Company representative was asked to produce the copy of the survey report of Shri B.M. Gupta which was done, and they argued that he had contacted the surveyor on 21.9.2004 and after 5-6 days, he visited the repairers

and have submitted his report with the claim as not payable under terms and conditions of the policy, as the same was due to wear and tear. Shri Anand Goyal contested that Shri Gupta was not a technical person, and firstly, he had not done the survey of his A.C and subsequently, he visited the repairers and just to justify his earlier decision that he has repudiated the claim on ground that, it was due to wear and tear he has not got the compressor opened. Further Shri Gupta still had the compressor with him, which could be inspected, if so desired. The Forum enquired from the insurance company, why, the compressor was not got open. There were no photographs taken of the compressor in open condition.

On examination of the papers submitted and after hearing both the parties, it is observed that, Shri B.M. Gupta conducted the survey for the Insurance company to assess the loss, as he has not examined the compressor by opening the same. He has not been able to sulstantiate the basis of his repudiation of the claim, the loss being due to wear and tear. The surveyor report being deficient as he had not been able to explain the cause of loss due to wear and tear. I have no hesitation in passing an award against the Insurance Company, wherein as per the estimate, the loss is for Rs.10350/-.

I pass an order that, the Insurance Company should pay 50% of the estimated amount, the deduction of 50% being towards depreciation and salvage cost of compressor. The insurance company should pay 8% interest on 50% amount from 1.11.2004 to 5.1.2007. This payment is subject to submission of payment receipt/bills by Smt Kamlesh Devi.

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

Delhi Ombudsman Centre
Case No. : GI/03/NIC/06
Shri Narender Nagpal
Vs
National Insurance Company Ltd.

AWARD dated 31.01.2007

The complaint was heard on 21st January, 2007. The complainant was represented by Shri Raju Gupta, Brother and Shri Rohit Nagpal, Son. The Insurance Company was represented by Shri Rakesh Chander.

Shri Narender Nagpal had lodged a complaint with this forum on 07.04.2006, that, he had taken a policy from National Insurance Co. Ltd. After medically examined, he submitted his Proposal form to National Insurance Co. Ltd and they issued their Mediclaim Policy from 28.10.2004 to 27.10.2005. He had been suffering from Diabetes for the last 5 years. The proposal was accepted with exclusion of disease related to diabetes. He was admitted in Shanti Mukund Hospital, due to bleeding from nose on the night of 12th February, 2005. As it was first year of mediclaim policy, he was told to submit all the relevant papers, after discharge for reimbursement and the same was done. After a long wait, he had received a letter dated 03.05.2005, stating that, his claim was repudiated under clause 4.2, which read as- “All disease/ injuries which are pre-existing, when the cover incepts for the first time”. However, he takes up the matter with the insurance company, for the payment of his claim and he did not receive any reply from the insurance company.

At the time hearing, the representative of National Insurance Co. Ltd. informed the forum that, as per the advice of the third party administrator, the claim was repudiated under clause 4.2 of the policy, and they had rightly repudiated the claim.

The representative of Shri Nagpal, informed the forum that, he was a diabetes patient, and he had disclosed the relevant facts in his proposal form and it was accepted with exclusion of the disease related to diabetes. However, Shri Nagpal suffered from Nose bleeding and was admitted in Shanti Mukund Hospital on 12.02.2005 and discharged on 17.02.2005. He was suffering from Bleeding from the Nose, which does not relate with Diabetes, and the claim has wrongly been repudiated.

After hearing both the parties and on examination of the papers submitted, it is observed that, Shri Nagpal, while taking the mediclaim policy had declared that, he was having Diabetes and had undergone all the medical test required prior to grant of Insurance Policy. National Insurance Co. Ltd. had excluded Diabetes and related disease from mediclaim cover. He was admitted at Shanti Mukand Hospital on 12.02.2005 with the case of Bleeding from the Nose around 8 P.M. He had been a case of Diabetes for 3 years. He had no history of HTN, CAD, and NSAID. He was diagnosed as a case of DM, Accelerated HTN with Epistaxis. The present claim has been repudiated by National Insurance Co. Ltd. on the grounds of present disease being pre-existing. I do not agree with the Insurance Company that, the mediclaim be repudiated, since, Shri Nagpal, was hospitalized for bleeding from the nose. His Blood Pressure at the time of admission was 220/120mm Hg. High blood pressure was the most probable cause for nasal bleed in present case. Shri Nagpal, was not having any past history of HTN and also HTN is not related to Diabetes. Hence, the present claim is within the purview of mediclaim policy and such is payable.

I, therefore, pass an award for Rs.14795/- along with 8% interest be paid to Shri Nagpal from 01.04.2005 till the time of payment.

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

Delhi Ombudsman Centre
Case No. : GI/102/NIA/06
Shri. Arun Kumar Palawat
Vs
New India Assurance Co. Ltd.

Award Dated : 22.02.2007

Shri A.K. Palawal had lodged a complaint with this Forum on 08.09.2006, that, he had taken a Mediclaim policy from New India Assurance Co. Ltd., from 16.09.2005 to 15.09.2006, and lodged a claim on the Insurance Company, which was rejected by Raksha TPA, under clause 4.3 of the policy. The complainant in his letter has mentioned that he was a mediclaim policy holder from 04.09.2000 to 03.09.2004 with United India Insurance Co. Ltd., Alwar. Further, from 04.09.2004 to 03.09.2005 he was insured with National Insurance Co. Ltd., Alwar. He had taken the Insurance Policy from 16.09.2005 to 15.09.2006 with New India Assurance Co. Ltd., Alwar. The Insurance Company representative came to him and assured that, only Cumulative Bonus amount benefit will not be allowed to him, due to the lapse of 12 days. He had further, informed that, he would enjoy all medical benefits of all types of disease as covered from 04.09.2000 till 15.09.2006. the representative of the Insurance Company, did not mention about clause 4.3 as stated in the letter of Raksha TPA Pvt. Ltd. dated 27.05.2006. And further, when he handed over the policy to him, he read in the column “subject to the exclusion of” there has not mentioned any type of the disease / sickness/ injury in it. He was also informed by the company’s representative that, he would enjoy benefits of all types of disease/ sickness/ injuries. He was operated for Hernia, the disease was hidden at the time of purchase of policy on 16.09.2005, his

intention was fair and good. He was advised by his doctor to operate the same without any delay. He completed all the formalities and his claim of Rs.9194/-was submitted to the New India Assurance Co. Ltd. and it was rejected under clause 4.3. As such he has requested the Forum to settle his claim.

At the time of hearing, the representative of the insured contested that, he was not informed about the exclusion 4.3 by the representative of the Insurance Company and if he had been informed he would not have taken the insurance policy. However, he was not provided with the terms and conditions of the policy. The representative of the Insurance Company contested that, the policy was given to the insured along with "the subject to hospitalization and domiciliary hospitalization" is attached and drew the attention of the Forum to the policy document. The assured Shri A.K. Palawal had been taking mediclaim policy since 2000, and he must have been well aware of the exclusion of the policy, in case the policy terms and conditions were not attached, he could have requested the Insurance Company to submit the same. However, as per clause 4.3 of the policy, "during the first year of operation of insurance cover the expenses on treatment of disease such as cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibrmyoma, Hernia, Hydrocele, Congenital Internal disease, Fistula in anus, piles, Sinusitis and related disorders are not payable", accordingly Harniya is not covered during the first year and they have rightly repudiated the claim.

After hearing both the parties, and on examination of the papers submitted, it is observed that, Shri A.K. Palawal has been taking the mediclaim policy from various Insurance Company since year 2000. From his letter dated 08.09.2006 it is observed that, the cumulative Bonus which he was enjoying with the other family members was less and therefore he must have preferred a claim on the Insurance Company and he must have received the payment. In view of this his contention that, he was not aware, that under the first year of the policy certain diseases are not covered, is not acceptable. Since there was a break in the insurance of 12 days, the policy is to be treated as fresh and under the circumstances any disease which is excluded in the first year is not payable. The Insurance Company has rightly repudiated the claim under clause 4.3 of the policy, since, Harnia is not covered under the first year.

I, therefore, uphold the decision of the Insurance Company repudiating the claim.

There is no further relief to be granted to the complainant.

The complaint is disposed of finally.

Delhi Ombudsman Centre
Case No. : GI/433/UII/05
Shri Arun Nandi
Vs
United India Insurance Co. Ltd.

Award Dated : 26.02.2007

Shri Arun Nandi lodged a complaint with this Forum on 22.02.2006, that he was covered under the Medical Insurance with United India Insurance Co. Ltd. since September 2004. For the policy period 2004-2005 Family Health Plan Ltd. was the TPA and for the period of 2005-2006, Vipul Med Corp Pvt. Ltd. was the TPA. Shri Arun Nanadi was suffering from hepatitis 'C' since August 2005, and he had been availing treatment at Batra Hospital under the supervision of Dr. Yogesh Batra on OPD basis for last 6 months. According to doctor's advice he had come to Batra Hospital for Interferron injection that is given on weekly basis under the supervision of the doctor for a couple of hours at the hospital. No emergency condition is risen so far that needs hospitalization for the treatment. He informed the Forum that, he was hospitalized in

March 2005 at Genesis Hospital, Kolkata for gall bladder operation, and was later on admitted to Kalyani Hospital, Gurgaon due to chest discomfort. Prior to operation of hepatitis C tests was carried out as per routine procedure and it was non reactive at that period. The fact is that, he had been infected with this disease after operation though possible cause of infection cannot be identified. He had lodged a claim up to November 2005 with Family Health Plan Ltd. TPA for United India Insurance Co. Ltd. for Rs.89775/-. Family Health Plan Ltd. vide their letter dated 03.11.2005 requested him for submission of discharge summary. He had submitted the letter dated 21.11.2005 enclosing authorization certificate from Dr. Yogesh Batra in support of nature of treatment being availed at the hospital. Family Health Plan Ltd. vide their letter dated 09.01.2005 repudiated the claim mentioning therein “As per their medical opinion, the present hospitalization is for the investigation and evaluation of the ailment. The treatment could have been done on out patient basis without the necessity of admission for the same. Hence, we regret to inform that, your claim is repudiated”. Shri Arun Nanadi has mentioned that, he has already clearly mentioned in his letter dated 21.11.2005 of availing the treatment on OPD basis, therefore the reason for rejection made by Family Health Plan Ltd. is contradictory as he had been infected with this disease subsequent to operation in the month of March 2005, within the policy period.

Family Health Plan Ltd. does not have the right for rejection of the claim. His claim for the expenses incurred for operation in the month of March 2005, was settled by Family Health Plan Ltd. vide their letter dated 13.07.2005. Considering the importance of the disease as per treatment, he has tried to avail medical treatment as recommended by the doctors. He has requested for the intervention of this Forum for settlement of the claim.

United India Insurance Co. Ltd. vide their letter dated 07.07.2006 informed the Forum, that, Shri Arun Nandi had taken the treatment from the Batra Hospital as an out patient and not admitted in the Hospital as an In patient. Mediclaim Insurance Policy does not cover the medical expenses for out patient treatment until and unless the insured is hospitalized, as such, the claim is not payable under the policy.

At the time of hearing, Shri Arun Nandi informed the Forum that, he was infected by hepatitis C after his gall Bladder operation in March 2005 and no possible cause of infection could be identified. He has found treated as an out door patient by Dr. Yogesh Batra till the time of hearing of the Grievance. He had lodged a claim with United India Insurance Co. Ltd. for Rs.89775/- on 07.10.2005 which has been rejected by them on the grounds that, he was been treated as an outdoor patient. He drew the attention of the Forum that, since this treatment was very expensive, one cannot afford to pay the expenses. He has got the clarification from Dr. Yogesh Batra, who mentioned that hospitalization was not necessary and the treatment only needs regular monitoring. Since, the treatment is for life threatening disease and involves a large expenditure, his claim should be paid. He further, mentioned that, such viruses are very much vulnerable to the society and the nation and the Insurance Company should consider this for settlement of his claim.

The Insurance Company representative mentioned that the Mediclaim policy, cover hospitalization and since Shri Arun Nandi is being treated as an outdoor patient the claim is not admissible under the terms and conditions of the policy.

After hearing both the parties and on examination of the papers submitted, I, observe that, Shri Arun Nandi was being treated for hepatitis C by Dr. Yogesh Batra of Batra Hospital prior to his operation for gall bladder, hepatitis C was non reactive, as such he did not have this disease till he was operated in March 2005 for gall Bladder. However,

subsequent to this operation in August 2005, it was diagnosed that, he was suffering from hepatitis C. The Insurance Company as per terms and conditions of the policy has repudiated the claim that, Shri Arun Nandi was treated as an outdoor patient as per terms & condition of the mediclaim Policy, which clearly states that, the person is to be hospitalized before any claim could be admitted the policy does cover domiciliary treatment of pre & post hospitalization consequently after the policy holder is hospitalized. Further, the certificate issued by Dr. Yogesh Batra has mentioned that, Shri Arun Nandi has been under his treatment and he has suffering from hepatitis C and is being treated with piylated injection interferon on OPD basis. He would require this treatment for 6 months. He does not need hospitalization for the said treatment and only needs regular monitoring, since the treatment is for life threatening disease and involves a large expenditure. His recommendation that his case for insurance reimbursement should be considered sympathetically and an exception be made to the "only hospitalized patient". Since, insurance policy being a contract, which has been agreed by both the parties, this Forum is guided by the same. I am to be guided by the terms and condition of the policy, as such the policy does not cover treatment without Hospitalization, therefore the Insurance Company has rightly repudiated the claim.

I, therefore, up hold the decision of the Insurance Company repudiating the claim.

The complaint is disposed of finally.

Delhi Ombudsman Centre
Case No. : GI/306/UII/05
Shri Surender Kumar Gupta
Vs
United India Insurance Co. Ltd.

Award Dated : 28.02.2007

Shri S.K. Gupta lodged a complaint with this Forum on 24.08.2005, that, he had taken a Mediclaim policy with United India Insurance Co. Ltd. from the past 10 years, for the sum insured of Rs.500000/- each for him and his wife, as per his personal capacity. Prior to March 2003, the policy was with National Insurance Co. Ltd., Noida, and later on transferred to United India Insurance Co. Ltd., with 50% accumulated bonus on the face of the policy. In March 2003, the cash less facility through TPA Family Health Plan Ltd. was granted. On second renewal, the premium cheque was returned unpaid due to the mistake of his office, and United India Insurance Co. Ltd. forfeited all accumulated benefits of the policy and issued a fresh policy against deposits of draft. In July 2004, he had fallen sick and was admitted in the North Point Hospital Pvt. Ltd., New Delhi. He was not permitted cash less facility by the United India Insurance Co. Ltd. and he later on filed a claim on 03.09.2004 with Family Health Plan Ltd. for Rs.57333/- and he was not informed about the status of the claim. Further, on 27.09.2004, he had fallen sick due to hepatitis and was admitted in Metro Multi speciality Hospital at Noida. He was granted cash less facility from 27.09.2004 to 30.09.2004. He had submitted his claim for Rs.183238/-. On his persistent reminders and request he has received a letter dated 08.02.2005 from Family Health Plan Ltd. rejecting his claim. He had taken up the matter on 26.02.2005 with the TPA about their wrong decision and he has been following up with TPA but he has not received any reply. He has therefore requested the Forum to pay both the claim amounting to Rs.240571/- without any further delay.

United India Insurance Co. Ltd. vide their letter, informed the Forum that, they had renewed the mediclaim policy of Shri S.K. Gupta from 10.02.2004 to 09.02.2005 and had issued a receipt on 03.02.2004 for Rs.18036/-. The cheque was dishonored due to insufficient funds and policy stands cancelled at the inception. The fresh mediclaim

policy was issued w.e.f. 18.03.2004 to 17.03.2005, with a gap of 36 days and was treated as fresh proposal and cumulated bonus was forfeited as the policy was not renewed on the date of expiry. The claim was repudiated by the TPA under exclusion of the mediclaim policy condition No.4.1 as the pre existing disease which was duly recorded on face of the policy. United India Insurance Co. Ltd. has subsequently wrote on 03.11.2006 for the adjournment of 15 days to conduct certain inquiries. However, United India Insurance Co. Ltd. vide their letter dated 21.02.2007 informed the Forum that, they have been able to sought out the claim matter and decided that, the prostrate being exclusion for first year of the policy may be disallowed. Whereas Hepatitis C disease contacted by the insured accidentally while doing blood transfusion may be paid as per policy condition. They had instructed the TPA accordingly and they have made payment of Rs.18240/- vide their cheque No. 136506 dated 24.01.2007. Apparently, the claim lodged by the insured of the higher amount but part of it presented to the TPA for payment. The insured have presented the papers for balance amount to the TPA and will be paid on merits as per policy terms and conditions.

At the time of hearing, the representative of Shri S.K. Gupta, drew the attention of the Forum to the hospitalization claim papers submitted by him and which were duly acknowledged by Family Health Plan Ltd., New Delhi on 11.01.2005, wherein he had submitted all the bills along with the summary thereof. On inquiry by this Forum from the representative of the Insurance Company, that, why the Insurance Company has only paid the portion of the claim, the representative of the Insurance Company was not able to reply.

After hearing both the parties and on examination of the papers submitted, it is observed that Shri S.K. Gupta had renewed the mediclaim policy on 10.02.2004, for which he had made the payment on 03.02.2004 for Rs.18036/-. However, the cheque was dishonoured, he took the mediclaim policy no. 221500/48/03/01536 effective from 18.03.2004 to 17.03.2005, which was after a gap of 36 days and the Insurance Company has rightly treated it as a fresh policy by not covering cumulative bonus, which was there on the earlier policy, as such the claim for Rs.57333/-, when he was admitted in North Point Hospital Pvt. Ltd. on 21.07.2004 and discharged on 27.07.2004, has rightly been repudiated under clause 4.3 of the policy, since, prostate is not covered in the first year of the policy. Further, he was hospitalized for Hepatitis C in Metro Multi speciality Hospital an Heart Institution on 27.09.2004 and discharged on 30.09.2004 for which he had submitted a bill for Rs.183237.50/- to the TPA Family Health Plan Ltd. on 11.01.2005, and only a part of this bill has been paid. I, therefore, pass an Award that, Shri Surender Kumar Gupta be paid the sum of Rs.183237.50/- and less the amount already paid, along with 8% interest from 01.03.2005 till the time of payment.

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

House Hold Policy.

Delhi Ombudsman Centre
Case No. : GI/403/NIA/05
Shri. Surinder Kumar Soni
Vs
New India Assurance Co. Ltd.

AWARD dated 21.03.2007

Shri S.K. Soni lodged a complaint with this Forum on 02.02.2006 that he is a retired officer of LIC of India and mediclaim policy was taken for the retired employees by LIC of India with New India Assurance Co. Ltd. He had filed a claim for Rs.65284.70/- for his wife Smt. Rama Soni for medical treatment and sent the same to Insurance Company on 28.12.2004 but to his great surprise he received a cheque for Rs.22465/- only. Smt. Rama Soni was under the treatment of Dr. Animesh Arya who recommended very strongly the use of CPAP machine as life saving machine for daily use, for which the Insurance Company did not make the payment, inspite of the fact that treating doctor recommend it very strongly. He sent his representation to the Regional Manager, New India Assurance Co. Ltd. on 07.03.2006, but he has not received any reply from him. He has requested the Forum to intervene in the matter.

The New India Assurance Co. Ltd. vide their letter dated 16.03.2007 informed the Forum that the case was settled for Rs.22465/- and an amount of Rs.42819/- was disallowed on account of external equipment. As per observation of the Panel Doctor, CPAP machine is an external aid.

At the time of hearing the complainant Shri S.K. Soni informed the Forum that his wife Smt. Rama Soni was admitted in the Maharaja Agrasen Hospital on 02.11.2004 as she was suffering from disturbed sleep at night, and subsequently on her hospitalization the doctor had recommended CPAP machine which was a means of Life saving for her, and which is meant to use on daily basis to get better and cured from this condition. In view of the doctor's opinion Shri S.K. Soni contested that his claim for CPAP machine should be paid as a desired life saving device.

The representative of the Insurance Company contested that CPAP machine was not covered under the policy and since it was for external use they have as per the panel doctor's opinion have not allowed its payment. The Forum requested the Insurance Company to submit the copy of the policy issued to LIC of India to examine the same. Shri S.K. Soni is also advised that he being a Retired Insurance Officer should realize the importance of policy terms and conditions and should be guided by it.

After hearing both the parties and on examination of the documents submitted, it is observed that the policy issued to LIC of India for its employees and their dependents and retire employees with their spouse only. The clause 1.0(D), which states as follows was examined:-

"Anesthetic, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and Similar expenses".

On going through the above policy terms and conditions, it is observed that the contention of Panel Doctor that CPAP machine is an external aid, and as such is not payable. However, from the above terms of the policy artificial limbs is also an external aid which is covered. Further it mentions "Similar expenses" which means that it is not possible for the Insurance Company to mention all types of aids that may be available from time to time and such CPAP fall under this category. If the Insurance Company does not allow CPAP machine for which it has issued a circular to its offices not to pay for this machine, then there should be a specific exclusion, as circulars do not form part of the policy as they are only in house instructions. As such I do not agree with Insurance Company, for not allowing the payment towards CPAP machine. I therefore pass an Award that the sum of Rs.42819/- be paid to Shri S.K. Soni.

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

Delhi Ombudsman Centre

Case No. : GI/404/NIA/05
Shri. Shiv Kumar Rupramka
Vs
New India Assurance Co. Ltd.

Award Dated : 22.03.2007

Shri S.K. Rupramka lodged a complaint with this Forum on 01.02.2006, that he had taken a mediclaim policy No. 323202/48/03/00414 from New India Assurance Co. Ltd. He had filed a claim with the TPA M/s Medsave Health Care, New Delhi on the above policy on 20.10.2004, for hospitalization of his wife Smt. Saroj Rupramka. He had written to the Insurance Company on 29.03.2005, and he had contacted the Regional Office of the Insurance Company in May 2005, wherein he was handed over a letter of TPA dated 12.05.2005. Immediately on 26.05.2005 he had sent a reply to the TPA and the copy to the Regional Office. There was no response and he had sent reminders and the last reminders to the TPA and the Regional Office on 09.07.2005. He was informed by Dr. J.S. Dahiya that his claim has been processed and passed by Medsave Health Care but due to some internal problem with TPA the payments were getting delayed. Further, he was informed that, they had discontinued the services with the TPA and they are getting all the files and cheques soon. But he was shocked to received a letter dated 29.12.2005 from the Insurance Company mentioning repudiation of the claim. He has requested the Forum that there was no response from the Insurance Company for over 14 months. As per IRDA regulation Insurance Company supposed to settle the claim within one month time from the date of receipt of the claim document. He has requested that his claim be paid along with interest from 22.10.2004.

The representative of the Insurance Company informed this Forum that they had already submitted their reply dated 23.03.2006. However, they informed the Forum that the mediclaim policy No. 323202/48/03/00414 was issued to the insured Shri S.K. Rupramka for the period 28.08.2003 to 27.08.2004 covering Smt. Saroj Rupramka, Shri S.K. Rupramka and Shri. Rohit Rupramka for sum insured Rs.2 lacs each with 20% cumulative bonus. Smt. Saroj Rupramka was hospitalized on 19.08.2004 at Max Hospital, Noida, with diagnosis type 2DM. The claim was submitted to TPA Medsave Health Care Ltd. which was received on 20.10.2004 for Rs. 29399/-. The TPA raised the queries vide their letter dated 22.11.2004 asking to send the duration of Diabetic Mellitus from the treating doctor. The said query was not replied by the insured and he was reminded by the TPA vide their letters dated 11.05.2005 and 16.05.2005. In response to this the insured submitted the letter dated 26.05.2005 from Dr. M.K. Gupta of Swami Vivekananda Hospital, whereas the treatment was taken at Max Hospital, Noida and consultant doctor was Dr. Arun Garg. In response to the doctor letter the TPA asked to produce all the previous policies copies vide their letter dated 31.05.2005 and 21.06.2005, which was not submitted by him. Since, the services of TPA Medsave Health Care were changed to M/s. Vipul Medcorp the claim files were called back by the Regional Office. From the hospital records, it has been revealed that Smt. Saroj Rupramka was suffering from Type 2DM since 16 years. In view of this there is no liability of the company under the policy as the disease for which treatment was taken was pre-existing and also there is non disclose of facts in the discharge card. As per our panel doctor Dr. Harish Nagpal, the Branch has repudiated the claim vide their letter dated 29.12.2005.

At the time of hearing Shri Rupramka informed the Forum that he has been taking mediclaim from the New India Assurance Co. Ltd. for the last 14-16 years and he is still continuing to take the same. His wife Smt. Saroj Rupramka was not suffering from any disease. His claim has wrongly been repudiated by the Insurance Company and he should be paid the claim amount along with interest.

The representative of the Insurance Company contested that Smt. Saroj Rupramka was suffering from Type 2DM for the last 16 years and as such at the time of hospitalization the disease is pre-existing which comes under the exclusion of the policy. Hence, they have repudiated the claim. On enquiry by this Forum that the claimant Smt. & Shri Rupramka were enjoying 20% Cumulative Bonus, and their son Shri Rohit Rupramka who was also covered under the policy was enjoying 25% of Cumulative Bonus. As such the minimum period of insurance would be atleast 6 years, as such it proves that they had taken mediclaim policy in 1997, how the disease been 16 years old, and in case it was so, they would have claimed some amount against the policy. The representative of the Insurance Company was unable to give a satisfactory reply.

After hearing both the parties and on examination of the papers submitted, it is observed that the contention of the Insurance Company that Smt. Saroj Rupramka was suffering from Type 2DM for the last 16 years, as and have repudiated the claim as pre-existing disease. On examination of the policy document it was observed she has been enjoying the cumulative bonus of 20% at the time when she was admitted in the Max Hospital and her son who was also covered under the policy was enjoying cumulative bonus of 25% which means that they must have taken the policy in the year 1997. On examination of the report of Dr. Harish Nagpal it is observed that Smt. Saroj Rupramka was operated for Carbuncle at Sita Ram Bharti Hospital, New Delhi, and it was only detected in February 2000, when she was suffering from DM, which is also informed by her family physician Dr. M.K. Gupta. This clearly shows that Smt. Saroj Rupramka was not suffering from the disease of DM at the time of taking the policy in the year 1997. As such the Insurance Company has wrongly repudiated the claim as a pre-existing disease.

I, therefore, pass an order that the claim be settled for Rs.29399/- along with 8% interest from 01.12.2004 till the time of payment.

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

Guwahati Ombudsman Centre
Case No. : 14-004-0042
Sri Dilip Kumar Bharali
Vs
United India Insurance Co. Ltd.

Award Dated : 17.10.2006

Facts (Statements and counter statements of the parties) :

Equivocally, the Insurer in the ‘self-contained note’ submitted that though the policy in question was a renewal one there was a break of 14/15 days before issuance of New policy after expiry of the previous one. That the policy cannot be treated as renewal one because ‘certificate of good health was not submitted at the time of renewal for consideration of renewal by the competent authority’. It was submitted that exclusion clause 4.1 is to be applied as treatment was done at a time when the disease was more than one year old. (The language used in self-contained note is confusing to make out clear and unambiguous meaning).

The claim of the complainant/Insured, however, is that his wife complained of pain & consulted doctor as a result she was hospitalized on 9.1.05 and discharged on 13.01.05. The medical expenses of Rs.31,300/- incurred during the hospitalization was claimed by forwarding necessary documents in support thereof. But no payment was made and hence this complaint intending direction from this authority for the payment

of the amount together with 15% interest per annum and a compensation of Rs. 3,00,000/- for harassment etc.

Decisions & Reasons

The copies of policies filed will show that the complainant had medi-claim policy for his entire family from the year 2000 onwards till the date of treatment in question and thereafter. All throughout its statements the authorities in the Insurance Company maintained that the policy covering treatment period is a renewal policy thus there is no escape from such assertion although there is a plea that 'certificate of good health' was not submitted for consideration during renewal. But fact remains from the assertions of the Insurance Co that for all practical purpose the policy was treated as renewal policy as no fresh proposal was demanded from the complainant and renewal policy was issued in spite of absence of certificate of good health.

Considering from other angle also there is nothing concrete to establish any case of pre-existence of the disease in question. The disease for which the treatment was done is 'acute cholecystitis' and there is nothing to show that the Insured had the knowledge of the disease next before the dates of her hospitalization & treatment. The facts upon which the Insurance Co. wants to capitalize are observations/remarks of the Doctor who was consulted by the Insured patient on 11/12/04 and thereafter. History recorded in the prescription by the Doctor is as follows :-

"(i) Pain Abdomen/vomiting - (on 11/12/04)

(ii) Suspected acute cholecystitis – (on 14/12/04)

Pain abdomen off & on for more than 1 year – History of severe pain in abdomen (on 10/12/04)." and in the same prescription Investigation for Ultrasonography of upper abdomen dt. 22/12/04 'USG whole abdomen' was advised. Therefore, it will not be proper to impute the knowledge of disease of chelecystitis simply on the complain of 'pain abdomen'. We are therefore of the opinion that under facts and circumstances discussed as above neither the exclusion clause 4.1 regarding pre-existing disease nor the status of the present policy being fresh one is acceptable and accordingly the complainant is to be given the relief of insurance benefit available under the policy in question subject to production & verification of requisite vouchers/money receipts/cash memos etc. However, we are of the opinion that other reliefs of compensation and interest sought are not applicable.

It is hereby directed that the Insurance Co. will make fresh assessment of the amount of medical reimbursement in the guidelines of discussions and observations as above within 60 days from today.

Guwahati Ombudsman Centre
Case No. : 11-004-0009
Mahabir Prasad Jallan
Vs
The New India Assurance Co. Ltd.

Award Dated : 06.11.2006

FACTS (Statements and counter statements of the parties)

In brief, the grievance of the complainant is that he submitted a medi-claim for Rs.62,859.90 on 16th November, 2004 in respect of expenditure incurred for the treatment of his son Sri Sashi Kumar Jallan but the insurer (The New India Assurance Co. Ltd.) offered him only Rs.41,380.00 through the Third Party Administrator (TPA) M/s. Medicare TPA Services (I) Ltd. without showing any reasons for such reduction in the amount of claim. That later on he could understand the entitlement as per terms

and condition of the policy and would concede to a deduction of Rs.5945.00 but not Rs.21,479.90 done by the insurer.

The insurer submitted that the offer of Rs.41,380.00+Rs.2,400.00, i.e., Rs.43,780.00 in total was made by the TPA considering the admissibility of the amounts claimed as per the assessment made by it (TPA) in the connected settlement sheet.

Decision & Reasons

On examination of the documents forwarded by the insurer we find that the complainant forwarded to the insurer a date-wise list of expenses incurred by him enclosing supporting vouchers/receipts/memos etc., but the insurance company through its TPA came to a conclusion by preparing a settlement sheet where only an amount of Rs.41,380/- has been recommended deducting certain amount as inadmissible. The settlement sheet prepared by the TPA without definitive particulars cannot be wholly depended upon to assess the actual expenses. Equally, the prescriptions of medicines has not been shown by the insured in a systematic way for proper verification and appreciation of correctness from the same. It appears that both sides adopted casual method of assessment of the actual medical expenses. We have taken the strenuous steps of adding the amount recorded in copies of different vouchers forwarded by the complainant and found an amount of Rs.51516.72 roughly. It may be remembered that the complainant has agreed the deduction of amount of Rs.5,945/- from a total amount of Rs.62,000.00 as reasonable thereby reducing his claim to Rs.56,914.90. There being no alternative, the only thing we can do, under the facts and circumstances above, is to make a lumpsum assessment of Rs.51,000.00 as reasonable amount to be paid to the complainant.

It is hereby directed that the claim will be settled at Rs. 51,000.00 provided the complainant/insured sends his letter of acceptance of this award as the full and final settlement of his claim etc.

Guwahati Ombudsman Centre
Case No. : 11-003-0028
Mr. Lakshmi Das
Vs
National Insurance Co. Ltd.

Award Dated : 07.11.2006

FACTS (Statements and counter statements of the parties)

The grievance of insured is non-settlement of medi-claim re-imbursement demands on pretext of ‘pre-existing’ clause of the policy in question. The complainant claims he purchased policies from 1992 onwards and hence the hurdle is not applicable etc.

The view of the insurer, vide letter dated 13th July, 2006 and dt. 21/09/2006 is that out of 4 (four) claims lodged amounting to Rs.30,606/- and Rs.23,522/- for Mr. Lakshmi Das and Rs.18,683/- and Rs.47,250/- for Mrs. Lakshmi Priya Das, claim for Rs. 47,250/- has been paid vide cheque no.437283 dt. 26/08/06 and other two of Rs.18,683/- and Rs.23,522/- are awaiting final disposal but claim for Rs.30,606/- has been rejected applying exclusion clause 4.1 of policy which excludes pre-existing disease from cover of the policy purchased etc.

Decisions & Reasons

It appears from the view expressed by the insurer that the claim of Rs.30,606.00 has been rejected by applying Pre-existing clause of policy on the basis of certificate issued by Doctor P.P. Sharma of down town hospital, Guwahati dtd. 08/08/06.

But there is nothing to connect this certificate directly with the ailments for which the treatment was undergone. The discharge certificate dtd. 21.11.05 shows that the patient was diognosed for the ailments of (1) chr. Calculus cholecystitis, (2) NIDDM with neuropathy & retinopathy, (3) Gingivtis for which he was treated.

It is not possible for a non-medical person to opine whether the above mentioned diseases were direct complications of hypertension in order to apply the pre-existing clause of the policy.

Be that as it may, the photocopies of the proposal forms for the year 1997-98 (15.12.97 to 14.12.98) have been forwarded to us by the insurer, one for Mr Lakshmi Das and another jointly for Mr. Lakshmi Das & Mrs. Lakshmi Priya Das. The insured/complainant, however, has not forwarded copies of policy documents since 1992 from which year he claims insurance cover. The complainant has enclosed only photocopies of the list of bill nos showing the amount against such bills and it is not possible to connect these with the actual expenses incurred or the treatment in question. For all these defects, we cannot give any definitive finding in this case and accordingly, are constrained to refer it back to the insurer to make a review of the claim exhaustively within 30 days from the date of receipt of copy of this judgement and order. The complainant will co-operative by furnishing copies of necessary documents from him.

In view of the discussions aforesaid, it is hereby directed that the insurer will review the claims of the insured persons both Mr. Lakshmi Das and Mrs. Lakshmi Priya Das particularly with reference to treatment undergone and policy conditions applicable and record appropriate findings on the merit of the claims.

Guwahati Ombudsman Centre
Case No. : 11-003-0063/06-07
Smt. Nirmali Kakati
Vs
National Insurance Co. Ltd.

Award Dated : 15.11.2006

Grievance

The insured/complainant is the joint policyholder along with her husband in the connected medi-claim policy. She states that they are policyholder for last 12 years and submitted premium for renewal of the policy on 26/06/2006 but were informed that since one of the proposer reached the age of 75 years, there is necessity for approval of the Regional Office and requirement of fresh proposal form, ECG report, blood sugar report and good health certificate etc. from a M.D. That the requisites were complied and the policy was renewed only w.e.f. 07/08/2006. That the delay in renewal of the policy was due to interference by the insurance company and it was not justified to repudiate the claim on the plea of ‘consequent effect of extended peril’ and hence this complaint.

Reply

The insurance company in their long ‘self-contained note’ submitted, inter alia, that Sri Deva Kanta Kakati (husband of the complainant) was a medi-claim policyholder since 01/03/93 and he continued to renew the policy with the approval of the higher authority and the latest policy was issued on 07/08/06. That, on earlier occasions, two claims were paid to the insured persons. That in connection with the present complaint/claim, the insured was admitted into hospital on 06/08/06 i.e., before the inception of the present policy (which incepted on 07/08/06) and was treated for ‘Diabetes Mellitus with

bilateral hydroureteronephrosis with chronic retention of urine'. That in the proposal form dated 07/08/2006 under heading 'Diabetes questionnaire', it has been clearly mentioned that date of diagnosis of diabetes was 1978 i.e., much before the inception of the first policy was taken in the year 1993 and on these above two grounds, the present claim is not tenable. That there is a gap of 1 month in obtaining the latest policy cover and accordingly, the present policy is to be treated as a fresh policy.

Decisions & Reasons

There is no denial that the insured was a patient of diabetes since 1978. In the 'Clinical Summary' part of the discharge certificate, it has been mentioned

Therefore, the expenses for treatment for diabetes & any disease/illness related diabetes are clearly excluded from the policy cover in case of present complainant/insured and in the discharge certificate it has been shown that the present complications related to diabetes. Moreover, the present policy, being fresh policy, there is no cover on the date of admission into the hospital. So, it may be treated as a 'pre-existing disease' also.

For the reasons and the discussions as aforesaid, we find that there is nothing wrong in repudiation of the claim and there is no scope for us to interfere.

Guwahati Ombudsman Centre
Case No. : 11-002-0059/06-07.
Bhabendra Nath Deka
Vs
The New India Assurance Co. Ltd.

Award Dated : 29.11.2006

The Grievance

The claim of re-imbursement of medical expenses amounting to Rs.12,059.00 for the treatment of Mrinal Jyoti Deka on the strength of medi-claim policy in question was not settled by the opp. Party/insurer on the plea that the insured was not a full-time student at the time of hospitalization and hence the complaint. Relief sought is Rs.13,000/-.

Reply

The son of the complainant, aged 23 years as per the discharge certificate after hospitalization from 22-11-05 to 25-11-05, was not admissible because it attracted the exclusion clause No.3.6 of the policy condition which goes as follows —

"Financially dependent sons up to the age of 21 years only, can be extended upto 25 years if pursuing full time higher studies in a recognized University."

Decisions & Reasons

Neither party forwarded copy of policy or the conditions but a copy of Group Medi-claim Insurance Policy no. 120700 48 04 00050 to cover employees and other dependents Life Insurance Corporation of India is available with us and Article 3.6 of it goes as follows :-

"3.6 DEPENDENTS OF THE EMPLOYEE SHALL MEAN Spouse.

Unmarried, financially dependent daughter.

Sons up to the age of 21 yrs only, can be extended upto 25 years if pursuing full time higher studies in a recognized University.

Financially dependent parents/parents-in-law of female employees.

In case of retired employees – spouse only."

So, for application of this policy there is an age limit of 21 years which can be extended upto 25 years 'if pursuing full-time higher studies in a recognized university' under Clause © of Article 3.6. In the present case, the complainant could not show by production of any valid or acceptable documents that at the time of hospitalization i.e., within 22/11/05 to 25/11/05, he was pursuing any full-time higher studies in any recognized university as required under the aforesaid policy conditions. There is also no document to show admission in I.I.M., Silpukhuri or in any other recognized institution before the date of hospitalization and it is the admitted position in the complaint letter of the complainant that at the time of hospitalization his son was of 22 years age. Therefore, we find nothing wrong in the decision taken by the insurer.

In the result, matter stands closed.

Guwahati Ombudsman Centre
Case No. : 14-003-0074/06-07.
Sri Sukanta Kumar Paul
Vs
National Insurance Co. Ltd.

Award Dated : 15.01.2007

Grievances

Complainant's wife, with insurance cover as noted above, suffered abdominal pain and discomfort on 25.03.06 and was advised immediate hernia operation by family doctor. M/s Med Save Health Care Ltd., Third Party Administrator (TPA), was approached by a letter for preauthorized cashless treatment but without response and due to urgency of the matter the insured Mrs. Taniya Pal got admitted in Rabindranath Tagore International Institute of Cardiac Science (R.T.I.I.C.S.), Kolkata, and got operated there on 03-04-06 incurring an expenses of rupees nineteen thousand four hundred fifty (Rs.19450.00). That on her return from Kolkata she lodged on 17.04.2006 the medi-claim for the sum spend along with requisite documents with the opp. party/insurer through the TPA as required but till date of the complaint nothing was done by the insurer and hence the complaint. Relief sought is payment of Rs.19450/- together with interest and ex-gratia etc.

Reply from Insurer

The contentions of the insurer vide short self-contained note filed are that claimant/insured had taken policy w.e.f. 04-05-1994 with several 'breaks' during renewal years but she never declared while submitting the filled up proposal form that she had undergone hysterectomy in the year 1976. That hernia operation on 03-04-2006 was arising out of hysterectomy underwent in 1976 as per the discharge summary issued by said RTIICS, Kolkata, for which reason the claim is not admissible as per the provision of the Exclusion Clause no 4.1. of the policy in question etc.

Decisions & Reasons

The Exclusion Clause referred to by the Insurer goes as follows –

"4. EXCLUSIONS

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of :

All diseases/injuries which are pre-existing when the cover incepts for the first time."

The insurance cover taken by the wife of the complainant from the contesting insurance company since the year 1994 with certain break-periods in between year to

year renewals is a fact admitted by the proposer (i.e., complainant) of the insured/claimant. The insurer has forwarded photocopies of the proposal forms of the previous years of insurance effective from 04-05-94 to 03-05-95 and 05-05-97 to 04-05-98 and it is understood that no fresh proposals were taken for the year of insurance effective from 13-05-2005 to 12-05-2006, sum assured being Rs.35,000/- (confirmed over telephonic conversations), under which the present claim has been lodged.

From the discharge certificate issued by RTIICS, we find that the present treatment of incisional hernia (lower midline) is directly related to the treatment of hysterectomy underwent by insured in 1976 but the latest proposal forms filled up and submitted by the husband of the insured with the signatures of the insured have omitted to mention the treatment of hysterectomy while answering the questions relating to 'Medical History' under item no.12 of the proposal form.

Therefore, we find there is a specific case of omission of the fact of hysterectomy undergone in 1976 by the wife of the proposer. It is true that strictly speaking incisional hernia may not be regarded as a 'pre-existing disease' and such disease may develop suddenly but here the question is a bit different and relates to non-disclosure of material facts in the proposal form which disclosure could have a bearing in the decision of the underwriting and therefore, the present case is hit by the principle of absence of Utmost Good Faith (Uberrimae Fide).

Thus, we find that in substance the repudiation of the claim is justified and there is no just ground for this authority to interfere.

In our opinion & on the basis of discussions aforesaid, no interference is needed from this authority and matter stands accordingly closed.

Guwahati Ombudsman Centre
Case No. : 14-003-0089/06-07.
Sri Ashish Sanyal
Vs
National Insurance Co. Ltd.

Award Dated : 02.02.2007

Grievance

The complainant resents that although he was having medi-claim policy cover, his medical re-imbursement claim was not paid by the insurance company in spite of several attempts made etc.

Reply

The insurance company finally came with the view that the claim in question had to be treated as 'no claim' for the reasons that the disablement was not permanent and total but only 50% and hence as per the terms and conditions of the policy, the claim is not tenable.

Decisions & Reasons

It appears that the policy in question is Janata Personal Accident **Insurance Policy**

The copies of the medical report forwarded by the complainant states that the insured developed Traumatic Paraperis and the certificate dated 06/04/05 issued by Mukhopadhaya Orthopaedic Clinic And Research Centre, Patna, also concluded stating that the 'patient has permanent disability due to weakness of both lower limbs'.

From these facts given above, there is no dispute that the insured sustained injury due to an accident leading to a case of partial disability. The medical board constituted by the insurer held that physical disability is around 50%.

Remembering the facts discussed, if we consider the conditions precedent given in the policy for coverage, it will be seen that the coverage was given only for " * * permanently totally and absolutely disabling the insured from engaging in or being occupied with or giving attention to any employment or occupation of any description whatsoever * * *" and not for other disabilities or percentage of disabilities. That being the position, as per the terms and conditions of the contract, it appears that the insured is not entitled to any relief under the given facts and circumstances. However, Clause (e) of the policy conditions quoted beforehand may create some confusion about the true nature and extent of disability due to the language used; but then, we cannot draw any definite conclusion thereof to find and hold that Clause (e) will give coverage to the undisputed injuries sustained by the insured.

In view of the discussion as above, we find that no interference from this Authority is required and matter stands closed accordingly.

Guwahati Ombudsman Centre
Case No. : 14-005-0091/06-07
Smt. Prabhabati Basak
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 02.02.2007

Grievance

Truck No.AS-15/2865 belonging to the complainant, Smt. Pravabati Basak with particulars of insurance coverage noted as above met with an accident near Sonapur on National High-way-37 on 13/10/05. The complainant lodged the claim. The insurance company, however, offered only Rs.58,000/-, but she refused to accept the same as it was according to her inadequate to compensate the loss sustained, etc.

Reply

The insurer stated that on receipt of the claim petition, the same was processed and settlement was offered at Rs.58,000/- which was not accepted by the insured. It appears that although there is a statement from the complainant that she had spent Rs.1,55,000/- and was claiming only relief of Rs.1,00,000/- , no documents have been filed to substantiate the quantum of her actual loss. There is no estimate bill, voucher, cash-memo etc., produced by her. There is, however, no dispute about the accident and the damage to the insured vehicle. Equally the insurer also has not forwarded to us the connected survey report, if any, or the assessment note etc. Therefore, for want of sufficient materials, the exact/actual amount of re-imbursement of the loss cannot be ascertained from our end and accordingly, it is ordered as hereunder.

In view of the discussions aforesaid, it is hereby directed that within 30 days from the date of receipt of the copy of this order the insurer will invite the insured at its Office to come along with all requisite documents and thereafter, taking the help of survey report, if any, assess the expenses incurred in repairing the damaged vehicle and settle the adequate amount of re-imbursement to be made and pay the same accordingly with intimation to this Office. The insured / complainant is directed to approach the insurer accordingly, may be through representative.

The matter stands disposed of for the time being.

Guwahati Ombudsman Centre
Case No. : 14-005-0095/06-07.
Sri N. Haque
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 05.02.2007

Facts (Statements and counter statements of the parties) :

The insured was suffering from ENT troubles etc. since December,2005 and took treatment at A.I.I.M.S., New Delhi, incurring an expenses of Rs.16,261/-. The disease was diagnosed as Vocal Cord Polyp (L) and he was advised to go for operation. The complainant was not cured even after such treatment at AIIMS and went for further treatment incurring Rs.27911.20 at Indraprastha Apollo Hospital, New Delhi, and again at Nightingale Hospital incurring Rs.21,667/-. The insured submitted bills totalling Rs.65839.20 but the claim was not settled.

The insurer submitted that the insured/complainant was hospitalized for hoarseness of voice on two occasions and the claim was lodged which were referred to concerned TPA, M/s. MedSave Health Care Limited which rejected the claim applying Clause 4.1 (Pre-existing Clause) and informed the complainant accordingly. That after receiving the rejection letter, the Office of the Insurer, Beltola Branch has written to the said TPA to review the claim and the reply is awaiting.

Decisions & Reasons

It appears from the correspondences, records, and documents forwarded to us that there is scope for review of the matter as the panel doctor of insurer suggested that diseases are not pre-existing and the insurer had already referred the matter to concerned TPA for review of the same. It also appears that the policy is continuous since 31.02.03. Thus, in our opinion, prima facie, the claim appears to be payable. It is therefore ordered as follows. In view of the facts stated beforehand, the matter is referred back to the insurer to arrive at a reasonable settlement/or to record its final decision on the merit of the claim on the basis of the documents already forwarded by the claimant/insured and any other documents to be submitted by the insured/complainant now within 10 days from the date of receipt of this judgement and order.

Guwahati Ombudsman Centre
Case No. : 14-003-0078/06-07
Sri SreeGopal Ajit Saria
Vs
National Insurance Co. Ltd.

Award Dated : 06.02.2007

Case for the Complainant

It is stated that the insured/complainant developed chest pain and was admitted in hospital on 30/06/04 for Angiogram and thereafter was operated at Suraksha Hospital, Kolkata on 12.07.04. That the complainant procured pre authorization letter from MedSave Health Care Limited for treatment agreeing to pay Rs.1,50,000/- and therefore, submitted further claim for re-imbursement of Rs.24,025.11. That the insurer vide letter dated 21.07.06 informed him that since the ‘parent claim of Suraksha Hospital’ was not considered by TPA (Third Party Administrator), the present claim was also not admissible on that ground.

Case for the Insurer

The insurer states that the claim file was called back by the TPA concerned for review but in spite of several correspondences, the file has not been returned after such review, if any. That as per the records, it appears that the present claim pertains to pre-hospitalization cost of a claim already rejected on ground of 'Non-declaration of DM and HT in pre-authorization format' for which the present claim of Rs.24,025.11 was also rejected applying policy conditions 3.1 & 3.2 which states that the pre and post hospitalization cost should have relevance to the disease for which hospitalization was necessitated and claim admitted. That any clear picture can be submitted to this Authority only after receiving the subject claim file from the concerned TPA etc.

Decisions & Reasons

From these statements of the parties as reproduced above, it appears that the insurer is yet to take final decision on the recommendation from the concerned TPA or otherwise. Moreover, the requisite particulars for consideration of the total claim from this end also is not available before us.

Within 30 days from today the insurance company/insurer will take all possible measures, if needed by sending personal messenger to their TPA, to collect file with the result of the review etc., and record its own findings on the issues relating to the claim vis-à-vis the policy terms and condition and contents of proposal form etc.

Guwahati Ombudsman Centre
Case No. : 11-004-0093/06-07
Smt. Manju Devi Pagaria
Vs
The United India Insurance Co. Ltd.

Award Dated : 13.02.2007

Grievance

Heritage Health Services, T.P.A. (Third Party Administrator) of United India Insurance Co. Ltd. repudiated the claim on the ground that incisional hernia is due to the complication of previous abdominal surgery performed before the inception of policy. Complainant claims that previous surgery was done on 21.3.05 but the hernia appeared only in the month of January,'06, so, this is not a pre-existing disease. That the various investigation reports signify that this is not due to complications of abdominal surgery as opined by the insurer but an ailment detected by Dr. Kausik Barua on 11-3-06 opining incisional hernia was only 3 months old on that date etc.

