Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11-004-0317
Mr. J G Dhanvani
Vs
United India Insurance Co. Ltd.

Award Dated : 10.4.2007

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified. It was observed from the records that the Insured child developed breathlessness with violent behaviour at midnight at 1.00 a.m. and had to be Hospitalised on the advice of the Consulting Physician. The Insurer repudiated liability on the basis of the opinion of their Medical Referee who opined that Hospitalisation was not justified. However, 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. 11-002-0301
Mr. S J Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 10.4.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for 'Koch's Spine with abscess, Rheumatic Fever and lung Fibrosis'. The Discharge Summary of the Hospital noted that the Patient had a history of Paraparesis, Breathlessness, Past history of Tuberculosis in childhood and a history of Rheumatic Heart disease and lung disease. The Policy commenced 3 months prior to the date of Hospitalisation. The clinical history quite clearly established the nexus with the disease which commenced 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. 11-005-0338
Mr. J J Dhagia
Vs
Oriental Insurance Co. Ltd.

Award Dated : 11.4.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the

Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0225
Mr. R V Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 11.4.2007

Delay in settlement of Mediclaim. The Claim for Rs. 158874/- was submitted on 23-7-2005. A sum of Rs. 150000/- was settled. The balance of Rs. 8033/- was settled only on 3-2-2007. There was no deficiency of compliance on the part of the Complainant. The case being one of deficiency in services of the Respondent Insurer, simple interest at 8% p.a. for the number of days in delay in settlement of the balance claim was awarded.

Ahmedabad Ombudsman Centre
Case No. 11-002-0302
Mr. D C Kharidia
Vs
New India Assurance Co. Ltd.

Award Dated : 11.4.2007

Partial settlement of Mediclaim. An amount of Rs. 13933/- was deducted out of the claimed amount. Rs. 10000/- towards Doctor's charges for assisting in the Operation and Rs. 3933/- towards Chemist's Bills for not carrying the name of the Patient. While it is true that the Hospital did not indicate the name of the Assisting Doctor in the 'Operative Notes', it is also established that the Complainant made the payment to the Hospital by Cheque in full. In such a situation, denial of the amount is not fair. Besides, there was unanimity in course of Hearing that absence of name of the Patient in the Chemist's Bill is a common deficiency often committed by the Chemists which again is not a strong ground to deny the amount to the Complainant, there being no other infirmity with regard to the said bills. As such, the Respondent was directed to pay Rs. 13933/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0321
Mr. R J Darji
Vs
New India Assurance Co. Ltd.

Award Dated : 11.4.2007

Repudiation of Mediclaim. The Insured was suffering from Breast Cancer which subsequently affected her Liver as well. Chemotherapy treatment was initially administered in the Hospital. Subsequently, Oral Chemotherapy was done at her residence, the reimbursement of costs of which were denied by the Respondent since the bills thereof were for a period beyond 60 days of discharge from the Hospital. Due to technical advances and progress in medical science, it is now possible to administer Chemotherapy through oral drugs taken under stipulated Medical precaution. In the instant case, the administration of Oral Chemotherapy on the Insured was done on certification by the treating Oncologist. There being no other infirmity in the claim, to deny the Policy benefit for treatment by mechanical application of the Policy Clauses is

not considered to be fair and justified. As such, the Respondent was directed to pay the full amount of Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0331
Mr. K H Rohadiya
vs
New India Assurance Co. Ltd.

Award Dated : 12.4.2007

Repudiation of Mediclaim: The Insured gave birth to a Child. 1½ months 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. 11-003-0274
Mr. B B Vyas
Vs
National Insurance Co. Ltd.

Award Dated : 18.4.2007

Repudiation of Mediclaim on the grounds of pre-existing disease. The Complainant was admitted to a Hospital for treatment of Coronary Artery double Vessel Disease. The Clinical notes of the treating Doctor certified that the Patient had no past history of Hypertension or Diabetes Mellitus. The Hospital Discharge Summary too noted Acute Inferolateral Wall MI, Hypertension (recently diagnosed) None of the Treatment papers made available on record from any Hospital, Doctors contain any indication of the subject disease having been pre-existing. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0329
Mr. S N Vyas
Vs
New India Assurance Co. Ltd.

Award Dated : 25.4.2007

Partial settlement of Mediclaim. The Claim was settled by deducting Rs.11682/- towards Bills having not been submitted with the Claim, for Home Visit charge of the Doctor, for bills pertaining to medicines taken after the post-hospitalisation period. These are very justified and primary requirements of any Insurer before settling any claim to determine the amount payable. As such, the complaint failed to succeed.