Reply

The Insured lodged claim seeking re-imbursement of expenses for treatment of Incisional Hernia. She was hospitalised from 5.04.06 to 8.04.06. The claim file was forwarded to Heritage Health Services Pvt. Ltd. (TPA) on 27.4.2006. On 05.07.06 the TPA informed the Insured that the claim is inadmissible as per terms and conditions of the medi-claim policy. The reason of repudiation is policy condition no.4.1 i.e., pre-existing. The TPA of the Insurer mentioned that "the present incisional Hernia is the complication of previous abdominal surgery done before the inception of policy. Hence treating the disease as sequel of previous abdominal surgery the claim stands for repudiation. After the original claim was sent back by the TPA it is seen that the claimant was operated for incisional Hernia on 6.4.06. She had undergone Total hysterectomy & bilateral salphingo-oophorectomy on 20.3.05/21.3.05. The cause of this operation was fibroid uterus which she had for last 2 years. After this operation she developed secondary infection too. She had also a past history of tubectomy 20 years back and total thyroidectomy 10 years back. The present incisional hernia was in the lower abdomen where the incisions of the previous operation was present. As per

Exclusion Clauses 4.2 & 4.3 of the policy, the claim of this operation was not admissible. Since hernia is from the operation from total hysterectomy, the present claim is not admissible etc. etc.

Decisions & Reasons

Dr. R.K. Talukder in his certificate dtd 18/8/06 mentions that he performed operation for hysterectomy on 21.3.05. Post operation routine check up also do not reveal any hernia of the incision on 22/6/05. The discharge summary of Sir Ganga Ram Hospital dt. 8-4-2006 mentions – "History : Patient was apparently well 3 months back when she noticed swelling in the right lower abdomen, gradually increasing in size ,……Hysterectomy done 1 year back, subsequently has post operative infection for 15 days". She has been diagnosed as "Incisional Hernia" for which operation was done on 06/04/06.

Considering that she had purchased insurance policy w.e.f. 10.3.05 and had her first operation on 20/3/05 & 21.3.05 for fibroid uterus from which she was suffering since last 2 (two) years and also she had history of tubectomy 20 years back & total thyroidectomy 10 years back, it cannot be straightway opined that there is a possibility of incisional hernia originating from the past cases. Insurer has not forwarded to us the proposal forms in order to examine whether all these diseases were declared at the time of inception /purchase of Insurance policy. The prescription dated 25/03/06 by Dr. Kausik Barua of GNRC shows 'incisional hernia' was detected on that date as 3 months old, hence it cannot have any relations with other ailments from which the insured suffered earlier.

On the subject of pre existing disease or suppression of previous ailment in medi claim, it was held in NIC vs. Bipul Kundu - 2005 CTJ 377 (CP) NCDRC New Delhi - that burden is on the insurer to prove pre existence of disease. It has been held also by several Fora that to apply the pre existing exclusion clause it must be held that the insured should have knowledge of the existence of disease when he or she purchased the policy. If such knowledge is to be attributed then the circumstances is to be established to hold the presumption good. In the instant case, we don't find any connection of the plea of pre existence with the facts of the case. The prescription produced by the complainant that was issued by Dr. K. Baruah on 25/03/06 has mentioned that the incisional hernia was of origin from a date 3 months back meaning thereby December, 2005 or later. The policy cover being given continuous from 10/03/2005 by renewal on 10/03/2006 it cannot be said that the disease was pre existing and the insured had knowledge of incisional hernia when she purchased the policy. There is a serious laches on the part of the insurer in not producing the proposal forms submitted by the insured in order to see what was the declaration made in this context while filling up the proposal forms. Therefore, we are of the opinion that the medi-claim in question has not been rejected on appropriate and valid ground and is liable to be reviewed by insurer on the basis of discussions as aforesaid.

In view of the discussions made and guidelines given, it is hereby directed that the Insurance Company would review the matter directly, or through the TPA, and do arrive at an appropriate decision on the matter in order to make proper settlement of the claim within reasonable time.

Guwahati Ombudsman Centre
Case No. : 11-005-0102/06-07.
Mrs. Shikha Sharma
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 12.03.2007

Facts (Statemetns and counter statements of the parties)

The complainant/insured Smt. Shikha Sharma, resents that her 'medi-claim' has been rejected by the insurer – Oriental Insurance Company Ltd, without any just cause and in spite of subsequent prayer for review nothing has been done till date ; hence the complaint.

The contentions of the insurer, inter alia, are that medi-claim policy was issued to the complainant for the period from 17.05.05 to 16.05.06 for sum assured of Rs.50,000/- only by its CBO-II, Guwahati. That the insured (complainant) was admitted with complain of – 'H/o bleeding P/v' into Arya Hospital on 06/05/2006 and discharged therefrom on 07/05/2006 but the original discharge certificate did not mention time of admission and time of discharge. That as per the relevant policy contract papers, under heading 'Definitions' item no.3, stipulates that the expenses on hospitalization are admissible only if the hospitalization is for a minimum period of 24 hours and that applying such condition the T.P.A. concerned has rejected the claim as the hospitalization was less than 24 hrs in the instant case. That neither the hospital authority nor the insured co-operated with it (insurer) in ascertaining these facts and insured violated the policy condition/item no. 5.5 which says that insured is required to furnish all documents needed by insurer to inquire/investigate into merit of the claim. That the matter is still open for review if requisite informations /documents are furnished by the insured who appears to have been trying to get insurance benefit upto the full extent of sum assured and that disease mentioned may not require such huge quantity of medicines within such intervals of short time as mentioned etc.

Decisions & Reasons

It appears that there are 3 (three) discharge certificates , two of which are undated, third one is dated 10/8. Two certificates were issued by M.O. but signatures are different. In one certificate date of admission is written as 6/5/06 & discharge on 7.5.06. In the 2nd certificate date of admission 6.5.06 (MD) & discharge 7.5.06 (3 P.M.). In the 3rd certificate date of admission is 6.5.06 (12 MD) i.e. midday, date of discharge 7.5.06 (3.00 PM). This certificate is signed by Medical Superintendent of Arya Hospital. The Medical Superintendent also on 21.11.06 issued a certificate mentioning the time of stay in the hospital. The prescriptions (copy) submitted are dated as 14.4.06; 20.4.06;26.04.06; 30.4.06; 5.5.06; 9.5.06 & 11.5.06. In prescriptions dtd. 5.5.06 advice for Hospitalization is mentioned. MedSave Health Care Ltd., the TPA concerned; repudiated the claim on 4.8.06 as the hospitalization was less than 24 hours and sent their decision to the Branch Office of the Insurer. However, there is no evidence to show that the decision has been communicated to the Insured.

The disease for which the insured/complainant was treated is DUB; meaning perhaps Dysfunctional Uterine Bleeding. It is a fact that one of the discharge certificates duly signed by M.O. has mentioned date of admission as 06/05/06 (12 MD) and that of discharge on 07/05/06 (03.00 p.m.) and the treatment was 'conservative'. We think interpreting 'MD' as 'mid-day' thereby coming to a conclusion that the admission was for more than 24 hours in the hospital may not be doubted unless there is a cogent reason to do so and we find from scrutiny that there is no good reason to doubt this discharge certificate.

So, we cannot say that the hospitalization for 24 hours is not a very strict condition and may be relaxed in from case to case or under given facts etc.

However, coming to question of cash memos of purchasing medicines and relevant prescriptions, it has been opined by the insurer that the disease concerned may not

appear to require such frequent prescriptions and that there is possibility of exaggeration etc. The exact objection taken by para 8 of the self-contained note in our opinion will bear some meaning.

Under the facts and circumstances, we are of the opinion that a detailed investigation is required in order to ascertain genuineness in the procuring of the cash memos vis-à-vis purchasing of the medicines and that only an expert opinion can determine the nature of treatment that was needed and the types of drugs that were required under the particular facts and circumstances in the case of treatment of the D.U.B. We are of the view that the demand made by the insured is on the highest side, particularly when the amount mentioned in the different prescriptions tend to reach the sum assured of Rs.50,000/-, perhaps with the wrong notion that the entire sum assured is to be recovered in case of any medi-claim arising during continuation of the policy.

In view of the discussions aforesaid, it is hereby directed that the insurer will be permitted to constitute a Medical Board in order to review the expenses incurred vis-à-vis the treatment undergone and the disease concerned in order to suggest the quality and quantity of drugs that were needed for cure of the insured.

In addition to that the insurer will be at liberty to verify and investigate the fact of purchase of medicines and procurement of cash memos in order to come to a definite conclusion whether the claim has been unnatural or not or enhanced to a higher sum than is required normally for the treatment of such kind of disease, i.e., DUB and whether pre-hospitalization and post-hospitalization is permitted under the facts and circumstances of the case.

Hyderabad Ombudsman Centre
CASE NO. : I.O. (HYD)/ G-11.004.126
Sri K. Radhakrishna Murthy
Vs
United India Insurance Co. Ltd.

Award Dated : 26.10.2006

The complainant was covered under an individual Mediclaim policy for a sum insured of Rs.2,00,000/- for the period 18.9.2002 to 17.9.2003. He was admitted to Medwin Hospital, Hyderabad on 03.03.2003 with complaints of severe back pain. He was diagnosed to suffer from Lumbar Canal Stenosis and underwent surgery for the same. The complainant lodged a claim for Rs.44,890/- with the insurer. The complainant was hospitalized and underwent another surgery for a similar illness again in August 2003. The insurer vide letter dated 13.01.2005 rejected the first claim (of March 2003) on the ground that as per medical records the patient was suffering from low backache since 4 years and therefore it was a pre-existing ailment and excluded from the scope of the policy. As regards the second claim (August 2003) the insurers' panel doctor opined that since a similar surgery was performed 5 months ago it was not possible for the problem to either regenerate or re-grow in a 72 year old person. The second claim was also not paid by the insurers.

The complainant contended that he was a regular Mediclaim Policy holder since 1999 and that the policy was renewed every year without a break. In June 2001, before leaving for the USA he submitted the renewal premium cheque to the insurer a month in advance of the date of expiry of the policy.

Unfortunately the cheque was dishonored for want of funds in his running savings bank account. This fact was informed to him after a delay of more than one and a half months from the date of dishonor of the instrument. He requested his tenant to remit the premium at the office and ensure renewal of the policy. The delay in renewal was

unfortunate and due to circumstances beyond his control. The insurer's contention that the disease was in existence 4 years prior to March 2003 was absurd. He consulted a doctor for the first time in 2003 only. He informed the insurer about the impending operation to his back in March 2003. After the surgery, the doctor informed him that L-3 was tender and prescribed medicines. Since there was no improvement in his condition he was advised another surgery which was done in August 2003. Moreover, he would not have deferred the operation for 4 years since 1999, if he were aware that he had the problem the first time since he took the policy, just to take advantage of insurance.

The insurer contended that the medical opinion obtained by the panel doctor at the Branch Office in June 2003 mentions clearly that the patient was having the problem since 1999 (as per the hospital records) and there was no question of the problem recurring within 5 months of the first operation.

However, since the policy for the period 2001-02 was renewed after a break of nearly 2 months, it was therefore considered as a fresh one and all the conditions and exclusions were applicable. As per rules in force, whenever a premium cheque is dishonored for whatever reason, the insurers have to cancel the policy ab-initio. In this case, the cancellation was done and informed to the insured at his address on 25.07.2001.

Held:

The insurers' representatives presented before me a copy of the Admission and Discharge Record pertaining to the March, 2003 hospitalisation and drew my attention to the "History of Complaint" wherein it is noted that the complainant was suffering from "low back ache radiating to the Right lower limb since 4 years". They contended that the first ever policy issued by them to the complainant was only from July 1999; thus clearly indicating that the onset of the illness around March 1999 was prior to the inception of the first policy. This argument is set aside, as it is purely an approximation but not a proof of the positive existence of an illness. It is seen that the insurer has a practice of extending the validity of an Individual Mediclaim Policy in case there is in force any Overseas Medical Insurance Policy operating concurrently. In this case the insured's earlier policy was for the period 22.07.2000 to 21.07.2001. If the validity of this policy were to be extended, (in view of the fact that the insured had an Overseas Mediclaim Policy for the period 19.06.2001 to 18.10.2001) the Individual Mediclaim Policy would expire on 19.11.2001. Since the policy in question was issued with effect from 18.09.2001 (after receipt of the premium), it should be treated as a continuous policy only.

Regarding the dishonoring of the cheque leading to cancellation of the policy the explanation of the insured that it was due to circumstances beyond his control is acceptable since his bonafides can be seen from the fact that he submitted the renewal premium cheque a month in advance of the date of expiry of the policy.

I also see no merit in the insurers' argument that the disease / illness was pre-existing as of July, 1999 since there is no evidence of any treatment taken. The medical opinions were taken over a period of 3 years on 22.06.2003, 18.05.2005, and 22.05.2006 for rejecting the claim on different grounds at different stages and the complainant was perfectly justified in feeling disillusioned and disappointed with the whole process that took more than 3 years. The insurers were not justified in repudiating teh claims. The complaint is allowed for both claims.

Hyderabad Ombudsman Centre
Case No. : G 11.008.128
K.Murali

Vs
Royal Sundaram

Award Dated : 30.10.2006

Sri. Murali, his wife Smt. Sukumari and 2 children were covered under the insurer's Health Insurance policy from 27.05.2005. Smt. Sukumari was admitted to hospital in May 2006 for an angiogram and later for a by-pass surgery. The claim lodged by Sri. Murali with the insurers seeking reimbursement of the medical expenses incurred was rejected stating that the illness was pre-existing, i.e. it existed prior to the insured taking the policy for the first time.

The insurer submitted that the illness diagnosed was Aorto Iliac Occlusive Disease with 90% Stenosis of Left Common Iliac Artery and 100% occlusion of the Right External Iliac Artery. They contended that this illness could not have developed during the currency of the policy and was, therefore, excluded from the scope of the policy. They pointed out that as per the definition of pre-existing condition given in the policy; the illness will stand excluded from the scope of the policy even if the insured person had no knowledge of the same at the time of taking the policy.

Held

The complainant stated that he was enrolled into the policy by the Tele-marketing staff of the insurer. He had conveyed all the data sought by them and had not suppressed or misrepresented in any way.

His wife had consulted a doctor for the first time on 16.12.2005 with a complaint of pricking sensation of the left foot which was there for only a few days prior to this date and not weeks or months. She was advised conservative treatment for a while and since there was no improvement in her condition, she was hospitalized first for Angiogram and later for a By-pass surgery in May 2006.

He claimed that as of May 2005 when the policy was taken, there were absolutely no symptoms of any ailment and his wife was quite healthy. It was only after 6 months of taking the policy that the first symptoms were observed.

Considering the fact that the earliest symptoms had arisen only several months after the policy was taken, I hold that the insurers were wrong in relying on one opinion, which appears to be only a surmise. I hold that it is not established that the disease was pre-existing. Complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.012.134
D. N. Rajakumari
Vs
ICICI Lombard General Ins.Co.

Award Dated : 31.10.2006

M/s. ICICI Lombard General Insurance Co. Ltd. insured Ms. Rajakumari under a Health Care Family Plan insurance policy issued for the period 24.09.2005 to 23.09.2006 for the first time. On 22.06.2006 she was diagnosed to be having a malignant mass in the left breast. She underwent Mastectomy of left breast on 03.07.2006 incurring an expenditure of Rs.58740/-. Further, she also underwent chemotherapy incurring about Rs.15000/- from 04.08.2006 to 07.08.2006 and again from 01.09.2006 to 03.09.2006.

The TPA rejected the insured's request for authorization of cashless treatment on 06.07.2006 citing a condition of the insurance policy, which excludes payment during 1st two consecutive years of insurance for treatment of certain specific diseases.

The insurers in their note to this office contended that the contract of insurance has to be read strictly in its natural meaning, unless there was an ambiguity. They contend that no wider meaning than what is contained in the policy is to be given. They submit that as per the exclusion condition 3 of the policy, the present claim was inadmissible.

Held:

The complainant submitted a copy of another Health Insurance Policy taken for her other family members for the period 07.05.2006 to 06.05.2007. She stated that the condition incorporated in her policy was vague and general, whereas the correct meaning and intention are made clear in the policy issued covering her other family members

I am inclined to accept the view that there are different plans, schemes offered by the insurers and a particular claim is to be reckoned with reference to the contract of insurance granted to that insured. On perusing the policy I note that the condition being contested stipulates that the company will not be liable for any medical charges during the 1st two consecutive years for ". Cataract, Arthritis, Hernia, Piles..and all internal tumours/cysts/nodules/polyps of any kind including breast lumps..."

It is not appropriate for me to interpret or judge on the wording of a policy, which is not the one on which the complained claim has arisen. In so far as the policy covering the complainant is concerned, I observe that the insurers have processed and rejected the claim as per the policy terms. Hence I decline to interfere with the decision of the insurer. Complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.003.0111
Ratan Hiro
Vs
National Insurance Co.Ltd.

Award Dated : 31.10.2006

The complainant's husband was covered under a Mediclaim Policy for the period 19.05.2004 to 18.05.2005 for a sum insured of Rs. 1,00,000/- each. He was hospitalised from 09.09.2004 to 14.09.2004 with complaints of depression disorders, dementia, Benign Prostatic Hypertrophy. The insurer settled claim lodged with the insurers for the expenses incurred at the hospital amounting to Rs.8481/-. The complainant lodged post-hospitalization claim with the insurer for the expenses incurred towards attender's charges. The insurers did not consider payment of this claim.

From the complainant's side it was submitted that attenders were engaged only on the advice of the doctor.

The insurer contended that the expenses of Rs.10,300/- were domiciliary expenses and do not fall within the scope of the Hospitalisation and Domiciliary Hospitalisation Policy issued to the complainant's husband.

The insurer's representative submitted that as per the policy they were willing to pay the Room and Nursing charges as defined in the policy falling either under Hospitalisation or the Domiciliary Hospitalisation sections of the policy. They contended that the policy does not provide for payment of attender's charges engaged at the residence of the patient. They stated that although in certain situations the policy does envisage payment for services of qualified nurse necessarily and

reasonably engaged at the residence, the present case was not one of them and also the services utilized were that of an attender and not a nurse.

Held

I am inclined to agree with the insurers that the present policy does not pay for the expenses of an attender in the current claim. Hence I decline to interfere with the decision of the insurers. Complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.093
J.P.Ere Gowda
Vs
New India Assurance Co.Ltd.

Award Dated : 31.10.2006

Sri J.P. Ere Gowda was covered under Mediclaim policy no.607604/48/04/75076 for the period 24.11.2004 to 23.11.2005. He was admitted in Narayana Hrudayalaya, Bangalore, with complaints of headache and abdominal pain on 20.06.2005. He was discharged on 21.06.2005 after conducting various tests, the result of which is 'Normal'. He submitted the claim for Rs.9360/- along with the required bills on 25.07.2005. The TPA processed the claim and sent a cheque for Rs.1000/- on 11.11.2005 considering it as a Health Check-up.

The insured contended that he has been covered under mediclaim policies for the past 16 years and he preferred not a single claim until this hospitalisation.

The TPA verified the papers and came to a conclusion that the treatment taken by the insured was only a Health Check-up and was not for any disease. Hence they reimbursed a sum of Rs.1000/- only, being 1% of average sum assured. As per the terms of the mediclaim policy, the cost of Health check-up is payable once for every four claim free renewals and is restricted to 1% of the average sum assured (excluding cumulative bonus).

Held

The complainant suffered an ailment and was admitted into hospital as per medical advice. The insurers may be justified in excluding the cost of Executive Heart Check Up and Chest X-Ray, since these are not found to be in relation to the complaints for which the complainant was admitted to the hospital. The insurers are directed to honour the claim for the rest of the treatment and tests excluding the Chest X-Ray and the Heart Check-up.

The complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.003.0130
Dr. Hegdekatti V. Prabhakar
Vs
National Insurance Co.Ltd.

Award Dated : 31.10.2006

The complainant and family were covered under a Health Insurance Policy by M/s National Insurance Co Ltd for the period 25.10.2004 to 24.10.2005 for the first time. The insured's 18-year-old son, Master Karthik was admitted to hospital from 22.09.2005 to 24.9.2005 for inferior turbinate hypertrophy and underwent surgical

reduction under GA on 23.9.2005. A claim made on the insurers for the medical expenses of Rs 17,329, which was rejected on the ground that the policy during the first year does not pay for Sinusitis and related disorders.

The complainant submitted that the sinuses and inferior turbinates were entirely different structures and that the involvement of inferior turbinates may be independent of sinuses. . The complainant who is a doctor contended that there was no connection between the sinuses and the illness for which his son underwent surgery.

In order to resolve this issue I have sought and obtained the opinion of a senior E N T Surgeon (Retd Professor of ENT and Superintendent, Govt. ENT Hospital, Hyderabad). He has given his opinion, after perusing the record that the ailment suffered by Master Karthik does not come under the head 'Sinusitis and related disorders'. He has opined that it was due to Allergic or Chronic Rhinitis.

In view of the opinion received, I have no hesitation in holding that the insurers were wrong in rejecting the claim. I direct them to honour and settle the claim. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0148
Gurpur Ganesh
Vs
National Insurance Co.Ltd.

Award Dated : 09.11.2006

Sri G. Ganesh had been covered by M/s. National Insurance Co.Ltd. under Health Insurance for more than 4 years.A request was made to the TPA of the insurer seeking authorisation of Cashless treatment which was approved by the TPA on 12.1.2006 upto a limit of Rs.27,100.

On the strength of this approval by the TPA, the nursing home discharged the insured on completion of treatment on 23.1.2006 without collecting any part of the bill of Rs.20,375/- from him. The hospital submitted the bill and other relevant papers to the TPA seeking settlement. However, the TPA on 11.5.2006 rejected the claim invoking clause 4.8 of the insurance policy.

The complainant conveyed that he had submitted a clarification dated 1.6.2006 from the treating doctor regarding the allegation made by the insurer on alcohol abuse. They submitted that the hospital had intimated the TPA of the insured's complaints of irritability, fight with parents and the proposed treatment including ECTS-Electro Convulsive Therapy). The discharge summary indicated that no Electric Shock Therapy was given and the complaints included ethanol abuse. The insurers submitted that under clause 4.8 of the policy the claim could be rejected as it arose out of ethanol abuse.

The insurer has since settled hospitalization and the post hospitalization expenses and the complainant's representatives confirmed receipt of the cheques. Thus, the issue before me is whether the delay caused in the settlement of the claim was justified.

From the chronology of the events detailed above, it is very clear that the claim was not processed properly or promptly and instead the TPA and the Insurance Company tried to play the blame-game, blaming the insured without keeping him informed about the correspondance between the TPA and the hospital. Thus it is a classic case of communication gap where three parties are involved and the TPA playing a key role.

From the above it emerges that, if the TPA and the insurance Company had followed the laid down procedures and showed some concern about the representations from

the insured, it would have avoided lot of inconvenience and infructuous correspondence all around.

Considering the totality of circumstances, I consider that an amount of Rs 1,000/- (Rs. One thousand only) would be just compensation for the expenses and hardship caused to the insured.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0113
Sri Bhgai Ramnath
Vs
The New India Assurance Co.Ltd.

Award Dated : 17.11.2006

The complainant and his wife were covered under Mediclaim policy for the period 05.08.2005 to 04.08.2006 for a sum insured of Rs. 1,00,000/- each. The complainant's wife underwent Angioplasty with Stent Implantation on 20.03.2006. M/s Good Health Plan, the Third Party Administrators (TPA) initially denied cashless access and vide their letter dated 18.05.2006, rejected the claim stating that: i) as per the proposal dated 05.08.2005, the patient had Coronary Artery Disease since 1999; ii) there was a gap of 35 days in the renewal of the policy and therefore the current policy was considered as a fresh policy; iii) the policy exclusion 4.1 excluded all pre-existing diseases.

The complainant contended that he was regular Mediclaim policyholder since 1988. There was break of 35 days in renewal of the policy due to the fact that he was out of town and also due to forgetfulness.

Owing to the break in renewal, the policy was treated as a fresh one and therefore all exclusions as applicable to a fresh policy were applied. Further the hospital records reveal that the patient had CAD since 1999. As such the ailment was pre-existing as on the date of issue of policy.

Since the proposal form clearly mentioned that the insured suffered from Heart problems since 1999 and further since the proposal form and declaration together form part of the contract, they were not liable to pay this claim

However the insurers could not explain as to why they inserted the entry "NONE" in the schedule of the policy under the column "subject to the exclusion of". As decided above the entire contract read together including the proposal makes it clear that the disease claimed for is excluded under the policy. Nevertheless I hold that the insured needs to be compensated for bad drafting of the policy and the unnecessary expectations created thereby. In the circumstances I direct the insurers to pay an amount of Rs. 5,000/- (Rupees Five Thousand only) as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.005.154
Dr. C.K. Ramesh Kumar
Vs
Oriental Insurance Co.Ltd.

Award Dated : 04.12.2006

The complainant insured himself and his family under the insurer's Mediclaim policy. He underwent 3 flap surgeries on various dates along with bone grafting for Chronic Gingivitis and Periodontitis. He lodged claims with the insurer for reimbursement of the expenditure incurred for the same. The insurers vide their letter dated 14.07.2006,

repudiated the claims on the ground that the treatment did not warrant hospitalisation and that the policy excluded out-patient treatment

In his case, admission was necessary, as he was a mild hypertensive. This was done to obviate any complications on account of increase in blood pressure during and post-surgery. He was not taking advantage of the insurance policy

Further the insured's statement that he was a hypertensive was not reflected in any of the Discharge Summaries submitted by the complainant. It is a practice that the treating doctor makes a note of the history of the patient's health condition before commencing treatment and the B.P. readings are noted in case the patient presented himself with those symptoms. The Hospital papers do not reveal that there was any duty doctor attending on the patient. In view of the same the claims were not tenable under the policy.

HELD:

No where in any of the Discharge Summaries did I observe the treating doctor's noting of the patient's general health condition. I agree with the TPA doctor that it is a practice to note the history of the patient especially when he is advised surgery. Further, I am given to understand that Flap Surgery is not a complicated procedure and generally takes 2-3 hours per sitting. The patient is generally prescribed a couple of sittings before the conclusion of treatment. To confirm whether the complainant was indeed a hypertensive as contended by him, I directed the insurer to produce the proposal form taken at the time of purchasing the policy. From the proposal form it is clear that the complainant was a non-hypertensive as he had answered in the negative to the questions related to Hypertension. The insured did not prove his hypertensive status nor did he bring on record the need for admission for the surgeries. As such I am inclined to agree with the insurer's decision of rejecting the claims.

Hyderabad Ombudsman Centre
Case No. : G 11.005.187
Y.Eshwar Rao
Vs
Oriental Insurance Co.Ltd.

Award Dated : 21.12.2006

The complainant and his wife were covered under Individual Mediclaim Policy for the period 08.12.2004 to 07.12.2005 for a sum insured of Rs.50,000/- each. The complainant's wife was admitted to Care Hospital, Hyderabad, on 05.10.2005 with complaints of Polyarthritis of small / large joints of one month duration. The Third Party Administrators (TPA), initially denied cashless access and subsequently, vide letter dated 25.10.2005, rejected the claim on the ground that the present hospitalisation was for investigation and evaluation of the ailment only. The letter also stated that the investigations could have been done on outpatient basis without admission in the hospital.

I am inclined to agree with the insurers that the patient was indeed admitted for evaluation. This is evident from the noting in the Discharge Summary under the heading "Course in the Hospital" where it is mentioned that the patient was "admitted for further evaluation…." The insurer stated during the hearing that the claim could be considered for Rs.500/- under the provision of Cost of Health Check-up as specified in the policy. I find that the insurers were not arbitrary in their decision. Since the insurers are willing to pay Rs.500/- (Rupees Five Hundred only) as the cost of health check-up, they are directed to pay the amount without any further delay.

Hyderabad Ombudsman Centre
Case No. : G 11.005.150
Smt.K.N. Poornima
Vs
Oriental Insurance Co.Ltd.

Award Dated : 05-01-2007

Smt. Poornima was insured under a Mediclaim policy from 30.06.2004 to 29.06.2005 and again from 27.07.2005 to 26.07.2006 (i.e. with a gap of 27 days) by M/s Oriental Insurance Co.Ltd., Bangalore. She underwent surgery on her left heel in the month of December 2005, wherein the diagnosis was “Retro Calcaneal bursitis left”. The TPA however rejected the claim stating that the illness was pre-existing.

Smt. Poornima stated that her problem was only of about 2 months’ duration when she went for surgery in December 2005.

Held

The insurers have since conveyed that after a second medical opinion and discussion with the TPA, they are of the opinion that the claim is payable if the complainant re-submits all the papers they would re-process the claim and settle as per policy conditions. Therefore, I direct the complainant to re-submit all the bills and treatment papers to the Divisional Manager of the insurance company within a month of the receipt of this award.

Hyderabad Ombudsman Centre
Case No. : G 11.004.189
Shri Adresh Dev
Vs
United India Insurance Co.Ltd.

Award Dated : 19-01-2007

The complainant was covered under a Mediclaim policy for a sum insured of Rs.70,000/- for the period 26.08.2005 to 25.08.2006 issued by M/s United India Insurance Co Ltd. He was admitted to Durgabai Deshmukh Hospital on 08.02.2006 with complaints of chest pain. He was diagnosed to suffer from HTN Grade II with absent left kidney with Angina. The complainant lodged a claim for Rs.12,500/- but the TPA rejected the claim on the ground that the treatment was for a pre-existing disease.

Held

The insurers based their decision to reject the claim on a noting made in the Discharge Summary by the hospital authorities that the patient had Hypertension since 5 years. However they chose to ignore the next statement that he was not on medication. However on perusal of the Case History and Progress Notes of the patient, I observe that the treating doctors and nurses have consistently noted that the patient was suffering from Hypertension since 3 months and was not on medication. The complainant stated during the hearing that although he was admitted with chest pain, the doctors ruled out that he was having any cardiac problem at the time of discharge after evaluation. He also added that for the first time he was informed that he was having high Blood Pressure with a reading of 160/100. The insurers based their decision on the noting in a report which does not find any mention in the bedside noting of the doctor/nurses. In fact these records are deemed to be authentic as they are based on the actual health condition of the patient from time to time during his stay in the hospital. The insurers were unable to produce any other evidence in support of their stand. In view of the fact that the complainant was ignorant of the fact that he did

not have a left kidney since birth, I do not find any merit in the insurers' insistence that the insured suppressed facts material to his health. I am inclined to give the benefit of doubt to the complainant and direct the insurers to honour, process and pay the claim as per the terms and conditions of the policy without any further delay.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0193
Shri Chada Kasi Viswanadham
Vs
New India Assurance Co.Ltd.

Award Dated : 09-02-2007

The complainant was covered under a Mediclaim policy for a sum insured of Rs. 1,00,000/- for the period 27.11.2005 to 26.11.2006. He was admitted to Sai Krishna Neuro Hospital, with complaints of restlessness and fever since 2 days. M/s Family Health Plan Ltd. (FHPL), the Third Party Administrators (TPA), initially gave a clearance for cash-less facility to the extent of Rs. 6000/-. Subsequently an enhancement request was received from the hospital for a total amount of Rs.9655/-. The TPA later repudiated the entire claim on the ground that the present hospitalisation was for investigation and evaluation of the ailment which did not warrant admission to the hospital.

The complainant stated that

i) He consulted doctors at Sai Krishna Neuro Hospital on 03.08.2006, one of the approved hospitals in the list supplied by the insurers/ TPA, since he was having high fever with chills.

ii) The doctors at the hospital informed the TPA that the estimated cost of treatment would be approximately Rs. 10,000/-. In response to this request, the TPA vide their communication dated 03.08.2006 authorised cashless facility to the extent of Rs.6000/- only.

iii) The total in-patient bill was Rs. 9655/- and the hospital authorities requested him to pay Rs. 3655/- being the amount in excess of the cashless amount sanctioned by the TPA.

iv) He approached the TPA and sought reimbursement of Rs. 3655/-. However, he was informed that the TPA, vide their letter dated 05.08.2006 ,withdrew the cashless facility as the hospitalisation was mainly for investigations and evaluation.

v) He was admitted in the hospital only under the advice of the treating doctor. He had absolutely no control in determining the course of treatment administered to him. His claim was genuine and merited settlement. He was a regular Mediclaim policy holder since the year 2003-04 and the policies were renewed without any break.

The insurers contended that the TPA authorised cashless facility to the extent of Rs. 6000/- based on the diagnosis given by the treating doctor that the patient was admitted for 'hyperpyrexia with early Parkinson's disease'. In view of the inconsistency between the course of treatment and the provisional diagnosis for which the cash-less facility was sought, the TPA cancelled their earlier authorisation. The admission was primarily for investigation and evaluation which could have been done as an out-patient and there was no need for admission. The discharge summary reveals that the patient was a known case of Parkinsonism since 10 months. Therefore the decision taken by the TPA was in order.

HELD

It was only after the TPA gave the green signal for bearing the expenditure, that the complainant was admitted to the hospital. I understand that the Admission Request Note forms the basis for the TPA to accord cash-less service. From this document I note that the treating doctor/ hospital clearly noted the patient had “high temperature + Insomnia + early P.D”. This implies that the patient was treated for the symptoms as mentioned in the note.

The complainant accepted during the hearing that he was treated for P.D. also in addition to fever, sleeplessness and high blood pressure. However he was unable to furnish the break-up for the treatment. Since there are lapses on both sides, I direct the insurers to settle the claim for Rs.6000/- (Rupees six thousand only) as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0210
Shri V Rama Rao
Vs
United India Insurance Co.Ltd.,

Award Dated : 26-02-2007

Sri V. Rama Rao a retired bank employee has been continuously insured from 1997 with various offices of United India Insurance Co. Ltd, under Mediclaim Scheme. He also had insurance with M/s New India Assurance Co. Ltd. under a group policy. He had undergone eye treatment at Narayana Nethralaya, Bangalore from 14.2.2006 to 15.02.2006 and claimed Rs. 39,834/- from M/s United India Insurance Co. Ltd. Of this, only Rs.16,405/- was paid by the insurers thus disallowing Rs.23,429/.

The complainant stated that there was a scheme from the Pharmaceutical company ‘Novartis’ whereby the second and third dosage of a medicine could be obtained at cheaper rates if booked together, in advance. During the course of a previous surgical procedure he was told that he would have to take the same treatment again and the costly medicine required for both occasions can be paid for at cheaper rate by booking then. (The cost of this earlier procedure was reimbursed by M/s New India Assurance Co Ltd.) He accordingly paid for two doses and utilised one dose for the earlier treatment.

Against that earlier cash memo he drew the second dose of medicine and utilised it for the latter treatment of February 2006, following which he lodged his claim on the insurers United India Insurance Co. Ltd. The insurers, M/s United India did not accept this narration and contended that as the sum insured was exhausted earlier in the New India’s policy, the un-reimbursed amount is being claimed from them now and this is not allowed as per their rules.

Held

The documents submitted by the complainant included a certificate dated 25.7.2006 from the Pharma company, a certificate from the treating hospital and copies of the bills and invoices of the Pharma company. From these, I observe that the Pharma company confirmed the scheme and the treating doctor has confirmed his advice to the complainant to avail himself of the lower price under the scheme. From the invoices and bills it is clear that the amount of Rs.23,429/- (which is the amount in dispute) was paid in advance to the Pharma company on 8.7.2005 but the medicine was taken delivery of on 14.2.2006. This date of 14.2.2006 corresponds to the hospitalisation for which M/s United India Insurance have accepted liability and settled a part of the claim.

Thus it is extremely clear that the amount of Rs.23,429 was incurred by the complainant only as a cost of the medicine used during the February 2006 hospitalisation. I direct the insurers to release this amount of Rs.23,429 together with interest as prescribed in the IRDA: Protection of Policy holders' Interests Guidelines 2002.

Hyderabad Ombudsman Centre
Case No. : G 11.003.255
Sri Amula Harinath
Vs
National Insurance Co.Ltd.

Award Dated : 23.03.2007

The complainant, a member of Golden Multi Services Club, was covered under the above policy for a Capital Sum Insured of Rs.2,00,000/-. He was injured in his left eye when some chemical fell into it on 05.09.2005. The insurer, vide letter dated 07.02.2007 addressed to the complainant, requested the insured to furnish evidence of accidental injury. They also added that the intimation of claim was sent to them with a delay of 2 months 17 days, violating Condition No.1 of the policy.

The complainant contended that he sustained a chemical injury to his left eye on 05.09.2005. He was first taken to a local hospital and administered first aid. Thereafter he consulted L.V.Prasad Eye Institute, Hyderabad, on 06.09.2005 and underwent a series of operations and was still under treatment. Despite the surgery he is totally blind in the left eye. There was a delay in submission of documents on his side as he did not receive the Medical Certificate from the authorities in time. The said certificate was received by him only on 05.12.2005. He mailed the said certificate alongwith all the claim related papers on 10.12.2005 to the insurers. Since he lost total sight in his left eye, he was entitled to receive 50% of the sum insured as compensation. .

The insurers' local representatives contended that the insured did not submit proof of accidental injury, especially Police FIR. In their opinion, the onus of proof in the form of substantiating documents lies with the claimant.

Held

The complainant, in his various letters addressed to the insurers, had always mentioned that there was a delay and also explained that the delay was for reasons beyond his control. He was waiting for the Medical Certificate which he was able to procure only on 05.12.2005. I note that without any further delay, he mailed the same alongwith the other medical reports to the insurers on 10.12.2005. As such the insurers are directed to condone the delay, process and pay the claim after receiving the documents from the complainant.

Hyderabad Ombudsman Centre
Case No. : G 11.003.280
Complainant: Smt P.Manjula
Vs
National Insurance Co.Ltd.

Award Dated : 23.03.2007

The complainant, a member of Golden Multi Services Club, was covered under the above policy for a Capital Sum Insured of Rs.5,00,000/- for the period 23.08.2004 to 22.08.2007. He was injured in a road accident on 01.09.2005. He was admitted to Sai Krishna Neuro Hospital for treatment. He succumbed to injuries on 26.09.2005. The insurer rejected the claim on the ground that intimation of the claim was received after

a delay of 2 months and 13 days and the claim papers were submitted to them after a delay of 3 months and 22 days.

Held:

The complainant submitted all police documents including the Police Final Investigation Report to the insurers. Further, I am unable to comprehend what the insurers have missed by this delayed intimation. Their pleading that they are deprived of an opportunity to investigate the cause of death / merits of the claim cannot be accepted as the documents submitted such as police FIR, Final Investigation Report have clearly and in unambiguous terms established the cause of death. I am reasonably convinced that the delay was neither intentional nor with malafide intentions. As such, I direct the insurers to condone the delay and process the claim.

Hyderabad Ombudsman Centre
Case No. : G 11.004.249
Sri Vegesina Kasi Viswanadham
Vs
United India Insurance Co.Ltd.

Award Dated : 23.03.2007

Sri Viswanadham had Medical Insurance from 19.08.2003 to 18.08.2006 which included 3 policy years. He underwent surgery for Cataract in the Right eye on 26.04.2005 i.e, in the 2nd year of policy. The claim for reimbursement of Rs.22,000/- incurred for the surgery was settled by the insurers. On 21.04.2006, i.e., during the third year of policy, Sri Viswanadham underwent surgery for cataract in left eye, incurring Rs 23,978/. The claim for the same was initially approved by the insurers for only Rs.13,400/-.

The complainant stated that there was a delay of more than 7 ½ months on the part of insurers' Branch office who sent him the settlement offer after he took up the matter with their Regional office at Visakhapatnam. On 11.12.2006, he requested the insurers to reconsider their offer, but did not receive any response.

After the above complaint was lodged with this office, the insurers vide their letter dt 22.01.2007 retracted on their earlier offer of Rs.13,400/- and repudiated the claim totally. The insurers relied on the condition No.3 of the policy and said that cataract stood deleted from the scope of the policy as it was a first year exclusion.

Held

The insurers had their facts wrong. While the first policy was for the period 19.8.2003 to 18.08.2004 they submitted that the first policy was from 19.08.2004. Basing on incorrect data the insurers contended that the surgery to Right eye in April 2005 fell in first year exclusion but was wrongly paid for by their office. I find that the record clearly establishes that the 2004-05 policy was of the 2nd year. The insurers have also not shown any reason for reducing the claim amount. I find absolutely no merit in the arguments or the action of the insurers in the part-processing of this claim and therefore direct the insurers to pay the claim in full.

Hyderabad Ombudsman Centre
Case No. : G 11.004.316
Smt. Sumedha Jawalkar
Vs
United India Insurance Co.Ltd.

Award Dated : 23.03.2007

Dr. Ram Jawalkar was insured under a group Tailor-Made Trauma Care Health Insurance policy. He was admitted to Care Hospital, Hyderabad on 5.1.2006 with Acute shortness of breath. On admission he was found to have Acute Renal failure. He died of Cardio-Respiratory arrest on 5.02.2006. During the month long stay at the hospital, medical expenses were incurred, which Smt. Jawalkar claimed from the insurance company. Her claim was limited to Rs.1,50,000/-, the sum assured under the insurance policy. The insurance company rejected the claim invoking the policy exclusion 4.1 for pre existing conditions.

The insurers state that as per the hospital case sheet/ progress notes, the insured had Hypertension for 22 years, Oedema of feet since 1997 and filarisis since 1996. They contended that the illness suffered by the insured viz chronic kidney disease was secondary to hypertension, which was pre-existing and hence not covered within the terms and conditions of the policy.

HELD:

I observe that the hospital progress notes records the following:

7.1.06 (i) Acute Chronic Renal failure - Secondary to HTN (long standing)

7.1.06 (ii)Background / history of:

a) HTN since 22 years b) DM Type 2 since 1 month

c) Filariasis d) Allergic to Penicillin

e) Non smoker f) Ex-ethanolic

Having gone through the record, I am inclined to conclude that Dr. Jawalkar had long standing HTN. From the papers submitted by Smt. Jawalkar it is clear that Dr. Jawalkar had Filariasis and Oedema of feet from 1996/1997. The insured had consulted Dr. Deshpande in April, 2002 for filariasis/ oedema both legs. While his insurance is effected from 21.8.2002, in the proposal the insured had indicated only Hernia in the column for ‘diseases suffered’. Thus it is observed that the complaints for which he was taking treatment in 2002 were not made known to the insurers through the proposal form. The insurers have placed before me the opinion of a Nephrologist who noted that edema feet from 1997 is a sign of kidney disease. In view of the above, I consider that the insurers’ decision of rejecting the claim is justified. Therefore, I decline to interfere with their decision.

Hyderabad Ombudsman Centre
Case No. : G 11.004.248
Smt. Sita Kamala
Vs
United India Insurance Co.Ltd.

Award Dated : 23.03.2007

Smt. K. Sitha Kamala was covered under a Health Insurance Policy for the period 25.5.2005 to 24.5.2006 for a sum assured of Rs.3,00,000/-. From 18.01.2006 to 25.1.2006, she was hospitalized at Krishna Institute of Medical Sciences, Hyderabad and underwent Bilateral Total Knee replacement following complaint of Bilateral Ostrearthritis Knees. A request for cash less hospitalization was made to the TPA of the insurers, mentioning that the insured had pain in both knees for last 1 year, increased since last 6 months. The TPA approved a cash-less hospitalization limit of Rs.
60,000/-.

On completion of treatment the hospital sent the discharge summary and sought reimbursement of the approved amount of Rs.60,000/- from the TPA. The insured also

lodged her claim with the insurers' TPA mentioning that the total expenses charged were Rs.3,33,601/- of which she incurred Rs.2,73,601/-, the balance being the pre-authorised amount. The insurers' TPA rejected her claim and also withdrew the earlier approved cash less amount of Rs.60,000/- since the discharge summary submitted by her mentioned complaint of pain - both knees 25 years, aggravated for past 6 months.

The complainant submitted that she had been healthy all these years and that the pain in her knees was only a few months old when she decided to go in for surgery. She also submitted her passport showing that she had traveled out of the country on long journeys to USA / Canada in the 1980's and 1990's. The cumulative bonus she earned was 40% indicating 8 claim-free years. The complainant contended that she had insurance from 1993. The complainant submitted that the corrected discharge summary showing complaint of pain both knees 1 year should be relied upon.

The insurers confirmed that Smt. Sita Kamala had insurance for several years for a sum insured of Rs.95,000/- and basing on clams-free experience, was also eligible for a cumulative bonus of 40% or Rs.38,000/- during the year 2005-06. They highlighted the fact that the insured had increased the sum insured from Rs.95,000 to Rs.3,00,000 with effect from 25.5.2005. The insurers allege that this increase was made probably keeping in view the prospective treatment.

Held

The complainant has been able to prove with evidence that she had undertaken strenuous foreign trips. This leads me to conclude that the discharge summary indicating complaints of pain for 1 year can be relied upon. Thus, as the surgery was undergone in January 2006, the early symptoms had appeared by the first half of 2005. The increase of sum insured from Rs.95,000/- to Rs.3,00,000 was made in May, 2005. Thus, the knee problem is clearly a pre-existing condition when the increase in the sum insured was made. However, for the basic sum insured of Rs.95,000/- and the corresponding cumulative bonus, this can not be treated as a pre-existing condition.

Therefore, I direct the insurers to honour the claim for Rs. 95,000/- together with the cumulative bonus. The rest of the claim is not considered.

Hyderabad Ombudsman Centre
Case No. : G 11.004.291
Dr.K. Venkata Nagendra Babu
Vs
United India Insurance Co.Ltd.

Award Dated : 30.03.2007

The complainant purchased a Mediguard Policy to cover himself and his wife for a sum insured of Rs. 3,00,000/- and Rs. 1,45,000/- respectively for the period 24.09.2005 to 23.09.2006. He underwent Coronary Angiogram on 17.12.2005 and lodged a claim for Rs. 18,000/- with the insurers which was paid. Subsequently, in April 2006, he under-went Angioplasty with stent implantation. He received discharge voucher from the insurers on 7.11.2006 for Rs.1,62,000/- only as against his claim of Rs.2,46,063/-. The insurers contended the insured was having a Mediclaim policy since 2002 for a sum insured of Rs.1,80,000/- The discharge summary of Care Hospital, for the first hospitalisation, mentions that the patient had HTN/DM-6 months duration and CAD- Unstable Angina. This indicates that the insured had the disease prior to enhancement of sum insured, i.e. on 24.09.2005. Since the ailment dated back to the previous policy period they restricted the sum insured to Rs.1,80,000/-and processed the claim. Since they had already settled an

amount of Rs.18,000/- they approved the claim for the balance of Rs. 1,62,000/- being the eligible amount.

HELD:

It is surprising to note that no proposal/details were elicited from the insured while enhancing the SI. The policy reflects a sum insured of Rs.3,00,000/- for the complainant and against his name reflects cumulative bonus of 10%. This means that the insured is eligible for 10% Cumulative Bonus on the entire sum insured of Rs.3,00,000/-. A plain reading of policy indicates that Dr. K.V. Nagendra Babu, is covered for a sum insured of Rs.3,00,000/-and enjoys a cumulative bonus of 10%. Having accepted the insured's request for enhancement, and also having issued the policy, the insurers cannot dodge the issue.

In my opinion, the insurers have accepted the policy and now cannot shy away from their liability. There is no evidence to support their stand that the disease was existing as on 24.9.05. They are directed to pay the balance of Rs.84.063/- due to the complainant.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-110/2006-07
Sri.M.Santha Kumar
Vs
The New India Assurance Co.Ltd.

Award Dated : 10.10.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a claim by the respondent under Pravasi Suraksha Policy No. 760602/2001/47/80307 effective from 2.1.2001 to 1.1.2006 covering the complainant and his family including parents. The complainant's father Sri.Chathukutty had undergone CABG at Kovai Medical center on 10.10.2005. The discharge summary showed that he was hypertensive for 5 years and therefore the insurer concluded that the history was suppressed in the proposal form in Jan.2006. However, in Sept.2005, the AIMS Kochi had evaluated his case and in the discharge summary of the AIMS, the duration of hypertension was mentioned as 4 years corresponding to some time in Sept.2001 whereas the proposal for insurance was submitted in Jan.2001 itself. The complainant mentioned that Shri.Chathukutty had no problems of hypertension in Jan.2001 and therefore there was no question of suppression of material facts. Moreover, between Sept.2005 and Oct.2005, the duration of hypertension could not have varied to the extent one year (4 years to 5 years). On the whole, the insurer was unable to prove the case of suppression of pre-existing disease in the person of Shri.Chathukutty and therefore the claim was found payable. The insurer had not disputed the expenses of Rs.1,15,523/- and the sum insured was found to be Rs. 2 lakhs. Hence the repudiation was set-aside and the insurer was advised to honour the claim.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-077/2006-07
Lt.Col.(Retd.) A.M.Sagir
Vs
National Insurance Co.Ltd.

Award Dated : 31.10.2006

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 had commenced

a medical insurance on 15.11.2002 and renewed the same without break upto 15.11.2004. After 15.11.2004, there was a break of 15 days and the fresh policy had commenced only from 1.12.2004. In the meantime, from 25.8.2005 to 12.9.2005, the complainant had taken treatment at Vaidyamadam Vaidyasala at Thrithala and the insurer repudiated the claim saying that the insurance policy issued from 1.12.2004 was based on a fresh proposal and therefore it was a fresh policy. The first consultation being before the inception of the policy on 1.12.2004, the claim was reportedly hit by Cl.4.1 of the medi claim policy. However, the complainant maintained that he had not given a fresh proposal on 1.12.2004 and the renewal was based on the proposal given in 2002. It was also found that even the current year policy had mentioned only the proposal given in the year 2002. The insurer could not prove the veracity of the fresh proposal submitted on behalf of the client by their Development Officer. The claim was only for Rs.16,274/- and the insurer being unable to prove the case, the claim was allowed by this Forum.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-141/2006-07
Sri.Babukutty Philipose
Vs
United India Insurance Co.Ltd.

Award Dated : 29.11.2006

The complaint under Rule No.12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a medi claim by the insurer. The policy was issued covering account holders of M/s.Andhra Bank. The policy had commenced in 2004, but it was renewed in 2005 only after a break of 10 days. The complainant had undergone thyroid operation in December 2005 and the TPA of the insurer repudiated the claim treating the disease as pre-existing. The complainant's doctor had opined that the swelling was only of 10days duration. However, the independent expert opinion from M/s.Apollo Hospital, Hyderabad confirmed that such problems normally existed for substantially long durations of months or even years. In such circumstances, more particularly, since there was a break in insurance, it was proper that the insurer had taken it as a pre-existing disease and repudiated the claim. The repudiation of the claim was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-141/2006-07
Sri.Babukutty Philipose
Vs
United India Insurance Co.Ltd.

Award Dated : 29.11.2006

The complaint under Rule No.12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a medi claim by the insurer. The policy was issued covering Account holders of M/s.Andhra Bank. The policy had commenced in 2004, but it was renewed in 2005 only after a break of 10 days. The complainant had undergone thyroid operation in December 2005 and the TPA of the insurer repudiated the claim treating the disease as pre-existing. The complainant's doctor had opined that the swelling was only of 10 days duration. However, the independent expert opinion from M/s.Apollo Hospital, Hyderabad confirmed that such problems normally existed for substantially long durations of months or even years. In such circumstances, more particularly, since there was a break in insurance, it was proper that the insurer had taken it as a pre-

existing disease and repudiated the claim. The repudiation of the claim was upheld and the complaint was dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-138/2006-07
Sri.K.P.James
Vs
United India Insurance Co.Ltd.

Award Dated : 13.12.2006

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.100901/ 48/04/01869 held by the complainant covering his father also. During 14.2.2005 to 16.2.2005, the complainant's father was hospitalized at Lourde's Hospital due to sudden onset of giddiness and loss of hearing. The records revealed that there was actually no treatment administered in the hospital. Only investigations were conducted in an outside the hospital at various centers by shifting the patient occasionally. The MRI scan etc. were done at a different Medical Centre. From the facts of the case, it was clear that the entire treatment could have been taken as an outpatient and hospitalisation were not at all necessary. The medi claim policy provides for reimbursement of treatment expenses for hospitalized treatment only. The investigations done and the medications administered could all have been carried out as an outpatient. In these circumstances, the decision of the TPA/insurer was found to be in order and hence the complaint was dismissed as devoid of merits.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-221/2006-07
Sri.P.A.Sajeed
Vs.
National Insurance Co.Ltd.

Award Dated : 20.03.2007

The complaint under Rule No.12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a claim by the respondent insurer under medi claim Policy No.57800/48/05/8500001570 covering the complainant as an employee of M/s.Blue Mountain Exporters, Kochi. The complainant was hospitalized at Sangeeth Nursing Home, Kochi for a medical condition called VERTIGO from 3.5.06 to 9.5.06. The relative claim preferred before the insurer for an amount of Rs.1882.02 was repudiated by them on the ground that the condition called VERTIGO did not need hospitalisation and the entire procedure could have been completed under OPD. However, the complainant had undergone inpatient treatment at the instance of the treating doctor and he had submitted all records including the Discharge summary to the insurer. The respondent insurer had very casually dealt with the case without going into its merits and hence the repudiation was set-aside. The insurer was directed to settle the claim of the complainant and the case was disposed of.

Kolkata Ombudsman Centre
Case No. : 440/14/002/NL/09/05-06
Shri S.Wajid Ali
Vs
The New India Assurance Company Ltd.

Award Dated : 14.11.2006

Facts & Submissions:

The complaint was regarding delay in settlement of mediclaim on the ground of non-submission of documents

The complainant Shri S.Wajid Ali had a mediclaim policy for more than 10 years, which included his wife Mrs. Rehana Wajid for the last 10 years, but the policy that matters during the period of disease was effective from 20.12.02 to 19.12.03. There was a delay in renewal of the policy of about 50 days when compared to the dates with regard to the previous policies, which expired on 31.10.02. The complainant stated that there was a break in the insurance policy due to the fault of the Chennai Office of the insurer. However, in spite of the delay the claim falls within the policy period mentioned above. The complainant stated that the detection of the disease was made on 14.06.03 when it was found that Mrs. Rehana Wajid had lump in both breasts for a few months along with retraction of nipple.

The insurance company obtained the panel doctor's opinion from Dr. Vineet Kumar Mittal. According to the Doctor, the complainant had not submitted any prescription or treatment records prior to 10.06.03. The patient had not undergone evaluation for 2-3 months for the said disease though her husband himself was doctor. He was of the opinion that unless the previous prescriptions are available, a final decision could not be reached as the policy was only 6 months old.

The insurance company in their self-contained note dated 16.11.05 stated as under:

1) The above policy was effective from 20.12.2002 to 19.12.2003. The previous policy no. 712500/48/01/00008 had expired on 31.10.2002 and there was a break of 50 days. Accordingly, fresh proposal was called for with all medical reports (copy enclosed) and conditions applicable for a 1st year policy again came into force.
2) The material claim has been lodged in respect of Mrs. Rehana Wajid (wife of S.Wajid Ali) in connection with C.A. Breast-camo+Surgery.
3) Completed Claim form (Copy enclosed) with supporting documents was received by this office on 10.02.2004.
4) Claim papers received from the claimant were forwarded to our panel doctor for his opinion regarding pre-existence of ailment.
5) As per the Medical opinion of our panel Doctor (Copy enclosed) it was revealed that Mrs. Ali had lump in both the breasts for a few months along with retraction of nipple for some period as is evident from Prescription dated 14.06.2003 (Copy enclosed)
6) Hence, it was concluded that relevant claim had to be supported by all treatment records since the beginning (i.e., prior to 14.06.2003) before coming to a final decision, keeping in view that the same has been lodged against a six months old policy.
7) Accordingly a letter dated 17.04.2004 was served to Mr. Ali (Copy enclosed) calling for all papers relating to the first detection of the disease. A follow-up letter dated 27.12.2004 was again sent urging Mr. Ali to furnish the papers called for within 15 days.
8) Finally on 01.03.2005, a no claim letter was served to Mr. Ali for non-submission of documents called for. Our stand was reiterated vide our letter dated 16.09.2005 on receipt of Mr. Ali's letter dated 27.08.2005. Copies of related correspondences are enclosed herewith."

Decision :

It was a fact that Shri Wajid Ali had taken a mediclaim policy long back and the insurance company also allowed “No Claim Bonus” for all these years. However, there was a break in taking the mediclaim, though it might not affect the claim itself as the disease occurred during the life of this policy. The periodical reference that Shri Wajid Ali himself was a doctor did not hold good as he seemed to be only general Physician as per the proposal documents and might not be an expert in detecting the disease mentioned. That was the reason probably Mrs. Wajid Ali was sent to doctor Dr. Ghazala Rauf, who was a Obstetrician & Gynaecologist. Therefore, rejection of the claim only on the mere fact that there was no prescription prior to 14.06.03 and on the fact that the husband was also a doctor was not acceptable and it was felt that the insurance company should have given relief on the declaration made by the claimant and should have settled the matter by giving benefit of doubt to the complainant. The insurance company was directed to settle the claim together with interest as per the prevailing bank rate for the delay in settling the claim. No compensation for mental agony was considered in the light of interest being paid.

Kolkata Ombudsman Centre
Case No. : 155/13/002/NL/06/2006-07
Smt. Ranu Chatterjee
Vs
The New India Assurance Co. Ltd.

Award Dated : 16.11.2006

FACTS & SUBMISSIONS :

The complainant Smt. Ranu Chatterjee took a mediclaim policy from the insurer The New India Assurance Company and the same was issued subject to exclusion of “Cataract and UTI”. At the time of accepting the first policy a full medical report was submitted and she was not having knowledge that she had been diagnosed as having Cataract and UTI infection. According to her all the conditions under clause 4.3 shall be excluded in the first year only. Therefore, cataract and UTI should not have been excluded in the renewed contract, though she had agreed to the exemption at the time of first year policy. She stated that it was done in a hurry and confusion and, therefore, it should be included.

The petition was admitted as being a dispute on the legal construction of the policy in so far as such dispute relates to a claim.

The New India Assurance Company stated that they had accepted the proposal on 07.12.2004 when the age of the insured was 62 years and the policy was accepted subject to exclusion of Cataract and UTI, which was duly intimated. The insurance company stated that this was not an exclusion under clause 4.3 of the mediclaim policy and since the exclusion was at the time of acceptance, it would continue in the next policy also.

Decision :

On going through clause 4.3 of the mediclaim policy, it is clear that the diseases mentioned therein would not be covered during the first year of the operation of the policy. The clause 4.3 is reproduced as under:

“During the first year of operation of insurance cover, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterctomy for

Menorrhagia, Fibromyoma, Hernia, Hydrocele, Congenital Internal disease, Fistula in anus, Piles, Sinusitis and related disorders are not payable. If these diseases (other than congenital internal disease/defect) are pre-existence at the time of proposal, will not be covered even during subsequent period of renewal too."

The complainant seemed to have misinterpreted that cataract & UTI were part of Clause 4.3 and had claimed that since the policy under operation was the 2nd policy, the clause 4.3 should not have come into operation.

It may be informed that while issuing the policy, the insurance company has a right to exclude certain diseases being outside the scope of clause 4.3 of the policy from the coverage of the mediclaim policy. They have duly excluded Cataract and UTI as can be seen from the copy of the proposal forms submitted to this office, which says as under:

"Agreed on exclusion of Cataract and UTI"

Therefore, the right to exclude certain disease not contained in clause 4.3 continues year after year and the person taking the insurance cover should have been careful before accepting such exclusions. Therefore, we did not agree with the contention that cataract and UTI were part of clause 4.3 of the policy. They have been specifically excluded in the first year of the policy and it would continue to be excluded in the renewed policy. Therefore, the request for removing the condition of excluding Cataract and UTI could not be acceded to.

Kolkata Ombudsman Centre
Case No. : 578/11/003/NL/10/2005-06
Shri Amit Agarwal
Vs
National Insurance Company Ltd.

Award Dated : 20.11.2006

FACTS & SUBMISSIONS :

The complainant Shri Amit Agarwal had taken a mediclaim policy with National Insurance Company Ltd. since last 4 years. There was no break in the renewal of the policies. In May 2005, the complainant was admitted to the hospital for treatment of acute abdominal pain. He was discharged after prescribing necessary medicines to be taken at home. He filed a claim for Rs. 18303/- to M/s Family Health Plan Ltd., TPA of the insurance company, on 27.05.05. The TPA rejected their claim on 09.06.05 on the ground that the expenditure for hospitalization was only for investigation and evaluation of ailment. According to the TPA, this could have been done without admission to the hospital.

The complainant did not agree with the decision of the TPA stating that he was advised hospitalization by his attending doctor Dr. Manoj Agarwal. The submissions were not considered by the insurance company.

The complainant's plea was that he was admitted to the hospital on the advice of Dr. Manoj Agarwal for his abdominal problems and the TPA could not have held it as hospitalization for investigation and evaluation of ailment.

The insurance company sent a self-contained note dated 13.04.06, the brief details of the same are as under:

The insured/patient Shri Amit Agarwal was admitted to Belle Vue Clinic on 06.05.05 and discharged on 07.05.05. He was diagnosed for the ailment of Esophageal Candidiasis. The insurance company contacted the TPA, Family Health Plan Ltd., and a detailed note was submitted by the TPA to the insurance company giving reasons for

rejection. The insurance company did not take any panel doctors' opinion as the claim was dealt with by their TPA M/s Family Health Plan Ltd. They simply agreed with the decision taken by the TPA and repudiated the claim.

Decision :

There was no dispute about the coverage of the policy. Prescription papers dated 30.04.05 & 06.05.05 indicated that the patient had severe pain in the abdomen, persistent vomiting, dehydration and was advised admission in Belle Vue Clinic by Dr. Manoj Agarwal. As per discharge certificate, the patient was diagnosed as suffering from Malabrorption, Esophagial Candidiases. Some medicines were prescribed and he was discharged. It was clear that the claimant was admitted to the hospital under serious pre-conditions of ailment, which was evident from the prescription of Dr. Manoj Agarwal. Under these circumstances, the claim that the expenditure involved was only for investigation and evaluation of ailment by the TPA and subsequent agreeing of repudiation by the insurance company on the conclusion drawn by the TPA could not be accepted. The insurance company were directed to pay the claim of Rs. 18303/- (Rupees eighteen thousand three hundred three) only.

Kolkata Ombudsman Centre
Case No. : 503/11/002/NL/10/05-06
Smt. Purabi Biswas
Vs
The New India Assurance Company Ltd

Award Dated : 27.11.2006

FACTS & SUBMISSIONS :

The complainant had taken a medi claim policy issued by the insurer, The New India Assurance Company Ltd. for the period 18.04.04 to 17.04.05 for a sum insured of Rs. 1,50,000/- for self including her spouse and one son for sum insured of Rs. 50,000/-. The sum insured of Rs. 1,50,000/- includes Rs. 1,00,000/- original sum insured and Rs. 50,000/- enhanced sum insured with effect from 18.04.02. The combined policy earned a bonus of Rs. 25,000/- on the sum insured, which can be bifurcated into Rs. 20,000/- on the original sum insured and Rs. 5,000/- on the enhanced sum insured. Correspondingly, policy in the name of her son for sum insured of Rs. 50,000/- earned cumulative bonus of Rs. 10,000/-.

The complainant claimed Rs. 1,60,934/- in connection with treatment of her husband Shri Dilip Kumar Biswas for heart disease, who had undergone Coronary Artery Bypass Surgery on 07.05.04. After a lot of correspondence, the insurance company partially settled the claim at Rs. 1,20,000/- on 27.04.05 and Rs. 40,934/- was disallowed on the ground that the enhanced sum insured for Rs. 50,000/- was made during the period when the disease was pre-existing. Not being satisfied by the decision, this complaint has been filed.

The insurance company took the opinion of the panel doctors and according to them Shri Dilip Kumar Biswas was suffering from hypertension for 3-4 years and the enhanced sum insured for Rs. 50,000/- was taken only on 18.04.02. Therefore, the original sum of Rs. 1,00,000/- plus cumulative bonus of Rs. 20,000/- was settled and remaining Rs. 40,934/- was held as discount and, therefore, not payable.

According to the complainant, the records of B.M.Birla Heart Research Centre stated that "Jaw pain and precordial heaviness on exertion – 4 months". Similarly, the consultant Cardiac Surgeon Dr. B.Biswas stated that there was choking sensation (angina class-II) for five to six months. The complainant was surprised as to how the

insurance company came to a conclusion that the disease existed for the last 3-4 years. Further, he stated that the medi claim insurance was taken for the last 4 years and there was no claim of either hospitalization or domiciliary hospitalization. According to him, the discharge summary dated 01.05.04 gave some wrong details and the insurance company depended more on discharge summary than on other two reports mentioned above.

According to the insurance company the policy was incepted in the year 2000 for a sum insured of Rs. 1,00,000/- and continued till incidence of the claim along with cumulative bonus of 20% on the original sum insured. The sum insured was later increased to Rs. 1,50,000/-. The above claim was settled and paid by M/s Medicare TPA Services (I) Pvt. Ltd. on 04.08.05 for Rs. 1,20,000/- and the remaining amount of Rs. 40,934/- was not paid because the panel of doctors opined that the insured was suffering from hypertension for 3-4 years and the enhanced sum insured of Rs. 50,000/- was taken only on 18.04.02.

Decision :

From the records, it was noticed that the family physician Dr. S.B.Das stated that during regular check up, he did not find that the insured was having hypertensive pts. The discharge certificate issued by B.M.Birla Heart Research Centre, Kolkata mentioned that hypertension existed for 3-4 years, although Dr. T.Praharaj certified that it existed only for 3-4 months. According to the family doctor, BP was around 130/90 mm of Hg Pulse 72. The insured complained of heaviness in the chest and occasional breathing difficulties during exertion. He was then referred to the cardiologist Dr. N.Nath on 25.01.04. On further investigation at B.M.Birla Heart Research Centre, Dr. T.Praharaj suggested bypass surgery. Dr. D.Biswas performed the surgery on 07.05.04 and discharged the insured on 16.05.04. Dr. D.Biswas himself certified that illness was for the past 5-6 months. The exact details of the various certificates are as under:

B.M.Birla Discharge Certificate dated 01.05.04 in column “Case History” and clinical findings stated that:

“H/o Jaw pain throat heaviness and occasional lt. Arm pain on walking, which reduces on rest since last 3-4 months. Was an ex-smoker, hypertensive since last 3-4 years

Echo – LVEF 69%, No RWMA diastolic compliance C/Angeo – Positive.”

As per report of Dr. Tarun Praharaj, the attending physician dated 30.04.04, it was stated that the patient had a history of Jaw pain and precordial heaviness on exertion – 4 months.

In the discharge summary, Department of Cardiac Thoracic Surgery, B.M.Birla Heart Research Centre, it was stated that the patient has a complaint of choking sensation (angina class-II) for 5-6 months. Shortness of breathe on exertion (class-I) during pain. No past history of MI.

From the above, it was clear that the insurance company made settlement of the claim, which indicated that they were not fully satisfied for making full payment of the claim. However, it was clear that the insurance company had typically passed its partial repudiation only on the facts that the disease was pre-existing for 3-4 years going outside the purview of extended policy taken in 2002.

It was clear that the insurance company had not taken up with the hospital authorities for the various irregularities found in the above submission such as duration of illness mentioned in the discharge certificate, the periods mentioned in the certificate given by Dr. T.Praharaj, etc. The certificate given by Dr. S.B.Das, family Physician, had not been taken into consideration at all. If the illness was only having a duration of 3-4

months and not 3-4 years, then the disease could not be called pre-existing on the date of sum insured i.e., 18.04.2002. There was no comment by the insurance company on this point. Under these circumstances, the case warranted review for confirmation from the hospital regarding the duration of illness mentioned in the discharge certificate. The insurance company were directed to find out the correct position of period of disease from the hospital authorities. If the illness existed for 3-4 months and not for 3-4 years, then the insurance company would settle the balance amount of claim of Rs. 40,934/-.

Kolkata Ombudsman Centre
Case No. : 543/11/003/NL/10/05-06
Smt. Sabita Ghosh
Vs
National Insurance Company Ltd.

Award Dated : 27.11.2006

FACTS & SUBMISSIONS :

The complainant had taken a mediclaim insurance policy from National Insurance Company through its agent M/s Golden Multi Services Club Ltd. (GMSCL) since 2002. The claim fell within the period of the policy from 23.08.2003 to 22.08.2004. She had submitted a mediclaim for Rs. 15987/- for hospitalization and treatment for Lung disease under the above policy. The complainant was under treatment of Dr. Sekhar Chakraborty, Siliguri and as per his advise, she was referred to Kolkata for Bronchoscopy and check up. Bronchoscopy needed hospitalization and pathological examination and, therefore, she was admitted to the hospital. The complainant, as per rules, submitted a fitness certificate and pathological reports to National Insurance Company through its agent GMSCL, Siliguri. She received a reply from National Insurance Company after a lapse of one year stating that the claim is not admissible due to pre-existing disease i.e., Rheumatic Heart Disease. She disputed the refusal and represented to the insurance company for settlement of the claim, which was of no avail. Hence, she has approached this forum.

From the records, it appeared that no Doctors' opinion has been taken by the insurance company before repudiation of the claim.

According to the complainant, her doctor at Siliguri had advised her to get Bronchoscopy done along with other pathological reports. She was admitted to Orchid Nursing Home, Kolkata on 10.02.04 and after hospitalization, pathological tests related to lung disease were performed; she was discharged.

In the self-contained note, the insurance company stated that the patient was admitted to Institute of Pulmocare & Research, (Orchid Nursing Home), Kolkata on 10.02.04, where she was diagnosed to be a patient suffering from Rt. Upper lobe consolidation multivalvular heart disease – sequel to rheumatic fever. The claimant had been to Dr. S.Mallick on 12.08.03 for her ailment and thereafter, she consulted Dr. Sekhar Chakraborty and continued her treatment under him from 21.08.2003 to 06.01.2004. However, prescription dated 09.02.2004 of Dr. Parthasarathi Bhattacharyya revealed that the claimant was a known patient of rheumatic heart disease with moderate MS with MR, AD and AR. Keeping all the above in view, the insurance company repudiated the claim.

Decision :

On going through the evidence, it was found that the claim was only for the hospitalization for Bronchoscopy and pathological check ups required for lung disease.

She was admitted on 10.02.2004 and discharged on 11.02.2004 after prescribing warm saline gargle and for some further tests after 7 days. As per the self-contained note, she had been to Dr. S.Mallick on 12.08.2003 for her ailment and thereafter, consulted Dr. Sekhar Chakraborty and continued here treatment under him from 21.08.2003 to 06.01.2004. However, there was also a prescription dated 09.02.04 of Dr. Parthasarathi Bhattacharyya, in which he had mentioned that the claimant was a known patient of rheumatic heart disease.

However, on going through the discharge certificate, it was found that there was no mention of rheumatic heart disease; the patient was discharged in a hemodynamically stable state. Follow up was to be done by Dr. P.S.Bhattacharjee with reports. The insurance company did not establish that these tests, which were done for lung disease, were connected to rheumatoid heart disease. There had been no effort made to find out that the respiratory distress was due to rheumatic heart disease, which could be seen only from the mention made by Dr. Bhattacharya, in which he stated that it was a known case of rheumatic heart disease. In our opinion, the insurance company should have found out from a specialized doctor that various check-ups and pathological tests for which the claim had been made (for lung disease) were connected to rheumatic heart disease. Therefore, it was felt that the claim should be settled. Accordingly, the insurance company were directed to pay the claim of Rs. 15987/- (Rupees fifteen thousand nine hundred eighty-seven only).

Kolkata Ombudsman Centre
Case No. : 068/13/003/NL/04/2006-07
Shri Aloke Dhar
Vs
National Insurance Company Ltd.

Award Dated : 27.11.2006

FACTS & SUBMISSIONS :

The complainant, his wife and son were insured with the insurer for about 7 years. While renewing the policy for the period 24.01.2006 to 23.01.2007, the sum insured were increased from Rs. 50,000/- to Rs. 65,000/- in the case of self and Rs. 45,000/- to Rs. 50,000/- in the case of complainant's wife and son. On receipt of policy document, the complainant found that the enhanced sum insured was not included in the first year of coverage. The insurance company did not withdraw the stipulation in spite of representation made by the complainant.

According to the complainant, including such stipulation that the enhanced coverage was not applicable for the first year was not correct for the following reasons:

The company having received the premium for the enhanced sum insured, delaying the coverage till the next year would not be proper;

While accepting the renewal premium, the company did not communicate the above condition;

Individual mediclaim policy being approved by IRDA/RBI, no such exclusion could be incorporated in the policy.

In the self-contained note, the insurance company stated that the mediclaim cover for the family commenced on 24.01.1997 for a sum insured of Rs. 15000/- for each member. During the renewal for the period 2000-01, the sums insured were increased to Rs. 30000/- for self and Rs. 25000/- for his son. Again, during the year 2005-06 the complainant requested the insurance company to enhance the sum insured to Rs.

50000/- for self and to Rs. 45000/- each for his wife and son. During renewal a specific condition was included in the policy that “the enhanced sum insured is excluded for the first year” as the increment was deemed as first year policy. According to the insurance company, such underwriting measure was taken to reduce the claim ratio under mediclaim portfolio. According to them, no other insured made such a complaint in this regard.

Decision :

It was felt that this measure is usually not taken in the case of mediclaim insurance. Only some diseases are excluded as ‘Exclusion Clause’ of the mediclaim policy. It may be conceptually correct that condition like postponing the cover is a tool available to the underwriter for restricting the risk. The contention of the insurance company lacks justification as it was imposed without proposer’s consent and thereby the complainant was deprived of any opportunity to review his request for enhancement of sum insured before the commencement of the policy itself. Added to that, the insurance company enjoyed the premium in respect of the enhanced sum, insured, however, without accepting any liability.

It was, therefore, felt that the imposed restriction should be withdrawn forthwith. Accordingly, the insurance company were directed to withdraw the imposed restriction with immediate effect and provide coverage for full sum insured to the complainant, his wife and son for the remaining period of the policy.

Kolkata Ombudsman Centre
Case No. : 680/11/002/NL/12/2005-06
Shri Ajoy Kumar Basu
Vs
The New India Assurance Company Ltd.

Award Dated : 04.12.2006

FACTS & SUBMISSIONS :

Shri Ajoy Kumar Basu underwent a cataract operation on his right eye on 19.04.05 for which an expense of Rs. 8638.55 was incurred. He submitted a claim to M/s Medicare TPA Services (I) Pvt. Ltd., being the TPA of New India Assurance Co. Ltd., on 02.06.05. The claim was repudiated as the operation was performed within one year of waiting period and the policy was renewed late by 41 days; though the complainant contended that it was without a break since 1996-97. According to the complainant, the break occurred due to dishonour of cheque submitted for renewal, which was not intentional. In spite of his representation, the insurance company did not settle his claim. Being aggrieved, he approached this forum for relief.

The insurance company, in their self-contained note, stated that the mediclaim policy was incepted since 12.04.1998 and had been renewed without any break upto 11.03.2004. Afterwards, from the records, it could be seen that a fresh policy was issued 41 days later w.e.f. 22.04.2004 for the period 22.04.04 to 21.04.05. The policy was treated as a first year policy by the insurance company and, therefore, the cataract operation was not covered under the first year Exclusion Clause No. 4.3. Hence, the insurance company repudiated the claim.

Decision :

On going through the evidence submitted by the insurance company and the pleas made by the complainant, though the dishonour of cheque was unintentional, it could be seen that the insurance cover was granted afresh after a lapse of 41 days from the

expiry of the previous policy. However, from the petition filed by the complainant it could be seen that the operation was done on 19.04.05 while the next policy was renewed w.e.f. 22.04.05. In short, 3 days before the expiry of the running policy. If the complainant would have known that the running policy would be treated as first policy and the expenses incurred on cataract operation would not have been allowed, he would have as well got the operation fixed during the tenure of the next renewed policy beginning from 22.04.05, as the cataract operation was not an emergency one and could have been postponed by 3-4 days. This argument had a strong logical force.

Keeping in view that the lapse occurred due to unintentional mistake of the policyholder and if the insurance company had informed him that the policy would have been treated as new policy and first year Exclusion Clause would have come into operation, he would have as well got the operation postponed by a few days in such a manner that the insurance cover could have been granted and clause 4.3 would not have come into force. However, the insurance company were technically correct in refusing to reimburse the claim as the policy was renewed late by 41 days. Keeping in view both points, it was felt that payment of ex-gratia of Rs. 8000/- would meet the ends of justice. Accordingly, the insurance company were directed to pay Rs. 8,000/- (Rupees eight thousand) only.

Kolkata Ombudsman Centre
Case No. : 713/11/002/NL/12/2005-06
Shri Ram Prosad Ghosh
Vs
The New India Assurance Compoany Ltd.

Award Dated : 07.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim on the ground of pre-existing disease by invoking Exclusion Clause No.4.1 under Mediclaim Insurance Policy.

The complainant along with his wife and mother, Smt.Aparna Rani Ghosh were covered under Individual Mediclaim Insurance Policy. His mother was diagnosed as suffering from Papillary Adeno CA in throat on 1.1.2005 based on the FNCA report dt.29.12.2004. According to the petitioner the patient was taken to Tata Memorial Hospital, Mumbai for treatment of Carcinoma of thyroid where she was admitted on 10.1.2005 and was released on 17.1.2005. As the petitioner took a policy for his mother, he lodged/submitted/filed a claim for hospitalisation expenses of his mother along with all required documents to the Insurance Company. According to the petitioner, the claim was repudiated after 4 months of submission by the TPA, M/s.TPA Services (I) Pvt. Ltd., on the ground that the disease was pre-existing. The complainant represented against the decision of the Insurance Company and requested the Insurer to give the basis on which the disease held to be pre-existing. In spite of his representation, the claim was not settled. Being aggrieved, he approached this forum for redressal of such grievance.

Apart from the points stated above, the complainant further claimed that the apparent symptoms of the patient as per the medical reports did not indicate any pre-existence of the disease. Therefore, he pleaded for relief.

The Insurance Company issued this policy by their Burdwan Branch on 12.7.2004 and they received a claim intimation on 27.1.2005 and subsequently a claim for Rs.46,922/- was filed. The claim papers were forwarded to the TPA who in turn requested the Insured to supply the relevant documents with regard to the date on which the first diagnosis of thyroid cancer was made. On receipt of the relevant documents the TPA

repudiated the claim on the ground of pre-existing disease. The TPA's decision was based on panel doctor's opinion. According to the panel doctor's opinion the severity of the disease indicated pre-existence. Being dissatisfied by the TPA's decision, the complainant represented with a CT Scan report. The TPA requested the Insured to produce attending doctor's certificate about the commencement of the disease, its symptoms and signs appeared first. However, the complainant did not furnish any such document to the TPA. Keeping in view of the terms and conditions of the policy, the claim was repudiated.

From the available documents, it could be seen that the Insurance Company did not furnish any details of the panel doctor's opinion as to why the disease was felt as pre-existing. Similarly, the complainant did not explain as to why he did not submit the attending doctors's certificate/comment about the date of onset symptoms of the disease and its duration. Based on the information available it is not possible for us to form/arrive at any conclusive decision with regard to the pre-existence of the disease. The factum of the treatment was started within five and half months from the inception/commencement of the policy could not be an indicator of possible pre-existence of the disease, but the complainant had specifically asked to prove that the disease was pre-existing. But, the Insurance Company failed to submit any such proof.

Therefore, it was felt that the Insurance Company did not conclusively arrive at a decision to prove that there was pre-existence of the complainant's mother disease. Accordingly, the Insurance Company were directed to settle the claim in favour of the complainant.

Kolkata Ombudsman Centre
Case No. : 584/11/008/NL/10/05-06
Shri Samareswar Kahali
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 13.12.2006

FACTS & SUBMISSIONS :

The complainant, Shri Samareswar Kahali had taken a Health Shield Premiere Insurance Policy from M/s Royal Sundaram Alliance Insurance Company for the period 27.05.04 to 26.05.05 for a sum insured of Rs. 2,00,000/-. The complainant filed a claim for Rs. 1,84,504.75 for treatment of triple vessel disease by undergoing Coronary Bypass Graft Surgery at B.M.Birla Heart Research Centre, Kolkata during the period 03.05.05 to 15.05.05. The insurance company repudiated his claim on the ground of pre-existing disease vide their repudiation letter dated 30.07.05. Further, the insurance company once again upheld the repudiation on 08.09.05 on a representation filed by the complainant. Being aggrieved, the complainant filed this petition to this forum for redressal of his grievance.

The complainant in his representation stated that he had never suffered from diabetis, hypertension or elevated lipids as was evident from the pathological report prior to and during his hospitalization. He also submitted a certificate dated 19.09.05 from Dr. D. Kahali in support of the genuineness of the claim. Dr. Kahali was the person who was treating the complainant and he clearly stated that the patient was never diabetic or hypertensive or dyslipidaemic individual. According to him, he was always normal with regard to above. Temporary and transient elevation of blood sugar level following admission to the hospital was because of stress of the coronary angiogram and bypass surgery and according to his certificate the blood sugar never satisfied the criterion of a diabetic individual as defined in the literature. The drug he prescribed for the patient

was for the anti ischaemic therapy and not for hypertension. He further stated that severe triple vessel CAD is a disease a person can suffer without knowing of the same and may be preceded with certain cardiac death. Even after this certificate, the insurance company upheld the repudiation.

In the self-contained note, the insurance company stated the repudiation was based on two factors. One was pre-existing condition of disease and the other was first year exclusion under the policy. They had based their decision on the investigation report sent by the investigator Mr. Chris Mansukhani and two doctors opinions, Dr. Geeta Raman Iyer and Dr. K.V.Sathyanarayan Sa and to corroborate the opinion of the two doctors, the insurance company referred the claim to a specialized doctor Dr. R.Jaychandran, who in his report dated 15.12.05 gave his views as under:

“In view of smoking and diabetes the triple vessel coronary ... is pre-existing disease.”

As there was difference of opinion between the versions of the complainant and the insurance company, a hearing was fixed on 13.12.2006.

The complainant stated that he relied on the opinion given by Dr. D. Kahali, who was also the person who treated him at the time of hospitalization and surgery. According to him, there was no pre-existing disease and the disease was detected during the cover period of the insurance policy and he was operated immediately on the discovery of cardiac disease.

The insurance company stated that certain documents like previous lipid profile, diagnosis of hypertension and Diabetes Mellitus were called for and the same had not been produced. However, they obtained some documents from the Birla Heart Research Centre with regard to diabetes. From the Birla Research Institute chart, which indicated fluctuations in the sugar count during his stay in the hospital for the period 03.05.05 to 15.05.05 on few days (about 6 days). These fluctuations were sufficiently answered by Dr. D.Kahali in his certificate by stating that these fluctuations prior to and after the operation were due to stay in the hospital followed by stress and it was a temporary phenomenon and could not be stated that there was pre-existing Diabetes Mellitus and hypertension. However, on questioning, it is learnt that the insurance company had not given an opportunity to the patient on the papers that have been relied on.

The analysis of the report submitted by Mr. Chris Mansukhani indicated that the patient had a history of smoking (about 5-7 cigarettes a day), while the in-patient records indicated that he was a non-smoker. Anyway, there was no literature available to indicate that cardiac problem occurred due to smoking. However, Dr. Kahali in his report stated that temporary blood pressure and temporary elevated diabetic count was due to stress of hospitalization and impending coronary operation. The investigator took the opinion of Dr. Geetha Raman Iyer. According to that opinion which was based on the same facts submitted to the doctor mentioned above that the patient was a continuous cigarette smoker having hypertension and Diabetes Mellitus and long standing dyslipidaemia, which was responsible for severe coronary narrowing and myocardial ischemia giving rise to TVD and angina on exertion. Therefore, the doctor concluded that the disease was pre-existing. Nowhere Dr. D.Kahali’s opinion was discussed. The investigator came to the conclusion that the certificate of Dr. D. Kahali was taken as he was the nephew of the patient. According to the investigator, the insured was already on treatment of HTN/Angina and was advised medication for the same in the advise of admission. As per discharge advise, the insured was required to attend BMBHRC Cardiac rehabilitation center after 6 weeks for a fresh lipid profile and therefore, a previous lipid profile was done and according to him report were not submitted and were withheld by the insurer.

According to the complainant only one lipid profile was done at the time of hospitalization and that too to find out whether there were any changes in the lipid profile. Fresh lipid profile was done after 6 weeks.

Decision :

After going through the arguments of both the complainant and the insurance company, it was felt that the insurance company repudiated the claim on the documents collected by them from the hospital authorities. The documents described the status of diabetes and hypertension during the period of hospitalization and according to us it was felt that hypertension and increase in diabetes was only due to stress and fear of coronary surgery. In fact, the insulin was administered to reduce the sugar count in the blood so that the infections, if any, after the operations are cured. In fact, the immune suppressants given during the operation would generally reduce the capacity to fight any infection after the operation and, therefore, insulin is also given to see that sugar in the blood is not increased on one side while medicines are given to increase the immunity. Therefore, the administration of insulin does not indicate that there was pre-existing Diabetic Mellitus. Any medicine given after the operation for hypertension does not indicate that there was a pre-existing disease. We were not satisfied with the way repudiation has been done by the insurance company. No proper opportunity had been given to the insured to defend his claim, as the papers obtained from the hospital have not been given to the claimant. Therefore, the insurance company were directed to give proper opportunity and take into consideration the fact that the only profile available to the insurance company was the profile with regard to DM, HTN and lipid and reconsider their conclusion that the disease was pre-existing because of its existence during the period of hospitalization/ operation as it does not straightway give an opinion that the patient was having DM and HTN, prior to the insurance cover. The insurance company were directed to review the claim after taking into consideration the aforesaid facts and decide the claim on merit.

Kolkata Ombudsman Centre
Case No. : 192/13/003/NL/06/2006-07
Shri Bibek Prasad Routh
Vs
National Insurance Company Ltd.

Award Dated : 15.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding Exclusion of ‘hysterectomy’ and ‘heart diseases’ from the scope of the cover under Mediclaim Insurance Policy.

Smt. Abanti Routh, complainant’s wife, was covered under individual Mediclaim Policy since 18.12.2001 for Sum Insured of Rs.3 lacs. Before inception of the cover, the complainant submitted some medical investigation reports, as desired by the Insurance Company. In the beginning of the policy itself, the Insurance Company specifically excluded heart disease and hysterectomy from the scope of the cover. The complainant represented to the various authorities of the insurance company against the absurd exclusion, as there was no pre-existing disease at the time of inception of the policy. Further, according to the petition, the ECG submitted by Smt. Routh, did not reveal any disease/injury pertaining to her heart ailment. Even after such representation, the Insurance Company kept on renewing the policy with the same exclusion till 2004-05. Eventually the complainant refused to accept the policy for the year 2005-06, protesting against the Insurance Company’s refusal to delete the exclusion. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The complainant further stated that the Exercise Stress Test of his wife was undertaken under the care of a Consultant Cardiologist. The treating doctor opined that she did not have “any apparent or overt heart disease”. Even with such opinion, the Insurance Company did not change their stand.

According to the Insurance Company, the wife of the complainant underwent hysterectomy in November, 1997 before taking the Mediclaim Insurance policy. Before granting cover, ECG reports for both husband and wife were asked for, which were submitted after about 5 months on 26.4.2002. Thereafter, the policy was released subject to exclusion of heart disease in respect of Smt. Ababti Routh, wife of Shri Bibek Prasad Routh, based on her ECG report, which showed “Incomplete R.B.B.B. & Minor S.T.T. changes of Inferior wall”. Thereafter, the policy was renewed every year till 30.12.2006, with the same exclusion.

Decision :

After going through the various arguments by the complainant and arguments from the Insurance Company, it was felt that exclusion of heart disease from the scope of the cover year after year, just because of one ECG report taken before inception of the Mediclaim Insurance Policy, did not seem to be correct. However, as the policy was going to expire on 30.12.2006, no directions for the change of conditions were given, as it was a prerogative of the underwriter to restrict the risk exposure while going for the cover. Further, it was recommended that the Insurance Company should seek a specialised opinion before excluding the ailment/disease from the scope of the cover for the new policy, as and when applied for, or in the case of renewal of this policy.

Kolkata Ombudsman Centre
Case No. : 726/11/002/NL/12/05-06
Smt. Nisha Shah
Vs
The New India Assurance Company Ltd.

Award Dated : 15.12.2006

FACTS & SUBMISSIONS :

The complainant, Smt. Nisha Shah was covered under mediclaim policy issued by The New India Assurance Company Ltd. for the period 30.04.04 to 29.04.05 for sum insured of Rs. 5 lakhs. The complainant was having mediclaim policy with the same insurance company since 1992. However, due to her absence the erstwhile policy could not be renewed in the year 2004 in time and the policy was renewed for the period 30.04.04 to 29.04.05. (In short, this policy was deemed to be a fresh policy as there was a considerable time of lapse). The complainant was admitted to Woodlands Medical Centre Ltd. for surgery of the uterus on 27.04.05 and discharged on 05.05.2005. The claim was submitted to the TPA of the insurance company viz., M/s Medicare TPA Services (I) Pvt. Ltd., but the same was repudiated as the claim preferred in the first year of inception and Hysterectomy was excluded as per the policy condition. It was also held that the disease could not have developed in one year and the same was treated as pre-existing. The complainant represented to the insurance company but of no avail. Being aggrieved, she approached this forum for necessary relief.

The insurance company confirmed that the complainant was having mediclaim policy continuously from 1992 till 16.02.04. Due to her travel to various places in Rajasthan, Himachal Pradesh, etc. she forgot to renew the policy and the same was renewed w.e.f. 30.04.2004. In November’04, the complainant first felt problem in her uterus and took necessary action for medical check up and investigation. Later she was admitted to the hospital on 27.04.05 for surgery of uterus. Dr. Pranab Dasgupta of Woodlands

Medical Centre Ltd. diagnosed that she was having “Bulky uterus with adenomyosis” and the treatment was given to her for “Abdominal total hysterectomy with bilateral salpingo-oophorectomy”. The operation was done on 28.04.05. The insured filed a claim on 05.07.05 for Rs. 1,53,609.09 to the insurance company, who subsequently forwarded to the TPA. The TPA repudiated the claim on 02.08.05 for the reasons mentioned in the above paragraph. The insurance company could not condone the delay for renewal of the policy as the break was about 60 days and according to them, the policy had to be treated as a new policy and both pre-existing disease and exclusion clause were invoked for repudiating the claim.

Decision :

From the available documents, it could be seen especially from the discharge certificate that there was no past history mentioned therein. Therefore, the disease in the uterus could not be treated as pre-existing before the policy was incepted. With regard to exclusion clause 4.1 of the policy condition, we found that she was operated on 364th day after the policy was taken on 30.04.04. We also found that she renewed the policy w.e.f. 30.04.04 to 29.04.05. Therefore, if the operation had taken place after 1st May’05, the clause 4.1 would not have come into play. However, the complainant was not careful enough to renew her policy in time and, therefore, the condition that clause 4.1 should be applied as per the self-contained note of the insurance company could not be totally ignored. Therefore, keeping in view that the claim would have been given to her in the renewed policy for the period 30.04.05 to 29.04.06, had she got the operation done during that period should be taken into consideration for determining the admissibility of the claim. Keeping in view the above reasons, the insurance company were directed to settle the claim at Rs. 80,000/- (Rupees eighty thousand) only as ex-gratia.

Kolkata Ombudsman Centre
Case No. : 607/14/005/NL/11/2005-06
Shri Debo Prosad Das
Vs
The Oriental Insurance Company Ltd.

Award Dated : 20.12.2006

FACTS & SUBMISSIONS :

The complainant Shri Debo Prosad Das had taken a mediclaim policy with The Oriental Insurance Company Ltd., from 24.10.1995 and renewed it continuously without any break till 23.10.2006 covering self, his wife and son. He filed a claim for Rs.39,995.10 on 09.06.2003 for the treatment of his wife Smt. Keka Das in a hospital in Kottakkal, Kerala for Cerebellar Degeneration for the period 08.03.2003 to 06.04.2003. The patient was diagnosed as suffering from Cerebellar Degeneration on 21.04.1997 as allopathic treatment did not give much relief the other methods like ayurvedic treatment were done with some positive response. As the insurance company had not settled the claim after many efforts, the petitioner filed this petition for redressal of grievances before this forum.

In response to the repudiation made by the insurance company the Insured stated that invoking the exclusion clause 4.1 was not correct, as this policy existed since 24.10.1995 and Cerebellar Degeneration was detected on 21.04.1997. Medical records indicated that there was surgery for L5 S1 done on 06.08.1996 at Kolkata by Dr. Sandip Chatterjee and this was done to give the patient comfort and freedom from back pain. The Insured had also replied that the patient was having only disease of

Cerebellar Degeneration and that it could not be connected with the operation done for Disc Prolapse. According to the complainant the Discharge Certificate issued by Ayurvedic Hospital did not indicate anything connected with the operation done for Disc Prolapse.

In spite of the replies given by the Insured, the insurance authorities repudiated the claim saying that the patient had knowledge of the disease prior to the inception of the policy as revealed from the prescription of Dr. Sujit Kumar Das dated 22.07.1996.

Due to difference in the version submitted by the insurance authorities and the complainant a hearing was fixed. From the averments made by the husband of Smt. Keka Das, it could be easily seen that the treatment taken at Ayurvedic Hospital in Kerala was for imbalance while standing and walking, difficulty in getting up from sitting posture and in walking unsteady gait, pain in low back region pain and swelling in multiple joints and hypertension. According to the MRI of the brain as diagnosed by Dr. Shyamal Das on 03.06.1997 the impression given was for there was a mild Cerebellar Degeneration. The insurance authorities relied on the certificate given by Dr. Subrata Sen dated 27.08.2004, in which he stated as under :-

“Imbalance while standing and walking, difficulty in getting up from sitting position, the symptoms for which Smt. Keka Das was treated is definitely due to Disc prolapse diagnosed in 1996 and treated surgically”.

This simply suggested that imbalance while standing was due to Disc prolapse diagnosed in 1997 treated surgically.

Decision :

The opinion given by Dr. Shyamal Das that there was a mild Cerebellar Degeneration in 1997 could not be referred back to the operation done for Disc prolapse. According to us the surgery done was only for L5 and S1 and the patient improved substantially. Later after the policy was taken the patient started to get the disease of mild Cerebellar Degeneration and therefore the patient went to Kerala for treatment. Therefore, it could not be imagined that Cerebellar Degenration had started showing signs in the patient at the time of surgery of L5 S1 in 1996. Therefore, we were of the opinion that the claim should not have been repudiated connecting the surgery with Cerebellar Degeneration and coming to a conclusion that Cerebellar Degeneration existed before start of the cover under the policy. The insurance company were directed to settle the claim at Rs.39,995.10.

With regard to the other grievance for arbitrary reduction of Cumulative Bonus, it was learnt that the mistake were admitted by the insurance company and accordingly, the insurance company were directed to restore the proper Cumulative Bonus under the policy to the policyholder.

Kolkata Ombudsman Centre
Case No. : 736/11/003/NL/01/2005-06
Shri Dilip Kumar Thakurta
Vs
National Insurance Company Ltd.

Award Dated : 20.12.2006

FACTS & SUBMISSIONS :

The complainant Shri Dilip Kumar Thakurta submitted a claim to the insurance company on 25.01.2005 for prostate surgery at Bombay Hospital for an amount of Rs.46,444/-. The claim was rejected by M/s Family Health Plan Limited (FHPL) being

the TPA of the insurance company. On the fact that the ailment was pre-existing due to open prostactomy in the year 1987 and this mediclaim policy was taken in January 1998 nearly 11 years after the surgery. The repudiation of the claim was upheld by the insurance company even after representation made by the complainant. Hence, he has come to this forum for redressal of his grievances.

Further in his representation before the insurance company the complainant stated that he was completely cured after the prostate surgery in the year 1987 and, therefore, according to him the present ailment should not have been considered as pre-existing after a gap of 11 years. While making this petition before this forum he enclosed a Doctor's certificate Dr. S.K.Thatte, Consultant Urologist, Bombay Hospital and according to his opinion the present ailment i.e., re-growth of prostate has occurred only a year back. As per his opinion the claimant was entitled for payment of claim lodged to the insurance company.

In the self-contained note given by the insurance company the complainant took a mediclaim policy from 19.01.1998 and continued without any break till 18.01.2007. At the time of inception of the policy the complainant submitted reports as both pathological and clinical and after considering this reports the insurance company had issued the policy. However, his claim for prostate operation at Bombay Hospital was rejected by the TPA, M/s FHPL on the ground of pre-existing disease as per clause 4.1 of the mediclaim policy that due to the reason that he had undergone open prostectomy in 1987 and the fact that the Insured had not declared in the proposal form submitted by the Insured. The repudiation was confirmed by the insurance company and confirming insurance company contended as under :-

While confirming the repudiation decision of TPA, the insurance company contended that (1) Any recurrence of ailment in prostate has no time bar in medicine. These recurrence as per medical opinion has no time frame of reference. (2) The proposal for this insurance cover should have the declaration of 1987 surgery where upon any prostate related ailment would have fallen under general exclusion. Hence the policy becomes null & void for suppression of material fact.

To find out the correct version of both Insured and the insurance company a hearing was fixed.

The complainant during the course of hearing reiterated that the disease occurred long after the previous surgery and relied on the opinion of the doctor, Dr. S.K.Thatte. However, he could not reply why he did not mention the fact of surgery in the proposal form before taking the mediclaim. He only stated that the proposal form was written by the agent and he signed the same without going through it.

The authorities for the insurance company reiterated that claim was repudiated on the grounds mentioned in the self-contained note and not mentioning the occurrence of surgery in the proposal form was the main reason for repudiation.

Decision:

On going through both versions of Insured and the insurance company we were unable to agree with the arguments of the complainant. Surgery is a major event in one's life and not mentioning it in the proposal form would take away the prerogative of the insurance company to underwrite the risk or to refuse to issue the policy. Under these circumstances, the decision of repudiation was justified and the complaint was dismissed.

Case No. : 724/11/002/NL/12/2005-06
Shri Ranjan Mukherjee
Vs
The New India Assurance Co. Ltd.

Award Dated : 20.12.2006

FACTS & SUBMISSIONS :

The complainant Shri Ranjan Mukherjee had taken a Mediclaim Policy in the year 1998 covering his mother Smt. Purnima Mukherjee. She was first hospitalised on 07.07.2004 at Calcutta Medical Research Institute for treatment of Nephropathy and hypertension and was discharged from the hospital on 24.07.2004. As per the petition, patient was again admitted on 31.10.2004 with Diabetic complications and expired on 23.12.2004. The complainant filed two claims with the insurance company on two mediclaim policies running for the period 16.10.2003 to 15.10.2004 and 16.10.2004 to 15.10.2005. The TPA according to the petition rejected the claims made by the complainant on the ground that the disease of diabetes was pre-existing and the treatment for the disease related to diabetes was not allowed. The complainant filed the representation to the insurance company, which in turn confirmed the repudiation made by TPA. Hence, being aggrieved by the repudiation the complainant approached this forum.