Ahmedabad Ombudsman Centre

Case No. 11-002-0345
Mr. J C Gandhi
Vs
New India Assurance Co. Ltd.

Award Dated : 30.4.2007

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. 11-011-0328
Mr. A V Sabalpara
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 30.4.2007

Repudiation of a Claim under Health Insurance Policy due to non-disclosure of material facts while proposing for insurance-The Insured was hospitalised for Fracture of Tibial Condyle with Crush Injury on Right Leg. Claim was repudiated since the Insured had not disclosed the fact of his having accidental injuries and fracture of right leg due to a road accident prior to the date of filling in the proposal form for insurance. The current bout of hospitalisation was to remove the Screw from the Right Leg. Non-disclosure of the operation denied the respondent an opportunity to underwrite the case properly. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-005-0337
Mr. N H Parmar
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30.4.2007

Repudiation of Mediclaim: The Insured was injured in an accident and suffered facial injuries and thereafter dental dislocation. The treating Surgeon treated the outer wounds by hospitalisation and then referred the case for Dental Surgery. Surgery took place in a Dental Clinic for complete dislocation of Dental Joints which required re-implantation. Claim was repudiated since the Respondent referred the treatment to be of a Dental nature while the circumstances showed that they were in fact caused due to an accident. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 14-004-0124
Sri T D Krishnamurthy
Vs
United India Insurance Co. Ltd.

Award Dated : 30.4.2007

Delay in settlement of Mediclaim. The Insured had complied with the requirements on 26-10-2004. A Cheque for settlement of the Claim was issued only on 14-5-2005. Again, the cheque thus issued with unreasonable delay was dishonoured due to deficiency in respect of the signatures in the cheque. The Insurer issued a fresh cheque on 27-10-2005. The Insured complained for compensation for the delay in settlement of the Claim. During the course of Hearing, while the Respondent admitted their fault, regretted for it, also pointed out that subsequent to the filing of the Complaint, they had made a payment of Rs. 5600/- as compensation for the service deficiency. The Complainant confirmed having received the compensation, but sought further amounts against deficiency of service which was apparently at 12½% of the Claim amount. However, the compensation having been received to the extent of Rs.5600/-, no further relief was considered necessary to dispose the complaint.

Ahmedabad Ombudsman Centre
Case No. 11-005-0348
Mr. P P Pipaliya
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30.4.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of “Prolapsed IV Disc L5-S1 with DVT”. There was on record, an old X-Ray report of the Spine, five years prior to the Hospitalisation, which mentioned that there was decreased L5-S1 disc space. The Policy commenced 2 years prior to the date of Hospitalisation. As such, the Claim attracts Exclusion Clauses of pre-existing disease. It was also observed that no disclosure of the Investigations done in 2001 was done while filling up the proposal form for the current Mediclaim policy. Thus, even the allegation of non-disclosure got established. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0040
Sri. A R Rajput
Vs
New India Assurance Co. Ltd.

Award Dated : 10.7.2007

Repudiation of Mediclaim for the period beyond 60 days of Hospitalisation: The Insured was hospitalised for treatment of Malignant Lesion in the Right Lung viz. Lung Cancer. The Treating Oncologist took him through a course of Oral Targeted Therapy. As is known, earlier treatment of Cancer by Chemotherapy could be administered only on hospitalisation. However, due to technical advance and progress of Medical Science, it has been rendered possible to have such Therapy to be administered orally without hospitalisation. The Respondent took a further opinion from an Oncologist who opined that the subject treatment of Cancer is in line of Oral Chemotherapy. But for scientific advancements, the Therapy would have been administered on hospitalisation only and the Claim on it would have been payable. Still when the treatment and its associated expenses had been incurred by a sufferer of such a dreaded disease like Cancer, the factor of hospitalisation alone in all fairness should not be a ground to deny reimbursement. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre

Case No. 11-004-0013
Mr. B D Vakharia
Vs
United India Insurance Co. Ltd.

Award Dated : 16.7.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of 'Left Eye Retina Detachment'. The Discharge Summary of the Hospital noted IOL implementation done approximately 5 years back for Cataract in both the eyes. The History had commenced well prior to the commencement of the Policy. However the Medical Opinion noted that Retinal Detachment can occur at any age, risk factor for its development is 'High Myopia" after Cataract Surgery. It was also observed that no disclosure of Cataract was done while filling up the proposal form for the Mediclaim policy. Thus, even the allegation of non-disclosure got established. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0064
Ms. S Devadasan
Vs
New India Assurance Co. Ltd.

Award Dated : 16.7.2007

Repudiation of Mediclaim:: The Insured was hospitalised. Claim was repudiated since, the Indoor Case Papers of the Hospital was not submitted by the Insured. It was observed that the Hospital had not co-operated in this regard, even though the Insured had made reasonable efforts to persuade the hospital to comply. It was not found fair on the part of the Respondent to repudiate the Claim by invoking the condition that non-submission of information would deny benefits under the policy. As such, the repudiation was set aside and the Respondent was directed to pay the full Claim amount.

Ahmedabad Ombudsman Centre
Case No. 11-005-0259
Mr. D B Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 16.7.2007

Partial Repudiation of claim under Mediclaim Policy-It was observed that the Mediclaim cover incepted in 2001 with Sum Insured of Rs. 50000/-. The same was increased to Rs. 1 lac w.e.f. 2003 and to Rs. 2 lacs w.e.f. 2004. Claim was repudiated on the ground that there was misstatement with regard to the coverage in the said subsequent Proposal for Rs. 2 lacs which also resulted into a Policy. During Hearing, the Complainant admitted to the misstatement but alleged to have been misguided by the Agent. As such, it was not possible for the Forum to examine on the subject.

Ahmedabad Ombudsman Centre
Case No. 11-005-0049
Mr. B H Nirmal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30.7.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0048
Mr. R. S. Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 30.7.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0058
Ms. M. M. Chandlekar
Vs
New India Assurance Co. Ltd.

Award Dated : 31.7.2007

Repudiation of Mediclaim: The Insured was admitted to a Hospital for treatment of Heart Disease. While submitting the Claim, a structured form has to be filled in by the attending Doctor/Hospital. In this case too, the form was submitted by the Hospital which noted that the Complainant had a history of Chest Pain and was having Blood Pressure related illness for the last 6 months, for which she was also taking medication. The Mediclaim Policy had been issued subject to an exclusion for Hypertension and related disorders for 2 years. When calculated back, it takes one within the two year period for which the exclusion was applied. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0239
Smt. N Y Parekh
Vs
New India Assurance Co. Ltd.

Award Dated : 4.6.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured had sustained burns on both of his foot soles due to the heat of the terrace

floor. The said incident occurred in August, the month subsequent to monsoon. Materials on record show that the Cause of Death as Cardio-respiratory arrest. The Primary Cause is Septicaemia and the Secondary Cause is Diabetes Mellitus and Chronic Renal Failure. It was observed that the deceased had a history of Diabetes Mellitus for 15 years and that Diabetic Neuropathy made the critical contribution in producing blisters in the foot-soles rather than alleged harm done by the terrace surface solely heated by natural sunlight that too in the month of August. The inception of the disease being prior to the date of commencement of the Mediclaim coverage, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0054
Mr. N K Bhatt
Vs
New India Assurance Co. Ltd.

Award Dated : 12.6.2007

Repudiation of Mediclaim due to delayed submission of Claim papers. The Complainant was hospitalised for treatment of Hepatitis A with Cholestasis or Malaria. After 8 months of discharge, the Claim papers were submitted to the Respondent. The delay being a gross violation of the Policy Conditions, the decision of the Respondent to repudiate the subject Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0334
Mr. L M Sharma
Vs
United India Insurance Co. Ltd.

Award Dated : 13.6.2007

Repudiation of Mediclaim on the ground that the treatment was for Congenital Internal Disease: The Insured was operated for “Accessory Navicular of the Foot” under Spinal Anaesthesia. The Respondent Insurer relied on the opinion of the Medical Referee that Accessory Navicular is a congenital internal disease meaning that a person is born with the extra bone. Since, treatment for Congenital Internal disease is excluded in the first year of the Policy, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0015
Mr. G R Gurjar
vs
United India Insurance Co. Ltd.

Award Dated : 13.6.2007

Repudiation of Mediclaim : The Insured underwent treatment by way of ‘Hysterectomy for Menorrhagia’ in the first year of inception of the Mediclaim Cover. The Mediclaim Policy excludes reimbursement specifically for the said disease in the first year of inception of the Policy. The Complainant submitted that the Mediclaim coverage was taken from New India Assurance Co. Ltd. Earlier. However since there was a delay of 6 days to renew the cover with the Respondent Insurance Company, this Coverage should be held to have incepted afresh as a new Contract. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-005
Sri. D A Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 14.6.2007

Repudiation of Mediclaim: The Insured was hospitalised to treat morbid Obesity with Hypertension, Joint Pain and Depression. The treatment was done by way of an operation (Laprascopic Gastric Bypass). The Respondent repudiated the Claim stating that the subject surgery was a Cosmetic Surgery. The Operating surgeon had noted that the said surgery was done on morbidly obese patients to treat morbid obesity and its complications. WHO had defined obesity as a disease. Thus the same cannot be concluded to be Cosmetic Surgery. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0024
Sri. N G Parmar
Vs
New India Assurance Co. Ltd.