The representation filed by the complainant to the TPA enclosed a certificate given by Dr. P.K.Banerjee, dated 19.01.2005 which stated as under:-

"This is to certify that Late Purnima Mukherjee who was a resident of 63/41, Harish Chatterjee Street, Kolkata – 700 025 was under my treatment for last five years. About 2 ½ years back she started having high blood sugar level for which treatment was started"

He further stated in the representation that the patient was suffering from diabetis for 20 years was not correct and according to the certificate given by the doctor she was suffering for only 2 ½ years.

In the self-contained note, the insurance company stated that the repudiation of the claim made by the TPA on the ground of pre-existing nature of disease was supported by the panel doctors' opinion and according to that the patient was diabetic for last 20 years. The second hospitalisation claim was also repudiated on the same ground as referred to in the repudiation of the first claim.

Decision :

As per the documents submitted by both the parties it was confirmed that the deceased patient Smt. Purnima Mukherjee was suffering from Diabetic Mellitus and was the proximate cause of her illness for which the hospitalisation claim was submitted by the complainant. The dispute only was on the duration of Diabetic Mellitus that the patient had been suffering from. According to the panel doctor of the insurance company Dr. Arup Ratan Datta dated 23.06.2004, it can be easily seen that Late Purnima Mukherjee was a patient for DM for 20 years. However, the certificate issued by the House Physician Dr. P.K.Banerjee that the patient was under his treatment for last 5 years and only about 2 ½ years back she was started having high blood sugar and treatment was started from then.

It was also found that the patient was covered under Mediclaim policy since 16.10.1998 and as per confirmatory note issued by the insurance company to their TPA dated 25.11.2004also indicated that there was no claim till date in respect of late Purnima Mukherjee. Later the Office of the Insurance Ombudsman called for the proposal forms

under the documents on 05.12.2006 filed at the time of taking the policy. The insurance company promptly submitted the said documents.

From the documents it could be seen that in the personal details with respect of Purnima Mukherjee, it was observed that she had declared 'Yes' against column no. 13 (n) regarding any disorder of the stomach, ulcer, bowel or gall bladder, kidney stones etc. and also under item no. 15 it was mentioned about gallstone removal in 1994 and she answered the other questions as 'No' particularly with respect to item no. 13 (n) – diabetes or any other urinary diseases. Further it was found that on the face of the proposal form dated 19.10.1998 submitted to the insurance company the insurance authorities put a remark dated 16.10.1998 as under :-

"Risk of Heart Disease to be covered only after submission of original ECG report of Smt. Purnima Mukherjee".

It was also found that they received ECG report dated 24.09.1998 which showed sign of hypertension being 170/80 and no exclusion had been made under the policy with regard to diseases connected under hypertension. From the above available documents it was clear that proposal form mentioned the disease that she was suffering and naturally those diseases she was not suffering have not been mentioned. Similarly it could be presumed that the insurance company was aware of the existence of illness but they allowed the policy to run without exclusion. Therefore, there was a genuine effort on the part of the Insured to give full details with regard to question no. 13 and therefore we tend to agree with the certificate given by the house physician Dr. P.K. Banerjee. The insurance company did not exclude any disease even after making a note as mentioned above in the proposal form. Under the circumstances we did not agree with the decision of the insurance company on repudiation of the claims made by the complainant. The insurance company were directed to settle the claims as per relevant policy sum insured with CB entitlements.

Kolkata Ombudsman Centre
Case No. : 794/15/003/NL/01/2005-06
Shri Niloy Dutta Chowdhury
Vs
National Insurance Company Ltd.

Award Dated : 22.12.2006

FACTS & SUBMISSIONS :

The Complainant Shri Niloy Dutta Chowdhury had Mediclaim and Personal Accident Policy with the National Insurance Company Ltd. from 2001, the policy has been renewed till 2003-04. At the time of renewal for the period 2004-05, the complainant deposited the premium cheque towards renewal at the insurance office on 06.09.2004. According to the petition, the complainant did not receive any premium receipt or any certificate of insurance from the insurance company. A representation filed before the insurance company was not replied. He once again paid further renewal premium for the period 2005-06 vide cheque dated 06.09.2005 and sought for receipt and policy certificates for both present year and the previous year. Once again his representation before the insurance company was of no avail. Being aggrieved, due to non receipt of insurance policies, the complainant approached this forum.

According to the insurance company he was an Agent of the company. There was an agreement between the insurance company and the agents that the agent would not deposit premium for the personal insurance against their own agency code, compliance

with the provisions of section 41 of the Insurance Act 1938. The section is quoted below for convenience:-

"Under Section 41 of Insurance Act 1938 Prohibition of Rebates says (which is printed on the proposal form) "No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurers."

Decision :

From the self-contained note of the insurance company, it was found that the complainant, an agent of the insurance company, had placed his own insurance for the period 2004-05 knowing fully well about the decision. The premium cheque was not deposited and the same was returned to the complainant as per the insurance company's computer system records. Even for the next year 2005-06, the complainant presented a premium cheque for the policy. The insurance company requested him to take back the cheque and get insured elsewhere. The complainant agreed to take back the cheque, but he did not do so. Since the complainant was not eligible to get any rebate in the premium the risk was not underwritten by the insurance company. This was also communicated to the complainant.

From the above circumstances it was clear that two issues are involved:-

Whether agency commission is payable to the agent, who gives premium to the insurance company for which he is an agent.

Non-issue of insurance policies.

Under Redressal of Public Grievances Rules 1998, question of allowability of agency commission is outside the scope of this office.

With regard to non-issue of insurance policy documents, it was clear that the company had not encashed the premium cheques and the complainant was aware of the same. Unless the premium cheques and proposal form are accepted, no policy bond can be issued. Since, the pre-condition of accepting the cheque has not been done by the insurance company, non-issuance of insurance document does not arise. Therefore, even this issue falls outside the scope of RPG Rules, 1998. Therefore, the complaint was dismissed as non-maintainable. However, from the records it was found that the company had not returned the premium cheques. The insurance company were directed to return the premium cheques to the complainant explaining the reasons thereof.

Kolkata Ombudsman Centre
Case No. : 764/11/002/NL/01/2005-06
Shri Tarun Dasgupta
Vs
The New India Assurance Co. Ltd.

Award Dated : 22.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim on the ground of pre-existing disease by invoking Exclusion Clause No.4.1 under Mediclaim Insurance Policy.

The complainant, Shri Tarun Dasgupta had a Mediclaim Policy with the New India Assurance Co. Ltd., Thakur Pukur Branch since 1999 and it was continued upto 8.4.2002. In the year 2002-03, the policy was transferred to 11, Prafulla Sarkar Street

office of New India Assurance (NIA). The Insurance Company issued a fresh Mediclaim Policy for Sum Insured of Rs.75,000/- commencing from 12.4.2002 to 11.4.2003 and the mediclaim policy continued thereafter without a break upto 2005-06 i.e. upto 11.04.2006. The complainant filed a claim to the Insurance Company on 24.5.2004 for reimbursement of expenses incurred during hospitalisation at Wockhardt Hospitals from 19.3.2004 to 25.3.2004 with regard to enlarged Prostate Gland (TURP) and Osteoarthritis knee joint operation and finally TURP was done in the hospital. The Insurance Company repudiated the claim on the fact that the disease was pre-existing and the policy that was taken with effect from 12.4.2002 to 11.4.2003 was a fresh one. The complainant also stated that he had a continuous policy since 1999 and symptoms relating to enlarged Prostate and Osteoarthritis knee joint existed for the last 5 to 6 years. The policy was incepted way back in 1999 and possibility of pre-existence of the disease cannot be ruled out. There is no evidence to prove that that the complainant had any past history of hospitalisation and treatment taken or diagnosed by a doctor prior to 1999.

As there were gaps in the evidences submitted by the Insurance authorities and the complainant, a hearing was fixed, where both the parties attended. The complainant's initial resentment was that how he was treated by the Insurance authorities since 2004 and how many mistakes have been committed by the Insurance authority at the time of issuing the policy from 12.4.2002 to 11.4.2003. The entire set of papers was handed over to the Insurance Ombudsman during hearing. According to him, the policy was shifted from one Branch to another Branch for the convenience of the Agent of the Insurance Company. He stated that he issued the premium cheque well within the time to renew the policy and he did not fill any new proposal form. He also stated that if there was a break in continuation of the policy how the Insurance Authority enhanced the Sum Insured to Rs.75,000/- from Rs.30,000/- for the period 12.4.2002 to 11.4.2003. He firmly stated that the policy has been continued from 1999 and that the disease could not be concluded as pre-existing.

The representatives of the Insurance Company strongly defended their stand and stated that the policy was to be treated a fresh policy, as there was break in continuation of the policy for three days. When asked about the new proposal form, it was found that that there was no new proposal form and the policy was accepted on the basis of the proposal form existed in the earlier Branch of the same Insurance Company.

As far as waiver in condoning the break period of three days and continuation of the policy is concerned, the Insurance Company stated that they had never been approached by the Insured for such waiver. The Insured then stated that the question of waiver does not arise as he thought that the policy was a continuous policy.

Decision :

Now the question arises whether the disease was a pre-existing one or not. The prescription of Dr. Kalyan Sarkar dt.9.2.2004 indicates that the patient was suffering from Prostate and Osteoarthritis knee joint problem for the last 5 to 6 years. Even, if one takes 5 years, it is found that the patient was admitted to Wockhardt Hospitals on 19.03.2004 and therefore, 5 years before from the date of admission would be 19.3.1999. So, it marginally fell outside the scope of the cover period of the policy, which started from 9.4.1999. Since the certificate given by the doctor, which was only estimated period, we do not think that the marginal period, as mentioned above could be taken into consideration for repudiation as pre-existing disease.

Further, the Insurance Company should prove that the insured has the knowledge of such disease and did not disclose the same in the proposal form after having such knowledge with unquestionable evidence.

Under the circumstances, it was held that the policy was running continuously without any break from 9.4.1999 to 11.4.2003, as the break in period already discussed could not be substantiated by the Insurance Company with evidences to prove that the policy for the period from 12.4.2002 to 11.4.2003 was a fresh policy.

The estimated period of 5 to 6 years by the doctor in his certificate will also not specially help the Insurance Company to suggest that the disease was a pre-existing one. Hence, the benefit of doubt should be given to the Insured and according to our opinion the disease was not a pre-existing one. Hence, the Insurance Company were directed to settle the claim of Rs.40,645.48 incurred for the treatment of Prostate Gland (TURP) undertaken during hospitalisation.

Kolkata Ombudsman Centre
Case No. : 739/11/003/NL/01/2005-06
Smt. Shyamali Biswas
Vs
National Insurance Co. Ltd.

Award Dated : 26.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim on the ground that the disease was pre-existing under Mediclaim Insurance Policy.

The complainant, Smt. Shyamali Biswas in her complaint stated that she was covered by a Mediclaim Policy taken by her husband, Shri Alok Narayan Biswas from National Insurance Co. Ltd., for the period from 1.6.2004 to 31.5.2005 for a Sum Insured of Rs.60,000/-. A claim for hospitalisation was filed with the Insurance Company for her admission to the hospital for the period from 8.8.2004 to 17.8.2004 for treatment of Neurological problem. The TPA of the Insurance Company, namely M/s. Family Health Plan did not entertain the claim for settlement on the ground that the disease was pre-existing. According to the complaint, the attending surgeon, Dr. Rahul De of National Neurosciences Centre, Calcutta confirmed the fact that the reason for refusal of the claim has nothing to do with surgery that the patient underwent under his direct care. Dr. Rahul De further stated that the ailment was emergency in nature and had no relation with Hypertension or Diabetes Mellitus. In spite of the complainant's representation to the Insurance Company, they repudiated the claim as pre-existing and therefore, she approached this forum for redressal of her grievance.

The TPA of the Insurance Company, M/s. Family Health Plan repudiated the claim due to the following reasons :-

" Ms. Shyamali Biswas Female/50 years got admitted to National Neuroscience on 08.08.04 with Subarachnoid Hemorrahge due to Ruptured left MCA Eneurysm. Patient is a known Diabetes Mellitus, Hypertension Hypothroid Policy status is fresh starting from 01.06.04.

It has been argued by Dr. R. De (Neuro Surgeon) that 'A Ruptured Berry aneurysm was not a pre-existing condition, but a medical emergency'.

In this respect, we recall the following medical facts :

Berry aneurysm may not be congenital. They develop in patient due to weakness in the 'Medial layer of the artery/arteriotes';

The causative reason for development of aneurysm is not known. But it is a medically established fact that Hypertension is one of the predisposing condition to the development of Berry aneurysm.

(Ref.: Harrison's Ed-15th).

Hence, though the exact event of rupture of this MCA aneurysm is not pre-existing to the date of inception of policy, the condition (Hypertension in this case) leading to the development of this aneurysm and subsequently leading to it's rupture is certainly a pre-existing one."

The Insurance Company in their Self-contained Note (SCN) defended the repudiation decision of the TPA and stated that on the basis of the opinion given by the doctor, Dr. Tapas Kumar Chaudhuri, as mentioned in the above paragraph, the TPA decided the merit of the claim.

Decision :

From the above, it was clear that there was difference of opinion that prevailed between the expert opinion of doctor, Dr. Tapas Kumar Chaudhuri of TPA and the attending doctor, Dr. R. De (Neuro Surgeon). The patient was admitted in the hospital for Subarachnoid Haemorrhage due to Ruptured left MCA Eneurysm and not for Hypertension. Dr. R. De, the attending physician had denied any relation of Hypertension with the disease for which the patient underwent treatment. Dr. Tapas Kumar Chaudhuri's opinion that Hypertension may be the proximate cause leading to the development of the disease. From this it was clear that the doctors' opinions were diametrically opposite. Therefore, it was clear that patient having the knowledge of the existence of the disease at the time of the proposal was not simply possible, when two experts are differing.

Further in a recent judgement given by the National Commission for dispute redressal on 'Pre-existing disease' which appears that " Most people are unaware of the symptoms of the disease that they suffer from and hence cannot be made to suffer merely because the Insurance Company observes clause 4.1 in a malafide manner to repudiate claims" and that the burden of proof that the patient had the knowledge of the disease before the policy was taken solely falls on the Insurance Company.

Further, it has been stated that knowledge of the pre-existing disease must be within the knowledge of the Insured before taking out such policy and it has to be proved by the Insurance Company that the Insured has taken the policy knowing fully well that a disease was existing and that the same has been disclosed at the time of filling the proposal form. According to our opinion taking a cue from the above decision, the Insurance Company did not have the evidence to prove that the Insured had the knowledge of such disease at the time of taking the policy. Apart from that the opinion of the attending doctor who diagnosed the patient clearly indicated that the disease was not pre-existing.

Under the circumstances, the Insurance Company were directed to settle the claim fully.

Kolkata Ombudsman Centre
Case No. : 781/11/002/NL/01/2005-06
Shri Santosh Ranjan Saha
Vs
The New India Assurance Company Ltd.

Award Dated : 26.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim on the ground of pre-existing disease by invoking Exclusion Clause No.4.1 under Mediclaim Insurance Policy.

The complainant, Shri Santosh Ranjan Saha, was covered under Mediclaim Policy since 1988 without any break. He was admitted to Apollo Hospitals, Chennai during 01.02.2002 to 09.02.2002 for treatment of Coronary Artery Disease (CAD) etc. His claim for Rs.93,793/- was settled by the Insurance Company. Later, the complainant was again hospitalised during the period from 29.12.2003 to 1.1.2004 and 11.1.2004 to 20.1.2004 at Woodland Hospital and Medical Research Centre, Kolkata for treatment of the same type of disease. The complainant filed the claims for the subsequent stages of hospitalisation and the same were repudiated by the TPA of the Insurance Company as being pre-existing disease. The TPA held that the First Degree AV Block with LBBB since 1999 existed prior to inception of the policy. Despite representation to the Insurance Company, the claims were not paid. Being aggrieved, the complainant approached this forum for redressal of his grievances.

Further, the complainant contended that the claim for disease CAD was existing from 1969 cannot be correct as no person can stay with the disease like CAD for such a long time. He further stated that the Coronary Angiogram (CA) was done at Manchester in July 1988 and it was normal. Later the Angiogram was done in Kolkata on 16.1.1997, which revealed Single Vessel Disease and this clearly proved that the complainant developed the disease long after taking the policy. According to him, the Discharge Summary Report of Apollo Hospitals, Chennai indicated that the First Degree AV Block had disappeared until 2002, when he had undergone permanent Pacing at Apollo Hospital. Therefore, according to him the disease could not be treated as pre-existing. According to the complainant, two opinions were obtained by the TPA of the Insurance Company from Dr. Soven Sinha could not be treated as impartial as he opined in his report that the First Degree Heart Block with LBBB was indicative of chronic heart disease and was existing around 1969. In the second opinion, he stated that Diabetes, First Degree Heart Block with LBBB and Coronary Artery Disease were pre-existing and would account for the complainant's ailment.

According to the Insurance Company, the Mediclaim Policy was in existence since 1995-96 covering himself and his wife for Rs.1 lac each. The Discharge Certificate issued by the hospital authority during the period of hospitalisation from 29.12.2003 to 01.01.2004 after the treatment indicated that the complainant was treated for Diabetes Mellitus (type-II) with Diabetic Neuropathy, Coronary Artery Disease (Tripple Vessel Disease), Cervical Spondylosis, LBBBB etc. The claim for that period was Rs.44,280/-. The patient was once again hospitalised between 11.01.2004 to 20.01.2004 for the treatment of LBBB Syncopal, CAD, Cervical Spondylosis, Hyper Uricalnia, Hypothyrodism etc. The related claim was for Rs.1,55,743/-. Both the claims were repudiated on the ground that the First Degree AV Block with LBBB existed from 1969. The Insurance Company obtained a second opinion from Dr. Soven Sinha who once again confirmed that the disease was pre-existing in nature. The Insurance Company invoked the Exclusion Clause No.4.1 of the policy conditions under Mediclaim Policy.

Decision :

On going through the available evidences and documents on record, the case could be summarised as under :–

(a) The Discharge Summary dated 09.02.2002 of Apollo Hospitals, Chennai diagnosed the ailment as CAD, Left Bundle Branch Block, Tripple Vessel Disease, DM, Cervical Spondylosis. It also recorded the history of CAD (1988 normal and 1997 Single Vessel Disease), IHD, First Degree AV Block and Persistent LBBB since 1969.

The Discharge Summary of Woodlands dated 01.01.2004 recorded DM (Type-II) with Diabetic Neuropathy, CAD (Tripple Vessel Disease), LBBB, Cervical Spondylosis, ? Hypoglycemia attack. The second Discharge Summary of Woodlands dated 20.01.2004 recorded the diagnosis as LBBB – permanent pacing done, CAD – Tripple Vessel Disease, Cervical Spondylosis, Hyperuricaemia and Hypothyrodism.

(b) The Insurance Company settled the claim at Apollo Hospitals, Chennai for Rs.93,793/- for the treatment undertaken during the period 1.2.2002 to 9.2.2002. The claims for further treatments from 29.12.2003 to 11.1.2004 and 1.1.2004 to 20.1.2004 were repudiated, as mentioned above on the ground as pre-existing.

It could be seen that the diseases were recorded in the Discharge Summary were substantially similar and all of them definitely included heart ailment. Therefore, it was clear that the Insurance Company settled the claim for treatment of heart ailment at Apollo Hospitals, Chennai, even after knowing the history of LBBB since 1969. Therefore, it was clear that the Insurance Company did not consider heart ailment of 1969 with the plea as pre-existing. It was interesting to note that the Insurance Company again while renewing the policy for the year 2002-03 and subsequently did not exclude the heart disease from the scope of the risk. Therefore, from the analysis as discussed above, it was clear that the Insurance Company was unjustified in invoking exclusion clause no.4.1 on the subsequent claims. Hence, the Insurance Company were directed to settle the claim as per policy details.

Kolkata Ombudsman Centre
Case No. : 779/11/004/NL/01/2005-06
Shri Ratan Chatterjee
Vs
United India Insurance Co. Ltd.

Award Dated : 26.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim on the ground of pre-existing disease under Mediclaim Insurance Policy by invoking Exclusion Clause No.4.1 of the policy conditions.

The complainant filed a claim with the TPA of the Insurance Company namely M/s. ICAN Health Services Pvt. Ltd., for the treatment of Gastric Erosion in the case of his wife, Smt. Ranjusree Chatterjee at Kothari Medical Centre, Kolkata on 23.12.2004. The TPA repudiated the claim on the ground that the subject disease was pre-existing one. According to the TPA, the Insured was suffering from abdominal pain in the Epigastric Region, which they held to be a pre-dominant symptom for Gastric Erosion for the last 2 to 3 years. Against this view of the Insurance Company, a representation was sent by the complainant stating that there was an unintentional mistake in noting the case history of the patient by the attending physician of Kothari Medical Centre that the patient was suffering from 2 to 3 years. In support of his argument, the complainant submitted a certificate issued by the said hospital saying that through oversight the period of suffering of the patient was mentioned as 2 to 3 years, whereas it should be 2 to 3 months. Despite such representation, the TPA did not pay the claim. Hence, the complainant approached this forum for redressal of his grievance.

The Insurance Company along with their self-contained note sent an Investigation Report of Shri L. K. Bararia dt.26.12.2005. In his report, Shri Bararia stated that in the Discharge Summary and the treatment sheets, so obtained from the hospital, that the patient was suffering from the disease intermittently for the past 2 to 3 years and she had history of Toxoplasm and treated for H-pylori. The Insured had history of

constipation and recurrent vomiting for the last 10 years. Therefore, he held that the disease was pre-existing.

Further, the Insurance Company stated that the claim was lodged in the second year of the Mediclaim Policy. The Investigator, Shri L. K. Bararia investigated the internal document of the hospital after the complaint was lodged that there was a mistake in the certificate issued by Kothari Medical Centre.

Decision :

From the above documentary evidence, it was clear that the Investigator relied on the documents and records supplied by the hospital authority. In a hospitalisation benefit policy, the hospital records are basic and relevant for settlement of mediclaim. The hospital records revealed that the patient was having disease for the past 2 to 3 years and was having the history of vomiting for the last 10 years. Such records were obtained by the investigator from the hospital on 22.12.2005 i.e., more than 8 months after the rectification certificate issued by the Registrar and the attending doctor of the said hospital . Therefore, the certificate produced by the complainant was not based on the records available with the hospital authorities. As the repudiation on the ground of pre-existing disease was corroborated with documentary evidence, it was held that the claim could not be covered within the policy condition and the Insurer was justified in repudiating the claim on ground of pre-existing disease.

Kolkata Ombudsman Centre
Case No. : 658/11/003/NL/12/05-06
Smt. Jeeja Ghosh
Vs
National Insurance Company Ltd.

Award Dated : 27.12.2006

FACTS & SUBMISSIONS :

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

The complainant's mother, Smt. Jayasree Ghosh, was admitted to Repose Clinic & Research Centre Pvt. Ltd. on 26.08.2004. Subsequently, she underwent Pelvic Floor Repair (PFR) on 27.08.04. On a policy taken by the complainant from National Insurance Company for the period 27.04.04 to 26.04.05, a claim for Rs. 26,790.85 was lodged with the TPA of insurer M/s Genins India Ltd. for the treatment of Pelvic Floor Repair. The TPA repudiated the claim stating that the present condition was pre-existing one. According to them, such a condition of cystocele could not have developed within a period of 4-5 months requiring PFR. Hence, this petition has been filed before this forum for redressal of her grievance.

To obviate the difficulties in the evidence available on record, a hearing was fixed wherein only the representatives of the insurance attended and the complainant herself was absent.

During the hearing, the insurance company supported their TPA's repudiation on the strength of opinion received from Dr. V.K.Mittal, Chief Medical Officer of TPA itself. Dr. Mittal opined from the clinical cases that such a condition of cytocele could not have developed with a period of 4-5 months requiring Pelvic Floor Repair. Therefore, the disease was held as pre-existing.

For a letter issued by the Office of Insurance Ombudsman, the insurance company replied as under:

"It is very surprising when a doctor of Genins India quoted such comment we cannot ignore it. Genins India was appointed by our Higher Management. We are not medically

technical person. They have repudiated the claim as per the documents submitted by the insured. We are sorry to comment on this regard as they had taken the decision correctly."

Decision :

It was surprising that the insurance company defended the repudiation made by the TPA solely depending upon the statement given by Dr. V.K.Mittal, who was the doctor of the TPA. They did not make any effort to get hospital records nor did they make any effort to get a panel doctors opinion. The aforesaid reply only underlines the fact that no efforts were made by the insurance company to find out whether the disease was pre-existing or not.

On going through the evidence that are brought on record, it was found that the insurance company did not produce any other document evidencing insured's knowledge of the disease prior to taking the policy. Further, the prescription dated 10.07.04 of Dr. Siddhartha Chatterjee only recorded "difficulties in passing urine", but without any duration thereof. The discharge certificate of the hospital i.e., Repose Clinic & Research Centre also was silent about the history of the disease. Under these circumstances, it could be seen that there was no evidence pointing towards insured's knowledge about existence of the disease or its symptoms while proposing for insurance. The insurance authorities, who attended the hearing and produced the medical test reports at the time of proposal were also found to be clean, which suggested that patient was healthy at the time of granting of cover under the insurance policy. In view of the above, the insurance company had failed to adduce any evidence supporting pre-existence of disease. Hence, it was held that the repudiation made on the above ground was incorrect and accordingly, the insurance company were directed to settle the claim of Rs. 26,790.85 (Rupees Twenty six thousand seven hundred ninety and paisa eighty five) only.

Kolkata Ombudsman Centre
Case No. : 665/11/003/NL/12/05-06
Shri Achinta Kumar Bose
Vs
National Insurance Company Ltd.

Award Dated : 28.12.2006

FACTS & SUBMISSIONS :

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

The complainant stated that he was admitted to Good Hope Nursing Home on 25.06.2003 with an abdominal pain as per advice of Dr. Kalyan Bose for investigation and treatment. Further, he was diagnosed from 'pain abdomen – Occ. Severe anorexia, H/O Jaundice'. The patient was discharged on 26.06.03. He filed a claim for Rs. 44,583/- with the TPA M/s Family Health Plan Ltd. on 09.07.2004. The TPA repudiated the claim on the basis of panel doctor's opinion stating that the treatment could have been taken as an outpatient. The complainant represented to the insurance company against the TPA's decision, but the claim was not paid. Being aggrieved, the complainant has come before this forum for redressal of his grievances. The complainant further felt that the insurance company/their TPA were wrong in coming to a conclusion that the investigation and treatment could have been taken as an outpatient. According to him, he could not have avoided the attending doctor's advice. Therefore, he pleaded that the claim may be settled.

The insurance company, along with their self-contained note, forwarded medical observation of Dr. Tapas Kumar Chaudhuri, TPA's Medical Officer, which read as under:

"The patient was thoroughly investigated (CT/MRI of Brain, Eye testing, UGI Endoscopy, Colonoscopy, LFT, Blood Sugar, Lipid Profile, Urea, Creatinine, etc., Amylase and Lipase). He was not prescribed any medicine. Hence, the admission was primarily for the purpose of investigation".

Therefore, the claim was rejected under clause 4.10. The insurance company further stated that the complainant took an individual mediclaim policy on 14.06.2002 covering himself, his wife and son for sum insured of Rs. 50,000/-, Rs. 30,000/- and Rs.20,000/- respectively. The policy has been running with the same sum insured without any break. The insurance company repudiated the claim for the following reasons:

There was no mention of any specific disease for which the admission was taken; In the test reports, there was no diagnosis to find out whether the patient was suffering from any disease; No treatment was undertaken as per diagnosis while being admitted in the Nursing Home. Further, no medicine was administered for abdominal pain.

The insurance company felt that one day admission in the Nursing Home was for tests only and to take undue advantage from mediclaim insurance. According to them, the TPA rightly repudiated the claim as per policy exclusion 4.10, which reads as under:

"Charges incurred at Hospital or Nursing Home primarily for diagnostic, x-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home."

Decision :

It was clear that any mediclaim policy would respond to hospitalization claim only when the expenses are incidental to diagnosis and treatment of the positive existence of a disease. There was no mention in the discharge certificate of any treatment having been undertaken while the patient was in the Nursing Home. The discharge certificate indicated only the various tests conducted at the Nursing Home and the medicines prescribed on discharge.

From the various circumstances and facts of the case that the medical officer pertaining to the TPA's conclusion that admission was primarily for the purpose of investigation and tests and not for diagnosis and treatment of positive existence of disease seems to be correct. It was, therefore, felt that application of exclusion clause 4.10 was justified and accordingly, the same was upheld. The complaint was dismissed without any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 610/11/003/NL/11/05-06
Shri Sisir Kumar Bose
Vs
National Insurance Company Ltd.

Award Dated : 28.12.2006

FACTS & SUBMISSIONS :

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

The complainant's wife, Smt. Mira Bose (since deceased), was covered under two mediclaim policies. The first one was a Group Mediclaim policy issued by National Insurance Company under the Allahabad Bank's Scheme for a sum insured of Rs.

1,50,000/-. The second policy was an individual mediclaim policy directly taken from National Insurance Company for sum insured of Rs. 1,00,000/-. The complainant was admitted to Calcutta Medical Research Institute on 18.09.04 following complaints of persistent vomiting for 3 days. The patient was diagnosed as suffering from acute interstitial nephritis (? Acute or chronic) with renal failure, COPD with pneumonitis and acute exacerbation, etc. as per the discharge summary. The patient was discharged on 14.10.2004. A total expenditure of Rs. 3,90,704/- was incurred. Out of the said amount, Rs.2,20,139/- was realized from the bank and further amount of Rs. 1,50,000/- was realized from the insurance company under the Allahabad Bank Scheme. The complainant filed a claim under the individual mediclaim policy for the balance unrealized amount of Rs. 20,565/-. The TPA M/s Family Health Plan Ltd. repudiated the claim under the individual mediclaim policy on the ground of pre-existing disease by refusing cashless facility by their letter dated 15.11.2004 to the hospital. Despite further representation to the insurance company, the claim was not settled. Being aggrieved, the complainant approached this forum for disposal of his grievances.

According to the complainant, the policy taken separately from the insurance company was for the additional benefit. The discharge certificate and hospital records indicated that the patient was admitted on 18.09.04 for the treatment of persistent vomiting and after that complaint like gastritis, acute renal failure, etc. were detected. As a result, a different doctor took charge of the patient and therefore, the question of pre-existing disease does not arise.

The insurance company, in their self-contained note observed as under:

“The complainant Mr. Sisir Kumar Bose have a Group Mediclaim Policy No. 100600/46/03/8500494 for Rs. 1,50,000/- under Allahabad Bank’s scheme under Group Mediclaim Policy.

The said Group Mediclaim Policy of Allahabad Bank waives of clause 4.1, 4.2 and 4.3 respectively and under the said policy Family Health Plan Ltd. was settled four number of claims viz., (i) Acute intestinal Nephritis with Renal failure (ii) Chronic Obstructive Pulmonary disease with Pneumonitis and acute Exacerbation (iii) Mesanigioproliferative Glomerulonephritis and (iv) end stage of renal disease on COPD with septicaemia.

The complainant Mr. Bose has approached us for standard Mediclaim insurance vide proposal dated 11.02.2004 for sum insured Rs. 1,00,000/- each for his family i.e., 1st dependent Late Mira Bose (wife of Mr. Sisir Kumar Bose) and 2nd dependent Sanjib Kumar Bose (Son of Sisir Kumar Bose). In this connection we issued a policy no. 100800/48/03/8503499 against the said proposal. A photocopy of proposal form and policy copy are enclosed for your perusal.

Initially, Family Health Plan were in receipt of two authorization request for cashless treatment i.e., 30.11.2004 and 04.02.2005 respectively from Calcutta Medical Research Institute under the policy no. 100800/48/03/8503499 which was rejected by them under clause no. 4.1 since clause no. 4.1, 4.2 and 4.3 are covered under standard Mediclaim policy, based on the medical observation of Dr. Tapas Kumar Chaudhuri Medical Officer of Family Health Plan, a photo copy which is enclosed herewith for your perusal.

Finally, the Family Health Plan Ltd. has not received any claim file under policy no. 100800/48/03/8503499 from the member for reimbursement.

It will be not out of place to mention that the subject matter has been discussed in presence of representative of Family Health Plan Ltd. Complainant Mr. Bose along with our Sr. Divisional Manager at our office about the fate of the claim and we are able to

make him convince about the reason for the denial of cashless treatment and the existence of a disease prior to the commencement of the policy no. 100800/48/03/8503499 which is not covered under the standard Medical Policy."

Decision :

From the above facts, it was clear that the Group Mediclaim Policy issued under the Allahabad Bank scheme had waived the pre-existing disease as they were related to exclusion clause 4.1, 4.2 and 4.3. But the 'pre-existing disease' exclusion still stood applicable in the case of individual mediclaim policy. Each claim has to be dealt with relevant policy terms and the complainant cannot claim that both the policies should respond equally to his claim. The TPA of the insurance company has confirmed that they have settled four claims in respect of the patient for treatment of (i) acute intestinal nephritis with renal failure; (ii) COPD with pneumonitis and acute exacerbation; (iii) Mesangio-proliferative glomerulonephritis; (iv) end stage of renal disease on COPD with septicaemia, under the Group Mediclaim policy. So, it was clear that the insurance company were within the framework of norms and settled the claim and there was no harassment to the complainant.

From the medical opinion, it was clear that disease of such severity could not have taken place within seven months before the treatment. Therefore, it was clear that the disease was pre-existing. Keeping in view the individual mediclaim policy condition, the disease was pre-existing and it was felt that no further amount was payable to the complainant. Accordingly, the repudiation made by the insurance company was confirmed and the complaint was dismissed without any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 671/11/003/NL/12/05-06
Smt. Rita Mazumder
Vs
National Insurance Company Ltd.

Award Dated : 28.12.2006

FACTS & SUBMISSIONS :

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

FACTS & SUBMISSIONS :

The complainant Smt. Rita Mazumder had taken a mediclaim insurance policy issued by National Insurance Company for the period 22.08.04 to 21.08.05, being the renewal of earlier insurance policy expired on 21.08.2004. The complainant was hospitalized for treatment of abdominal pain and subsequent operation was done on 09.08.04 at Woodlands Medical Centre Ltd., Kolkata. She made a claim for the expenses incurred for hospitalization and operation to the TPA and complied with all the requirements. The TPA rejected her claim on the ground of pre-existing disease. The complainant clarified the position by giving a certificate given by the doctor, who treated her viz., Dr. (Mrs) Archana Basu, which indicated that there was no pre-existing disease. In spite of this certificate, the insurance company did not allow her claim and, therefore, being aggrieved she filed this complaint for necessary relief.

The above facts indicated the complainant's view with regard to her claim and she relied on the certificate given by the attending doctor Dr. (Mrs) Archana Basu.

The insurance company sent a self-contained note. Brief facts of the case were as under:

The period of the cover of the mediclaim policy was 22.08.2003 to 21.08.2004 for sum insured of Rs. 1,50,000/-.

At the time of taking the policy, the complainant did not declare the pre-existing disease or her illness for which she was hospitalized and treated during her previous hospitalization from 09.04.03 to 17.04.03 for abdominal hysterectomy with bilateral resection of chocolate cyst etc. done on 10.04.03 long before the inception of the policy mentioned above. According to the insurance company, there was gross misrepresentation in column no. 13(f) and 17 of the policy.

The claimant filed her claim for Rs. 1,17,205/- for two consecutive hospitalizations. First one at Paramount Nursing Home for the period 14.07.2004 to 21.07.2004 under Dr. Archana Basu where the treatment was entirely limited to a number of diagnostic procedure/investigations and was advised at the time of discharge that Laparotomy has to be carried out after biopsy report is available. The second hospitalization was at Woodlands Medical Centre Ltd. for the period 08.08.2004 to 20.08.2004 under the same doctor for performing the operation.

As per the discharge summary of the Woodland Medical Centre Ltd. the patient had pain in lower abdomen with feature of sub acute intestinal obstruction due to adhesion of coils of small intestine, sigmoid colon, urinary bladder and parts of rectum to a cystic swelling deep in the left side of pelvis. The Laparotomy at Woodlands Medical Centre Ltd. was done on 09.08.2004. The patient developed small gap in the lower lengitinal wound, which was repaired under L.A. on 18.08.2004.

The TPA noticed that the insured suffered similar adhesions in abdomen and underwent Laparotomy with total abdominal hysterectomy in April 2003, which was not mentioned in the proposal form and, therefore, treated as pre-existing disease and rejected the claim vide their letter dated 15.03.2005.

The TPA further confirmed that during the patient's hospitalization at Paramount Nursing Home, a CT Scan of whole abdomen was carried out by Quadra Medical Services Pvt. Ltd. under the advice of Dr. Archana Basu, the report of which clearly indicated that hypodense left adenexal SOL and in view of previous history of endometriosis, endometriosis cyst was the most likely possibility. Based on the above views, the TPA had repudiated the instant claim under the exclusion clause 4.1 of the policy issued to the insured.

Recommendation made by the TPA was confirmed by the insurance company in spite of the certificate given by Dr. Archana Basu. They based their opinion on the CT Scan report mentioned above and according to them the second hospitalization originated most likely from the earlier surgery in April'03.

Keeping in view the totality of nature of illness and the treatment undertaken, the insurance company opined that there was a breach of contract by way of not disclosing pre-existing ailment.

Decision :

On perusal of the proposal form submitted by the insurance company, it was established that there had been non-disclosure of material fact i.e., past illness history and also particulars of operation sustained by the insured before taking the mediclaim insurance. However, certificate of Dr. Archana Basu indicated that the development of cyst in the pelvic region, which was operated on 09.08.04, seemed to have appeared about a month ago before treatment of the patient was started. The feature of this particular abdominal pain seemed to be a sub acute intestinal obstruction i.e., adhesions of coils of small intestine, sigmoid colon, urinary bladder and parts of rectum which caused a cystic swelling deep in the left side of pelvic and according to the doctor it does have any bearing for previous operation of total abdominal hysterectomy which caused removal of ovaries on 10.04.03.

After considering the above facts and evidence, we were of the firm opinion that there was non-disclosure of material fact with regard to the operation that had been conducted on the patient before the cover of the policy started. However, according to the attending doctor's certificate, the claim for the operation done during the cover period was for the disease, which could not be connected with the previous operation of total abdominal hysterectomy. Accordingly, it was felt that to meet the ends of justice, the insurance company should refer the claim to a specialist doctor outside their panel in order to obtain his valued opinion whether the instant claim had any relation to the earlier illness not disclosed with the insurance company at the time of taking the policy, which consequently resulted in the dispute for admission of claim.

After receiving the opinion of the specialist doctor, the insurance company would settle the claim on merit.

Kolkata Ombudsman Centre
Case No. : 830/11/003/NL/02/05-06
Smt. Jayashree Mukherjee
Vs
National Insurance Company Ltd.

Award Dated : 28.12.2006

FACTS & SUBMISSIONS :

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

FACTS & SUBMISSIONS :

The complainant, Smt. Jayashree Mukherjee filed a claim for Rs. 87,946.55 for pre and post hospitalization expenses of her daughter covered under the policy taken from National Insurance Company for the period 03.09.2001 to 02.09.2002 only on 15.05.05 i.e., nearly 3 years after the actual hospitalization. The insurance company repudiated the claim as the claim was received late and after the expiry of the covered period. The representation against this claim was of no avail and hence this petition was filed seeking relief of Rs. 87946.55. The complainant further stated that for the same period of hospitalization, she had filed a claim of Rs. 1,49,468, which was repudiated by the insurance company on the ground of pre-existing nature of disease invoking clause 4.1 of the policy. She had sought redressal before the Hon'ble Ombudsman and the same was awarded to her in January 2005. Thereafter, she filed a claim for pre and post hospitalization, which was repudiated against which this petition was filed. According to her, there was no delay in submission because her main claim was subjudice.

In the self-contained note, the insurance company stated that the complainant had a mediclaim policy for self, her spouse and daughter since 2000. They also stated that they paid the award given by the Hon'ble Insurance Ombudsman for hospitalization in January 2005. The claim for pre and post hospitalization period after the award of Hon'ble Ombudsman for the same disease has been filed late i.e., nearly after 3 years of the hospitalization and, therefore, the insurance company felt that they repudiated the claim correctly.

Decision :

From the documents and evidence that have been brought on record, it was clear that the Hon'ble Ombudsman had passed an order for whatever claims that was sought for and there was no dispute for the same. It was surprising why the complainant did not add the pre and post hospitalization expenses at the time of original complaint, which was disposed of by the Hon'ble Ombudsman. If the documentation was not available at the time of original complaint, there was no bar for her to submit the documentation of

pre and post hospitalization before the Hon'ble Ombudsman so that he could have taken a decision with regard to those expenses also. Policy condition states that the claim should be filed within a reasonable time so that the insurance authorities have the right to verify such a claim. In this case, delay in the claim is nearly 3 years and as the Hon'ble Ombudsman has given a full and final decision with regard to the previous claim, it was felt that the present Ombudsman would not be able to interfere in the same case for further reimbursement of expenses. Accordingly, the complaint was dismissed without any relief to the complainant.

Kolkata Ombudsman Centre
Case No 886/11/002/NL/03/2005-06
Dr. Rupa G. Barwani
Vs
The New India Assurance Co. Ltd.

Award Dated : 05.01.07

Facts & Submissions :

This petition was filed by the complainant due to total repudiation of claim under Mediclaim Insurance Policy.

The complainant, Dr. Rupa G. Barwani was admitted in Nightingale Diagnostic Centre on 20.6.2003, as advised by Dr. Urmila Sen Chaudhuri to undergo some tests, which required hospitalisation. She was discharged on 21.6.2003. The bill for the hospitalisation expenditure was Rs.5,404/- covering 1 ½ days room-charges, pathology and radiology charges. The Insurance Company repudiated the claim citing policy condition no.2.3 of Mediclaim Policy according to which the expenses on hospitalisation for a period of less than 24 hours was not admissible. However, representation to the Insurance Company was of no avail. According to the complainant, the hospital authority charged for 1-½ days, as room charges and therefore, the claim for hospitalisation was for more than 24 hours. Therefore, the claim should be settled. Being aggrieved, she approached before this forum for redressal of her grievance.

According to the complaint, she was deprived of her rightful claim because she spent 50 minutes less time in the clinic. Had she stayed two complete days in the Centre, the Insurance Company could have settled the claim. Therefore, rejection was made on the part of the Insurance Company merely on technical ground, which could have been avoided. Moreover, the Nursing Home had charged 1-½ days as room-rent. The complainant submitted doctor's certificate in support of her claim.

The Insurance Company stated that the claim arose in the first year of Mediclaim Policy. The discharge certificate of the hospital indicated that the total duration of stay in the hospital was for 23 hours and 10 minutes. Therefore, the Insurance Company held that the policy condition No.2.3 on "Expenses on hospitalisation" for a minimum period of 24 hours were admissible and the complainant had not fulfilled that. The complainant argued that the certificate given by the hospital was erroneous. In response to a letter written by the Insurance Company in this regard, the hospital authority informed that the patient was admitted only for 23 hours and 10 minutes, as mentioned in the Discharge Certificate.

Decision :

Apart from the policy condition No.2.3, it was observed that the claim was only for investigation and some tests and not for any treatment. It was also observed that as per Clause No.4.10 of the Mediclaim Policy, such expenses were excluded from the

scope of the policy for reimbursement. The Clause No.4.10 of the Mediclaim Policy reads as under :-

" Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existences or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home".

Though, the Insurance Company did not cite the Clause No.4.10 and only they defended on repudiation on the ground of Clause No.2.3, this office also found that there was no merit in the argument of the complainant. Therefore, the repudiation made by the Insurance Company was upheld.

Kolkata Ombudsman Centre
Case No. : 847/14/002/NL/03/2005-06
Shri Probal Mukherjee
Vs
The New India Assurance

Award Dated : 05.01.07

Facts/Submissions :

This petition was filed by the complainant for delay in settlement of the claim under Mediclaim Insurance Policy.

Complainant, Shri Probal Mukherjee filed his claim for reimbursement of hospitalisation expenses. In the midnight of February 27-28, 2005, the complainant suffered severe chest pain and as per doctor's advice, he was admitted to B. M. Birla Heart Research Centre on 5.3.2005 and was discharged on 6.3.2005. He submitted his claim for hospitalisation expenditure amounting to Rs.20,518/- on 14.3.2005 to the TPA of the Insurance Company (NIA). The TPA asked for the details of hospitalisation in 1994 and even after compliance of their requirement, the complainant's claim was not settled by the Insurance Company. Hence, he filed the petition before this forum for redressal of his grievance.

According to the complainant, the documents required by the TPA, was submitted with regard to the treatment of his chest pain in 1994 and a certificate to this effect of Dr.Sanjoy Kumar Dey dt.27.8.05 was also furnished. As per the certificate, the doctor who attended the patient in June, 1994 mentioned that to the best of his knowledge the pain was due to reflection of OESOPHAGITIS and was not due to any cardiological cause.

The Insurance Company stated that the subject claim was dealt with by M/s. Medicare TPA Services (I) ltd., being the TPA of the Insurance Company. They obtained the opinion of their panel doctor, Dr. Priyadarshan Majumdar and according to him, the claim form indicated that the patient was hospitalised in June 1994 and inspite of requesting on several occasions, the complainant did not furnish the details of the same. He further stated that the patient was in the hospital for less than 24 hours and therefore, the claim could not be settled. The TPA in their letter dt.3.7.2006 also conveyed to the Insurance Company about such past treatment details of chest pain, which took place in 1994. Since there were no documents submitted by the complainant, the claim was repudiated on the basis of opinion given by the panel doctor of their TPA, Dr. Priyadarshan Majumdar.

Decision :

From the pathological report of B. M. Birla Heart Research Centre dt.5.3.2005, it was observed that the patient had past history of chest pain and he was hospitalised in

1994. The complainant did not deny such hospitalisation. The doctor's certificate dt.27.8.2005 of Dr. Sanjoy Kumar Dey did not speak about the hospitalisation treatment in 1994. Therefore, this office did not have such infrastructure to decide that the present ailment was not related to the past ailment in 1994. As this forum did not have such type of infrastructure, it was directed to the Insurance Company to appoint a specialist doctor outside their panel of doctors in order to determine the merit of the claim as per the policy provisions.

Kolkata Ombudsman Centre
Case No. : 834/14/003/NL/03/2005-06
Shri Ranen Roy Chowdhury
Vs
National Insurance Co. Ltd.

Award Dated : 05.01.07

Facts & Submissions :

This petition was filed by the complainant for delay in settlement of the claim under Mediclaim Insurance Policy.

The complainant, Shri Ranen Roy Chowdhury submitted a claim for Rs.9,454/- against his post hospitalisation treatment to the TPA of the Insurance Company on 24.5.2005. The claim was not settled for more than 6 months after filing the same. When contacted with the Insurance Company's TPA, M/s. Family Health Plan Ltd., they stated that they could not collect the relevant papers from the hospital where the patient had undergone hospitalisation treatment and therefore, the claim could not be settled. Being aggrieved by this delay, he approached this forum for redressal of his grievance.

The complainant was admitted to Belle View Clinic on 16.3.2005 for treatment of his accidental injury and he was discharged from the hospital on 20.3.2005. He filed this petition as the claim got delayed in settlement even after repeated representations with the Insurance Company.

The Insurance Company confirmed that the complainant was covered under a Mediclaim Policy for the period from 23.2.2001 to 22.2.2006 continuously without any break for a Sum Insured of Rs.50,000/-. He was allowed cashless facility during his stay at Belle View Clinic. Due to delay in settlement of the claim, the complainant sent his representation to the Insurance Company who took up the matter with their TPA, M/s. Family Health Plan Ltd. by requesting them to take necessary action in the aforesaid claim vide their letter dt.20.12.2005. In response to that letter, the TPA wrote a letter to the complainant on 14.2.2006 asking him to submit the medical report in regard to the injury sustained, from Belle View Clinic and police diary. Subsequently, the Insurance Company sent a reminder to the TPA on 8.2.2006 requesting them to take a prompt action in the subject claim.

Decision :

From the above discussion, it was clear that the cashless facility was given to the patient for hospitalisation treatment when it was found in order. Therefore, there should not be any restrictions in settling the post hospitalisation treatment, as per policy conditions. It was obvious that the documents required by the TPA, had already been provided by the nursing home authorities and on the basis of which they allowed cashless facility. In the light of the above, the TPA could have easily collected the required documents and should have settled the claim and need not had to wait for non-availability of the required documents. Therefore, this office directed the Insurance

Company to settle the claim for Rs.9,454/- along with interest at a rate which was 2% above the bank rate prevalent in the market during the period of delay.

Kolkata Ombudsman Centre
Case No. : 859/11/005/NL/03/2005-06
Shri Ashok Kumar Gupta
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 12.01.07

Facts & Submissions :

This petition was filed by the complainant for partial repudiation of the claim under Mediclaim Insurance Policy.

The complainant, Shri Ashok Kumar Gupta lodged his claim for hospitalisation to the Insurance Company for his cataract operation to the tune of Rs.20,570/- in the month of March, 2003. According to him, inspite of compliance of all the requirements, as sought for by the Insurance Company, the insurance company settled the claim for Rs.9,670/- only out of the total claim of Rs.20,570/- and a Loss Voucher to this effect was issued for the said amount without considering the bill for Rs.10,000/- given by M/s. Sunetra, as per Receipt No.7354. He did not accept the claim and represented against the decision of the Insurance Company stating why the total amount of claim should not be paid. There were no clarifications with regard to the deductions made by the Insurance Company and they disallowed the bill of M/s. Sunetra. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The complainant underwent cataract operation of his left eye on 28.1.2003 at Apollo Gleneagles Clinic, Kolkata. Dr. Amitava Biswas who was attached to M/s. Sunetra did the operation. As, M/s. Sunetra did not have such hospital facilities of their own and as they had an arrangement with Apollo Gleneagles Clinic, the operation was performed at Apollo Gleneagles Clinic. Subsequently, he submitted his claim for both the expenses incurred at Apollo Gleneagles Clinic as well as M/s. Sunetra for reimbursements. The bill amounting to Rs.10,000/- towards Doctor's fees and other charges of O.T. as per certificate issued by M/s. Sunetra was not entertained by the Insurance Company, on the ground that the operation was conducted at Apollo Gleneagles Clinic. According to him, the documents provided by M/s. Sunetra would be sufficient for the Insurance Company to settle the claim. A detail break up of the fees of the doctor, Dr. Amitava Biswas, who performed the operation and other O.T. charges issued by M/s. Sunetra vide receipt no.7354, had already been submitted for reimbursement.

The Insurance Company stated that while processing the claim, they found that a receipt of Rs.10,000/- including doctor's fees and other charges of O.T. issued by M/s. Sunetra and therefore, they wanted a receipt to be given by the attending doctor, Dr. Amitava Biswas. The complainant did not agree to submit such receipt and therefore, the Insurance Company was forced to settle the claim for Rs.9,670/-. After a lapse of about one year, the complainant once again pursued his claim with the Insurance Company and submitted a bifurcated receipt from M/s. Sunetra, which was not sufficient to settle the issue as M/s. Sunetra did not have any O. T. of their own. Therefore, the Insurance Company once again requested the complainant to submit a receipt either from Dr. Amitava Biswas who had done the operation or from Apollo Gleneagles Clinic where the operation was performed. The complainant did not comply with the same.

Decision :

In the instant case, the doctor who conducted the operation was attached to M/s. Sunetra, which was only the intermediary between the complainant and Apollo Gleneagles Clinic Hospital. Since the patient consulted Dr. Amitava Biswas, the Insurance Company could not reimburse the same person who did the operation at Apollo Gleneagles Clinic Hospital and therefore, any amount paid to M/s. Sunetra. As per the policy conditions they would pay all the expenses to the doctor operating the patient and to the hospital for services provided like hospitalisation and O. T. The Insurance Company correctly denied the payment made to M/s. Sunetra. The complainant could have got the reimbursement of all the expenditures, if he had obtained a receipt from the doctor who had done the operation. Therefore, this office did not agree with the arguments made by the complainant. It was found that the Insurance Company was not averse to payment of expenditure incurred on operation, if the complainant provided proper receipt. Hence, the complaint was disposed of without any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 853/11/002/NL/03/2005-06
Smt. Purbita Bayen
Vs
The New India Assurance Co. Ltd.

Award Dated : 12.01.07

Facts & Submissions :

This petition was filed by the complainant for non-granting of cashless facility under Mediclaim Insurance Policy by M/s. Medicare TPA Services (I) Pvt. Ltd., being the TPA of the New India Assurance Co. Ltd.

The complainant, Smt. Purbita Bayen filed her complaint for denial of cashless facility for her ‘Gall Stone’ operation by the Insurance Company under the Mediclaim Policy, which was incepted on 17.3.2005. The complainant consulted Dr. D. Banerjee and thereafter, consulted Dr. P. K. Nath Barbhuiya who advised her for operation. Finally, as per advice of Dr. Ramesh Agarwalla attached to Wockhard hospital, the patient got admitted for operation on 24.10.2005. As per the hospital estimate, the cost of the operation was Rs.38, 000/- and she requested for a cashless facility on her mediclaim policy, which was denied. Her representation to the Insurance Company also did not yield any result. Therefore, she approached this forum for rederessal of her grievance.

The complainant stated that due to non-availability of cashless facility under the policy, the patient could not take hospitalisation treatment benefit and the operation had to withhold due to paucity of funds leading to risk of life and mental agony. Therefore, she requested that this office should issue directions to the TPA of the Insurance Company to provide cashless facility.

The Insurance Company stated that the Insured along with spouse had taken a mediclaim policy w.e.f. 17.3.2005. According to the self-contained note, the request for cashless facility made by the complainant was forwarded to the TPA, M/s. Medicare TPA Services (I) Pvt. Ltd. of the Insurance Company who referred the matter to their panel doctor for opinion. In response, the panel doctor opined that multiple calculi couldn’t occur within a period of ‘six months’ from the date of inception of the policy. Therefore, they rejected the cashless facility. When the matter was referred to the Insurance Company, they took up the matter with their TPA vide letter dt.12.12.2005. After a lapse of considerable time, only the Insurance Company could ascertain the reason for refusal to grant cashless facility by the TPA. They further stated that they

did not receive any communication from the complainant regarding claim for hospitalisation treatment and operation that had been lodged with the TPA.

Decision :

From the above discussion, it was clear that the cashless facility for hospitalization treatment was provided to the Insured only when the illness was found to be in order under the policy conditions. On the other hand, it was understood that it would be otherwise admissible only when the illness for which the hospitalization treatment required fulfilled the policy conditions under Mediclaim policy. Therefore, prima-facie if the TPA or the Insurance Company came to a conclusion that the expenditure incurred for an ailment was not admissible under the policy, they did not give any cashless facility to the insured.

The complaint did not strictly come under any category of the prescribed Rules under the Redressal of Public Grievances Rules – 1998. Therefore, in the first instance the complaint should not have been admitted. As mentioned above, it was felt that cashless facility should be allowed only in the case if the subsequent claim was allowable under Mediclaim Insurance Policy. Hence, the complaint was disposed of accordingly.

Kolkata Ombudsman Centre
Case No. : 016/11//002/NL/04/2005-06
Shri Ray Singh Bothra
Vs
The New India Assurance Co. Ltd.

Award Dated : 12.01.07

Facts & Submissions :

This petition was filed by the complainant for repudiation of claim under Mediclaim Insurance Policy by the Insurance Company through their TPA, Medicare T.P.A. Services (I) Pvt. Ltd.

The complainant, Shri Ray Singh Bothra took a Mediclaim Policy jointly, consisting self, wife and son from the New India Assurance Co. Ltd., for the period 30.1.2004 to 29.1.2005. He was admitted to B. M. Birla Heart Research Centre, Kolkata on 19.5.2004 for a chest pain radiating to the back associated with mild shortness of breath. After tests and investigation were done at the hospital, he was discharged on 25.5.2004. The complainant filed a claim for Rs.49,924/- under the aforesaid policy. The Medicare TPA Services (I) Pvt. Ltd., being the TPA of the Insurance Company repudiated the claim on the ground that the expenses on hospitalisation were only incurred for the purpose of investigation and tests and no diagnosis was made which confirmed any ailment. They repudiated the claim as per policy condition no.4.10. The complainant represented against the decision of the Insurance Company and it was not considered favourably. Being aggrieved by such repudiation, the complainant approached this forum for redressal of his grievance.

The Insurance Company sent a self-contained note dt.15.6.2006 stating that that the Discharge Summary of B. M. Birla Heart Research Centre revealed that he was suffering from non-cardiac chest pain and his stay in the hospital was uneventful. The various documents were submitted to the TPA to settle the claim that in turn repudiated the claim, as tests and investigation indicated only normal parameters. The claim was repudiated by invoking Exclusion Clause No.4.10 of the policy conditions. The request for re-consideration was also sent to the TPA who once again confirmed repudiation on the same ground.

Decision :

The Discharge Certificate given by the hospital authorities indicated that the complainant was admitted to the hospital under the advice of Dr. Anil Mishra and the patient underwent various tests/ investigation and the chest pain was diagnosed as non-cardiac chest pain (Musculo Skeleton) and the complainant's stay in the hospital was uneventful. It was also found that the patient was directly admitted to the ICCU and parental antieschaemic was started. After stabilization, the patient was shifted to the Ward. ECG was found normal. From the policy conditions 4.10, it was clear that the above tests/investigation did not indicate any ailment for hospitalisation. The patient was simply discharged without diagnosing any disease or ailment whatsoever. This office did not find any merit in allowing the claim of the complainant for conducting such investigation and tests. No diagnosis was found with regard to any ailment or disease. Therefore, this office confirmed the repudiation held by the Insurance Company and the complaint was disposed of without giving any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 032/11/003/NL/4/2006-07
Smt. Chhanda Ghosh
Vs
National Insurance Co. Ltd.

Award Dated : 12.01.07

Facts & Submissions :

This petition was filed by the complainant against non-payment of expenses incurred for hospitalisation under Mediclaim Insurance Policy.

The complainant, Smt. Chhanda Ghosh was admitted to Kothari Medeical Centre on 23.06.2005 as per doctor's advice with complaints of sudden on-set of severe low back pain, pain in left knee and ankle with swelling, pain in wrists, thumbs, shoulders, small joints and shortness of breath etc. After receiving the medical treatment, she was discharged on 25.4.2005. The claim for Rs.12,228.80 was filed with TPA of the Insurance Company, M/s. Family Health Plan Limited (FHPL). The TPA repudiated the claim on the ground that the hospitalisation was for the purpose of investigation and evaluation of ailment only, which could have been done as 'outpatient' without being admitted to the hospital. The complainant argued that the Discharge Summary indicated admission to the hospital realising the seriousness of the illness and that she was diagnosed as suffering from Lumber Spondyolosis, early degenerative changes of left knee etc. Therefore, according to her, repudiation on the ground that investigations could have been done as 'outpatient' was not tenable. The complainant represented to the Insurance Company did not yield any result. Hence, she approached this forum for redressal of her grievance.

The Insurance Company stated that on admission to the hospital, a series of investigations were performed on the complaint in respect of Thyroid, Platelet, Urea acids, Blood Sugar, Pulmonary Function Test, C-reactive protein, Liver Function Test, so and so forth. The findings of all such investigations were within normal limits. However, X-ray showed loss of lumbar lordosis and early osteoarthritis, Lumbosacral Spine & Left Knee. The admission advice dt.23.6.2005 of Dr. S. Ghosh did not reveal any sign and symptom, which indicated any emergency. The said doctor's certificate dt.7.9.2005 explaining the reason for admission revealed that the patient was admitted for proper diagnosis through a series of investigations. Considering the above facts,

the claim was rejected under exclusion clause no.4.10 of the standard Mediclaim Policy.

Decision :

From the above discussions, the facts can be summarised as under:-

The hospital admission advice dated 23.06.2005 of Dr. Subed Ghosh of Kothari Medical Centre only recorded certain investigations and complaint of "Generalised body ache, joint pain, weakness." The Discharge Summary of the hospital also did not mention about any treatment having been given to the patient other than conservative management with pain killer tablets etc. The subsequent certificate dated 07.09.2005 of the attending doctor clearly recorded that to establish the exact cause and nature of involvement and level of degeneration; it was wise to get the patient admitted and to do the investigation.

It was clear that the hospitalisation was only for acute back pain, ankle swelling etc. The same could have been done as 'outpatient', as per doctor's advice. Therefore, the question of getting various tests done as inpatient did not arise. However, exclusion clause no. 4.10 was invoked as the results of various investigations revealed that there was no ailment to be treated. Therefore, the Insurance Company was correct in their decision in repudiating the claim. Hence, the complaint was disposed of without giving any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 860/11/004/NL/03/2005-06
Smt.Aparna Chatterjee
Vs
United India Insurance Co. Ltd.

Award Dated : 16.01.07

Facts & Submissions :

This petition was filed by the complainant against partial repudiation of claim under Mediclaim Insurance Policy.

The complainant's husband, Shri Anil Kumar Chatterjee was admitted to S.S.K.M. hospital during July, 2003 for treatment of heart and kidney ailment. A claim for Rs.1,16,000/- had been filed with the Insurance Company. However, the latter forwarded a loss voucher offering to settle the claim at Rs. 33,000/- only, even though the Sum Insured under the policy was Rs.1,50,000/-. According to the Insurance Company, the Sum Insured was increased from Rs.30,000/- to Rs.1,50,000/- w.e.f. 15.01.2002 and the Insured was known to be a patient of renal impairment, HTN etc. for a long time. The Insurance Company referred the kidney related claim paid by them to the patient in the year 2000 and the incremental Sum Insured of Rs.1,20,000/- was subjected to Exclusion Clause as being pre-existing disease. The representation against the partial repudiation with the Insurance Company was of no avail. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The complainant further stated that the cover was granted with enhanced Sum Insured without any exclusion, as per the policy. The policy schedule clearly written 'None' against entry, 'subject to the exclusion of'. According to the complainant, if they had known that pre-existing disease would be excluded, they would not have paid the extra premium required for incremental Sum Insured and therefore, according to the complainant, the exclusion clause 4.1 was not applicable. Therefore, the claim should be paid in full.

The Insurance Company stated that the claim was settled earlier when the insurance cover was Rs.30,000/-. From the facts stated above, as per the Insurance Company the incremental Sum Insured was referable to ailment of kidney related disease. Therefore, according to them, the incremental Sum Insured attracted the exclusion clause no.4.1 of the policy conditions. Further, they appointed M/s. Commercial Investigation Bureau for an investigation whether the insured was suffering from the said ailment or not. In turn, they obtained an opinion of the panel doctor, Dr. C. P. Sharma. According to the opinion of the panel doctor, the insured was suffering from kidney related disease, which was pre-existing at the time of enhancement of Sum Insured. Therefore, they settled the claim only for Rs.33,000/- being the maximum amount allowable under the policy along with 10% Cumulative Bonus.

Decision :

It was clear from the above discussions that the Insurance Company was aware of the fact that they settled the claim in respect of kidney related disease in the year 2000. They were also aware that such disease was existed at the time enhancement of the Sum Insured from Rs.30,000/- to Rs.1,50,000/-under the policy. Therefore, they should have excluded the known disease at the time of enhancement of Sum Insured under the policy and they did not specifically exclude the same, though they had an option available. Therefore, it would be reasonable to hold that the Insurance Company extended the cover for all diseases, which were otherwise covered under the original policy. Further, the contention of the Insurance Company that the pre-existing disease was not manifested in the policy documents issued to the Insured was not tenable. As the liability of the Insurer could be determined as per policy documents issued only, it was felt that the partial repudiation was not justified. The Insurance Company was directed to pay the rest of the amount after ascertaining the same from the documents submitted by the complainant.

Kolkata Ombudsman Centre
Case No. : 044/11/4/002/NL /04/2006-07
Shri Subodh Krishna Ray Chowdhury
Vs
The New India Assurance Co. Ltd.

Award Dated : 19.01.07

Facts & Submissions :

This petition was filed by the complainant for total repudiation of the claim under Mediclaim Insurance Policy issued by the New India Assurance Co. Ltd.

The complainant, Shri Subodh Krishna Ray Chowdhury took a Mediclaim Insurance Policy from the above Insurance Company for self and his wife, Smt. Usha Ray Chowdhury for a Sum Insured of Rs.80,000/- each with Cumulative Bonus. Smt. Ray Chowdhury was treated at Kothari Medical Centre on three occasions. A claim for Rs.25,324/- was submitted to Medicare TPA Services (I) Pvt. Ltd. on 12.7.2005 for reimbursement. The delay for reimbursement was informed to the Insurance Company. Later, the complainant received a letter addressed to the New India Assurance Co. Ltd. by their TPA saying the claim was not payable since the hospitalization was for less than 24 hours. According to the complainant, the claims for identical cases were reimbursed by the TPA. A further representation to the Insurance Company did not yield any result. Hence, this petition was filed for relief.

The complainant further stated that, the time of admission and the time of discharge, as mentioned in the Discharge Summary did not reflect the correct picture of the actual timings because the time of admission and the time of discharge varied because the

discharge from the hospital was made only after proper check up and after completing the other accounting formalities. He, however, stated that one of his claims, other than the claim in question was paid even though the duration of hospitalization was less than 24 hours and he was unable to understand why the claim for hospitalization of his wife was repudiated when the same was also less than 24 hours.

The Insurance Company stated that they took up the matter with their TPA for a number of times and they ultimately concluded that the claim was not payable as per terms and conditions of the policy. They also confirmed the decision taken by the TPA for repudiating the claim. The letter addressed by the TPA to this office indicated the following facts: -

Smt. Usha Ray Chowdhury was admitted to Kothari Medical Centre with complaint of Chronic Degenerative Changes on Right Knee, being Diabetic and Hypertensive patient under the treatment of Dr. M. S. Ghosh. Wherein she was given intra articular injection at her right knee and was discharged on 19.6.2005. She was further admitted on 25.6.2005 with the complaint of O.A. changes of knee joint under the same Doctor and she was given similar treatment and was discharged on the same day. Later, she was again admitted on 2.7.2005 with the complaint of O.A. on both joints under the same Doctor and she was discharged on 3.7.2005. The patient was requested to submit a certificate from the attending doctor to certify commencement of Osteo-Arthrites and also for the commencement of Diabetis and Hypertension. After a series of communications, the patient complied with some documents, as sought for by the Insurance Company. Finally, after deliberating with the Claim Insurance Department, opinion of panel doctor and going through the documents supplied, it was adjudicated by the Insurance Company that the patient was in the hospital for less than 24 hours in all the three cases and therefore, the claim was not admissible in terms of the policy conditions. The letter also indicated that they were aware that they have settled the claim of Shri Subodh Krishna Ray Chowdhury, while they repudiated the claim of Smt. Usha Ray Chowdhury by invoking Exclusion Clause No.2.3. In this case, according to them that there was less than 24 hours hospitalisation in all the three occasions. According to them, they have even suggested whether they could ignore small time gap to the Sr. Divisional Manager of the Insurance Company. The Sr. D. M. emphasized the condition under clause no.2.3 would be applicable only in certain cases where 24 hours time period is specifically relaxed. According to him, in this case, even if less than 24 hours hospitalization is specifically relaxed, the treatment was for chronic degenerative changes on the right knee which has not been specifically mentioned under Clause No.2.3 of the Mediclaim Policy. Accordingly, the above letter clearly gave the circumstances and reasons under which the claim of Smt. Usha Ray Chowdhury was repudiated.

Decision :

From the above discussions, it could be seen that the claim paid to Shri Subodh Krishna Ray Chowdhury could not be compared with the claim made to Smt. Usha Ray Chowdhury. The reasons given by the TPA of the Insurance Company that they genuinely tried to pay the claim, but due to the policy conditions with regard to the disease to be treated under Clause No.2.3, even if 24 hours time limit was relaxed, they could not settle the claim in favour of the complainant. Under the circumstances, this office did not have any alternative, but to confirm the action taken by the Insurance Company. Hence, the petition was disposed of accordingly without giving any relief to the complainant.

Kolkata Ombudsman Centre

Case No. : 179/11/002/NL/06/2006-07
Shri Parveen Kumar Gupta
Vs
The New India Assurance Co. Ltd.

Award Dated : 07.02.07

Facts & Submissions :

The complaint was regarding total repudiation of claim on the ground that Appendix was an excluded disease/peril under Mediclaim Insurance Policy.

The complainant stated that his son Master Sourav Gupta was covered under Mediclaim policy along with other members of the family and his cover was subject to an exclusion of "Appendix". The Insured was suffering from Intra abdominal adhesion and was treated on 22.01.2005 by Dr. Om Tantia at ILS Multispeciality Clinic, Salt Lake, Kolkata. A claim for Rs.53,707.43 was filed with the Insurer's TPA, M/s Medicare TPA Services (I) Pvt. Ltd. The said TPA sought clarification regarding cause of such extensive adhesion in the pelvis. In response, the complainant submitted a clarification of the attending physician, Dr. Tantia, stating that no definite cause was ascertainable for such extensive adhesion in the pelvis in this case. However, the TPA repudiated the claim on the ground that appendix was excluded from the scope of policy because of the history of appendectomy in 2002 and that the adhesion were due to appendectomy. In his representation to the insurance company, the complainant referred to the certificate given by Dr. Om Tantia and sought review of the rejection by TPA. However, despite such representation the insurance company did not settle the claim. Subsequently, the TPA reiterated the repudiation stating that Dr. Tantia had only opined "no definite cause to be ascertained in this case" and that no biopsy was done or any other investigation were carried out to ascertain the cause of adhesion. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking relief of Rs.52,500/-.

The insurance company stated that the Insured was covered with 5% C.B, subject to the exclusion of 'Appendix'. The required documents were submitted to TPA on 25.02.05 and, after scrutinizing, the TPA asked for the attending doctor's opinion regarding extensive adhesion on the pelvis. The Insured submitted Dr. Om Tantia's opinion dated 12.05.05 to TPA and the latter repudiated the claim. On receipt of the complainant's representations, the TPA once again confirmed their stand stating that Dr. Tantia had only opined "no definite cause to be ascertained in this case". The TPA also observed that no biopsy was done or no other investigation was carried out to ascertain the cause of adhesion. According to the TPA, as there was a definite history of previous abdominal surgery, the claim was not admissible.

Decision :

From the available evidences, it was found that the panel doctor of TPA sought the certificate given by the attending doctor about the cause of extensive adhesions in the pelvis. According to them, the certificate given by Dr.Tantia could not ascertain any definite cause. However, the repudiation made by the TPA on the advice of their panel doctors citing the reason that the claim was relatable to appendectomy of 2002 would not be correct, as there was no negative indication by the attending physician. In other words, the appendectomy operation done in 2002 held to be the reason for extensive adhesions in the pelvis could not be cited as part of 'Appendix', which was excluded as per the policy conditions.

Under the circumstances, this office upheld the decision of the Insurance Company in repudiating the claim.

Kolkata Ombudsman Centre
Case No. : 159/11/002/NL/06/2006-07
Shri Kallol Polley
Vs
The New India Assurance Co. Ltd.

Award Dated : 07.02.07

Facts & Submissions :

This complaint was regarding rejection of cashless treatment facility by the TPA of the Insurance Company, the New India Assurance Co. Ltd., under Mediclaim Insurance Policy.

The complainant stated that he was admitted to Kamineni Hospital, Hyderabad with complaints of intolerable neck and back pain with difficulty in walking, for 3 days. The complainant informed the hospital authorities about the cashless facility and he provided them with all the details. However, the complainant was informed by the hospital authorities that the Insurer's TPA, M/s Medicare TPA Services (I) Pvt. Ltd., refused to approve cashless facility. Left with no other alternative, the complainant had to borrow money and pay the bill of Rs.20,997.76. Subsequently, the complainant represented to the insurance company against the TPA's action and filing a claim for reimbursement of the hospitalisation expenses. However, despite representation for early settlement, the insurance company did not pay the claim. Being aggrieved the complainant approached this forum for redressal of his grievance seeking relief of Rs.20,997.76.

The insurance company stated that the admission to the hospital was required primarily for investigation of a suspected disease. A claim for such expenses was excluded as per clause 4.10 of the Mediclaim Insurance Policy. The Insurer further stated that on receipt of the complaint, the matter was immediately referred to their TPA and based on their response, the insurance company concluded that the decision for denial of cashless benefit was based on the documents/test reports of the entire treatment, and nothing was found as emergency requiring admission. Therefore, the decision taken by the TPA was within the scope of Mediclaim policy.

Decision :

From the available evidences, it could be seen that the Medical Officer, Dr. Tapas Kumar Chaudhuri, who belonged to TPA, indicated that the complainant was having a history of pain in the neck and dorsal spine since 2 months, which was localized, continuous non-radiating in nature. It was also found that there was no trauma, tingling, falls and fever. The complainant sought for cashless facility for the above complaint and there was no definite diagnosis at the time of admission and the patient was admitted primarily for investigation and evaluation of his suspected Dorsal Spine Lesion. As the admission was primarily for investigation and evaluation, cashless facility was not granted.

It was felt that the complaint was only in rejection of cashless facility, which should not have been admitted in the first instance under the Redressal of Public Grievances Rules 1998. This was only against refusal of grant of cashless facility and not any kind of repudiation of claim. However, in this particular case a cashless facility was denied because the admission to the hospital was only for primary investigation and evaluation of a suspected disease, which attracted exclusion clause 4.10 of the mediclaim policy. The Insurance Company could grant a cashless facility only when the ultimate claim considered to be payable under the policy conditions. Therefore, this office agreed with the decision taken by the insurance company for denying the cashless facility and it

was upheld. Hence, the complaint was disposed of without giving any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 153/11/002/NL/06/2006-07
Shri Nitish Chandra Saha
Vs
The New India Assurance Co. Ltd.

Award Dated : 07.02.07

Facts & Submissions :

This complaint was regarding total repudiation of claim on the ground of pre-existing disease under Mediclaim Insurance Policy.

The complainant stated that he contacted Hepatitis B disease requiring admission to Woodlands Medical Centre Limited from 09.11.2005 to 17.11.2005 within 4 months of inception of cover. A claim for Rs.48,915.50 was filed with the insurance company on 24.01.2006, along with necessary documents. The TPA of the insurance company, M/s Medicare TPA Services (I) Pvt. Ltd., asked for a certificate from the attending doctor as to whether the complainant had history of alcoholism and also called for a USG abdomen report. The consultant doctor, Dr. Satyabrata Pulai, certified that the complainant did not consume alcohol. Subsequently, the TPA repudiated the claim on the ground that the disease was pre-existing. The TPA alleged that the complainant was detected to have Hepatitis B related chronic liver disease, which could not have developed within a short period of 4 months. Representing against the repudiation, the complainant stated that at the time of claim he was fully fit but after a few months, he was detected to have Hepatitis B. According to the complainant, even the doctor told that this type of disease might grow at any time, unknown to the patient. Despite such representation, the insurance company did not settle the claim. Being aggrieved, the complainant approached this forum for redressal his grievance seeking relief of Rs.48,915.50.

Decision :

The insurance company primarily justified the grounds of repudiation made by their TPA, namely M/s. Medicare TPA Services India Private Limited. The reason given by the TPA was that the policy was only 4 months old and the patient was detected to have hepatitis B leading to chronic liver disease with portal hypertension. According to them, this disease could not develop within this very short time owing to the fact that there were evidences of Grade-II Esophageal Varices, portal hypertension Gastropathy and Splenomegaly. As these changes could not develop within 4 months of inception of the policy, the disease was held to be as pre-existing and according to the insurance company the claim was not payable.

On going through the prescription dt. 01.12.2005 given by Dr.Subrata Maitra of Woodlands Medical Centre Limited, it was found that it was a follow up case of “Malaena due to Esophageal Varices due to liver dysfunction –Hepatitis B + ve”. The doctor further stated in his certificate dt. 16.11.2005 that the disease was probably of some duration and the patient was not aware of it. It was detected only when the investigations were done for Esophageal Varix. Further, the Discharge Summary of Woodlands also did not indicate/disclose any duration with regard to the disease. The medical opinions furnished by the insurance company did not conclusively establish that the disease was pre-existing. Therefore, this office found that the decision of repudiation taken by the Insurance Company was not tenable, particularly when there was no direct evidence to establish that the disease was in existence prior to inception

of the policy. Considering all these aspects, this office directed the Insurance Company to pay the entire claim.

Kolkata Ombudsman Centre
Case No. : 131/11/005/NL/05/2006-07
Shri Aparajit Bardhan
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 07.02.07

Facts & Submissions :

This petition was filed by the complainant against repudiation of claim under Mediclaim Insurance Policy issued by the Oriental Insurance Co. Ltd. through their TPA, M/s. Heritage Health Services Pvt. Ltd.

The complainant stated that he took a Mediclaim Insurance Policy from the Oriental Insurance Co. Ltd. for the period 11.12.2004 to 10.12.2005 for self and his wife for sum assured of Rs.50,000/- and Rs.35,000/- respectively. He lodged a hospitalisation claim of Rs.13,829/- for treatment of his wife Smt. Anjana Bardhan who was suffering from the illness of 'Ovarian Cyst', to the Insurance Company's TPA, M/s. Heritage Health Services Pvt. Ltd., Kolkata on 09.08.2005. But his claim for the said treatment was repudiated by the Insurance Company as per their TPA's letter dt.28.09.2005 on the ground that the patient was admitted to the hospital for investigations and treatment of 'Primary Infertility' only which was not covered under the policy. On receipt of such repudiation letter, the complainant represented against the decision of the Insurance Company on 07.11.2005 and stated that his wife Smt. Anjana Bardhan was admitted in the Medical College Hospital, Kolkata primarily for 'Ovarian Cyst' and the hospital authority did wrongly mention 'Primary Infertility' in their Discharge Voucher. The complainant, therefore, requested for a review and asked for payment. But since the Insurance Company did not change their original decision of repudiation, the complainant had filed this complaint for relief of Rs.13,829/-.

The Insurance Company stated that on their further review of the claim based on the complainant's representation and on examining the matter thoroughly, they confirmed their earlier decision of repudiation done by the TPA on the ground that the patient was admitted for investigation and treatment of primary infertility only, which was not covered. Hence, the claim was repudiated, as the disease was an excluded peril under the Mediclaim Policy issued to the complainant.

Decision :

It was found from the hospital prescription dt.22.03.2005 that the patient was suffering from primary infertility. On further investigation it was found that the patient had 'Ovarian Cyst'. Therefore, the necessary medical management was provided to the patient in the hospital for the said illness. As per policy condition, it was known that the primary infertility was not covered under the scope of the Mediclaim Policy. However, the complainant lodged a claim for 'Ovarian Cyst', although that could be the reason for infertility. This office did not find that the Insurance Company had taken any such expert opinion with regard to the admissibility of the claim before repudiation. Therefore, this office directed the Insurance Company to appoint a specialist/expert doctor outside their panel of doctors to specifically find out whether the treatment or medical management given to 'Ovarian Cyst' could be connected with primary infertility or was it the proximate cause for the primary infertility. After getting the report from the specialist doctor, the Insurance Company should decide the claim on its merits.

Kolkata Ombudsman Centre
Case No. : 854/11/003/NL/03/05-06
Shri Sushil Kumar Ganeriwala
Vs
National Insurance Company Ltd

Award Dated : 12.02.07

Facts & Submissions :

This petition was filed by the complainant for reimbursement of hospitalization expenses under a mediclaim policy issued by National Insurance Company through Golden Multi Services Club of GTFS.

The complainant was admitted to the hospital on 28.10.2003 and was discharged on 03.11.2003 for operation in gall bladder for removal of stone. He intimated the hospitalization on 06.12.2003, there being a delay of 1 month 8 days and submitted the claim on 18.03.2004, the delay being 3 months 14 days. He stated that the delay was due to the fact that he was mentally depressed and he was the only male member in the family as his son was below 5 years. There was nobody to inform the insurance company with regard to the hospitalization. He also stated that the delay should be condoned for the above reasons, as the claim was repudiated by invoking policy condition 5.3 and 5.4. However, the insurance company did not agree with the representation and defended their repudiation decision.

The insurance company, in their self-contained note, stated that policy conditions 5.3 and 5.4 were violated, as there was a delay of 1 month 8 days in intimation and 3 months 14 days in filing the claim from the date of discharge from the hospital on 03.11.03. They repudiated the claim invoking policy conditions 5.3 and 5.4. They also felt that it was needless to scrutinize the papers, as the contract was null and void due to violation of policy conditions.

A hearing was fixed where both the parties attended. At the time of hearing, the complainant stated that the delay in intimation and submission of the claim papers was due to the fact that he was mentally depressed and there was no male member to do this job. The fitness certificate dated 15.09.04 submitted by him indicated that he was fit after the review on 10.11.03. He was informed that even if this date is considered, he should have intimated the hospitalization before 17.11.03, but the same was done on 06.12.03, there being a delay of 18 days. Similarly, he should have filed the claim on 10.12.03, while the claim was made on 18.03.04, being a delay of 3 months 7 days. He could not give any reason for explaining the delay.

On the other hand, the representatives of the insurance company reiterated the same reasons that have been cited in the self-contained note.

DECISION :

On going through the evidence and facts informed in the personal hearing, we found that there was no reason that could be a “reasonable cause” for delay in intimating and for delay in submission of the claim. We were unable to agree with the complainant that he was mentally depressed and there was no male member either to intimate or file the claim after 10.11.03. Under these circumstances, we regretted the explanation given for the delay in intimation and submission of the claim papers and confirmed the repudiation made by the insurance company. The petition was disposed of without giving any relief to the complainant.

Kolkata Ombudsman Centre
Case No. : 017/11/003/NL/04/2006-07

Miss Soma Paul
Vs
National Insurance Co. Ltd.

Award Dated : 14.02.07

Facts & Submissions :

This petition was filed by the complainant against repudiation of claim on the ground of pre-existing disease under Mediclaim Insurance Policy.

The complainant, Miss Soma Paul was initially covered under a Mediclaim Policy effective from 17.4.2003 to 16.4.2004. This has been subsequently renewed in time and is in force till date without a break. She was sick with high fever and was detected on 28.10.2004 that she was suffering from Malaria (positive P Vivax). After treatment for few days, she again developed temperature and breathlessness and under the advice of Dr. P. K. Roy, she was admitted to ICCU of Lansdowne Nursing Home on 30.10.2004. According to her, this developed into diabetes and renal failure. She submitted a claim through TPA of the Insurance Company, namely – M/s. Family Health Plan Ltd. The TPA repudiated the claim on the ground that the disease was pre-existing in nature. The representation made by her also did not yield any result. She further stated that malaria was originally treated and according to her the diabetes and hypertension were the results of such illness. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The Insurance Company stated that the patient, Miss Soma Paul submitted the documents, which included the treatment particulars given by Dr. P. Chakraborty of Lansdowne Nursing Home on 5.11.2004. In that document, she was suffering from Diabetes Mellitus for 5 years and Hypertension for 4 years. According to them, she was suffering from Diabetes Mellitus and Hypertension which she did not disclose the same in the proposal form before inception of the policy. Therefore, she suppressed the material facts. Another physician, Dr. T. Chowdhury, the Medical Officer of the TPA felt that Miss Soma Paul had history of Diabetes Mellitus and Hypertension and she was aware of the ailment before inception of the policy. Therefore, due to these reasons, the Insurance Company repudiated the claim.

Decision :

Before giving to any concrete and conclusive decision about the admissibility of the claim, this office had to face confusion and confrontation with the contrary evidences, though all the evidences were submitted by the complainant, one at the time of making the claim with the Insurance authorities, one at the time of making representation and one at the time of hearing. The complainant's main plea was that the doctor in the hospital should not have written the Diabetes Mellitus and Hypertension without consulting the patient or her near or dear as the documents were written in the ICCU itself. According to them, the patient started having Diabetes Mellitus and Hypertension after the malaria fever, which further led to renal failure.

Keeping in view of the arguments put forth by the complainant and the insurance company, this office felt necessary that an opportunity should be given to both the parties to justify their stand. Therefore, this office directed the insurance company to appoint a specialist/expert doctor outside their panel of doctors after consulting the complainant as acceptance of the same and then obtained a report with regard to the duration of Diabetes Mellitus and Hypertension. After that the Insurance Company was directed to review the decision of repudiation of claim, already made.

Kolkata Ombudsman Centre

Case No. : 787/11/005/NL/01/05-06
Smt. Usha Harlalka
Vs
The Oriental Insurance Company Ltd.

Award Dated : 15.02.07

Facts & Submissions:

This petition was filed by the complainant for repudiation of a mediclaim policy by M/s Heritage Health Services Pvt. Ltd., being the TPA of Oriental Insurance Company.

The complainant, Smt. Usha Harlalka, took a mediclaim policy for self and her husband Shri Shiv Prakash Harlalka from 17.07.2000 till 16.07.2004 and was renewed from 21.07.04 to 20.07.05. Shri Harlalka fell ill on 18.04.05 and as per advice of Dr. Sashi Kant Agarwal and Dr. Manoj Agarwal he was hospitalized during the period 06.05.05 to 11.05.05 for liver disease. The complainant filed a claim for Rs. 52,998.75 to the insurance company, but the TPA repudiated the claim on the ground of pre-existing disease invoking exclusion clause 4.1 of the mediclaim policy. Repeated representations to the insurance company were of no avail. Hence, she filed this petition for relief.

In his representation, the complainant submitted a certificate from the attending physician Dr. Manoj Agarwal dated 24.10.05, which is stated as under:

“Mr. Harlalka was admitted under my care with an acute hepatitis illness c jaundice and high ACT level and decompensation. He had a fatty liver on ultrasound but that was not the cause of the hepatitis. Many asymptomatic individual can have a USG finding of fatty liver.”

Therefore, the complainant was surprised how the disease was treated as pre-existing disease. According to her, the policy was not a new policy, but only a continuation of their earlier medical policy and, therefore, the question of renewal without declaration of any problem/disease did not arise. According to her, it could not be treated as first year policy and therefore, the disease could not be treated as pre-existing treating the present renewed policy as a new policy. She further submitted a certificate dated 01.12.2005 from Dr. Shashi Kant Agarwal, Consulting Physician, in which he categorically stated that the patient Shri S.P.Harlalka, to his knowledge, did not have any chronic illness.

The insurance company sent a self-contained note wherein they stated that the policy was renewed w.e.f. 21.07.04 while the previous cover was over on 17.07.04. The renewed policy was given without cumulative bonus and there was no declaration of any pre-existing disease. The insurance company referred to Dr. Indraneel Saha for his expert opinion, who certified that the patient was having a chronic liver disease and hence, there was a misrepresentation of fact with regard to ailment. Basing on this opinion, the insurance company repudiated the claim stating that the disease was pre-existing in respect of the renewed policy.

A hearing was fixed where both the parties attended. The representatives of the insurance company stated that the hepatitis suffered by the patient, who was one of the insured under the mediclaim policy taken by the complainant, was pre-existing in respect of the policy that was renewed after a lapse of 4 days. When they were asked how Hepatitis could be treated as pre-existing, they stated that the opinion given by Dr. Indraneel Saha was that the patient was having chronic liver disease and therefore, they defended the repudiation of the claim.

The complainant and the patient Shri S.P.Harlalka attended and he stated that they sent their person to pay the insurance premium on 17.07.04, which could not be

accepted by the company as their computers were down. Therefore, he sent the money 3 days later on 21.07.04, which was duly accepted and the policy was renewed from 21.07.04 without being asked about signing of proposal etc. Therefore, she was under the impression that the old policy was continuing without any break. Therefore, if the old policy is to be held to be continuous and the new policy is taken as 21.07.04, the insurance company have to prove, according to the complainant, that the patient was having any disease before 17.07.2000 when the policy was originally started.

DECISION :

There were two points to be decided, whether the break of 4 days had to be taken as a break in policy and if there was a break, then whether the Hepatitis occurred to patient on 06.05.05 could be stated to have existed between 18.07.04 and 20.07.04. According to us, if the break in policy has to be treated as per the norms of the insurance company as a break, then the policy that ran from 21.07.04 to 20.07.05 was a new policy. Therefore, any hospitalization claim for a disease has to be checked whether pre-existing or not as per policy condition 4.1. Since the infection was discovered on 06.05.05 i.e., about 10 months after the cover of the new policy, the insurance company should establish that the disease existed before that date. The disease in question, in this case was jaundice due to Hepatitis infection. We do not think that the patient was having the disease before 21.07.04 though there may be fat liver. We tend to agree with the opinion given by Dr. Manoj Agarwal and Dr. Shashi Kant Agarwal.

If the delay of 4 days is condoned due to the explanation given by the insured, then the insurance company have to produce evidence that the disease was pre-existing before 17.07.2000. Obviously, they do not have any evidence as per the records. Under these circumstances, we treated that the submissions made by the insurance authorities with regard to repudiation as untenable and accordingly, we allowed the claim of the insured. The insurance company were directed to pay the claim.

Kolkata Ombudsman Centre
Case No. : 039/14/004/NL/04/06-07
Shri Priyodarsan Sen
Vs
United India Insurance Company Ltd

Award Dated : 15.02.07

Facts & Submissions :

The complainant was this petition, as the insurance company did not settle a claim under the mediclaim policy for a long time.

The complainant was having a mediclaim policy from 2001 with United India Insurance Company Ltd. Before that period, he was having a mediclaim policy with The New India Assurance Company Ltd. He was suffering from sleep Apnea and he went to Vellore for treatment. The TPA of the company was intimated well in advance and they gave cashless facility for certain portion of treatment while they denied the same for angiography. The angiography report indicated surgical treatment required for removal of soft palate and tissues inside the mouth. Therefore, he was admitted in the hospital from 07.04.05 to 10.04.05. He sought a relief of Rs. 46,410.66 and reduced Rs. 18,000/- for cashless treatment and made a net claim of Rs. 28,410.66.

The insurance company sent a self-contained note wherein they stated that in spite of their best efforts, the TPA M/s Paramount Health Services Pvt. Ltd. did not provide cashless facility to the complainant for his treatment at Vellore as that ailment could be pre-existing and policy condition 4.1 might probably have to be invoked. The TPA was

advised to take up the claim papers put up by the insured and TPA, in turn, sent a letter to the insured on 06.06.06 requesting him to furnish discharge certificate, all investigations reports for the period of hospitalization and certificate of duration of ailment from the treating doctor. According to them, the insured did not send these documents and, therefore, the claim could not be processed by the insurance company.

HEARING :

A hearing was fixed. Representatives of the insurance company attended while the complainant did not attend. After hearing the representatives of the insurance company, we decided to pass an ex-parte order on merit in the absence of the complainant.

DECISION :

From the above discussion, it was clear that the insurance company had not yet repudiated the claim. They were not able to process the claim due to non-availability of certain documents as mentioned above. We, therefore, requested the insured to co-operate with the insurance authorities and submit all the required documents. At the same time, we requested the insurance authorities to get whatever documents that is required, if possible, without inconveniencing the insured and settle the claim as per policy conditions.

Kolkata Ombudsman Centre
Case No. : 021/11/004/NL/04/06-07
Shri Prakash Churiwala
Vs
United India Insurance Company Ltd.

Award Dated : 15.02.07

Facts & Submissions :

This petition has been filed by the complainant, Shri Prakash Churiwala, for repudiation of his claim under mediclaim policy by invoking the pre-existing clause by United India Insurance Company Ltd.

The complainant, Shri Prakash Churiwala, lodged a hospitalization claim under a mediclaim policy with United India Insurance Company Ltd., which was running for the period 26.06.01 to 25.06.02. In August'01, as he was suffering from sores in the mouth, he consulted a dentist Dr. Kallol Kumar Sinha, who treated him with medicine and injection. As the biopsy report gave a doubt of cancer, Dr. Sinha referred him to Dr. Chanchal Goswami, who asked him to go in for CT Scan. He was once again referred to another doctor Dr. Anil Poddar for surgery.

Later, in anxiety, the insured consulted senior Oncologist Dr. A.P.Majumdar, who wrote "Ulcer Right Cheek" detected on dental case – 1 month. The complainant then went to Bombay Hospital for further treatment. The insurance company repudiated his claim on the ground of pre-existing disease and treated the claim as closed. The complainant represented to the insurance company several times, which also did not yield any result.

In his representation, the complainant stated that the repudiation has been wrongly done as cancer was detected after the policy ran for more than 15 months. He did not agree with the opinion given by Dr. Anil Poddar that the patient was having complications since 2-3 years. According to the complainant, the policy was taken on 25.06.2000 and the data available with the department from the hospitals only indicated initial stage of cancer and, therefore, could not be pre-existing. According to

the complainant, the opinion of Dr. A.P.Majumdar was not accepted by the insurance authorities. Being aggrieved, he approached this forum and sought necessary relief.

The insurance company stated that Shri Prakash Churiwala took a mediclaim policy first time from 26.06.2000 and renewed for the period 26.06.2001 to 25.06.2002. He lodged a claim on 24.12.2001 for his treatment for the period 06.09.01 to 18.09.01 for oral cancer. According to them, on perusal of prescription of Dr. Anil Poddar and prescription of Dr. Kallol Kumar Sinha, it could be observed that the patient was having disease for last 2-3 years i.e., before 1998-99 as the date of inception was 26.06.2000. The insurance company, therefore, held the disease as pre-existing.

HEARING :

A hearing was fixed where both the parties attended. The insured Shri Prakash Churiwala could not attend and on his behalf, his father Shri Rambhagat Churiwala attended. He was duly allowed to represent his son. Shri Rambhagat Churiwala stated that his son went to the hospital for a tender pain. The medicine and injections given by the dentist could not cure the sores in the mouth and, therefore, he was referred to another doctor, who got the CT Scan done. The patient was asked to meet Dr. Anil Poddar, who after going through the documentation was of the opinion that the patient was likely to have oral cancer. Then he went to Dr. A.P.Majumdar, a renowned Oncologist, who clearly stated that there was cancerous “ulcer right cheek” and probably 1 month old and then the patient went to Bombay for treatment. According to him, Bombay Hospital records also stated that the disease was one month old. Therefore, according to him, the insurance company was not correct in repudiating the claim. He pleaded that his claim may be allowed.

The insurance authorities defended the repudiation action by stating that they based their decision on the prescription dated 04.09.01 of Dr. Anil Poddar, C/H of which stated “used to get some burning sensation in the (R) cheek off and on but feels an ulcer/mass in (R) cheek – 2-3 years”. He was suggested to get biopsy done. The insurance company also based their repudiation decision on the prescription dated 11.08.01 of Dr. Kallol Kumar Sinha, which stated “difficulty in opening of mouth, ulcer on right cheek since 1 ½ years gradually increasing”.

DECISION :

From the above discussion, we found that Dr. Kallol Kumar Sinha stated that ulcer existed for 1 ½ years while Dr. Anil Poddar stated that the patient had ulcer on right cheek since 2-3 years. Therefore, there was certain confusion with regard to the date of occurrence of the ulcer. The question when the ulcer has become cancerous had not been discussed by any of the doctors mentioned above. However, the Oncologist specialist stated that the ulcer had become cancerous about a month back and the disease was successfully treated. Now, the question arises whether the insured was in the knowledge of cancerous ulcer in the cheek at the time of taking the policy on 26.06.2000. If we take 1 ½ years as mentioned by Dr. K.K.Sinha as the duration of ulcer in the right cheek, it would be only the beginning of ulcer at the time of taking the proposal. Obviously, this could not have been mentioned in the proposal documents. Therefore, the insured was not in the knowledge that he was having a cancerous ulcer until he consulted Dr. A.P.Majumdar. Under these circumstances, we were unable to agree with the insurance company that cancerous ulcer has set in before the inception of the policy and the disease was pre-existing. The arguments given by the insurance company were not tenable as they have not produced any forceful evidence to indicate that the disease was pre-existing. Therefore, the insurance company were directed to pay the claim.

Kolkata Ombudsman Centre
Case No. : 891/11/004/NL/03/2005-06
Shri Santi Ranjan Bal
Vs
United India Insurance Co. Ltd.

Award Dated : 16.02.07

Facts/Submissions :

This petition was filed by the complainant against repudiation of claim by M/s. Family Health Plan Ltd., TPA of the Insurance Company under Mediclaim Insurance Policy issued by the United India Insurance Co. Ltd.

The complainant, Shri Shanti Ranjan Bal took a mediclaim policy no. 030200/48/04/03463 for the period 29.03.2005 to 28.03.2006, which was continuously renewed since 1999 without a break. He lodged a hospitalisation claim for Rs.26,198.13 on 27.09.2005 to the insurance company towards treatment of his heart disease. The TPA of the Insurance Company, namely M/s. Family Health Plan Limited repudiated the claim stating that the heart disease was pre-existing. The complainant filed a representation to the Insurance Company and they in turn have confirmed the repudiation made by the TPA. Hence, this petition has been filed seeking relief.

The complainant further stated in his representation as under: -

i) The claimant did not suffer any heart disease earlier and therefore question of pre-existing condition does not arise. As he already declared about such disease in his declaration made on 24.03.1999 at the time of taking insurance, the insurance company did not discover anything new and the policy was issued accepting such declarations without any exclusion;

ii) As per doctor's certificate of Dr. Suvro Banerjee, it was very specific that the Diabetes were well controlled and was not the reason for his admission to the hospital and the complainant was surprised how the TPA could get an idea that he was admitted to the hospital for management of the ailment (D/M) which is related to pre-existing condition;

iii) The angiography was done to determine the status of heart and not for the treatment of Diabetes. Although the complainant asked for the details particulars of the Medical Team of the TPA about their qualification and registration repeatedly but he was not provided with the same might be cause that the TPA repudiated the claim based on unsound medical opinion. He, therefore, believed that there was no bonafide reason in repudiation of the claim and his claim should be immediately settled without further delay.

The Insurance Company confirmed that the policy was in force since 26.03.1999. They relied on the medical report given by Dr. Tapas Kr. Choudhuri, the Medical Officer of the TPA, who stated that the patient was suffering from longstanding diabetes mellitus i.e. one of the most important pre-disposing factors for coronary artery disease. The onset of the disease i.e. diabetes mellitus was started way back in number of years before the inception of the policy. Therefore, the claim was repudiated invoking exclusion clause no.4.1 of the policy conditions.

Decision :

The Insurance Company repudiated the claim stating that the disease was pre-existing and the insured did not mention the same in his proposal form. But during the hearing, it was found that the Insured mentioned the details of past illness in his representation.

Therefore, it was clear from the hearing that the Insurance Company ought to have settled the claim after going into the details of the proposal form. Therefore, the Insurance Company was directed to settle the claim.

Kolkata Ombudsman Centre
Case No. : 845/11/002/NL/03/2005-0
Shri Sujit Datta Roy
Vs
The New India Assurance Co. Ltd.

Award Dated : 16.02.07

Facts/Submissions :

This petition was filed by the complainant, Shri Sujit Datta Roy against repudiation on the ground that the disease was pre-existing made by the Insurance Company.

The complainant was admitted to Holy Family Hospital, Mumbai twice in the month of March 2004 and was diagnosed to have suffered a stroke (CVA). He filed a claim with the insurance company for reimbursement of expenses of Rs.70,563/-. However, the Insurance Company namely, the New India Assurance Co. Ltd., turned down the claim on the ground of pre-existing disease and non-disclosure of the history of hypertension in the proposal form. On representation, the complainant submitted a certificate from Dr. J.P.Jadwani, a renowned cardiologist. According to the Doctor's certificate, one could not be sure as to whether the hypertension was responsible for his stroke i.e. CVA. Despite such representation, on review the insurance company stood by their earlier decision highlighting that as per Dr. Jadwani's certificate the complainant was having hypertension for many years and the complainant knew the same. The insurance company alleged suppression of fact and stated that as per their panel doctor, the hypertension had direct relation to the CVA. Being aggrieved, the complainant approached this forum for redressal of his grievances.

The policy incepted way back in 2001 and the claim was lodged in the 3rd year. The Insured did not declare in the proposal form about having been suffering from hypertension for last 25 years – which fact was evident from the hospital's Discharge Card and prescription of Dr. Sanjeev Khanna, - and specifically denied knowledge of any positive existence or presence of any ailment, sickness, etc., whereas the attending Cardiologist Dr. J.P.Jadwani clearly recorded that it was a known case of hypertension. Accordingly, the claim was repudiated on the ground of suppression of fact relating to hypertension existing prior to inception of policy.

Decision :

It was observed that the complainant placed his arguments based on the opinion given by the senior cardiologist, on the other hand the insurance authorities repudiated the claim based on the documents submitted by the patient himself. During the course of hearing, the complainant stated that the documents on which the Insurance Company passed their decision were not correct, as the history of hypertension was not properly stated. It was found that the facts are contradictory in nature. Therefore, it was decided that both the parties should get an opportunity to finally decide whether the disease was pre-existing one or not. Therefore, the Insurance Company was directed to appoint a specialized doctor outside their panel of doctors, which was also acceptable to the complainant to have his opinion on the subject claim. The specialist doctor's decision would be final and based on that expert opinion; the Insurance Company would take their final decision.

Kolkata Ombudsman Centre
Case No. : 111/11/003/NL/05/2006-07
Shri Banwari Lal Kanodia
Vs
National Insurance Company Ltd.

Award Dated : 05.03.07

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim for reimbursement of hospitalisation expenses under pre-existing clause of mediclaim insurance policy.

The complainant Shri Banawari Lal Kanodia stated that he had taken a mediclaim insurance policy with his wife from National Insurance Company Limited, Muzaffarpur Divisional Office on 01.01.2002 firstly, which was for the period from 01.01.2002 to 31.12.2002. Again it was renewed from 01.01.2003 to 31.12.2003. From 03.01.2004 he took the policy from Muzaffarpur Branch office for the subsequent period upto 02.01.2007.

In the first week of September 2004, the complainant felt some problem and consulted his family doctor, Dr. Amalendu Kumar on 06.09.2004 and after thorough examination the doctor advised him to go to Chennai or Mumbai for better check up and treatment because he found some problem with prostate gland. He accordingly visited Chennai and was also treated at Mumbai and he informed about the same to the insurance company vide his letter dated 30.09.2004. After treatment he returned to Muzaffarpur in January 2005 when he renewed his policy for further period from 03.01.2005 to 02.01.2006 and he submitted his claim with all cash memos, bills and relevant documents to the insurance company on 01.06.2005.

The complainant after waiting for a long time, had visited the office of the insurance company and asked about the settlement of his claim and the insurance company routinely replied that the claim papers had been collected by their TPA and they would settle the claim in time. On 08.11.2005 he received a letter from M/s Geninis India Ltd., the TPA of the insurance company about furnishing of check up documents which the complainant collected from the hospital and sent it to the TPA on 25.11.2005 through Speed Post. Again in February 2006 when he contacted M/s Genins over phone at their Kolkata, New Delhi and Patna Office, the complainant was told by the TPA that all claim papers were misplaced and due to this, his claim could not be settled and requested him to furnish the papers to them. He accordingly complied with their request and submitted all papers vide his letter dated 17.02.2006. Since the claim was not settled the complainant further wrote to the insurance company for the delay in settlement of the claim vide his letter dated 17.04.2006. After that the insurance company informed the complainant vide their letter dated 21.04.2006, received by the complainant on 26.04.2006, that his claim has been repudiated by their TPA as per their letter dated 06.03.2006 assuming the development of problem with the prostate gland since 2 to 3 years. But he stated that since he had never felt any difficulty before he has not filed any claim for such problem and he felt difficulty only in September 2004 when his family physician advised him to proceed to Chennai or Mumbai for further treatment. Although the complainant represented to the insurance company for settlement of his claim but it was of no avail and he therefore, submitted his complaint to this forum seeking relief of Rs. 2,56,315/-.

The insurance company stated that “as per Apollo Hospital Master Check up report dated 12.09.2004 supported by such mention in the Tata Memorial Hospital notes dated 19.10.2004 the disease Prostatomegaly was existent for 3 years i.e., w.e.f. 12.09.2001. The Insured had taken policy from us w.e.f. 03.01.2004 hence, the above disease comes under the exclusion of the policy as it was pre-existent at the time of insurance i.e., on 03.01.2004. Therefore, the TPA has very rightly repudiated the liability. In our view the complaint of the Insured is baseless fabricated and quite incorroborative of the requirement of the policy. Hence the same is not acceptable”.

HEARING :

A hearing was fixed where both the representative of the insurance company and the complainant attended.

The representative of the insurance company stated that they passed their repudiation on the certificate given by the hospital in which it was stated that the Insured was suffering from Prostatomegaly for more than 3 years and therefore it was deemed to be pre-existing. He was informed that Prostatomegaly as per the medical dictionary meaning is nothing but enlargement of the prostate gland. The representatives of the insurance company have stated that they only relied on documentation and the opinion of the doctor of TPA. They could not produce the opinion given by the doctor of the TPA.

DECISION :

On going through the evidence that has so far been put before us it was found that the Insured was suffering from enlargement of prostate gland and was not in the knowledge that the prostate gland became cancerous until investigation and tests were taken up. The mere enlargement of prostate gland could not be treated as pre-existing disease as the claim was for cancer in the prostate gland and its treatment later. Under these conditions we were unable to agree with the arguments of the insurance company with regard to repudiation of the claim. The reasons given by them were not tenable as the fact that prostate gland has become carcinogenic before the inception of the policy. Therefore, we allowed the claim and the insurance company were directed the claim should be paid as per the policy condition.

Kolkata Ombudsman Centre
Case No. : 127/11/003/NL/05/2006-07
Shri Nishat Haider
Vs
National Insurance Company Ltd.

Award Dated : 05.03.07

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim for reimbursement of hospitalisation expenses on the ground that the claim was for congenital external disease, which is excluded under the policy exclusion clause 4.8.

The petitioner Mr. Nishat Haider in his petition dated 11.05.2006 and further details submitted in the ‘P’ form dated 08.06.2006 stated that he had taken a mediclaim insurance policy from National Insurance Company Ltd., Ranchi Branch Office – I for a sum insured of Rs.40,000/- for the period 29.10.2004 to 28.10.2005.He was hospitalised at Kashyap Eye Hospital, Purulia Road, Ranchi on 08.07.2005 for treatment of “Excessive Conjunctival Folds LE” and operation for Conjunctival Fold recession and Excision LE was done under Dr. B.P.Kashyap. Thereafter he filed his claim to the insurance company. He received a letter dated 04.02.2006 from M/s

Genins India Limited, the TPA of the insurance company repudiating his claim under clause 4.8 of the mediclaim insurance policy and, the insurance company sent him a letter dated 14.02.2006 in confirmation of the repudiation done by their TPA. The complainant represented to the insurance company against such repudiation but was of no avail. He therefore, filed his complaint to this forum for a relief of full claimed amount incurred into operation and treatment of eye + Rs.50,000/- for continuous mental agony and harassment.

The insurance company in their self-contained note dated 12.07.2006 have stated that the complainant was issued a mediclaim policy No. 170201/48/04/8500000487 for the period 29.10.2004 to 28.10.2005 with coverage as per mediclaim policy excluding any pre-existing disease and general exceptions. On receipt of the claim documents the claim file was sent to their TPA M/s Genins India Limited on 23.08.2005 along with all supporting documents for further necessary action in the claim. The TPA repudiated the claim on the ground that it was a claim for congenital external disease/defect/ anomaly which is an exclusion under clause no. 4.8 of the policy and accordingly, they issued necessary repudiation letter to the complainant.

HEARING :

A hearing was held. Mr. Nishat Haider, the petitioner wrote a letter dated 10.02.2007 and requested therein that his arguments may be placed before the Hon'ble Insurance Ombudsman, an order can be passed as deemed fit. On the other hand the representative of the insurance company attended.

The case was heard and the representatives of the insurance company stated that their repudiation based on the ground that operation for Conjunctival Folds recession was congenital (external nature) and therefore is excluded as per the policy condition 4.8. However, he stated that a congenital disease of internal nature would attract provision in policy condition 4.3 in which it is stated that such disease is excluded for reimbursement of payment in the first year of the policy cover and in case, if such a disease is in the knowledge of the Insured it is not covered at all.

DECISION :

As per the Discharge Slip dated 11.07.2005 of Kashyap Eye Hospital, the complainant's disease was diagnosed as 'Excessive Conjunctival Folds LE'. In the opinion of the Insurers' TPA, M/s Genins India Limited, such condition was a congenital external anomaly and, hence, not covered under the mediclaim policy. However, the insurance company/ their TPA did not submit any medical opinion from a registered practitioner. We are, therefore, unable to take a decision, with regard to the repudiation made by the insurance company.

As per the submissions made by the insurance company, congenital disease, whether internal or external, are not payable during the first year. The loss has taken place under the first year of mediclaim policy. Under these circumstances, the insurance company shall not be liable only if the disease of Excessive Conjuntival Folds LE is a congenital anomaly. Accordingly, I direct the insurance company to refer the entire matter to a specialist doctor outside their panel for his opinion as to whether the disease is a congenital anomaly. The complainant may be allowed an opportunity to represent his views directly to the specialist doctor. Based on the opinion of the specialist doctor, the insurance company shall review the claim and convey their final decision to the complainant, along with a copy of opinion given by the specialist doctor. If the complainant is not satisfied with the final decision of the insurance company, he shall have the liberty to approach this forum again.

Kolkata Ombudsman Centre
Case No. : 094/11/004/NL/05/2006-07
Shri Tapash Kumar Sen
Vs
United India Insurance Co. Ltd.

Award Dated : 06.03.07

Facts/Submissions :

This petition was filed by the complainant against repudiation of a claim under Medi Guard Policy issued by the United India Insurance Co. Ltd.

The complainant, Shri Tapash Kumar Sen took Medi Guard Policy No.031901/48/05/00048 from United India Insurance Co. Ltd., Siliguri Branch, Hilcart Road, Siliguri for a sum insured of Rs.25,000/- for the period 07.04.2005 to 06.04.2006. All on a sudden on 11.05.2005 the complainant had an abdominal pain and consulted Dr. Debasish Paul and after investigation he was diagnosed for acute appendicitis and operated at Paramount Nursing Home, Siliguri on 15.05.2005. He submitted his hospitalisation claim for the said operation on 28.06.2005, but the Insurance Company repudiated his claim under clause 4.1 of the policy vide insurance company's letter dt.23.09.2005. On receipt of repudiation letter the complainant represented to the Insurance Company for payment of the claim. Even after such representation the Insurer did not change their original decision of repudiation and communicated the same to the complainant vide their letter dt.07.02.2006. Being aggrieved for such action of the Insurance Company and the complainant approached this office for relief amounting to Rs.19,799/-.

The Insurance Company defended their decision of repudiation with the following observations: -

i) The policy was incepted for the first time w. e. f. 07.04.2005 for self and his wife with sum insured of Rs.25,000/-;

ii) The insured was admitted to Paramount Hospital Pvt. Ltd. on 12.05.2005 for treatment of Acute Appendicitis and lodged the claim on 12.05.2005;

iii) Insured submitted documents/bills/cash memo in support of his claim to their Siliguri Branch Office on 28.06.2005;

iv) Insured, Shri Tapash Kumar Sen approached Shri V.Sarkar, M.S. On 12.05.2005 with c/o. pain lower abdomen since the last 4 days (overwriting 7 days without initial/signature of doctor V. Sarkar) diagnosed his disease-Acute Appendicitis. It is also observed from the USG of whole abdomen, prescribed/advised by Dr. Debashis Paul abdomen that the impression was Hepatomegaly with fatty infiltration (grade 1), Mild splenomegaly (no focal lesion), Small cortical simple cyst in right kidney, Appendicitis;

v) Insured did not submit prescription/advice for USG of whole abdomen underwent on 12.05.2005;

vi) Siliguri Branch Office wrote letter to the insured dated 31.08.2005 requesting him to submit prescription advising him for undergoing USG of whole abdomen and also for blood test for TC/DC. Insured submitted prescription of Dr. Debashis Paul dated 11.05.2005, which is complementary, and there was no advice for USG of whole abdomen. In the said prescription (Complementary) it is observed that the insured went to Dr.Debashis Paul on 11.5.2005 with pain in lower abdomen for 2 (two) days.

The insurance company also supported their repudiation decision with the opinion of panel doctor Dr. Bhadra.

Decision :

This office did not agree with the arguments put forth by the representatives of the Insurance Company, as the doctor himself corrected and certified the total number of days that the patient was having pain and accordingly, he corrected from 7 days to 4 days. However, even if, it considered the number of days as 7 days when the patient was having pain and the date of operation performed on 12.5.2005, then the pain would have started on 6.5.2005 and not on 5.5.2005. In that case, the operation, which was performed on 12.5.2005, would exactly fall on 30th day i. e. on 6.5.2005 of the policy cover. It was not understood why the Insurance Company would be too technical in one day's difference. Keeping in view of the above, it was felt that the claim was payable. Therefore, this office directed the Insurance Company to pay the claim, as per the policy conditions.

Kolkata Ombudsman Centre
Case No. : 265/11/005/NL/07/2006-07
Shri Sudhirendra Kumar Deb
Vs
The Oriental Insurance Company Ltd.

Award Dated : 09.03.07

Facts & Submissions :

This complaint is against total repudiation of claim as "pre-existing disease" under Mediclaim Insurance policy.

The complainant stated that he and his wife, Smt. Namita Deb, were covered under mediclaim policy from 13.11.97 without any break. Smt. Deb underwent an operation of gall bladder and appendix in 1990 and the same fact was declared in the proposal form. Subsequently, on 25.07.2005 the complainant's wife underwent a hernia operation at the ILS Multispeciality Clinic, Salt lake at the instance of doctor. Following discharge on 27.02.2005, a claim for Rs.10,977/- towards hospitalisation expenses was filed with the insurance company. But, their TPA – M/s Heritage Health Services Pvt. Ltd. – repudiated the claim. The TPA stated that incisional hernia was due to previous surgery of 1990, which took place prior to commencement of policy and the disease was pre-existing. The complainant represented arguing that the hernia developed after about 15 years of the surgery and about 8 years of the policy commencement. He contended that the hernia developed gradually and became visually pronounced, without any complaint, hardly a couple of years back. To obviate any possible strangulation and keeping in view the patient's age and obesity, the surgeon advised operation. The complainant further argued in his representation that the report on examination of the patient by a competent doctor submitted with the proposal as per the Insurers' stipulation, did not reveal any inception of hernia. So, according to the complainant, hernia did not exist before the commencement of the mediclaim policy. Despite representation, the insurance company/TPA did not pay the claim. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The insurance company stated that the complainant took the policy on 17.11.1997 and in the proposal form it was declared that Smt. Namita Deb had undergone Gall bladder operation on 12.11.1990. On receipt of the complainant's representation, the insurance company obtained an opinion from their panel doctor, Dr. S.Sen, who opined that the incisional hernia developed as a result of previous operation in 1990. Therefore, the

claim attracts exclusion clause 4.1, i.e., “pre-existing” disease. Under the circumstances, the TPA’s decision have been corroborated by the insurance company.

DECISION :

From the self-contained note it could be seen that the complainant took a policy from 17.11.1997 and had declared in the proposal form that his wife Smt. Namita Deb had undergone a gall bladder operation on 12.11.1990. This clearly indicated that the insurance company was having the knowledge that the Insured had undergone a gall bladder operation. Therefore, the question whether the hernia had also occurred before the inception of the policy. As per the definition of hernia in the Butterworths Medical Dictionary it is the protrusion of an internal organ through a defect in the wall of the anatomical cavity in which it lines, or into a subsidiary compartment of that cavity. Incisional hernia means hernia through an operation scar.

In this case definitely the operation took place before the inception of the policy. Therefore, there would be a scar. Occurrence of hernia can happen any time during the life time and existence of the scar inside the body. The evidence that has been quoted by the insurance company does not indicate when hernia occurred.

On going through the records it was revealed the complainant’s wife underwent a hernia operation on 25.07.2005 i.e., nearly after 15 years of gall bladder operation. This indicated that hernia happened after a long time but only whether it happened before the inception of the policy or not could not be ascertained.

Under these circumstances, it was held that the arguments and reasons given by the insurance company were not tenable. The insurance company were directed to pay the claim as per policy conditions.

Kolkata Ombudsman Centre
Case No. : 832/10/003/NL/03/2006-07
Shri Kumud Sharma
Vs
National Insurance Company Ltd.

Award Dated : 30.03.07

Facts & Submissions:

This was a petition received through e-mail from Shri Kumud Sharma alleging wrongful rejection of cashless treatment benefit by Insurers’ TPA, M/s Family Health Plan Limited, on the ground of pre-existing disease.

The complainant stated that his father, Shri Anil Sharma, was admitted to AMRI, Kolkata on 22.01.2007 for treatment of Brain Haemorrhage under Dr. Balaram Prasad. The patient was covered under mediclaim policy with cashless facility and, accordingly, cashless treatment was requested. Initially, on 29.01.2007, the Insurers’ TPA informed having sanctioned an amount of Rs. 35,000/- towards cashless treatment. However, after 2 days, on 01.02.2007, such facility was denied stating that the disease was pre-existing. Contesting the TPA’s contention, the complainant stated that Brain Haemorrhage could not be a pre-existing illness since the patient could not have survived with it for a long time without any treatment. The complainant has further stated that the operation was of emergency nature, which clearly indicated that it was a critical illness. The complainant filed his complaint to this office seeking direction to pay the hospital bills under cashless facility as he was not in a position to pay the same.

It was apparent that the decision to reject the cashless treatment was based on initial documents that gave a ‘prima-facie’ impression that the disease could be pre-existing.

In the absence of full documents, no comment was possible on the appropriateness of holding the disease as pre-existing. So, the complainant should file a formal claim on the insurance company along with all medical documents after the treatment. If the insurance company or their TPA repudiates the claim, the complainant may approach this forum after complying with the requirements of the Redressal of Public Grievances Rules, 1998.

In view of the above, we refrained from intervening in the matter.

Lucknow Ombudsman Centre
Case No. : G-21/11/04/06-07
Shri Shiv Mohan Tiwari
Vs.
United India Insurance Co. Ltd.

Award dated 25.01.2007

Shri Shiv Mohan Tiwari had lodged a complaint with Insurance Ombudsman for alleged unjustified offer of Rs.2760/- by United India Insurance Co. Ltd., DO-2, Lucknow in full and final settlement of claim as against the estimate of Rs.27814.61 submitted by the complainant. The complaint of the complainant was also that he had not received the policy document and was also not aware as how a small amount of Rs.2760/- was being offered in full and final settlement of the claim. The insurer on the direction of the Ombudsman submitted a copy of policy document no.080202/47/96/00000195 which had been issued covering tractor no.UP-33-E9175 belonging to the complainant for an IDV of Rs.2,40,000/-. Since the policy was issued subject to IMT endorsement nos.7, 21, 24, 36 & 40, the claim was settled as per the provisions of these IMT endorsements and the complainant was offered an amount of Rs.2760/- in full and final settlement of the claim. The Insurance Company submitted an account giving stating the amounts which were allowed and the amounts which were not allowed and the provisions under which they were not allowed. The company also submitted a detailed computation sheet as per which final liability of Rs.2860.80 was arrived at. Since the Insurance company had determined this liability as per terms and conditions of the policy and its endorsements which as per the insurer's despatch register had been sent to the complainant on 17.05.04 by courier, the amount of Rs.2860.80 was awarded in full and final settlement of the claim amount and the estimate submitted.

Lucknow Ombudsman Centre
Case No. : G-16/11/01/06-07
Shri Aman Arora
Vs
The Oriental Insurance Co. Ltd.

Award dated 31.01.2007

Shri Aman Arora had lodged a complaint with Insurance Ombudsman for alleged unjustified repudiation of claim by The Oriental Insurance Co. Ltd. under policy no.22104/48/2005/206 on his own life on the ground that the disease for which he had taken treatment from 01.04.05 to 12.04.05 was a pre-existing disease. The insurer in its support submitted the opinion of Dr. R.K. Kakkar, a general physician. On the other hand the complainant submitted the opinion of Dr. Nirmal Pandey, consultant Neurologist who opined that the life insured probably did not have the disease since childhood and that it was diagnosed in October 2004 only. In order to arrive at a proper conclusion the matter was referred to an independent Neuro Surgeon who opined that

the disease of Myasthenia Gravis can be an inherited disease but in this particular case does not appear to be so. Further it was also not possible to specify as whether the disease was existing prior to 1998. Since the insurer had not submitted any positive evidence to the effect that the disease was existing prior to 08.06.98, the benefit of doubt was given to the complainant and the letter of repudiation was set aside and the insurer was asked to process the claim as per rules and policy condition of the mediclaim policy, other than 4.1 & 4.8 of the policy.

Lucknow Ombudsman Centre
Case No. : G-22/11/02/06-07
Smt. Shakuntala Agarwal
Vs.
National Insurance Company Ltd.

Award dated 31.01.2007

Smt. Shakuntala Agarwal had lodged a complaint against alleged repudiation of claim under mediclaim policy taken by her husband Shri J.N. Agarwal on the ground that the treatment undertaken by him was in respect of diabetes, a pre-existing disease. The complainant submitted that although the disease was existing prior to the first insurance during March, 1992 but it was made specifically known to the insurer and that it had further settled few claims in between relating to the illness suffered on account of complications of diabetes. The insurer on the other hand submitted that all the pre-existing diseases whether known or not known were excluded and that the claims in between had been settled by them as at that time duration of the existence of the disease of diabetes was not known. The question whether all the diseases including known as well as unknown are excluded was left undecided but in the facts and circumstances of the case no interference was made with the decision of the Insurance and its TPA repudiating the present claim under the policy.

Mumbai Ombudsman Centre
Case No. :GI-058 of 2006-2007
Smt Sunita Udesh Mudras
V/s.
The New India Assurance Company Limited

Award Dated : 08.11.2006

Smt Sunita Udesh Mudras who was covered under the Group Mediclaim policy issued to the employees of Life Insurance Corporation of India was hospitalized at Holy Spirit Hospital on 07.06.05 to 11.06.05 for diagnostic hysteroscopy with laproscopic drainage of bilateral chocolate cyst. When she preferred a claim for the said hospitalisation, the Company repudiated the claim invoking clause 4.8 of the policy.After perusal of the records parties to the dispute were called for hearing on 1st November, 2006. The analysis of the case reveals that the Company rejected the claim on the basis of their panel doctors opinion that the primary cause for the surgery was infertility hence as per the exclusion clause 4.8 of the mediclaim policy the claim was not payable. It is clear from the reports that the Complainant consulted the first doctor for infertility but on diagnosis of cyst in the right ovary as per sonography report, hospitalisation was done to remove the cyst. Surgical intervention was required to remove the cyst to avoid malignancy and other future complications. Because the cyst was observed while taking the treatment of Infertility therefore, it falls under the purview of exclusion clause 4.8 is perhaps more technical approach to put the claim under exclusion clause. The opinion taken by the Insurer from Dr. Dastur and that of the Complainant is

different whereas the Dr. Susan Sodar, M.D.,D.G.O.had done the surgical procedure. No where it is disputed that the removal of the cyst falls outside the purview of the mediclaim policy. The objection is on the process–line of treatment.The cyst was observed in sonography which was done to diagnose the reasons for not conceiving. Removal of huge bilateral multiloculated chocolate cyst of 5x4 cm size was necessary to avoid any future complications in the body, though as a secondary benefit this may allow the spill in the ovary tube after the obstacles are removed and chances of conceiving will increase. However, the cyst is not the only reason for infertility there are many other reasons which are to be investigated in the present case otherwise the lady might have conceived by this time. All expenses for infertility treatment per-se may fall before the hospitalisation, but the expenses for removal of cyst will fall under surgical intervention. Therefore, the contention of the respondent to treat the entire expenses under infertility and denial of the same under clause 4.8 is not justified and hence such a decision of The New India Assurance Company Limited is intervened by the following order:

The claim of Smt Sunita Mudras for the expenses incurred by her for her hospitalisation at Holy Spirit Hospital on 07.06.05 to 11.06.05 for hysteroscopy with laproscopic drainage of bilateral chocolate cyst is allowed and the expenses incurred before the admission to the hospital on 07.06.05 are disallowed.

Mumbai Ombudsman Centre
Case No. :GI-53 of 2006-2007
Shri Raghu Rao
V/s.
National Insurance Company Limited

Award Dated : 10.11.2006

Shri Raghu Rao who was insured with National Insurance Company Limited was admitted to Bombay Hospital for Acute Coronary Syndrome Anteroseptal Ischemia (Unstable Angina) and after initial investigations he was again admitted to Jaslok hospital where PTCA with stenting was done to LLX. When a claim was preferred by Shri Raghu Rao for the said hospitalizations the M/s Medicare TPA Services (I) Pvt Ltd repudiated the claim stating that coronary artery disease was a complication of long standing Hypertension and hence the claim was not payable. After perusal of the records parties to the dispute were called for hearing. On scrutiny of the records it reveals that the TPA of the Company M/s Medicare Services Pvt. Ltd has repudiated the claim on the ground that the Concentric Left Ventricular Hypertrophy is a sign of long standing Hypertension which cannot develop over 1 year and 7 months of policy duration and therefore, the disease must be pre-existing. Obviously the moot point would be to establish first of all whether Shri Raghu Rao had Hypertension before taking the policy. It is true that Hypertension is indeed one of the major risk factor for Coronary artery diseases. It increases peripheral resistance resulting from vasoconstriction or narrowing of peripheral blood vessels and over a time it causes greater damage. But Unfortunately the concerned TPA nor the Company has established that Shri Raghu Rao was under continuous treatment for long period and only assuming that the concentric Left Ventricular Hypertrophy is a sign of long standing Hypertension does not establish that it was known to the claimant. In fact, documentary evidence is required in support of the decision while applying the exclusion clause, which they have failed in this case. In fact, the Insurer should ensure sound medical screening including pathological examinations like ECG, Blood sugar, urine etc while granting mediclaim polices to people at higher age so that claims are

not denied in presumption of pre-existing diseases. There is no attempt on our part to probe into the underwriting part but it is commented in view of the Complainant's statement that he had submitted ECG and Blood sugar report and the Company's denial for having not received and still they issued the policy and further renewed it. From all these notings and in the absence of any corroborative evidences procured to prove it otherwise, there is no reason to believe that the patient was already suffering from Hypertension since long time. The conclusion made by the TPA in their repudiation letter is unsubstantiated by facts and documents. Though the recent LVH might be contributed by hypertension, smoking and drinking habits but it has not been proved that Hypertension existed prior to the policy being taken in 2003. Therefore, the benefit of doubt goes in favour of the Complainant.

In the facts and circumstances the decision of the Company to reject the claim is not sustainable as TPA and the Company have failed to substantiate their viewpoints to justify pre-existence of illness as per clause 4.1.

Mumbai Ombudsman Centre
Case No. : GI-002 of 2006-2007
Smt Malini Rashmikant Desai
V/s
The New India Assurance Company Limited

Award Dated : 14.11.2006

Shri Rashmikant Desai alongwith his wife and daughter were covered under the Mediclaim policy issued by The New India Assurance Company Limited continuously since 1999 and had earned Cumulative Bonus. Smt Malini R Desai wife of Shri Rashmikant Desai was hospitalized for HTN c IHD c Anginal pain. When Shri Rashmikant Desai preferred a claim for the said hospitalisation M/s Raksha TPA repudiated the claim invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision of the Company, Smt Malini Desai represented to the Company and after reviewing the representation, the TPA reiterated their stand of repudiation. Hence being aggrieved, Smt Malini Desai approached this Forum seeking intervention of the Ombudsman for justice.

After perusal of the records parties to the dispute were called for hearing. The relevant records produced to this Forum have been scrutinized thoroughly. It would be evident from the various statements and hospital record that Smt Malini Desai had a problem of chest pain in the morning of 2.9.05 and again in the night before admission for which she was hospitalized at 22.24 hrs, which was necessary as per the Complainant. The issue before us is whether hospitalisation was absolutely necessary and whether hospitalisation was utilized for solely for diagnostic purpose. As per the Complainant it was necessary to avoid any risk at night due to chest pain and hence she was admitted to the hospital at late hours. But as per hospital records she did not have any critical emergency necessitating hospitalization. The emergency of admitting the patient at 22.24 hours was also examined. During the hospitalisation in the above case except for diagnostic tests no specific treatment other than what the patient was already taking with some alternative medicines including that of acidity was administered. Treatment was given conservatively and only investigations were carried out. The repudiation of the claim by the Company on the ground that no hospitalisation was required in this case is justified. Hence I do not feel the necessity to interfere with the decision of the Insurer to repudiate the claim as per clause 4.10 of the mediclaim policy.

Mumbai Ombudsman Centre

Case No. : GI-03 of 2006-07
Shri A.J. Dave
V/s.
The Oriental Insurance Co. Ltd.

Award Dated : 16.11.2006

Shri A.J. Dave and his family took a Mediclaim Policy from Oriental Insurance Company in the year 2005-06 bearing No.123105/48/05/2407 (15/1/2005 to 14/1/2006) for a SI of Rs. 2 lakhs for himself and his wife and Rs. 50,000/- each for his two children.

Shri A.J. Dave lodged a claim for Rs. 19,263/- in respect of his wife, Smt. Minaxi Dave's hospitalization at Sanjeevani Hospital on 25/12/2005 for pain in abdomen and vomiting. She was treated and discharged from the hospital at their own request on 27/12/2005. When Shri Dave preferred a claim under the policy, Oriental Insurance Company's TPA –Raksha, repudiated the claim under exclusion clause 4.10. The parties to the dispute were called for a personal hearing on 7th November, 2006.

Analysis of the case reveals that Smt. Dave consulted Dr. Suresh S. Rao , Gastrointestinal and General Surgeon of Sanjeevani Hospital on 21/12/2005 for pain in abdomen and vomiting. As per his prescription note, she had a history of similar complaint one year back. She also had a history of surgery for incisional hernia three years back and x-ray of abdomen taken on the same day revealed there was presence of multiple abnormal dilated small bowels loops having concerntina appearance in the central mid abdomen suggestive of dilated jejunal loops. She was advised urgent hospitalization. However, they preferred to take a second opinion of their family doctor, Dr. H.H. Mistry on 24/12/2005 and on his advice, Smt. Dave was admitted to Sanjeevani Hospital on 25/12/2005 under the care of Dr. Suresh S. Rao. The Discharge card and Indoor case papers mention history of intestinal obstruction in April 2004, history of pain in abdomen and vomiting on 21/12/2005 but at present asymptomatic. She was recently detected of Hypertension since 6 months and on medication, she was operated for incisional hernia in 2002. Her CT Scan of whole abdomen dated 25/12/2005 reveal infra umbilical /left para umbilical Spigelian hernia containing oedemaous jejunal loops and the impression was to rule out intermittent/sub-acute intestinal obstruction. She was treated with oral medications and she was discharged from the hospital on 27/12/2005 at her request.

The TPA's contention was that Smt. Dave got herself admitted on 25/12/2005 even though she was advised urgent hospitalization by Dr. Suresh Rao on 21/12/2005 and on admission she was asymptomatic. During her stay in the hospital she was given oral medication and no active treatment was given. Since there was no emergency for her to be hospitalized and only oral medication was given during her hospitalization and the line of treatment did not warrant hospitalization. So they repudiated the claim under exclusion clause 4.10. However, Shri Dave was not convinced with the reasons for the repudiation of his claim as he stated that his wife was hospitalized at the recommendation of Dr. Suresh Rao whom he had consulted when his wife had pain in abdomen and vomiting on 21st December, 2005 and also as recommended by his family doctor, Dr. H.H. Mistry. He also emphasized that as she felt better after the treatment and owing to his son's HSC examination, they decided to postpone the operation and she was discharged from the hospital on their request. The issue before us is whether hospitalization was absolutely necessary and whether hospitalization was utilized

solely for treatment of the positive existence or presence of any ailment or surgery for which confinement was required at Hospital.

On examination of the hospital papers it is noted that the patient was advised hospitalization on 21/12/2005 by Dr. Rao but the Complainant chose to consult his family doctor and only after CT Scan on 24/12/2005 the patient was admitted to the hospital on recommendation of his family doctor after a gap of four days i.e. on 25/12/2005. Moreover, the patient was asymptomatic on admission. The CT scan did reveal dilated jejunal loops which may be the reason for intestinal obstruction and required hospitalisation for clearing of obstruction under the supervision of an expert medical practitioner and it was on the advice of two Doctors. She was given oral medications only during hospitalization and since she felt better and had no complaints the following day she opted to get discharged from the hospital. This shows that hospitalisation was not utilized for treatment of the ailment diagnosed or surgery for which the confinement was required at hospital. The patient was discharged from the hospital on the request of the Complainant and not on the decision of the treating medical practitioner. From the above it is evident that though the hospitalization was necessary but it was not utilized for the treatment of the positive existence of the ailment for which confinement was required at Hospital.

In the facts and circumstances, I have no ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-233 of 2006-2007
Shri Nalin C.Jhaveri
V/s
The New India Assurance Co.Ltd.

Award Dated : 20.11.2006

Shri Nalin C.Jhaveri was covered under the mediclaim policy issued by the New India Assurance Company Ltd. alongwith his wife, Smt.Bhavna N.Jhaveri for Sum Insured of Rs.1,00,000/- each and for his children Rs.50,000/-. The policy was issued with an exclusion of Hernia for Shri Jhaveri and his wife for the period from 08.02.2002 to 07.02.2003. In the year 2004, Shri Jhaveri increased the SI to Rs.2lakhs for himself and his wife and for children Rs.1 lakh. The claim arose under the policy No.111400/48/03/15471 for the period 08.02.2004 to 07.02.2005. Smt. Bhavna N.Jhaveri was admitted in Sir Hurkisondas Nurrotumdas Hospital during the period from 16.12.2004 to 22.12.2004. The diagnosis made at the hospital was Uterine fibroids and minilaprotomy was performed on 17.12.2004. Shri Jhaveri availed cashless facility from TPA M/s TTK Healthcare which was denied initially by them and subsequently an amount of Rs.90,000/- was sanctioned to him. After hospitalisation, Shri Jhaveri claimed for the balance amount from the TPA and they settled the claim for Rs.20,000/-. Not satisfied with the settlement of the claim, Shri Jhaveri represented to the company, stating that the Company should settle the claim as the increased Sum Insured was Rs.2 lakhs. Not getting any favourable reply, Shri Jhaveri approached the Insurance Ombudsman on 12.07.2006 with a pray that the claim should be settled in full and final.

On examination of the policy, it has been observed that Shri Jhaveri increased the SI under the policy to Rs. 2 lakhs for himself and his wife during renewal on 8/2/2004 and in the same year on 16/12/2004, his wife was hospitalized for fibroid in the uterus for

which hysterectomy was advised and minilaparotomy was performed. In fact, from the underwriting point of view, all sum insured increases are fresh contracts to the extent of the amount increased and claims arising within a few months from the increase in SI are liable to be examined thoroughly. Hysterectomy falls under exclusion as per Clause 4.3. In the present case the ailment for which Smt. Jhaveri was hospitalized was Hysterectomy for uterus fibroids which is also known as Fibromyoma which falls under the above exclusion clause. For better understanding, we quote below what is Uterine Fibroid or Fibromyoma –

" A benign tumour of fibrous and muscular tissue, one or more of which may develop in the muscular wall of the uterus. Fibroids often cause pain and excessive menstrual bleeding and they may become extremely large. Some Fibroids can be removed surgically in other cases removal of the uterus (hysterectomy) may be necessary."(quoted from Oxford Concise Medical Dictionary, Indian Edition.)

In view of the above exclusions, the increased Sum Insured could not become available for the present claim for Hysterectomy and so the Company's action of restricting the said claim to the original Sum Insured of Rs. 1 lakh + 10% CB is justified. Since Rs.90,000/- was already sanctioned through cashless facility, the balance Sum Insured available under the Policy was only Rs. 20,000/-. Hence the Insured's reimbursement claim of Rs. 62,022/- could be only to the extent of Rs. 20,000/- owing to the exhaustion of original Sum Insured plus the accrued cumulative bonus of 10%. In view of the above, the company cannot be faulted for invoking Exclusion Clause 4.3 of policy. The decision of the company not to pay the increased Sum Insured does not call for any interference.

Mumbai Ombudsman Centre
Case No. : GI-06 of 2006-07
Shri Maganlal K. Tank
V/s.
The New India Assurance Co. Ltd.

Award Dated : 27.11.2006

Ms. Neha Maganlal Tank took a Mediclaim Policy covering herself and her parents on 27/1/1998. In the following year she excluded herself from the policy and the policy was renewed covering her father, Shri Maganlal Tank and her mother, Smt. Joyti Tank.. The Policy was being continuously renewed and on 22/11/2005 Smt. Jyoti M. Tank, was admitted to Ashwini Maternity and Surgical Hospital with complaints of lump in right breast for which modified radical mastectomy was performed. She was discharged on 28/11/2005. The claim preferred by her was repudiated by the Company's TPA – TTK Health Care for non-disclosure of material fact stating that there was a history of Colon Cancer surgery done in Aug. 1990 which was not disclosed at the time of inception of the first policy in 1998. Aggrieved by the decision of the TPA, Shri Tank visited the Insurance Office to check about the non-disclosure in the proposal form. However he was informed by the Incharge that all old records were not kept in the office and lying in the Godown. He was surprised as to how then the TPA was so sure that there was non-disclosure of facts without going through the proposal form. He represented the case for review , but not getting any favourable reply, he approached the Office of the Ombudsman for redressal of his grievance. Parties to the dispute were called for hearing on 9th November, 2006.

Analysis of the case reveals Smt. Jyoti Maganlal Tank was admitted to Ashwini Maternity & Surgical Hospital on 22/11/2005 for complaints of lump in Rt. Breast & Axilla. She was advised modified Radical Mastectomy and was treated and discharged

on 28/11/2005. She had earlier consulted Dr. Vimal Jain and as per his notings she was a known case of Carcinoma Transverse Colon, Dukes B2. A Radical Transverse Colectomy was done at H.N. Hospital in August, 1990. Lump in the right breast was noticed 15 days ago. She had no other medical illness and no family history of cancer. Prior to consulting Dr. Vimal Jain she had also consulted Dr. Manoj Kamdar on 15/11/2005 and the same history is mentioned in his notings also. She was advised mammography and FNAC of breast and Axilla . The TPA rejected the reimbursement of the claim based on the notings of history of Colectomy done in August 1990 and non-disclosure of the same. The Company was asked to furnish a copy of the proposal form filled in by the Insured during the hearing to which they replied that all their old records were destroyed. However, the representative of the Company suggested that they would obtain a second opinion from a specialist with regard to the linkage of cancer of colon with breast cancer for which they were asked to submit the report latest by 21st November, 2006. No such report was received by this time from the Company, however a letter was received requesting to extend the time limit. No such permission was granted looking to the pendency of the case. The decision of the Company to reject the claim on the grounds that Colon cancer surgery done in 1990 was not disclosed at the time of taking policy is not proved as they have failed to produce the proposal document and other medical reports at the time of taking the proposal. Shri Tank in his deposition at the hearing stated that he had disclosed in the proposal form for his wife that she had under gone hysterectomy and Colectomy at H.N. Hospital but does not exactly recollect the terminology used. He stated that when he visited the Divisional Office for Mediclaim Insurance, he was advised to consult Dr. Shekhar Shah for opinion with regard to granting of mediclaim cover for his wife. He submitted two blood reports of CBC and CEA which were examined by Dr. Shekhar Shah and was assured that Smt. Tank will be granted Mediclaim cover. However, since he felt that even after this the Company may raise some queries, he kept Dr. Mahesh B. Doshi's Consulting Surgeon's post operative notes of Colectomy done in 1990 ready, but in the meantime his wife was granted mediclaim cover by the Company. He has produced to this Forum the Xerox copy of two blood reports CBC, CEA and a report dated 21/1/1998 from Dr. Mahesh B. Doshi, M.S. (Bom.) a consulting surgeon describing the post operative position of Colectomy done for Colon Cancer. His statement can be well taken because on careful reading of the first policy issued by New India there is a remark "exclusion as shown overleaf" against the names of Shri and Smt. Tank and there is no such remarks against Miss. Neha Maganlal Tank. However, the exact details of the exclusions were not produced to this Forum either by the Company or by the Complainant. The complainant had submitted a certificate dated 13/12/2005 from Dr. Vimal J. Jain, M.S, M.N.A.M.S, Consulting Surgeon and Oncologist, stating that there was long interval between the two cancers i.e. more than 15 years and opined that the breast cancer should be considered a second primary cancer which has no connection with the first primary cancer of Colon. It has also been stated the current CEA level and ultrasound of abdomen showed normal findings and metastatic work up was negative. The Insurer have failed to produce any document that the material information about the first cancer was not disclosed at the time of taking the policy. However, the complainant produced the photocopy of the necessary medical reports from his possession which were dated back to 4/1/1998 and 21/1/1998, which she underwent for submission to the Insurer at the time of taking the policy but it looks that the policy was issued without calling for the medical reports. The Insurers also could not produce the details of "exclusion as shown overleaf" in the first policy taken in the year 27/1/1998 to 26/1/1999 and the subsequent policies renewed with exclusion

column “Nil”. In short, no evidence was produced for non-disclosure of pre-existing disease and there was no exclusion clause in the subsequent policies renewed as confirmed by the Insurer. The complainant maintained having disclosed about the colon cancer in the proposal form and had produced the photocopy of the medical examination reports underwent in 1998. Sum Insured was also reduced from 3 lakhs to Rs. 1.5 lakhs from 27/1/2000. All these facts takes to the conclusion that the Insurer has failed to prove their point. Whereas, the Insured could produce documents to prove that he had submitted what was required. Reduction in Sum Insured proves that he has no intention to take high Sum Insured to cover up cancer disease but reduced the sum insured looking to his financial condition. Under the circumstances, the complainant is entitled to the benefit of doubt and the claim amount under the above Mediclaim Policy.

Mumbai Ombudsman Centre
Case No. : GI- 16 of 2006-2007
Shri Deep Pal
Vs
New India Assurance Co. Ltd.

Award Dated : 05.12.2006

Shri Deep Pal along with his wife were covered under Mediclaim Policy No. issued by the New India Assurance Co. Ltd.. A claim was preferred under Policy No. 111200/48/05/81548 for the period 10/9/2005 to 9/9/2006. Smt. Pal was admitted to Beams Achiving Medical Excellence Hospital , Mumbai during the period 18/10/2005 to 20/10/2005 for Menorrhagia. When the claim for Rs. 1,08,282/- was submitted by Shri Deep Pal to M/s. TTK Healthcare Services (P) Limited, TPA, it was partially settled by them vide their letter dated 18/10/2005 for Rs. 82,682/- disallowing an amount of Rs. 25,600/- towards excess surgeons fees and anaesthetist’s fees . Not satisfied with the settlement, Shri Pal respresented to the TPA and also to the Company for review. His contention was that the BEAMS Hospital was a state of the art hospital and that the charges were spelt out to him at the time of consultation itself, so there was no question of inflated cost because of Mediclaim Policy. He further stated that Mediclaim Policy or TTK healthcare booklet does not mention of any restriction on charges payable. Since he did not receive any response from the Company, he opted for a complaint against the Company at this Forum vide his letter of 17/4/2006. The complaint was carefully examined and parties to the dispute were called for a personal hearing on 3rd November, 2006.

Shri Deep Pal appeared and deposed before the Ombudsman. He submitted that his wife was admitted to Beams Achiving Clinic for Hysterectomy and Laparoscopic surgery was done and got discharged within 2 days. He stated that there was no mention in the Mediclaim Policy about the restrictions on charges payable. His contention was the decision of the Company to deduct the surgeons fees and Anaesthesia charges is wrong. He demanded full settlement of the claim. He also informed that in a similar operation, the company disallowed a different amount.

The New India Assurance Co. Ltd. was represented by Shri N.V. Taralkar, Sr. Assistant and he was assisted by Dr. Dhiraj Gohil of M/s. TTK Healthcare. Shri Taralkar submitted that the deduction made in the surgeons fees and anaesthesia charges was according to the terms and conditions of the mediclaim policy and a copy of the policy document was placed before this Forum. On the question as to how you decide the

reasonableness of the charges, Dr. Dhiraj stated that they compare the charges made for same operation in other hospitals and decide the charges. He also stated that the claim is scrutinized by the panel of doctors of TPA who after verifying the particulars decide the reasonableness of the charges. The Company was asked to produce the statement of charges levied for Laparoscopy operation by different hospitals including Beams Hospital to make their decisions more objective. The report should be submitted latest by 14th November, 2006.

Analysis of the case reveals that Smt. Yardley Pal was admitted to BEAMS Hospital on 18/10/ 2005 for Mennorhagia since five months. The clinical history was Fibroid in the Uterus and she was advised Total Laparoscopic Hysterectomy. The time taken for the surgery was 40 minutes She was discharged on 20/10/2005 after proper treatment.

The TPA settled the claim for Rs. 82,682/- as against his claim of Rs. 1,08,282/- mainly on the ground that the surgeon's & anaesthetist's fees were quite high compared to even top-class hospitals in the city. In other words, the dispute is only on the quantum of claim sanctioned which could not satisfy the Insured. It is well known that the hospitals are having various fee chart for different surgeries and broadly they are classified into major and minor. But under major surgeries there would be some sophisticated and complicated surgeries which would demand more attention and precision in the surgery. Even considering that, the TPA and the Company felt that the charges were higher and therefore, they went by the policy conditions which governs the payment being reasonably and necessarily incurred. The Company was asked to submit the hospitalization papers along with the tariff chart for surgeries of different hospitals latest by 21st November, 2006. The TPA submitted the tariffs for surgeries of two reputed hospitals namely, Lilavati Hospital and Nanavati Hospital and the hospital papers were submitted on 1st December, 2006. On going through the Tariff Chart, it is observed that the fee for the surgery depends on multiple facts. The first is grade of surgery, which depends on the standard time for different surgery depending upon the number of hours taken to perform the surgery. The rates are enhanced if it is not planned, class occupied by the patient i.e. common,twin sharing, special and super deluxe.

It was clear from the discharge card that the time taken for surgery was only 40 minutes, and the type of room occupied was Deluxe. Hence taking an overall view of the rates quoted and the Hysterectomy and Laparoscopic surgery performed in this case, the charges allowed by the Insurer seems to be reasonable Therefore, this Forum does not feel appropriate to interfere with the decision taken by the Company in this case.

Mumbai Ombudsman Centre
Case No. : GI-031 of 2006-2007
Smt Manjulaben S Sheth
V/s
National Insurance Company Limited

Award Dated : 11.12.2006

Smt Manjulaben S Sheth who was covered under the mediclaim policy No.260400/48/04/8500000336 was hospitalized at Breach Candy Hospital for Right Total knee replacement. During the hospitalisation Smt Sheth had asked for cashless facility and the Third Party Administrator of the Company, M/s Paramount Health Services Pvt. Ltd sanctioned Rs. 1,50,000/-. After the discharge from the hospital,

when Smt Sheth preferred a claim for the balance amount of Rs. 1,50,000 the TPA repudiated the claim vide letter dated 25.10.2005 invoking clause 4.1 of the Mediclaim policy. Not satisfied with the decision of the Company, Smt Sheth represented to the Company /TPA for reconsideration of her claim and aggrieved by the decision Smt Manjulaben Sheth approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of her claim. Records of the case have been perused and the parties to the dispute were heard .The main dispute in this case is pre-existence of the ailment and overwriting of the duration of the ailment. On scrutiny of the discharge card of the Breach Candy Hospital the history states as pain in B/L knee joint (R) > (L) since 1 year with difficulty in walking and climbing stairs. No. H/o Injury no history of any chronic disease. The x-ray showed Osteoarthritis in both the knees. The remarks of the X-ray of Lumbo Sacral spine-AP and lateral was “Lumbar spine shows osteoporosis, scoliosis and degenerative changes.” It is a fact that osteoartherities leading to surgery takes a long time to develop into a big complication ultimately requiring surgery. However, the exact duration can vary with other health parameters which vary from case to case.The X-ray reports point out gross osteoartheretic changes of both knee joints. The type and grade of the disease is marked by progressive cartilage deterioration in synorial joints and vertebrae. The complication must have grown over a period, year by year requiring right knee replacement and that is why the Company called it as pre-existing.Since there is an attempt to overwrite the duration and make the statement which did not reflect the correct health status, may lead to a wrong conclusion. In view of this the benefit of doubt cannot be given to the Complainant. Thus rejection of the claim by the company appears to be in order. The Company has already paid the claim under the old policy with Cumulative Bonus.

In the facts and circumstances, I find the decision of the Company to restrict the claim to earlier policy and to treat the disease as pre-existing under the new policy for Sum Insured of Rs. 3 lacs taken in the year 2002 seems to be in order and this Forum has no valid ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. :GI-137 of 2006-2007
Shri Narendra G Goradia
V/s.
The New India Assurance Company Limited

Award Dated : 14.02.2007

The facts leading to the dispute are as follows:

Shri Narendra G Goradia took the mediclaim policy covering self and his wife for the first time on 21.4.2003 for Sum Insured of Rs.5,00,000 each. At the time of taking the policy the Company had taken medical examination and based on the medical report exclusion of Diabetes was put on the policy which was issued to Shri Goradia. Shri Goradia later on from 21.4.2004 shifted to Health Plus which was renewed for the period 21.4.2005 to 20.4.2006 under policy no. 111400/48/05/00082.

Shri Narendra Goradia was hospitalized at Bombay Hospital and Medical Research Centre from 21.9.2005 to 27.9.2005 for Left MI Stenosis. When Shri Goradia preferred a claim for the said hospitalisation, the Company referred the matter to their Medicolegal Consultant and based on their opinion repudiated the claim on the grounds of pre-existing ailment and non-disclosure of facts. Disagreed by the decision, Shri Goradia represented to the Divisional Manager of The New India Assurance Company Ltd and not receiving any favourable reply approached this Forum for justice.

After perusal of the records parties to the dispute were called for hearing on 18.1.2007. Shri Narendra G Goradia appeared and deposed before the Ombudsman. He submitted that he took the policy for the first time in April, 2003 and at that time he had undergone medical examinations at N.M. Medical college as per the rules of the New India. After the complete medical test the company issued the policy with exclusion of Diabetes which was accepted by him. He said initially he was covered under individual mediclaim policy and on the advice of his Agent he shifted to Health Plus because his agent advised him that in Health Plus exclusion of diabetes would be removed after 4 years of continuous policy. He submitted that the Company merely repudiated on the basis of pre-existing disease. He said the history noted in the Bombay Hospital that MRI was done 2 years back was not correct as he first consulted Dr. B.S.Singhal on 20.8.04 and he advised MRI and accordingly, MRI was done on 21.9.04. He said even the MRI report at that time showed no abnormality and no imaging findings of Parkinson. He said the doctor had prescribed Selegilene which is a mild tablet and was continued. He said the hospitalisation was for Brain infarct and there was no linkage between the infarct and the parkinson's disease. He further said that if for argument sake if the history is taken as 2 years from 24.9.2005 the date on which Bombay hospital gave the history on performing Angioplasty and stenting then also the history would go back to September, 2003 and the policy was taken in April, 2003. He submitted copies of the prescription dated 20.8.04 of Dr. B.S. Singhal and also MRI report dated 21.9.04.

The New India Assurance Co.Ltd. was represented by Shri R.K.Purohit, Assistant Manager. He submitted that the Insured took Individual Mediclaim policy in the month of April, 2003 and from April, 2004 the Insured shifted to Health Plus. He submitted that the policy was issued after medical examination and there was an exclusion of diabetes in the policy . He said the claim was rejected based on the history noted in Bombay hospital which stated MRI done 2 years ago showed 2 discrete small infarct in the deep white matter on the left side. He further stated the file was scrutinized by their Expert Medicolegal Consultancy and based on their opinion the claim was repudiated on the ground of pre-existing disease and non-disclosure of Parkinson's disease at the time of taking the policy.

The analysis of the claim would reveal that Shri Goradia was admitted to the Bombay hospital on 21.9.2005 with a history of right sided facial numbness since 2 days. The history noted was k/c/o/ DM and No H/o HTN/IHD. DSA (Digital Subtraction Angiography) was done on 22.9.05 and stenting of Left M1 done on 24.9.05 by Dr.Karepurkar.

The impression of Cerebral Angio states:

Total Occlusion of Right MCA. Excellent Retrograde flow into Right MCA from Cortical Branches of ACA and PCA. Mild Focal stenosis of Left CCA Bifurcation. Severe Focal stenosis of Left M1 at the Origin. Good Retrograde flow into Left MCA Via Cortical Branches of ACA and PCA Left VA Rudimentary.

The MR Angiography of the brain dated 21.9.2005 noted " the right middle cerebral artery is not visualized beyond a very short proximal M1 segment. Severe focal stenosis is also seen in the M1 segment of left middle cerebral artery however the distal artery and its branches are normal. Both anterior cerebrals arteries are normal." The conclusion was "Mild diffuse age related cerebral atrophy. Non visualization of right middle cerebral artery and focal stenosis in M1 segment of left middle cerebral artery".

The contention of the Company to repudiate the claim was based on the history noted in the Bombay hospital where it was stated that MRI done 2 years ago showed 2 discrete small infarct in the deep white matter on the left side. Let us examine the issue

As per the MRI done on 21.9.2004 by Dr. B.S.Singhal the clinical findings was Parkinsonism and details were as under:

“Routine fast sequences were acquired in multiple planes, to evaluate the brain. There is no evidence of atrophy of the mid brain, or thinning of the substantial nigra. There are no signal abnormalities identified in the basal ganglia. A small ill defined T2W hyperintense abnormality is seen in the head of the left caudate nucleus. Whether this represents a small ischemic lesion remains undetermined. There is no atrophy of the brain stem or cerebellar hemispheres.”

Remarks:

No abnormality involving the mid brain or basal ganglia

No imaging findings of Parkinson plus syndrome

Small T2W hyperintense lesion in the head of the left caudate nucleus possibly an ischemic lesion.”

It appears that the Company has based their repudiation on the basis on the above MRI findings. The entire facts and notings in the hospital cases papers reveal that the ailment was detected after taking the policy and the Company has also not submitted any documents to prove that the ailment was existing prior to the policy. The MRI done was on 21.9.2004 and the policy was taken on 21.4.2003. Dr. Anil P Karapurkar who was the Consulting and attending doctor in his certificate dated 15.2.2006 stated that MRI done 2 years ago was for diagnostic purpose and at that time he had no symptoms or signs of Cerebro-Vascular disease. The complainant has produced MRI Report which was actually done on 21.9.2004. Hence the rejection of the Company on the basis of pre-existing illness and non disclosure is not justified.

ORDER

The New India Assurance Company Ltd is directed to settle the claim of Shri Shri Narendra Goradia for the expenses incurred for his hospitalization at Bombay Hospital and Medical Research Centre from 21.9.2005 to 27.9.2005 for Left MI Stenosis. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. : GI-035 of 2006-2007
Shri Indravadan R Sheth
V/s
The Oriental Insurance Company Limited

Award Dated : 15.12.2006

Shri Indravadan R Sheth alongwith his wife and daughter was covered under mediclaim policy issued by The Oriental Insurance Company under Policy No.121100/48/05/4051 for the period 04.02.2005 to 03.02.2006 for Sum Insured of Rs. 50,000 each and the policy had also earned Cumulative Bonus. Shri Indravadan Sheth was hospitalized at Dr. Balabhai Nanavati Hospital from 08.12.2005 to 13.12.2005 for Anaemia ? due to GI Linear gastric Ulcers (Blood loss). When a claim was preferred for the said hospitalisation by Shri Indravadan R Sheth, the claim was repudiated by the TPAr of the Company, M/s Raksha TPA invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision he approached this Forum for redressal of his grievance. The records of the case have been perused and the parties to the dispute were called

for hearing.On scrutiny of the case it is revealed that Shri Indravadan Sheth was admitted to Dr. Balabhai Nanavati Hospital for Anaemia ? due to GI Linear gastric ulcers (Blood loss).The patient had a fall in bathroom and consulted his family doctor, he did not advise any hospitalisation and no prescription paper was produced by the Complainant as to how he was treated on the date of the accident but it appears there was no emergency for hospitalisation as felt by the doctor.From the above it is clear that immediately after the fall the doctor had not felt any emergency but looking to the complaint of the patient he advised the physician of the Nanavati Hospital for diagnosis. The patient was admitted to the hospital for number of tests like colonoscopy, whole body scan, MRI brain,2D Echo, sonograpy of abdomen and pelvis and many other tests for blood urine, stool, Liver, Lipid profile etc. were done.

From the analysis it is clear that the hospitalisation was done primarily for diagnosis. There was interference from the patient/ relative's side for conducting some tests. It may also be noted that many tests which were conducted were not directly related to the primary cause of the problem and therefore, the contention of the Company in repudiating the claim seems to be in order. However this hospitalisation had taken place as a consequence of a fall of the patient at home and its subsequent fear in the mind of the patient and the Insurer had also admitted the necessity for hospitalisation. Considering the circumstances which warranted hospitalisation, some of the investigations were necessary to evaluate the ailment. Therefore, this Forum takes a holistic view of the situation as a special case and allows 50% of the hospitalisation expenses on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI- 24 of 2006-2007
Smt. Dipti Kamdar
Vs
New India Assurance Co. Ltd.

Award Dated : 19.12.2006

Smt. Dipti Kamdar was insured under the Mediclaim Policy No. 111200/48/04/78725 of New India Assurance Co. Ltd. She was admitted to Shah Surgical Nursing for Vira Hepatitis on 7/6/2005 and discharged on 18/6/2005. She submitted her claim to the Company for Rs. 42,594/- on 12/1/2005 out of which the TPA – M/s. TTK Healthcare Services, settled the claim for Rs. 18,544/- only on 9/1/2006 which was accepted by the Insured. She represented to the TPA for the balance amount vide her letter dated 15/1/2005.

Smt. Dipti Kamdar was hospitalized at Shah Surgical Hospital & Maternity Home Pvt. Ltd. from 7/6/2005 to 18/6/2005 and the diagnosis was Viral Hepatitis. Since the treating doctor was an M.D. and DGO (Gynaecologist), the TPA wanted to probe into the matter and therefore discussed the matter with the Regl. Office of the Company. Based on the discussions, the TPA decided to partly settle the claim by paying a maximum of 5 days of hospitalization and treatment charges and because of this reason there was a delay in settlement of the claim. Thereafter, TPA and the Company examined and investigated other claims made by the policy holders who got admitted to the said hospital and based on the findings, the Company decided to de-panel the hospital for cashless as well as reimbursement claims and a circular was issued by New India, Regl. Office I.

In the light of the above let us examine the case of partial settlement. The Policy talks about reimbursement of " expenses necessarily and reasonably incurred" which is in the Preamble itself. It gives the authority to the Company to trim the costs as per

standard norms. In the history sheet it is mentioned that Smt. Kamdar's chief complaints were "Fever with Rigours, Nausea and Vomiting since 8 days and yellowish discoloration of sclera of eyes for which she was admitted. It is observed that Smt. Kamdar did not consult her family doctor, Dr. Rupal Shah (as mentioned in the policy) or any other doctor prior to hospitalization and chose to get admitted to the hospital directly without any recommendation from her family doctor. There are no notings of medicines taken or advised prior to hospitalisation. She had approached Dr. K.M. Shah directly and got admitted to the hospital. The medications received during hospitalization were more or less similar through out the hospitalization. The count of SGOT and SGPT done on first day of admission was 800.5 U/L and 700.4 U/L respectively which was very much on a higher side as the Normal Ranges were upto 40 U/L. However, no specialists were consulted. Urine Report done on 7/6/2005 shown Bile Salts and Bile Pigments Present (++) . The temperature recorded was 102 degree F. the first day and the following day 101 degree. Evening notes show patient having no fever and general condition fair. The next day the temperature has been recorded to be 100 degree . Evening temperature is normal and on 10/6/2005 Temperature of both morning and evening are normal. Thereafter the temperature fluctuated between 100 and 101 in the morning only and evening temperature recorded are all normal. Vomiting had subsided by the third day itself. Looking to the above notings, hospitalization for 12 days seems to be of a prolonged nature and not justified. In the Hospital Bill on account of 23 times visits by the doctor during 11 days of hospitalization @ Rs. 550 per visit has been charged. This amount seems to be on the higher side as it was not a case of criticality which required such frequent visits by a doctor and no other doctor was called for. Even if we take routine visit the charges seems to be on higher side.

The analysis of the complaint and the claim would reveal that the dispute about partial settlement is composed of two components (a) higher charges of doctor's fees and Room rent and (b) prolonged duration of admission at Hospital.

Mediclaim Policy is guided by the basic principles of Insurance viz. reimbursement of medical expenses "reasonably and necessarily incurred". The rationale for reduction in charges under doctor's visiting fees is based on comparable charges as per scale of fees in other hospital and the frequency of visit depends upon the nature of ailment and emergency of the case. The duration of stay at hospital is decided on the basis of the nature of diseases and the progress in the condition of the patient. As per the principles and practices any high cost need not be paid by the Insurer and after making some adjustments they may offer an amount and call upon the Insured to bear the balance in order to rule out any imbalance in total cost structures to maintain premium parity. Indeed it is difficult to appreciate and accept the logic as the Insured may have to bear it out of the pocket even after taking the Mediclaim policy which is unacceptable to him. However, taking an overall view of the entire situation as revealed in the hospital papers and the arguments put forward during the hearing this Forum takes 7 days as a reasonable period for hospitalization. Since the hospital was in the approved panel of the TPA any cut in the room charges (including nursing charges as they are not separately claimed) per day is not allowed. The Doctor's visit charges @ Rs.550 for seven days for one visit per day is allowed. There seems to be undue delay in settlement of the claims, therefore, Rs. 500 is awarded as for delayed settlement The individual claim should not be kept pending under the pretext of investigating the charges against the Hospitals for similar such cases.

Shri Keshav G. Kamat
V/s.
The Oriental Insurance Company Limited

Award Dated : 27.12.2006

Shri Keshav G Kamat was covered alongwith his family members under the Mediclaim policy issued by The Oriental Insurance Company Limited, D.O.121802. It is reported that when Shri Keshav Kamat took the policy for the first time in 1998 the Sum Insured was Rs. 1,00,000 which was increased to 5,00,000 in the year 2001. At the time of taking the policy Shri Keshav Kamat had disclosed in the proposal form that he was operated in 1978 for By-pass graft in leg. Shri Keshav Kamat was initially hospitalized at Dr.Kshirsagar's Nursing Home on 13.7.05 to 15.7.05 for Acute Pulmonary embolism with Diabetes Mellitus not on regular treatment and later on he was transferred to Wockhardt hospital on 15.7.2005 and after CT Pulmonary Angiography it was diagnosed as thrombus in left main pulm artery. When a claim was preferred for the said hospitalisation, the TPA of the Company, M/s Raksha TPA repudiated the claim. Not satisfied with the decision of the Company, Shri Keshav Kamat approached this Forum for intervention in the matter. After perusal of the records parties to the dispute were called for hearing.It is evident from the records and the submission of the Insured that he had by pass graft left lower limb in 1978 and later on underwent left great toe amputation. The Intensivisit notes of Wockhardt hospital stated he was k/c/o Diabetes Mellitus since 10 years and was diagnosed as pulmonary embolism.It is to be noted that Deep Vein Thrombosis occur in one or more veins in the deep venous system of the upper or lower extremities. In many cases the result of this is that "the thrombus will form and a portion of it will travel to the lung and create pulmonary embolism. It is a life threatening event when it occurs because the clot can occlude a vessel and stop the blood supply to an organ or a part. The thrombus, if detached, becomes an embolus and occludes a vessel at a distance from the original site; for example a clot in the leg may break off and cause a pulmonary embolus. This has exactly happened here in this case. Hence there is a linkage of Deep Vein Thrombosis and Pulmonary Embolism . Therefore, the same can be said to be pre-existing. Though the first Insurance Company had not mentioned it as an exclusion under the policy inspite of his disclosure, the policy bond issued in the year 5/2002 mentioned as "pre-existing diseases as declared". It is to be noted that as the main policy terms and condition excludes all the diseases pre-existing prior to the policy under exclusion clause 4.1, the Insured cannot take advantage that since he had disclosed in the proposal form and there was no exclusion on the face of the policy the claim should be paid.

In view of the facts and circumstances, the claim of Shri Keshav Kamat is not sustainable.

Mumbai Ombudsman Centre
Case No. : GI-040 2006-2007
Shri Rustom Dara Mehta
V/s
The New India Assurance Company Limited

Award Dated : 28.12.2006

Shri Rustom D Mehta who was covered under the Mediclaim policy issued by The New India Assurance Company Limited was hospitalized at Saifee Hospital from 12.2.2006 to 15.2.2006 for infected in growing Left toe nail and had undergone excision. When Shri Rustom D Mehta preferred a claim for the said hospitalisation to New India, the

Third Party Administrator of the Company M/s Raksha TPA repudiated the claim invoking clause 4.10 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Rustom D Mehta approached this Forum for justice.After perusal of the records parties to the dispute were called for hearing. On scrutiny of the records produced to this Forum, the discharge card and Indoor case papers of Saifee Hospital it was stated that the patient had undergone “nail excision with wedge excision” for infected in growing toe nail of Lt. foot under Local Anesthesia. It would be evident from the above that Shri Rustom D Mehta had some infection in the toe nail for which he consulted Dr. Rajan Powle and as per his advice he was admitted to Saifee hospital for removal of toe nail. The contention of Shri Mehta was that hospitalisation was necessary due to a by-pass surgery which he had undergone and the Company’s contention was that the treatment could be done on OPD basis. From the hospital records it is quite clear that there was no serious injury to the toe nail. The Insured had cut the nail too deep and there was pus formation and pain at the site. Looking to his past By pass surgery, the OPD was required in a good hospital where all facilities are available to tackle any emergency. This does not mean that for such a small procedure hospitalisation was warranted. In view of the above facts and circumstances, the repudiation of the claim was found in order.

Mumbai Ombudsman Centre
Case No. : GI-22 of 2006-07
Shri D.N. VORA
V/s.
Oriental Insurance Company Ltd.

Award Dated : 29.12.2006

Shri D.N. Vora was covered under Mediclaim Policy since 28/3/2001 for a SI of Rs. 2 lakhs. He renewed the policy without interruption and his present policy for the year 2005-2006 bearing No. 121600/48/05/3754 shows an accrued CB of 20%.

Shri Vora was admitted to Nityanand ICCU & Nursing Home on 8/8/2005 for chest pain discomfort, mild sweating . He was diagnosed to have Acute Anterior Septal Myocardial Infarction (ASMI) with DM. He was given initial treatment at Nityanand Nursing Home and he requested for transfer to Bombay Hospital for further management and therefore, he was immediately shifted to Bombay Hospital the same day. He was discharged on 14/8/2005 after satisfactory Angioplasty.

When he preferred a claim for Rs. 3,92,787/- in respect of both the hospitalizations, Raksha TPA rejected his claim under excl. 4.1 and non-disclosure of material fact. Their contention was that Shri Vora was suffering from diabetes since past 10 years which was not disclosed while proposing for insurance and the present ailment of IHD is a complication of Diabetes.

Let us examine the narration of history and clinical presentation from Nityanand ICCU & Nursing Home discharge card where he was admitted first on 8/8/2005. The diagnosis was clear that he had Acute Anterior Septal Myocardial Infarction (ASMI) with DM. He was given initial treatment and advised investigations. Shri Vora took discharge and got admitted the same day to Bombay Hospital and Medical Research Centre for further management and the history and examination findings in the discharge card were “case of chest pain, nausea, ASMI and h/o DM – 1 ½ yrs. However in their Indoor case papers it is clearly written that he was a k/c/o/ DM and on hypoglycemic drugs. It is also noted in Dr. Shishir’s Certificate that Shri Vora responded well to insulin therapy during his stay in Hospital. Also there are overwriting

at two places done in the duration of the h/o of DM, Type II to read as 1 ½ yrs. His Angiography revealed 70% mid LAD narrowing , left circumflex artery was large with proximal 80% narrowing He was given the option of Angioplasty and Bypass surgery and he chose the Angioplasty which was done in the same sitting on 11/8/2005.

Now let us examine since how long the Insured was covered under Mediclaim Policy. As per records submitted to this Forum, Shri Dhirajlal Vora and his wife and son were covered under Individual Mediclaim Policy from 28/3/2001 for SI of Rs. 2 lakhs each. However, during deposition at the hearing, a copy of the proposal form was submitted to this Fourm by the Company and on going through the same it was observed that there was a remark " transferred from Staff Mediclaim Policy" and the proposer has mentioned in the proposal form in the column of past insurance details that he was covered under Group Mediclaim Policy from 1/4/2000 to 31/3/2001. In his letter to the Regional Office dated 30/1/2006 Shri Vora has stated that he was a Development Officer, and was covered under Staff Mediclaim Policy till his retirement in 1998 and never claimed under Staff Mediclaim Policy. Thereafter he took an Individual Mediclaim Policy since 28/3/2001 which was in continuation of Staff Mediclaim Policy for an increased SI of Rs. 2 lakhs covering his wife and son. He renewed the policy without interruption and his present policy for the year 2005-06 shows an accrued CB of 20%. To confirm the continuity of the policy, the Company was asked to submit the details of the Staff Mediclaim Policy. There was no response from Oriental Insurance. Thereafter, there has been a few telephone calls by the department, to the Divisional Office in connection with the details, latest one being on 7/12/2006, but they have requested to give them a day or two more to locate the records since it was an old record. It was decided to grant them some time and they have sent us the details vide their letter dated 13/12/2006 received by us through fax on 14/12/2006.

The details of Staff Mediclaim Policy was received by this Forum on 14/12/2006 and their further clarification on the subject was received by us on 22/12/2006 and as per the Company's letter dated 13/12/2006, " Shri Vora was eligible for a SI of Rs. 70,000/- however on payment of extra premium he has opted for higher SI of Rs. 1,00,000/- in 1997. Again in 1998 he enhanced the S.I. to Rs. 3 lakhs and took a policy separately though there is a facility available to them even after retirement."

The letter and clarification given by the Company are contradictory as far as continuity of the policy is concerned. However, if we go by the proposal form filled up by the Insured when he took the Individual Mediclaim Policy, it is clear that he was earlier covered under the Staff Mediclaim Policy till 31/3/2001. He submitted a fresh proposal on 27/3/2001 for Individual Mediclaim Policy covering himself and his family for Rs. 2 lakhs each which is corroborated by the remarks on the proposal form by the Company "transferred from Staff Mediclaim Policy", while accepting the proposal. The fact that the Company did not insist for any pre-insurance medical reports for a person taking a policy at the age of 62 yrs. also makes this Forum presume that it might be because of the continuity from Staff Mediclaim Policy. Hence the continuity of the policy is proved. As regards history of DM, the Forum needed more details as there was an overwriting in the duration of the history of DM in the hospital papers because of which the exact health status of Shri Vora could not be known. Shri Vora submitted a random sample blood sugar report of 23/4/2003 to this Forum. Although the Complainant has not given first consultation papers/blood sugar reports to prove when the DM was first diagnosed, the random sample blood sugar report dated 23/4/2003 indicates that the patient was only mildly diabetic. Oriental Insurance Company and the TPA have not been able to produce any evidence of the pre-existence of Diabetes before the inception of the policy and have denied the claim only on the basis of history of

diabetes overwritten in the hospital records which this Forum finds is unjustified. In the absence of any evidence provided by the Company to prove that he was diabetic before the inception of the policy, it would not be taken as pre-existing while reckoning the fact that the policy was in operation from 1997 and the Insured had a claim free record. In view of the foregoing, the Company is directed to process the claim and pay admissible expenses of the claim.

Mumbai Ombudsman Centre
Case No. :GI-55 of 2006-2007
Shri Ajay Shah
V/s.
The Oriental Insurance Company Limited

Award Dated : 29.12.2006

Shri Vijay Shah had first taken mediclaim policy from 27.03.1991 to 26.03.1996 with United India Insurance Company Limited. Thereafter he shifted his policy to The Oriental Insurance Company from 26.3.1996 to 25.3.2000. The claim of Shri Vijay Shah arose under policy no 121100/48/06/53/ issued for the period 01.04.2005 to 31.3.2006 for Sum Insured of Rs. 1,50,000. Shri Vijay Shah was admitted to Jaslok Hospital and the diagnosis written in the discharge card was k/c/o renal transplantation (25 years back) with hepatoma Hepatitis 'B' positive status. A claim was preferred by Shri Vijay Shah for the said hospitalisation to the Company. In the meantime Shri Vijay Shah expired on 23.10.2005 due to Hepatocellular Carcinoma. The Third Party Administrator of the Company, M/s Raksha TPA Pvt Ltd repudiated the claim stating that as the Insured was a known case of Hepatitis B Virus since last 25 years and as this was the proximate cause of cirrhosis to develop, the claim was rejected under clause 4.1 of the mediclaim policy. Thereafter Shri Ajay Shah brother of Vijay Shah represented to the Company which was also not considered, hence being aggrieved he approached this Forum for justice. After perusal of the records parties to the dispute were called for hearing.It is evident from the records that Shri Vijay Shah had undergone renal transplantation in the year 1980 presumably when he was around 22 years of age and he was suffering from hepatitis prior to renal transplantation. Immunosuppressant drugs are usually given at the time of transplantation to prevent graft rejection As per the contention of the claimant Shri Ajay Shah his brother had no other problem after the transplant and hence it was not disclosed in the proposal form cannot be accepted. Perhaps it cannot be out rightly assumed that he was normal. He was on regular medicines and health state was monitored regularly.From all these notings and in the absence of any other evidences procured to prove it otherwise, it goes beyond doubt that the patient was a known case of Hepatitis B prior to taking the policy. The Insured has also concealed a major operation in the proposal which he had in USA in 1980 for kidney transplantation.

In the facts and circumstances the decision of the Company to reject the claim by invoking clause 4.1 of the mediclaim policy is sustainable.

Mumbai Ombudsman Centre
Case No. :GI-063 of 2006-2007
Smt Hazel H Chokshi
V/s.
The New India Assurance Company Limited

Award Dated : 05.01.2007

Smt Hazel H Chokshi was covered under mediclaim policy issued by The New India Assurance Company Limited under policy No.110902/48/05/70051568 for the period 16.7.2005 to 15.7.2006 for a Sum Insured of Rs. 1,50,000 with 35% Cumulative Bonus. It is reported that she was insured with the Company since 1998. When Smt Hazel Chokshi preferred a claim for her hospitalisation at Bhatia hospital on 25.8.2005 for left breast abcess, the Third Party Administrator of the company M/s TTK Health Care Services Ltd repudiated the claim by invoking clause 4.12 being pregnancy related and clause 2.3 being hospitalisation for less than 24 hours. Not satisfied with the decision Smt Chokshi approached the office of the Insurance Ombudsman seeking intervention of the Ombudsman for settlement of her claim of Rs. 16,510.The records have been perused and the parties to the dispute were called for hearing. The analysis of the case reveals that the Company has rejected the claim on the ground that the treatment was related to pregnancy clause, which fell under exclusion clause 4.12, and in addition as hospitalisation was not for 24 hours they invoked clause 2.3 of the mediclaim policy. On scrutiny of the papers and documents submitted to this Forum there is no record to show that the patient was admitted to Bhatia hospital. It is observed from the bill No. 1123 of OPD Operation charges of Dr. Amish V Dalal of Bhatia Hospital the charges for breast abscess and other materials were charged. The bill itself proves that the treatment was taken on OPD basis. Even the Routine culture and sensitivity test which was done mentioned under Bed/Ward as OPD. Hence it is proved that there was no specific hospitalisation and the entire treatment was taken on OPD basis. Removal of the abscess from the breast was not a major operation and generally for such cases hospitalizations are not required but such patients are kept under observation for some time. The treatment was taken on OPD basis and so the hospital had not issued any discharge card for which Smt Chokshi also admitted in one of her letters that no discharge card was issued to her by the hospital. The treatment which are taken on OPD basis are not covered under the mediclaim policy.In respect of clause 4.12 as per a note of Dr. Mahesh Kapadia to Dr. Amish Dalal it is stated that Mrs Hazel Chokshi delivered on 9.8.05 with a case of abscess in Left Breast since 4 days. Though the details of indoor case papers at the time of delivery were not made available to this Forum it was not possible to derive any conclusion about the development of the abscess in the breast. The Complainant has asked the TPA to prove that it was a complication due to maternity. From the papers in the file it cannot be concluded but the possibility also cannot be ruled out as the complication has arisen only after the delivery as per the period mentioned by doctor. Usually after child's birth, mother starts feeding the child and such problems can't be ruled out in the post natal period. Although the Insured stated it was cancer during the hearing but no histopathological reports were produced to prove it. In the facts and circumstances the claim of Smt Hazel H Chokshi is not tenable.

Mumbai Ombudsman Centre
Case No. :GI-064 of 2006-2007
Shri Sunil Krishnani
V/s.
The Oriental Insurance Company Limited

Award Dated : 08.01.2007

Shri Sunil Krishnani alongwith his wife was covered under mediclaim policy issued by The Oriental Insurance Company under Policy No.121800/2005/4607 for the period 05.12.2004 to 04.12.2005 for a Sum Insured of Rs. 3,00,000 each. Shri Krishnani took the policy for the first time on 05.12.2001. Smt Kajal S Krishnani was hospitalized at BEAMS Hospital, Mumbai for Supracervical Laparoscopic Hysterectomy with Burch

Colposuspension with Cystoscopy. When Shri Krishnani preferred a claim for the said hospitalisation, M/s Raksha TPA repudiated the claim invoking clause 4.1 of the mediclaim policy. Dissatisfied with the decision of the Company, Shri Krishnani approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman for justice. After perusal of the records parties to the dispute were called for hearing. It is noted from the certificate dated 13.4.2005 issued by Dr. Rakesh Sinha wherein he has stated that Smt Kajal Krishnani was having menorrahagia since 8 months whereas in other certificate dated 12.09.2005 it stated that Smt Kajal Krishnani was having menorrahagia for about 4 years and had consulted some doctor in the past. However, it was presumed to be Dysfunctional Uterine Bleeding and therefore no investigations were done. When menorrahagia persisted and the bleeding became excessive she eventually got an ultrasound done on 16th December, 2004 at Matrika hospital, Hyderabad where it was detected that she had fibroids.As per the diagnosis in the hospital, the insured had giant fibroids which was causing menorrahagia and the case papers recorded by the attending doctor stated that insured was a case of Menorrhagia since four years. In ladies excessive bleeding at the time of menstrual period either in amount or number of days is a symptom which may be due to emotional reasons or imbalance in hormones or some disease (fibroids) without diagnosis it is not known and remains untreated and may prevail for a long time as had happened in this case. But on this one can't presume that it was known to the insurer and thus it was pre-existing .The history of 4 years written in the case history is too scanty to arrive at a conclusion that the disease was prevailing as on the date of proposal. It is unusual that a person of normal prudence will wait for such a long time of four years to be eligible for medical benefits once the disease is diagnosed. As such the decision of the Insurer to reject the claim invoking clause 4.1 of the policy is unsustainable and therefore set aside.

The Insurer is directed to honour the claim as per the admissible amount. However since the Beams Hospital charges for Surgeons fee and Anesthetist do not commensurate with the prevailing market rate, the bill for such payment to be settled as per the tariff rate.

Mumbai Ombudsman Centre
Case No. : GI-67 of 2006-07
Shri Sanjay B. Jage
V/s.
United India Insurance Company Ltd.

Award Dated : 10.01.2007

Shri Sanjay B. Jage was covered under Mediclaim Policy since 29/11/2001 for a SI of Rs. 15,000/- He renewed the policy without interruption and his present policy for the year 2004-2005 bearing No. 020900/48/04/03249 showed an accrued CB of 15%.

As per the complaint letter of Shri Jage, he has stated that his claim for UTI/Gastritis was repudiated by the Company on the basis of history of alcohol consumption recorded in the Shahpur Diagnoistic centre's report.

Analysis of the case reveals that Shri Jage was admitted to Lifecare Speciality Hospital on 6/10/2005 for breathlessness and mild chest pain and the diagnosis was UTI + Gastritis. He was admitted in the ICCU and was treated and discharged on 7/10/2005 with an advice to follow up with Dr. Rane on 10/10/2005. He was advised routine tests and USG of abdomen, Pelvis which were done at Shahpur diagnostic center. The Shahpur diagnostic center's clinical history states H/o alcohol consumption c/o pain in

abdomen , obstructed urine, burning micturition. The USG Report of the Abdomen was normal except that liver showed diffuse fatty infiltration.

Thereafter he was again hospitalized on 17/10/2005 with similar complaints of severe pain in epigastric region, giddiness and breathlessness and he was again admitted in their ICCU and treated and discharged the same day with an advice to avoid spicy foods. The treatment given was more or less same as the first hospitalization. His upper GI endoscopy done at Vatsalya Nursing Home after discharge from the hospital state the findings as ' Antral Gastritis.' For better understanding we quote below the exact meaning of the word Antral Gastritis and its etiology. "Antral means Distal non-acid secreting segment of the stomach or pyloric gland region that produces the hormone gastrin." "Gastritis is inflammation of the stomach marked by epigastric pain or tenderness, nausea, vomiting, hematemesis and systemic eletrolyte changes if vomiting persists. Eitology - The cause is generally unknown, Gastritis may result from infection, excessive intake of alcoholic beverages, dietary indiscretions or an excess or deficiency of Hydrochloric Acid."

The TPA has repudiated the claim by linking the present ailment to alcoholism because there was a mention of h/o alcohol consumption in the Shahapur diagnostic centre's sheet. The hospital records mentions an advice to reduce spicy food and there was no mention of history of consumption of alcohol. However, the hospital has issued a clarification dated 25/2/2006 after the rejection of the claim that "though we have written the H/o of alcohol consumption, the patient is not a c/o alcohol consumption at the time of admission to the hospital.". Since gastritis could be caused due to dietary indiscretion as well as due to intake of alcohol the proximate cause for his gastritis may be due to his faulty diet habits and/or alcoholism for which the doctor has advised him to avoid spicy food. In this case , during the hearing, the Insured has admitted that he was taking alcohol.

Moreover, on scrutiny of the medical bills, there are a few discrepancies noted as regards admission to the hospital. On both the occasions Shri Jage was admitted in the ICCU and discharged from ICCU the next day or the same day. It is very strange that even though there was no criticality in the condition of the patient at the time of admission he was admitted to the ICCU. There are no notings of oxygen given to the patient in the hospital papers but the same has been billed by the Hospital for both the hospitalisations. Almost same medication has been given during both the hospitalization. If we carefully see the hospital bill chart of second admission i.e. on 17/10/2005 the timing noted in the bill for oxygen given, monitor, blood sugar strip are all 3.p.m. and the bill was prepared also at 3.00p.m. There occurs a doubt of less than 24 hours hospitalization in respect of the second hospitalization. He was advised Endoscopy on 18/10/2005 i.e. after discharge from hospital and the same was done on 21/10/2005 which revealed Antral Gastritis. There are no records as to what treatment followed after the examination of the Endoscopy report. The clarification given by the hospital as regards his alcohol consumption is not of much use as they have not clearly stated whether he used to consume alcohol occasionally or he was a habitual drinker, but there appears to be a closer linkage between the ailment and the alcohol. In the facts and circumstances, the Company's stand of invoking exclusion clause 4.8 is tenable.

The New India Assurance Co. Ltd.

Award Dated : 12.01.2007

Shri Girdharilal Jhunjhunwala was hospitalized at Jaslok Hospital from 1/6/2005 to 8/6/2005 for removal of abscess in the left cheek. The complaint is regarding partial settlement of post hospitalization claim amounting to Rs, 61,542/- out of which Rs. 10,797/- was settled by TPA. The main claim has been settled through cashless by deducting an amount of Rs. 2627/- which also is demanded by the complainant in the P-II form. Post surgery, Shri Jhunjhunwala was advised dressing for the wound for which he had employed a Male Nurse. The TTK has submitted the details of amount allowed and disallowed in respect of his post-hospitalisation bills giving reasons therewith. Not satisfied with the decision of the TPA the complainant represented to the grievance cell, RO who in turn referred the case to their Medico-Legal Consultancy and they have opined that the special nursing charges done at home are not payable. The Complainant was informed accordingly.

Shri Jhunjhunwala's contention was that he was a senior citizen suffering from Parkinson's disease and hence going to hospital for each dressing was not possible and the said nursing charges were incurred by him as per doctor's advise. He also stated that there are no provisions in the policy that it should be disallowed and in fact the policy allows nursing charges to be reimbursed. He therefore, approached this Forum for redressal of his grievance. The parties to the dispute were called for personal hearing on 1st December, 2006.

Analysis of the case reveals that Shri Jhunjhunwala preferred a cashless claim for a sum of Rs. 1,11,635/-. The claim was processed by M/s. TTK and after proper scrutiny of the expenses, they settled the claim for Rs. 60,000/- on cashless basis. The main dispute was only in respect of partial reimbursement of post hospitalization expenses to the tune of Rs. 10,797/- by the Insurance Company as against the claim of Rs. 61,542/- which mainly comprised of the private nursing charges of Rs.38,830/- and balance towards some medicines. The dispute in respect of non-allowance of certain medicine bills of post hospitalization were reviewed by the Company as per the discussions during the hearing and an amount of Rs. 4,961.67/- towards medicine was further allowed to the Insured from the total deducted amount of medicine bill subsequent to the hearing under advice to this Forum vide Company's letter dated 19th December, 2006. The issue now before this Forum is only regarding non-allowance of private nursing charges incurred by the Complainant in respect of a male nurse employed by him.

As regards engaging private nurse during hospitalization, the TPA observed that Shri Jhunjhunwala was admitted in deluxe class of Jaslok Hospital which was well equipped including nursing facility. Hence the need for engaging private nurses does not arise and this would be outside the purview of the policy and going by the clause 1.0 which essentially serves the basic insurance principles of paying only necessarily and reasonably incurred costs.

The Insured has stated in his letter that he was suffering from a deep and wide wound on his cheek and to make sure that no further infection developed in the wound after the removal of abscess, he was strictly advised regular dressing 3 times a day, one at the hospital and two at home as per the certificate of his attending doctor, Dr. Bhagwat and regular monitoring of blood sugar levels and blood pressure levels and it was for this reason that he engaged a male nurse as per his doctor's advice.

If we examine the discharge card, the treatment advised on discharge was application of ice packs and some gel one hourly, full diabetic diet and a few tablets and

injections. There is no mention for dressing to be done at home or nursing care on discharge. The complainant has submitted a certificate from the attending doctor, Dr. Bhawat dated 8/6/2005 advising two dressings daily and nursing care and two weeks rest at home which was issued by the doctor on his insistence. The said fact is disclosed by the Complainant himself in one of his letters addressed to the TTK Healthcare dated 23/8/2005.

Thus it can be inferred that Shri Jhunjhunwala availed the nursing facility on his own as a precautionary measure and to avoid inconvenience to his family members and advised by the doctor was obtained by the Complainant subsequent to his discharge. The Company has rightly allowed the post hospitalization dressing charges and the medicines bills and disallowed the nursing charges only In the light of the above analysis , I find the decision of the Company in disallowing the private nursing charges is quite reasonable and this Forum finds no grounds to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-429 of 2006-2007
Shri Inderjeet Singh
V/s.
Royal Sundaram Alliance Insurance Company Limited

Award Dated : 15.01.2007

Shri Inderjeet Singh Bhatia alongwith his family members were covered under the Health Shield Gold Insurance Policy issued by Royal Sundaram Alliance Insurance Company Limited to the Credit card holders of Standard Chartered Bank for the period from 29.3.2002. Smt Kripal Kaur Bhatia mother of Shri Inderjeet Singh Bhatia was hospitalized at Holy Spirit hospital for Subacute Intestinal Obstruction CVA (R) hemiplegia (L) MCA Infarct. When Shri Inderjeet preferred a claim for the said hospitalisation to the Company, the Company repudiated the claim on the ground of pre-existing disease. Aggrieved by the decision, Shri Inderjeet Singh approached this Forum for redressal of his grievance.After perusal of the records parties to the dispute were called for hearing. Company submitted that in the light of the categorical medical records the disease of the insured was clearly pre-existing at the inception of the policy. The claim was repudiated as being excluded by the above clause relating to pre-existing condition.

The case has been thoroughly examined at this Forum. It appears that Smt Kripal K Bhatia was suffering from host of diseases and complications, which were evident from the records forwarded to this Forum and the same were not disclosed while taking the mediclaim policy. The Company rejected the claim on the ground of pre-existing illness. The Complainant Shri Singh at the time of hearing agreed that his mother had suffered from the above mentioned diseases and the above ailments were not disclosed as there was no such column. Chronic bed ridden patients are prone to develop features of intestinal obstruction due to decreased bowel movements. Since the patient was suffering from host of ailments and bed ridden, the present problem falls under complications arising from the pre-existing diseases.

Under the facts and circumstances, this Forum does not feel appropriate to interfere with the decision of the Company in this case.

Mumbai Ombudsman Centre
Case No. :GI-215 of 2006-2007
Shri Adi M Tarmaster

V/s.

The Oriental Insurance Company Limited

Award Dated : 31.01.2007

Shri Adi M Tarmaster alongwith his wife was covered under the policy with The Oriental Insurance Company Limited, Divisional Office-121200. At the time of taking the policy for the first time in 1991, Shri Adi M Tarmaster had filled in the proposal form where in he had disclosed that he was operated for hernia 20 years ago and accordingly policy was issued for Rs. 83,000 without any exclusion. In the renewal year of 1999-2000, Shri Tarmaster increased the Sum Insured to Rs. 2 lacs which was further increased to Rs. 3 lacs in the year 2001-02. Shri Tarmaster was regularly renewing the policy without any break and had earned Cumulative Bonus .Shri Adi M Tarmaster was hospitalized at Asian Heart Institute for Acute AWMI where PAMI with stent to LAD was done. When Shri Tarmaster preferred a claim to the company for the said hospitalization, the Third Party Administrator of the Company, Raksha TPA Pvt. Ltd., repudiated the claim by invoking clause 4.1 of the mediclaim policy. Their contention was that as per the documents Shri Tarmastar had suffered IHD at the age of 42 years and as IHD was longstanding it was the proximate cause for the present ailment, hence the claim was not payable. Not satisfied with the decision of the company, Shri Tarmaster represented to the Company and not receiving any favourable response approached this Forum for intervention of Ombudsman in the matter of settlement of his claim. After perusal of the records parties to the dispute were called for hearing.The Company took the stand that he was a known case of IHD at the age of 42-43 years. But the Company has not been able to corroborate the statement with some proof of medical bills or prescriptions. It is to be noted that in the indoor case papers it is very clearly written that k/c/o/ IHD age of 42-43 years not on any treatment and he had no h/o Hypertension Diabetes Mellitus, Asthma or T.B. Usually a combination of Hypertension and Diabetes are considered to be most dreaded risk factors for Coronary Artery Disease which causes blockages in the arteries for which either angioplasty or by-pass surgery is done depending on the status of the blockage. Shri Tarmaster said he had some problem and that was detected due to stress and strain for which he was hospitalized at Irla Nursing Home on the advice of his family doctor but the Asian hospital recorded it as IHD which was not correct. The doctors had not prescribed any medicines for the same and only rest was advised. He said perhaps because of this he did not think that the same should be disclosed in the proposal form. It is evident that though he had suffered from some problem it was not proved that it was IHD or any heart ailment for which he was under regular medication. The Company is not justified in rejecting the claim without proof of positive existence of the illness and that to 30 years ago and the treatment taken for the same.

In view of the facts and circumstances, the decision of The Oriental Insurance Company Ltd to repudiate the claim is not tenable.

Mumbai Ombudsman Centre

Case No. : GI-502/ 2006-2007

Rear Admiral Auditto

V/s

The Oriental Insurance Company Limited

Award Dated : 31.01.2007

Rear Admiral A Auditto was covered under the Mediclaim Policy issued by The Oriental Insurance Company Limited, D.O. III since 1993. He included his son, Shri Devashish Auditto from 1997 and the policy was renewed continuously thereafter which also

earned Cumulative Bonus. Shri Devashish Auditto was hospitalised at Dr. L.H. Hiranandani hospital from 2.9.2005 to 22.9.05 for Ventral Hernia, Intestinal obstruction with perforation and gangrene small gut operated and hypertension. When the claim was preferred by Rear Admiral Auditto for the said hospitalisation, the Third Party Administrator of the Company, M/s Raksha T.P.A. repudiated the claim invoking clause 4.1 as the conditions were pre-existing and also non–disclosure of material fact at the time of proposal. Not satisfied with the decision, Rear Admiral Auditto represented to the Company/TPA but the TPA reiterated their stand of repudiation. Hence being aggrieved Rear Admiral Auditto approached the Office of the Insurance Ombudsman. The records have been perused and the parties to the dispute were heard . The papers have been scrutinized at this Forum and all the available records have been duly perused. It is noted that the Insured, Shri Devashish Auditto met with a road accident in the year 1993 and had sustained injuries to Pelvis, Tibia and Fibula (Lt) with rupture urethra and tear anal sphincter. It is to be noted that the Company had taken the opinion of their Medicolegal Consultant Dr. M.S. Kamath who has opined that the mediclaim policy excludes claims arising in connection with or in respect of pre-existing disease (accident) and non-disclosure of accident in the proposal form. From the history recorded in the hospital it leads us to the conclusion that Shri Devashish Auditto had met with a major accident prior to taking the policy which was not disclosed at the time of taking the policy. Hence it tantamounts to non-disclosure. If the accident and the operation undergone as a result of that would have been disclosed, the policy would have excluded ailments in connection with or in respect of earlier operation from the scope of the policy. It is noted that apart from ventral hernia, Shri Devashish Audito had undergone operation for Intestinal obstruction with perforation and gangrene small gut. Hernia is the protrusion or projection of an organ or a part of an organ through the wall of the cavity that normally contains it. It is very clear that in this case the Exclusion clause 4.1 under Mediclaim policy will apply as the claim has arisen in the year 2005 and hence the said clause would be applicable in this case.

In view of the facts and circumstances the claim of Rear Admiral A Auditto is not sustainable as per the policy terms and conditions issued to him.

Mumbai Ombudsman Centre
Case No. : GI-241 of 2006-07
Shri Zenobia Press
V/s.
United India Insurance Co. Ltd.

Award Dated : 05.02.2007

Smt. Zenobia Press was insured with United India Insurance Co. Ltd. since 24/10/2005. She underwent hospitalization for bleeding disorder at Breach Candy Hospital from 8/12/2005 to 12/12/2005. A claim was preferred by her which was rejected by the Company as per exclusion clause 4.1.

Analysis of the case reveals that Smt. Zenobia K. Press had taken a Mediguard Policy bearing No. 020300/48/05/04140 for the period 24/10/2005 to 23/10/2006 from United India for a sum insured of Rs. 5 lakhs. She was hospitalized on 8/12/2005 at Breach Candy Hospital and diagnosed to suffer from ITP (Idiopathic Thrombocytopenic Purpura) “A hemorrhagic autoimmune disease in which there is a pronounced reduction in blood platelets caused by the presence in the blood plasma of a substance that agglutinates platelets. Symptoms include bleeding from mouth, skin upon slight injury. Bleeding may also occur from the mucuous membranes , in serous membranes and

sometimes into the brain." (quoted from Taber's Cyclopedic Medical Dictionary 18th edition)". " Chronic ITP starts insidiously with gradual occurrence of bleeding from gums , purpura, menorrhagia etc. In many patients the disability is only mild. Remissions and exacerbations are seen. Infections, menstruation, or drugs like aspirin may precipitate bleeding episodes. Menstrual and intermenstrual blood loss in women may be severe and even life threatening." (quoted from API text book of Medicine 6th edition)

Indoor case papers of Breach Candy Hospital mentions a case of ITP with case of heavy menstrual bleeding since two years. Other past history details mentioned were vertigo since 25 years and appendicectomy done 19 years back. The Company rejected the claim as pre-existing based on the opinion of their panel doctor, Dr. M.S. Kamath who opined that that the patient had a bleeding problem much prior to taking the first policy and therefore, the Insured's case falls under the important exclusion clause pertaining to treatment of pre-existing disease and hence not payable.

The Company levelled the charges that the Insured has not disclosed about menorrhagia since two years The complainant vide her letter dated 17th July 2006 has contested this charges against her on the ground that it was not an ailment and is normal in a woman of her age and she was not under any treatment for the same. She also contested the conclusion made by the Company that Menorrhagia was the causative cause of ITP stating that the conclusion drawn by the Company has no medical basis. She substantiated her stand by stating that even before taking the policy her blood platelets count as per blood report dated 1/4/2005 was within normal ranges.

The Company came to conclusion that she suffered from ITP because of pre-existing Menorrhagia. While this would be possible from the medical view point as analysed above, it should be noted that the "idiopathic" itself denotes a disease or condition , the cause of which is not known or that arises spontaneously ." On final analysis therefore, since ITP can occur due to various other reasons and here the exact cause not being identified, the conclusion would be to strike a balance and a reasonable view would be to grant 50 % of the admissible expenses only as the Insured had answered in the negative to question no. 13 (f) of the Proposal form even though she was suffering from heavy menstrual bleeding since 2 years which was an indication of some future complications.

Mumbai Ombudsman Centre
Case No. : GI-268 of 2006-07
Shri. Ram Singh
V/s.
United India Insurance Co. Ltd.

Award Dated : 13.02.2007

Shri Ram Singh was covered under a Mediclaim Policy No. 020500/48/04/08059 for the period 14/3/2005 to 13/3/2006 for a Sum Insured of Rs. 20,000/- . His policy shows an accrued CB of 30%. A claim preferred under the policy for abdominal pain was rejected by the Company under exclusion clause 4.10 of the policy.

Analysis of the case reveals that Shri Ram Singh consulted Dr. Arvind J. Desai, Consulting Physician Haematologist & Oncologist for pain in abdomen. He advise x-ray of abdomen and Pelvis which was s/o ? bladder calculi. He advised hospitalization for investigation and treatment under his care at Sir Hurkisondas Hospital. Discharge card noted complaints of left sided abdominal pain in hypochondrium region with left renal

colic since 7days, history of retrosternal burning, pain increased one hour after meals, and h/o tobacco chewing, h/o haematuria since 1 year and h/o alcohol taking – stopped since 2 years. Repeat x-ray/ USG of KUB done on admission did not reveal anything and was normal. Other investigation reports were all normal. His provisional diagnosis was Renal Colic ? He was referred to a Urologist , Dr. Nayan Sanghvi for evaluation and further management who advised IVP which was also normal. USG of KUB showed mild benign prostatomegaly for which follow up was advised after discharge.

On examination of the hospital cases papers, it is evident that the admission was done to investigate the abdominal pain and to rule out Renal Colic ? uric acid calculus ?. The treatment given during the hospitalization were only oral medications. As the admission was only for management of the pain and to investigate into the root cause of the abdominal pain, the claim was attracting the provision of clause 4.10 of the Mediclaim Policy. The Investigations done during his admission, did not reveal any positive existence of a disease as the same were all within normal limits. Hence the claim would be falling under Excl. 4.10 and therefore the rejection of the claim by the TPA-M/s. Family Health Plan and thereafter by the United India Insurance Company's Grievance Cell is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-217 of 2006-07
Shri Zubin A. Sachinwala
V/s.
United India Insurance Co. Ltd.

Award Dated : 14.02.2007

Zubin A. Sachinwala took a Mediclaim Policy with United India along with his mother, Smt. Coomi Sachinwala aged 65 years for a Sum Insured of Rs. 1 lakh each effective from 10/6/2004. In the following year he increased the SI to Rs. 2 lakhs each. In the same year his mother, Smt. Sachinwala was admitted to B.D. Petit Parsee General Hospital for Uterine Prolapse with Cystocele and Rectocele on 26/1/2006 and vaginal hysterectomy with AP repair was performed. She was discharged on 3/2/2006. When a claim was preferred with the Company, the TPA, M/s. Medicare TPA Services under cashless facility the same was denied and finally the reimbursement claim was also rejected under exclusion 4.1.

The Company was advised to take an independent opinion from a Gynaecologist taking into consideration literature submitted by the party and the treating doctor's opinion.. The Company was asked to submit the report to this Forum on or before 22/1/2007.

Accordingly, the Company submitted an opinion from a Senior Obstetrician & Gynaecologist , Dr. Ismail B. Bandookwala , which was received by this Forum on 29th January, 2007. Dr. Bandookwala has opined that Prolapse or downward displacement of the uterus occurs due to the laxity of its supports. These supports are usually damaged due to stretching and injuries during pregnancy and delivery. These supports are further weakened after menopause with the tissues becoming lax and inelastic (an eg. being the appearance of wrinkles on the face). He has further stated that the symptoms of prolapse uterus start insidiously (usually after a delivery or after menopause) and progress very gradually, unless there is some gross injury to the supports of the uterus which is very rare. Although the patient may be comfortable in the early stages of prolapse, the symptoms could increase over months or usually years to reach the level of being intolerable. She may thus defer the surgery for several years. The treatment of prolapse in women who are past the menopause and also those who don't require any further child bearing usually involve removal of the

uterus along with prolapse repair. Further the histopathology report of the excised uterus indicates hyperkeratosis of the cervix and also the vagina. This is hardening of the areas of the internal genitalia after exposure to the outside for several years. (Normally in cases of prolapse only the cervix is exposed initially and the vagina would be exposed only after a further prolonged interval). Thus in general it may be very unusual for anyone to undergo such a surgery within 18 months from the inception of the policy."

What has been stated above is only the opinion of the Gynaecologist chosen by the Insurer. But the complainant has also submitted an opinion from her treating Gynaecologist, Dr. M.S. Chaina, according to which the progress of any ailment/disease does not go by the stipulated time and can progress and deteriorate at any given time. In view of the conflicting views of the Gynaecologists and as the Insurer has not produced any documentary proof for its pre-existence, merely on assumption, full denial is not justified. In view of this it is reasonable to allow 50% of the admissible expenses in this case.

Mumbai Ombudsman Centre
Case No. : GI-376 of 2006-2007
Smt. J.V. Malhotra
V/s
The Oriental Insurance Co. Ltd.

Award Dated :

Smt. J.V. Malhotra, was insured under the Mediclaim Policy of The Oriental Insurance Company Limited Co.Ltd., Mumbai for the period 22.12.2005 to 21.12.2006 for a sum insured of Rs.2,00,000/-, and was covered under the Mediclaim policy alongwith her family since 1997. She was hospitalised at Beams Hospital from 27.2.2006 to 1.3.2006 for Total Laparoscopic Hysterectomy. She preferred a claim for reimbursement of medical expenses of Rs.1,25,173/- incurred for the hospitalisation at Beams Hospital and the TPA of the Company, M/s Raksha TPA, settled the claim for Rs.92513/-. She made a representation to the TPA expressing her dissatisfaction over the partial settlement of the claim. Not satisfied with the decision, the Insured represented to the Company and not receiving a favourable reply, approached this Forum for reimbursement of the balance amount.

The analysis of the case reveals that Smt. Malhotra was admitted in Beams hospital under care of Dr.Rakesh Sinha and the nature of surgery was 'total laparoscopic hysterectomy'. In the discharge card it was mentioned that the patient was admitted on 27.2.2006 and got operated on same day.

The Company vide their written statement to this Forum had stated that the following amount was settled:

1) Surgeon charges charged are Rs.55,000/-, out of which Rs.35,000/- has been settled.
2) Anaesthetist charges are Rs.18,000/-, out of which Rs. 11,500/- has been settled.
3) Assistant charges Rs.3000/- has been deducted as requirement of an Assistant in Laproscopic Surgery is not justified.
4) Histopathological Report of Rs.2500/- out of which Rs.1500/- has been settled. (The investigation is outsourced that is, it is done in Nicholas Piramal Ltd.)

It is noted that the Surgeon's charges and anaesthetist charges were on higher side as compared to other hospitals where the Laproscopic Hysterectomy operations were

carried out. Hence an amount of Rs.20,000/- for Surgeon charges and Rs.6,500/- for anesthetist charges were deducted. Assistant Surgeon's charges of Rs.3,000/- were deducted as the presence of Asstt. Surgeon in Laproscopic Hysterectomy is not justified. The mediclaim policy permits only reimbursement of reasonable and necessary charges incurred by the insured.

It is observed that the company had settled only the necessary and reasonable charges as per the Mediclaim policy, considering the tariff prevalent in tertiary care hospitals in Mumbai and the decision of the company is based on a comparative study. Three diagnostic bills were disallowed as the reports were not provided by the Complainant. This can be paid on production of the reports and the tests undertaken. The Histopathological investigations were outsourced but without giving the full details of the charges paid to the Laboratory, a total amount of Rs.2500/- was raised by the hospital. In case relevant receipts for the various pathological tests can be produced, the full amount will be paid i.e. Rs.2500/- instead of Rs.1500/- against Histopathological Report.

Mumbai Ombudsman Centre
Case No. : GI-26 of 2006-2007
Smt. Rajkumari Sabherwal
V/s
United India Insurance Company Limited

Award Dated :

Ms. Shabhana Sabherwal and her mother Smt. Rajkumari Sabherwal were covered under Mediclaim Policy since 11.10.1999 for a Sum Insured of Rs.2 lakhs each with a cumulative bonus of 15% in the case of Smt. Rajkumari Sabherwal. Smt. Rajkumari Sabherwal, mother of the Proposer was hospitalized at Arya Vaidya Chikitsalayam, Coimbatore for Gridrasi (Sciatica) low back pain radiating to right leg for 35 days. When she preferred a claim for Rs.64,706/-, the TPA of the Company, Medsave Health Care repudiated the claim stating that low back ache does not warrant hospitalisation for 35 days and the treatment could have been taken under OPD basis and therefore the claim fell under operative clause 1.1 of the policy. Not satisfied with the decision of the Company, the Insured represented her case with the Grievance Cell of Regional Office and not getting favourable reply she approached this Forum for redressal of her grievance.

It is observed that the treatment received in this case at the hospital were oral medication, diet restrictions and oil therapy. From the line of treatment, it is evident that for such oil massage treatment therapy, there is no need for hospitalization and one could avail package of such continuous treatment without admission to the Hospital. Such treatment cannot be obtained even on domiciliary hospitalisation since as per condition 2.4 of the Mediclaim policy domiciliary hospitalisation would be granted only when the condition of the patient would be such that he/she cannot be removed to the hospital/nursing home or a patient cannot be removed to the hospital or nursing home for lack of accommodation therein.

The Complainant admitted that she took the initial treatment from Dr. Sanjay Agarwal of Hinduja Hospital, but did not get much relief for which she went to Coimbatore. It was therefore, a case of complete diagnosis done well before the hospitalisation in Coimbatore and in fact on the discharge card, it was mentioned that the low back pain was reduced and not cured and the patient was asked to continue other treatments as prescribed by them. It was a conscious move by Smt. Sabherwal to avail the treatment from Arya Vaidya Chikitsalayam for better results. Unfortunately under the terms of the

Mediclaim policy this would fall under clause 4.10 where hospitalisation is not justified due to any serious emergency health status. The Insured was capable of undertaking a journey to Coimbatore to receive a special treatment whereas it was stated by the Insured that her condition was so bad that she could hardly stand or walk, leave alone go for OPD treatment daily.

The line of treatment given to Smt. Sabherwal was repetitive which could be performed as an outpatient with proper advice and instructions. The Hospitalisation was not justified looking to the line of treatment given and the entire treatment was of conservative nature which did not require any critical monitoring of health status. Accordingly, the decision of the Company to reject the claim on the ground that it does not warrant hospitalization for 35 days and could have been taken under OPD basis is therefore, sustainable.

Mumbai Ombudsman Centre
Case No. : GI-240 of 2006-07
Shri R.G. Shringi
V/s.
New India Assurance Co. Ltd.

Award Dated : 15.02.2007

Shri R.G. Shringi and his wife were covered under Mediclaim Policy from 16/5/1989 and have been continuously renewing the policy with out any break. The complainant's wife Smt. Urmila Shringi was operated for Hernia on 10/8/2005 at Breach Candy Hospital and treated and discharged on 17/8/2005. When a claim was preferred for Rs. 68,655/- the TPA M/s Medi Assist repudiated the claim for hernioplasty on the ground that it was incisional hernia arising out of past surgery which happened to be because of delivery by cesarian section (LSCS) in 1978.

The analysis reveals that the TPA has gone by the Caesarian Section which was done in the year 1978, i.e. more than 27 years back. They held the view that it would fall under two exclusions 4.1 being pre-existing illness/injury. A further scrutiny reveals that the TPA related it to pre-existing illness i.e. surgery done in 1978. As regards the declaration in proposal form, the Company stated that as old records were destroyed it would not be possible to know about the declaration of the past surgery. Also a question arises whether it was an underwriting decision to safeguard against claim of hernia which may occur anytime in future in such cases after operation and thus put as an exclusion clause? Since there was no exclusion, the policy was open to cover all diseases. During the hearing the Company was asked to re-examine the case in the light of the discussion. However, the Company has vide their letter dated 24/1/2007 informed us that they maintain their earlier stand of repudiation.

The issue is whether the swelling (herniation) which started just a year before as per the history recorded at the time of hospitalization in the present case (as per discharge card) can be linked to be a fallout of Caesarian surgery done 27 years ago and whether outright rejection of the claim for hernia is justified. The company took a further view from their Consultant who wrote "Insured underwent operation for incisional Hernia. The name itself indicates that Hernia occurred out of incision on the abdominal wall due to past operation done. It is irrespective of the duration of past surgery." It is well known that a considerable time period may elapse after the primary surgery before an incisional hernia develops. It is an acceptable fact that Incisional Hernia arises through a surgical scar . If stretching and thinning of an abdominal scar occur, pressure from abdomen may cause protrusion of the part of the gut. But in the instant case the existing scars of incision for LSCS which had healed has not created

any complications whatsoever till the present one as recorded in the discharge card of the hospital which mentions " no h/o complications ". The duration of the past LSCS surgery is too long a period to reckon and outrightly deny the Hernia claim under pre-existing clause which has occurred after almost 27 years. The Insurer could not prove that the old LSCS surgery was not disclosed and there is no exclusion clause put by the Insurer. Therefore, the benefit of doubt goes in favour of the insured and invoking clause 4.1 is not fully justified being a 27 year old surgery and in the absence of any exclusion clause put by the Company, it is felt that the decision of the Insurer to reject the claim is not fully justified but since it was incisional hernia, it would also not be proper to allow full reimbursement. It will be in the fitness of the things to allow 85% of the admissible expenses in this case.

Mumbai Ombudsman Centre
Case No. : GI-306 of 2006-07
Shri Chandrashekar K. Shetty
V/s.
Oriental Insurance Company Ltd.

Award Dated : 19.02.2007

Smt. Varakshini Shetty was covered under Mediclaim Policy No. 121800/48/06/2841 issued by the Oriental Insurance Company Limited. Smt. Shetty was hospitalized on 22/2/2006 at P.D. Hinduja Hospital for bleeding per vagina since 3 ½ months. She was treated and discharged on 28/2/2006. When a claim was preferred the TPA rejected the claim under excl. 4.10.

Analysis of the case reveals that Smt. Varakshini Shetty was admitted for bleeding per vagina since three and a half months. Discharge card mentions diagnosis as Uterine Fibroid with PCOD (Polycystic Ovarian Disease). The Indoor case papers reveal that she was a case of mennorhagia since many years and a "k/c/o multiple fibroids in uterus since 2003, taking treatment on and off . Has come for D & C". History sheet of 23/2/3006 mentions no bleeding per vagina at present and thereafter from 24/2/2006 it is mentioned " no complaints minimal spotting p/v" . There is also a noting on the indoor case sheet dated 24/2/2006 planning for hysterectomy next month ." Thereafter the Insured was investigated for Cervical spine problem and various pathological tests and investigations were done during the course of hospitalization of 6 days which could have been done on OPD basis also. TPA rejected the claim on the basis of exclusion 4.10 Though she was primarily hospitalised for excessive bleeding for which she did receive treatment and was advised surgery, she did not undergo surgery at that time, instead preferred to take discharge from the hospital after investigations. However, she was again hospitalized in the month of July for the same problem and the claim was settled by the Insurer.

Looking to the above notings in the Indoor case papers it is clear that she was hospitalized for an ailment which was already diagnosed much prior to her hospitalization. Moreover, she did not adhere to the medical advice of Hysterectomy during the hospitalization for her personal reasons which clearly points to the facts that there was no emergency for hospitalization. Moreover there has been a prolonged hospitalization and the treatment given and investigations done during the stay at hospitalization was not in line with the diagnosis as mentioned in the discharge card. In view of the foregoing analysis, it is felt that the claim fell beyond the scope of the policy and hence not payable.

Mumbai Ombudsman Centre

Case No. : GI-275 of 2006-07
Shri Mahesh M. Bajaj
V/s.
The New India Assurance Co. Ltd.

Award Dated : 19.02.2007

Shri Mahesh M. Bajaj took a Mediclaim policy covering himself and his parents for the first time on 24/6/1999. The policy was issued with exclusion of diabetes in respect of his father, Shri Mohanlal B. Bajaj.

His father, Shri Mohanlal Bajaj was admitted to Breach Candy Hospital on 1/1/2006 with breathlessness on and off (increased since last 10 days) , cough with expectorant, alt. sensorium intermittently. The final diagnosis was acute MI with acute LVF in a patient with affective disorder. His claim for reimbursement of hospitalization expenses was not honoured by the TPA as his present illness was directly linked to the specific exclusion of diabetes under the policy .

A scrutiny of the policy reveals that the policy was issued with the exclusion of diabetes for which there was a clear exclusion in the policy which reads as below :

This Insurance shall not extend to pay any expenses incurred relating to the disease(s) /sickness/injury mentioned in the column i.e. (Diabetes) for consequences attributable thereto or accelerated thereby or arising therefrom." Therefore, it becomes a knowledge on the part of the Insured that he would not be covered for "diabetes and consequences thereof" as per the exclusion clause endorsed on the policy itself.

Let us examine past history and clinical presentation from Breach Candy Hospital. The diagnosis was clear that he had Acute Myocardial Infarction (MI) and Acute Left Ventricular Failure (LVF). Progress Notes reveals severe generalized LV dysfunction , LVEF 15%, his general condition was poor in the 2nd day of hospitalization, oedema +++. "Oedema is excessive accumulation of fluid in the body tissues, popularly known as dropsy. In generalized oedema there may be collections of fluid within the chest cavity or within the air spaces of the lungs (pulmonary oedema). It may result from heart failure or kidney failure, acute nephritis, nephritic syndrome, allergy to drugs." (Oxford Medical Dictionary). The chest congestion/infection which the Insured was suffering was a result of his oedema which in turn results from heart failure. Therefore the primary cause of his hospitalization was heart problem for which he was given Lasix 20 mg on the first day itself, which is substantiated in the hospital papers and also corroborated by the TPA doctor during the hearing.

It is also noted from the hospital papers that he had a past history of affective disorders. Progress Notes of first day mentions gradual onset of bizarre behaviour – spits food and tablets, non-adherence to medical advice, abusive, aggressive, hallucinating behaviour c/o bipolar mood swings. Daily History notes also mentions k/c/o DM, for which he was administered insulin injections, psychiatry illness. It is noted in the hospital papers that patient is grossly demented and according to his wife this deterioration has been progressive for the last 1 year. Unable to do any testing as he does not co-operate.

Thus from the above medical analysis, the Insured was primarily hospitalized for heart problem and the basic line of treatment was for heart problem and not for cough and chest congestions which erupted because of pulmonary oedema. Based on the disclosure of diabetes there has been clear exclusion under the policy which has been examined above in its total import and comprehensiveness to exclude consequences arising from diabetes. Therefore, New India's stand-point is tenable.

Mumbai Ombudsman Centre
Case No. : GI-079 of 2006-2007
Shri Dhiren M. Shah
V/s
The New India Assurance Co.Ltd.

Award Dated : 27.02.2007

Shri Dhiren M.Shah along with his wife Smt.Mona D.Shah was covered under a mediclaim policy of the New India Assurance Company Ltd., DO-112500 under policy no.112500/48/04/77945 for the period from 16.07.2004 to 15.07.2005 for a Sum Insured of Rs. 5 lacs each and had earned Cumulative Bonus also. Smt Mona D Shah was hospitalised at Bombay Hospital for Left L5-S1 Disc Prolapse. When Shri Dhiren Shah preferred cashless facility, the Company paid Rs. 1,23,049 directly to the hospital against his bill amount. After the discharge from the hospital, when Shri Dhiren Shah preferred further claim of Rs. 2,72,300/- inclusive of pre- and post hospitalization expenses, the Third Party Administrator of the Company, M/s Raksha TPA vide their letter dated 18.8.2005 sent a cheque for Rs. 10,300/- disallowing Rs.2,50,000 surgery charges charged by Dr. Turel and Rs. 12,000 for the treatment given by Dr. Atul Mashru as break up details were not submitted by Shri Shah. Not satisfied with the decision, Shri Dhiren Shah represented to the Company stating that Rs.2,50,000 was paid as a professional fees to Dr. Turel and his team who had performed sophisticated surgery and it was done as an emergency due to intractable pain and neurosurgical impairment and Rs. 12,000 was paid to his family doctor who had visited during the operation and after the operation. Aggrieved for not hearing any favourable reply from the Company, Shri Dhiren Shah approached this Forum for justice.After perusal of the records parties to the dispute were called for hearing.On scrutiny of the records it is revealed that the fee is independent of the fee stated in the bill of the hospital. The surgeon's fee of Rs. 45,000 shown in the bill is the basic amount according to the hospital tariff, out of which a significant percentage is retained by the hospital and this amount does not compensate the nature and caliber of my expertise and services.. There is also a bifurcation of Rs. 12,000 charged by Dr. Atul R Mashru. It is noted that mediclaim policy allows only for payment of expenses reasonably and necessarily incurred. The Company had honoured the hospital bills and since the total hospital bills were paid, there was no demand from the hospital for any balance payment. It would be evident that the dispute is only related to the separate payment of surgeon's fees submitted by the complainant as per the bill raised by the concerned surgeon. The Insured Shri Dhiren Shah has paid the amount of Rs. 2,50,000/- under proper receipt separately to Dr.Turel as agreed by him. As per the record available in the file, it has been observed that for taking cashless facility in pre-authorization form signed by Dr. K.E.Turel, in the column of surgical expenses Rs. 2.50 lacs was mentioned and the total expenses were shown as Rs. 4 lac. The TPA did not raise any objection and agreed for Rs. 3 lacs credit to the hospital.

From the above it is clear that the surgical expenses of Rs. 2. 50 lacs were in the knowledge of TPA and they have not raised any objection on it. The Insurer has also not denied that they will not pay such bills raised by the individual Doctor. In this case surgical expenses were mentioned as Rs. 2.50 lacs, and in the absence of any objection and other details available, it will be in the fitness of things to reimburse such expenses upto Rs. 2.50 lacs which includes all the stages right from primary check-up, pre-operation consultancy to post operation, follow up and personalized supervision. As the Doctor mentioned in his letter that his fee includes all the above expenses no

other Doctor's fee including family physician is payable under the head 'Surgeon's/ Consultant's Fee'.

In view of the above analysis the Company should pay the surgical fees as Rs. 2.50 lacs and pay the balance amount after adjusting the payment already made to the hospital under this head.

Mumbai Ombudsman Centre
Case No. : GI-241 of 2006-07
Dr. Tarun J. Sheth
V/s.
The Oriental Insurance Co. Ltd.

Award Dated : 28.02.2007

Dr. Tarun J. Sheth and Dr.(Smt.) Nayana T. Sheth were covered under Policy No. 121800/48/06/2693 issued by Oriental Insurance Company Limited for a period 9/8/2005 to 8/8/2006. Dr. (Smt.) Nayana Sheth underwent Left Cataract removal and lens implant surgery on 25/11/2005 at Iris Eye Centre for which she lodged a claim with the Company on 6/1/2006. However, she has not yet received any information in respect of her cataract claim from the Company. Subsequently, she was admitted to Nanavati Hospital on 5/2/2006 to 16/2/2006 for multisystem disorder with Lupus Nephritis. A claim for reimbursement of the expenses was rejected by the TPA under Exclusion Clause 4.1.

Analysis of the case reveals that Dr. (Shri) Tarun J. Sheth and Dr. (Smt.) Nayana T. Sheth were covered under Mediclaim Policy since 9/5/1997 –98 for a Sum Insured of Rs. 1 lakh each. The S.I. was increased to Rs. 3 lakhs each in the year 2001-02. Since then the policy was renewed continuously for Rs. 3 lakhs. In the year 05-06, Dr. Sheth sent the renewal cheque to the Company in time and a policy bearing No. 812/2006 was issued to him for the period 15/5/2005 to 14/5/2006. Consequent upon the dishonour of cheque the Company informed the Insured about the cancellation of the above –referred policy . A demand draft for the premium amount was paid by the Insured and a fresh policy was issued by the Company from 9/8/2005 to 8/8/2006.

Dr. (Smt.) Sheth underwent a left eye cataract surgery on 25/11/2005 at Iris Eye Centre for which a claim was lodged by Shri Sheth for which he did not receive any reply. The second claim of for Lupus Nephritis was rejected by the Company for the reason that Smt. Sheth was a k/c/o of HTN since last one year . She had a history of similar episode a year back i.e. in February 2005 which was before the inception of the policy and hence pre-existing.

The policy of 9/8/2005 was treated as the first year of the policy for which the Lupus Nephritis and HTN were considered as pre-existing as per excl. clause 4.1. The Insured was covered since May 1997 . The only break which came was due to bouncing of the cheque for which the Company was obliged to withdraw the cover already granted as a renewal which resulted into break of more than two months But looking to the past record of the Customer this Forum allows the benefit to the Insured of not to treat the past illness as pre-existing taking 8/2005 as the first incept of the policy but it should be May'97 when he took the first policy. In view of the above the company is directed to process both the claims.

Mumbai Ombudsman Centre
Case No. :GI-479 of 2006-2007
Shri Ajit Chakrabarti

V/s.

The Oriental Insurance Co. Ltd.

Award Dated : 28.02.2007

Shri Ajit Chakrabarti who was covered under the mediclaim policy no.121200/48/05/4883 issued by The Oriental Insurance Company Limited had preferred a claim for treatment of Coronary Artery Disease taken from Asian Heart Institute, Mumbai during the period 9.7.2005 to 13.7.2005. The Third Party Administrator of the Company, M/s Raksha TPA while perusing the papers noted that as per the hospital records the patient was suffering from Hypertension since 6-7 years and as Hypertension was the proximate cause of present ailment the policy was rejected under clause 4.1 of the mediclaim policy relating to pre-existing disease.Shri Ajit Chakraborty's further representations to the Company were also turned down and hence being aggrieved he approached the Ombudsman for payment of his claim.After perusal of the records, parties to the dispute were called for hearing. The records of Indoor case papers of Asian Heart Institute which is the main dispute was examined. Though there are no policy records to show that since when the policy incepted but in one of the letters of Rakhsa TPA dated 9.12.2005 they have admitted that as per their records the Insured was covered under the policy since 5 years. From all the above notings and in the absence of any corroborative evidences procured to prove it otherwise, there is no reason to believe that the patient was suffering from Hypertension prior to the inception of the policy. The conclusion made by the TPA in their repudiation letter is unsubstantiated by facts and documents other than the indoor case papers and the pre-authorisation form which do not show the same duration. Though the recent heart ailment might be contributed by hypertension but it has not been proved by the Company substantially that hypertension existed prior to taking policy to justify pre-existence of illness as per clause 4.1. Hence the benefit of doubt goes in favour of the Complainant.

Mumbai Ombudsman Centre

Case No. : GI-212 of 2006-2007

Shri Surendra Vejhurani

V/s

The New India Assurance Company Limited

Award Dated : 28.02.2007

Shri Surendra Vejhurani who was covered under Mediclaim Policy issued by The New India Assurance Company Limited, D.O. 141800 under policy no 141800/48/04/77389 was hospitalized at Jasraj Hospital from 08.03.2005 to 20.03.2005 and again on 07.06.2005 to 13.06.2005 for Koch's Dorsal Spine. When Shri Vejhurani preferred a claim for the said hospitalizations, the Third Party Administrator of the Company i.e. M/s MD India Ltd. deducted the stay and nursing charges from 14.3.05 to 20.3.05 in respect of his first hospitalization and for the expenses incurred under second hospitalization for the same illness, the TPA repudiated the claim stating that as the patient was on oral medication and as advanced mobilization physiotherapy which could have been done on OPD basis, the claim was not payable. His representation to the Company for consideration of his claim was also turned down by invoking clause 4.10 of the mediclaim policy.Being aggrieved Shri Surendra Vejhurani approached the Office of the Insurance Ombudsman. On scrutiny of the case we find that the Company has disallowed Rs. 9,138 for the hospital stay and nursing charges based on the indoor case papers. In this the TPA has taken a decision to curtail the stay in the hospital beyond 13.3.05. It is to be noted that patient can't use his own decision to get

discharged from the hospital. Here the admission was based on the recommendation of the doctor and nobody would like to take discharge at his own risk. The patient was admitted on the recommendation of the Doctor and was relieved on his advice. Thus we do not find a proper justification to curtail the stay charges at the hospital. In respect of the second hospitalization it is noted that there was no emergency hospitalisation and the disease for which he was admitted was already diagnosed. There were different investigations and tests carried out but no adverse remarks were observed in those reports. Hence it is clear that there was no necessity as such for admission to the hospital and the diagnosis was already known and no fresh diagnosis was arrived at and only oral medications were administered during the hospitalization. All these tests could have been done on OPD basis. Therefore, second hospitalization was not justified. However, we find on record a certificate issued by Dr. Shyam R Mukhis, M. S. (Ortho) recommending hospitalization for mobilizing the patient.

Keeping in view all the circumstances narrated above an ex-gratia payment of 50% admissible expenses for 2nd hospitalization be granted to draw a fine balance.

The New India Assurance Company Ltd is directed to settle balance amount of claim for his first hospitalization at Jasraj Hospital of Shri Surendra Vejhurani and pay 50% of the admissible expenses on Ex-gratia basis for 2nd hospitalization from 07.06.2005 to 13.06.2005. There is no order for any other relief. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. : GI-236 of 2006-07
Shri Addison Aranjo
V/s.
The New India Assurance Co. Ltd.

Award Dated : 30.03.2007

Shri Addison Aranjo was covered under Mediclaim Policy since 29/1/2003 for a SI of Rs. 5 lakhs. He renewed the policy the following year and lodged four claims under the policy No. 111200/48/03/13717 (29/1/2004 to 28/1/2005), out of which the first claim was fully settled by the Company and the second one was rejected by the Company for non-compliance and the third one is still pending. The fourth claim which is disputed was for treatment of Hepatitis C Infection for which Shri Aranjo was hospitalized at Bombay Hospital from 10/7/2004 to 11/7/2004. He lodged a claim for Rs. 1,71,224/- out of which the TTK settled the claim for Rs. 1,16,298 thereby disallowing Rs. 51,900/- as it was exceeding pre-hospitalisation expenses. Not satisfied with the decision of the TPA, the Insured represented his case to New India's Grievance Cell, for balance payment. Grievance Cell reviewed the case and observed that the claim attracted exclusion clause 4.1 and deserved outright rejection. They took a medicolegal opinion and accordingly rejected the claim and directed the TPA to recover the settled claim amount from the Insured as there was non-disclosure of material fact of Road Traffic Accident and blood transfusion undergone by the Insured years back. The revised decision/status of the claim was informed to the Insured by the Company.

From the medical documents it is clear that the Insured had met with a road traffic accident in 1989 for which blood transfusion was given and blood transfusion is one of the sources for contracting infection of Hepatitis C virus.

The Complainant argued that Hepatitis C virus was not unearthed or in existence at all during 1989 and that it was only detected in the year 1991-92 and to presume that cause of this infection was the blood transfusion given in 1989 was not correct. It was

reported by the Complainant that the Hepatitis C virus was diagnosed during the routine health check-up and he was referred to a Gastro-Enterologist for further management of the Hepatitis virus, but was he undertaking such medical check-ups regularly or was it for a different purpose due to some problem he was encountering is best known to the Insured. It is to be noted that the Insured took a mediclaim policy of Rs. 5 lakhs to start with, which is the maximum coverage available under the policy, in January, 2003 and went for routine medical check up in September, 2003 i.e. 8 months after taking the policy.

The Company levelled the charges that the vital material facts of vehicular accident resulting into operated fracture and blood transfusion were suppressed by the Insured at the time of proposing for insurance for the first time. The Insured counter argued stating that he had disclosed whatever was required in the proposal form. The Company initially expressed their inability to produce the proposal form to substantiate their stand during the hearing. However, later they submitted a zerox copy of the proposal form filled in by the Insured, wherein it was observed that the Insured had clearly mentioned 'No'/ 'Nil' to the question no.13(o), 15 and 16 and 17. Whereas the hospital records clearly mentioned "k/c/o Hepatitis 'C' and past history of RTA (Road Traffic Accident) years back, blood transfusion given ; Infected by Hepatitis 'C'. Though it is not proved that the patient was infected by Hepatitis c virus due to blood transfusion or subsequently by any other means, but the Insurer can set aside the insurance contract, for non-disclosure of material information which was vital for this case.

Further, it is also observed that the expenses incurred by the Insured during his hospitalization, were mainly for medicines only (Rs.1,60,716/-) which were incurred during pre and post hospitalisation period. The hospitalization expenses like Room/nursing/admn. charges amounted to around Rs. 7500/- only. This indicates that he was already diagnosed and was on treatment before this hospitalization.

In view of the above findings, the repudiation of the claim by the Company for non-disclosure is in order and this Forum does not find any valid ground to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-551 of 2006-07
Shri Arvind Dalal
V/s.
The New India Assurance Co. Ltd.

Award Dated : 30.03.2007

The dispute is regarding partial settlement of post hospitalization claim of Smt. Asha A. Dalal. The main claim has been settled to the tune of Rs. 73,259/- as against Rs. 75395/-. However the post hospitalization claim of Rs.16,625/- was settled for Rs.4425/- deducting Rs. 12,200/- which pertained to visits by Dr. Anil Mehta & associates who were family physicians during hospitalization and as well as home visits after discharge.

Analysis of the case reveals that the Complainant's wife, Smt. Asha Dalal was hospitalized at Breach Candy Hospital from 2/6/2005 to 9/6/2005 for liver failure due to acute Hepatitis B. As per discharge card, the advice on discharge was "medicines as prescribed and doses to be adjusted and restart calcium supplements" There was no mention of home visit of doctor on discharge. Also the type of treatment given in the hospital did not warrant home visits of doctors as there were no surgical procedures

involved in the treatment. Hence this Forum does not find any justifiable reason to interfere with the decision of the Company for disallowing the family physician's fee as claimed by the Complainant.

Mumbai Ombudsman Centre
Case No. : GI-506 of 2006-07
Shri Bharnal B. Lodha
V/s.
The New India Assurance Co. Ltd.

Award Dated : 30.03.2007

Shri Bharnal B. Lodha was covered under Mediclaim Policy No.112700/48/00/00239 since 2/2/2000. He was hospitalized at P.D. Hinduja Hospital on 23/11/2000 and he underwent CABG for which his claim was settled in full by New India. He did not have any problem of the heart after his CABG until the present one for which he was hospitalized at the same Hospital on 11/1/2005 and underwent angiography. His claim for reimbursement was repudiated by the TPA under exclusion clause 4.10.

Analysis of the case reveals that Shri Lodha was hospitalized at P.D. Hinduja Hospital. from 11/1/2005 to 14/1/2005 and diagnosis was IHD, Hypothiroidism and Low Back Pain. He underwent Angiography along with treatment for Low Back Pain. . Hinduja Hospital's Discharge Summary states that "he was a k/c/o IHD since 5 years. and on medicines. K/c/o Hypothyroidism since 5 months. CAG done in 2000 showed 90% LAD Stenosis. Now admitted with complaints of left sided chest pain off and on since last 1 to 1 ½ months radiating to back and neck. Coronary Angiography done on 12/1/2005 revealed Mild Ostial disease before high diagonal/ramus like branch, followed by 100% occlusion just after the diagonal. Mild Anterior Hypokinesia and LVEF 50%. He was advised medical management.

The claim was reviewed by the Company on representation received by the Insured and had referred the claim folder to their panel doctor, Dr. A.V. Patil also who opined that "even if the investigations are not abnormal, it is not decided by the claimant and was advised in view of chest pain by cardiologist and hence should be paid." However, the Company did not consider the opinion given by their own panel doctor and concurred with the decision of the TPA to reject the claim under clause 4.10 and further added that as per Mediclaim Policy terms and conditions, second time angiography charges are not allowed unless followed by Medical intervention. Coming to the point that second time angiography cost are not payable unless followed by Medical Intervention, it is an internal circular of the Company and not a policy condition. The Company has not put any such condition while renewing the policy nor the Insureds are kept informed about such restrictions in the policy terms and conditions. Further it needs to be noted that the Angiography was done on the recommendation of his Consultant/ treating physician and based on the CAG report, he was suggested medical management of the ailment. Under the circumstances the Insurer's stand that Angiography expenses would be payable only if followed by any medical intervention is not acceptable.

Mumbai Ombudsman Centre
Case No. : GI-158 of 2006-07
Shri Caesar D'lima
V/s.
National Insurance Co. Ltd.

Award Dated : 30.03.2007

Shri Caesar D'lima and his wife were covered under Mediclaim Policy since 1/4/1992. He renewed the policy continuously. He approached this Forum with a complaint for non-settlement of his claims under the Mediclaim policy by National Insurance Co. Ltd. as he did not get a favourable reply to his representation from the Company. Parties to the dispute were called for personal hearing on 23rd February, 2007.

Analysis of the case reveals that Shri D'lima was admitted to Hinduja Hospital on 22/6/1997 to 25/6/1997 for operation of nasal (right) block and the claim was settled by National Insurance. In the history sheet it is mentioned that he had past h/o of Inferior Wall MI, his HT was + , Smoking + and was taking Tab. Dilgard, Tab. Monotrate, Tab. Dispirin among other medicines. He was referred to a cardiologist for IHD & HT during hospitalization and treated for the same. His ECG taken revealed old inferior wall MI, his Ejection Fraction was 50%. His nasal block operation was performed after his HT and IHD were controlled. The exact duration was not mentioned about HT & IHD in the hospital record but it is clear that the patient was known case of HT & IHD.

He was again hospitalized for heart ailment in Suchak Hospital on 28/1/2005 to 5/2/2005. Transfer Summary of Suchak Hospital states diagnosis as "IHD with Hypertension with Renal Failure and Rt. Pneumonia.´ He was transferred to Holy Family Hospital for further management from 5/2/2005 to 14/2/2005 where the diagnosis was IHD with TVD with HT Nephropathy. PTCA to LAD with stent was performed on 12/2/2005 and it was remarked in the discharged card that he needs angioplasty of both Renals. He was again hospitalized on 22/2/2005 to 26/2/2005 at Holy Family Hospital for (bilateral) Renal angioplasty. Past Medical Background of Holy Family Hospital reveals he had a history of blood pressure, kidney problem and alcohol dependence which was further remarked "stopped from Aug. 2004 (taking occasionally). When a claim was preferred for the above hospitalizations, the TPA repudiated the claim under exclusion clause 4.1 . The repudiation was based on the following documentary evidences.

The past medical history of the Insured given by his wife stated he was suffering from High BP and heart attack since 1987. (This the insured feels has been inadvertently told by his wife as 1987 instead of 1997) (Our analysis - This argument of the Insured cannot be accepted as the hospital papers of Hinduja Hospital recorded past history of Inferior Wall Myocardial Infarction and HT for which he was already taking medicines which means he had the problem before 1997. Moreover, the prescription paper of Dr. Padaria submitted by the Insured after the hearing also indicates that he was on medicines from 1994. There is no proof that it was the first consultation paper.

The Certificate dated 5/7/2005 by the treating doctor, Dr. Robin Pinto , Hon. Cardiologist states that during admission on 4/9/2004 the patient has given history of hypertension since 27 years and History sheet of Holy Family hospital records HT/IHD since 18 years. (Our Analysis – Dr. Pinto in his certificate has confirmed that he was hospitalized on 3 occasions at Holy family, once in 1994 and twice in the year 2005 and at the time of every admission the patient has given different durations of HT and IHD

Indoor case papers of Holy Family Hospital dated 4/9/04 mentions that the Insured was a k/c/o HT since 27 years and was on treatment (Indoor case papers of 4/9/2004 not in the file). There are inconsistencies in the duration of the illness mentioned at various places but the hospital records cannot be set aside as history is given truthfully for better management of the disease. If we take the history as 18 years, it goes back to 1987 . The year 1987 was also reported by his wife. The first policy was taken in the year 1992 and it was renewed without break. In the year 1997 when he was

hospitalized for nasal block, other than oral medications and ECG no other investigations were carried out for IHD and it appears much seriousness was not attached to IHD problem but he was on medication for HT/IHD before hospitalization. The Complainant could not produce any evidence for the onset of the disease that it was not pre-existing. The Insurer has relied only on the history given at the time of various hospitalization which was quite inconsistent. They have not produced any concrete evidence to prove their point for rejection of the claim. Keeping these circumstances in view it will be appropriate to allow 50% of the admissible expenses of hospitalization.

Mumbai Ombudsman Centre
Case No. : GI-222 of 2006-07
Shri Pawan M. Lath
V/s.
The New India Assurance Co. Ltd.

Award Dated : 30.03.2007

Shri Pawan M. Lath along with his wife and two sons was covered under Mediclaim Policy since 10/12/2004. In the following year his son, Shri Ankush P. Lath , aged 20 years was hospitalized at Rohit Nursing Home on 11/2/2006 and the diagnosis was allergic Rhinitis with atopic Br. Asthama. He was treated and discharged on 16/2/2006. When a claim was preferred by the Insured, the TPA rejected the claim invoking excl. clause 4.1. .

Analysis of the case reveals that Shri Ankush Lath was hospitalized with chief complains of fever since 10 days and breathlessness with h/o cough and expectorations. He was diagnosed to have allergic Rhinitis with Atopic Bronchial Asthama with bacterial infection. It is also observed from the Indoor case papers , that the Insured was also seen by Dr. Damble, ENT Surgeon on 11/2/2006 and as per his notings “the patient had recurrent sneezing attacks with mucopurulaent Rhinorrhoea , headache and facial heaviness. He is a case of recurrent (both) ear itching and these episodes were since many years.” He further mentioned O/E “acute on chronic sinusitis with allergic rhinitis.” Also, from the pathological report of ‘complete blood count’ it is noted that the WBC count was on a higher side of 17,000 cu.mm. (Normal Range is 4000 – 11,000 cu.mm.) He was administered high doses of antibiotics and steroids. He was also administered O2 and SPO2 for 5 days. He was put on Injection Effcorlin – 100 mg IV, 8 Hourly. Indoor case papers clearly mentions that episodes of recurrent sneezing with mucopurulaent Rhinorrhoea since many years . Temperature recorded in the hospital papers ranged between 98-99 degree. All other investigation reports were normal. The Mediclaim Policy was taken only a year back.

In view of the above analysis, this Forum does not find any justifiable ground to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-552 of 2006-07
Shri Rameshchandra B. Shah
V/s.
The Oriental Insurance Co. Ltd.

Award Dated : 30.03.2007

Brief facts of the case are as under :

Shri Rameshchandra B. Shah was covered under Mediclaim Policy since 2001. His claims for dialysis & angiography/angioplasty lodged under Policy Nos.

121300/48/05/1565 & 121300/48/06/3525 were not settled by the Oriental Insurance Company. He represented to the Company and not receiving favourable reply to his representation lodged a complaint with this Forum. Parties to the dispute were called for personal hearing on 12th March, 2007.

Analysis of the case reveals that the Insured, Late Shri Rameshchandra B. Shah entered the Mediclaim Scheme at the age of 59 years and this was his first Mediclaim Policy for Rs. 5 lakhs, the maximum permissible limit, effective from 3/9/2001. As per the proposal form, there was no disclosure by the Insured of any previous illness/disease or injury if any, sustained by him and hence it appears that the Company presumed that he was enjoying good health. The Company also has not subjected the Insured to any pre- acceptance medical health check up. As per the Company's written submission, they have paid claims amounting to Rs. 53,315/- under policy no. 121600/48/04/1477 period 3/9/2003 to 2/9/2004 for chronic renal failure and six claims for dialysis under Policy No. 121600/48/05/1565 during the period 24/9/2004 to 23/9/2005 aggregating to Rs. 1,76,050/-. Another six claims reported during the same period for dialysis amounting to Rs. 2,61,781/- were not settled. The Insured further lodged 5 claims for dialysis under Policy No. 121300/48/06/3525 which were also rejected under clause 4.1. Then the Insured lodged claims for Angiography and Angioplasty undergone by him in April 2006 amounting to Rs. 4,11,541/- which was also repudiated by the TPA. The repudiations of these claims were done based on the recordings of the h/o 30 years of diabetes in the Breach Candy Hospital papers.

Scrutiny of the records reveals that the Company had settled the earlier claims for the diagnosis of chronic renal failure with IHD with DM, since the history recorded in the Bhatia Hospital papers mentioned c/o DM since 1 years and HT since 6 months. They also settled the claim in 2004 for the same ailments where the hospital papers recorded history as k/c/o of DM & HT & CRF since 1 ½ yrs. The present disputed claim were disputed on the basis of the history recorded for DM as 30 years in Breach Candy Hospital. Thus there was inconsistency in the history recorded in two different hospitals. To sort out the issue of discrepancy in the history of DM, the complainant was requested to submit medical prescription/blood sugar test reports to prove that the onset of diabetes i.e. it was not prior to the date of inception of the policy. In response to the request, the complainant submitted copies of three investigation reports out of which one report was for Glycosylated Haemoglobin dated 2nd November,2001. It is pertinent to note that the first policy for Rs. 5,00,000/- was taken by the Insured on 3/9/2001 and the Glycosylated Haemoglobin test was done on 2/11/2001 i.e within two months of policy inception. Although the report showed normal readings, it would pose a question as to why such a test was recommended by his doctor ? It is medically established that Glycosylated Haemoglobin test is currently one of the best ways to check diabetes is under control and it is a good measure of diabetic control. This test is used for monitoring the treatment in diabetics and is recommended to be done atleast twice a year.

The Insured underwent some investigations on the recommendations of Dr. Yogesh Parekh on 14 / 10 / 2000 for the reasons best known to them as prescription papers have not been submitted but while proposing for mediclaim policy, there is no such mention. Insurance Contract is a contract of utmost good faith. He underwent Glycosylated Haemoglobin test which is done to monitor the control of diabetes just after two months from date of taking the policy. In view of this the history written in the hospital goes back to prior to the policy inception. Though it is not proved by evidence but the circumstances indicate the existence of DM before the policy inception. Under the circumstances, the benefit of doubt does not favour the complainant. In view of this there is no justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-192 of 2006-07
Smt Helen Desa
V/s.
United India Insurance Company Ltd

Award Dated : 30.03.2007

Shri Anthony Desa and his wife Smt Helen Desa had taken the mediclaim policy for the first time on 28.8.2001 with Sum Insured of Rs. 50,000 each. Smt Helan Desa was hospitalized at Lilavati hospital and Research Centre from 09.10.2005 to 24.10.2005 for unstable angina with DM and Hypertension. When Shri Anthony Desa preferred a claim under policy no. 021200/48/05/02158 for the period 28.8.2005 to 27.8.2006 which had earned 20% Cumulative Bonus, the TPA M/s Family Health Plan Limited rejected the claim invoking clause 4.1 of the mediclaim policy. Their contention was that as per the hospital case papers the Insured was suffering from DM since 12 years hence the claim was not payable. Dissatisfied with the decision of the TPA, Shri Anthony represented his case for review and not getting a favourable reply to his representation he opted to lodge a complaint to this Forum against the Company for non-settlement of his claim. After perusal of the records parties to the dispute were called for hearing.

On scrutiny of the records submitted to this Forum it is observed that In the Indoor case papers the diagnosis was unstable angina in a k/c/o DM + HTN + IHD with Rt Hemiplegia + MCA Infarct. The diagnosis in the discharge card summary was acute confusion state , DM c Mild retinopathy, IHD-Unstable Angina, borderline HTN, Simple Partial Seizure . From the medical analysis as examined above, it is clear that Smt. Helen D'sa was primarily admitted for "chest discomfort, giddiness and disorientation." She was detected to have dengue during hospitalization and was also treated for the same along with other treatment. Smt.Helen D'sa entered the Mediclaim scheme at the age of 75 years with a host of pre-existing ailments and during the hearing the history of past illness recorded at hospital was admitted by them. Therefore, this Forum does not find any justifiable reason to interfere with the decision of the Insurer. However, looking to the recommendation of the treating physician that she developed dengue fever and looking to their age and financial condition, honesty in admitting the past illness, I award an ex-gratia payment of 50% of basic Sum Insured i.e. Rs. 25,000/- in this case.

Mumbai Ombudsman Centre
Case No. : GI-338 of 2006-07
Shri A. Agarwalla
V/s.
The New India Assurance Co. Ltd.

Award Dated : 25.05.2007

Shri A. Agarwalla along with his daughter were covered under Mediclaim Policy No. 110900/48/05/20/70050218 issued by The New India Assurance Co. Ltd. D.O. 110900 for the period from 10/4/2005 to 9/4/2006. Ms. Anang Agarwalla, daughter of Shri A. Agarwalla was hospitalized at Breach Candy Hospital on a day-care basis on 26/12/2005 for dental treatment. When the claim was lodged with the Company for the said hospitalisation, the Company's TPA – TTK Health Care, rejected the claim invoking exclusion clause 4.7 and condition 2.3 of the policy. The contention of the TPA was that the hospitalization was only for 6 hours and the treatment was for dental.

Records of the case have been perused and the parties to the dispute were called for personal deposition on 20th April, 2007

Subsequent to the hearing, Shri A. Agarwalla vide his letter dated 21st April, 2007 requested this forum to consider his fresh submission about the facts of the case and to condone his absence for the hearing. His fresh submission is quoted hereunder :

“There were 4 majorly impacted molars that required surgical excision and removal. Hospitalisation was done in Breach Candy Hospital, a hospital as defined in the Insurance Policy and an admit card was also issued. The surgery was carried out in the operation theatre by a dental surgeon and anaesthesia was also given. Post surgery the patient, Ms. Anang Agarwalla, my daughter was kept in the recovery room for the effects of anaesthesia to wear off. The doctor recommended overnight stay in the hospital but as I did not want to add to the cost of the procedure, I opted to get her discharged and take her home as permitted by the rules of the said policy in the case of dental surgery. I pray you to kindly direct the Insurance Company to settle my claim failing which, great injustice will be done as it is a well known fact that the Insurance Company is in the habit of finding the flimsiest of excuses to disallow even genuine claims.”

On a critical look at the nature of illness, diagnosis made and treatment received at the hospital, it would appear that it was a case of Pericoronitis – “which is an inflammation around the crown of a tooth, particularly a partially erupted third molar” for which excision of the pericoronial flaps, curettage and extractions were done. There was only a history of pain with no other complications recorded in the surgical discharge folio to justify hospitalization.

The Surgical Discharge Folio shows Chief Complaints : “ c/o severe toothache x 1 wk, difficulty during eating , severe headache. Operation : Excision of pericoronial flaps, curettage and ext. 8/88/8”.

From the above facts and circumstances, this Forum does not find any justifiable ground to interfere with the decision of the Company to repudiate the claim.