Award Dated : 15.6.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised. The Discharge Summary of the Hospital noted 'H/O Haematemasis (6 months back) & Underwent Sclero Session'. There was another noting of Cirrhosis of Liver-Portal Hypertension & Ascites. Besides, it also noted that the Complainant had Alocholic Liver Disease. The History of Haematemesis (Blood Vomiting) had commenced prior to the commencement of the Policy. As such, the Claim attracts Exclusion Clauses of pre-existing disease. It was also observed that no disclosure of the disease was done while filling up the proposal form for the current Mediclaim policy. Thus, even the allegation of non-disclosure got established. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0352
Mr. K P Bhavsar
Vs
New India Assurance Co. Ltd.

Award Dated : 19.6.2007

Partial settlement of Mediclaim: An amount of Rs. 7450/- was not allowed while settling the Mediclaim consisting of

- Rs. 3000/- towards OT Procedure-Deducted on criteria of reasonableness for which acceptable arguments were not available
- Rs. 2700/- towards Nursing Charges-Deducted on criteria of reasonableness for which acceptable arguments were not available
- Rs. 1700/- towards Miscellaneous Charges-Not payable as per Mediclaim Policy
- Rs. 50/- for Registration Charges-Not payable as per Mediclaim Policy

As such, the Respondent was directed to pay Rs. 5700/- in full and final disposal of the Complaint.

Ahmedabad Ombudsman Centre
Case No. 11-002-0062
Mr. P J Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 18.6.2007

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified. The Insured was suffering from 'Varicose Vein Rt. Leg' for which she was hospitalised. The Insured underwent Ultrasound guided Sclerotherapy under local anaesthesia at an X-ray Clinic which involved no hospitalisation. Subsequently, she was hospitalised under the care of the Vascular Surgeon. Claim was repudiated by the Insurer since Hospitalisation was for observation purposes only. However, Sclerotherapy is a recognised method of treating Varicose Veins, involving multiple injections. As it was conducted in the Hospital itself by an Endovascular Specialist, it is wrong to view that the hospitalisation in 'not necessary'. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0003
Mr. N J Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 18.6.2007

Partial settlement of Mediclaim: An amount of Rs. 4966/- was not allowed while settling the Mediclaim consisting of

- Rs. 4500/- towards Special Room charges for 3 days. The Patient was kept in PICU for one day and in the Special Room for 3 days. It was wrong on the part of the Insurer not to have allowed the charges for the stay in the special room.
- Rs. 450/- towards Nursing Charges-Deducted on criteria of reasonableness for which acceptable arguments were not available
- Rs. 16/- towards purchase of an item other than Medicines-Not payable as per Mediclaim Policy

As such, the Respondent was directed to pay Rs. 4950/- in full and final disposal of the Complaint.

Ahmedabad Ombudsman Centre
Case No. 11-002-0008
Mr. B J Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 18.6.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the

Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0041
Mr. S V Bhatt
Vs
New India Assurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0018
Sri M A Alam
Vs
New India Assurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-003-0011
Mr. H A Patel
Vs
National Insurance Co. Ltd.

Award Date: 29.6.2007

Repudiation of Mediclaim. The Insured was operated for Abdominal Hysterecomy on 13-5-2006. The Mediclaim Policy incepted on 12-4-2005. Claim was repudiated since the Policy excludes reimbursement of expenses towards Hysterectomy in the first year of the Policy and the Respondent had taken a stand that the operation being just subsequent to the expiry of the first year of cover makes it a case of planned hospitalisation just to derive the benefit of the Cover. However, the treating Doctor had described the disease suffered to be acute and had also noted that the problem was noticed 3 months earlier to surgery. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0027
Mr. R S Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim on the ground that Cataract is not covered in the first year of the Policy : The Insured had been operated for Cataract 9 months after the inception of the Policy. Claim was repudiated since the Mediclaim Policy excludes reimbursement for expenses on treatment of Diseases such as Cataract. However, the records showed notings of the Consultant Opthalmologists who had recorded history of trauma/injury to the Left Eye with an iron handle 3 months before the Operation. In the instant case, the Insured had suffered an Injury and not a disease, which had led to the Cataract operation. As such, repudiation was set aside and the respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 14-005-0001
Mr. P B Samariya
Vs
Oriental Insurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0039
Sri. J U Pandya
Vs
New India Assurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre

Case No. 11-002-0020
Mr. L R Shah
Vs
United India Insurance Co. Ltd.

Award Date: 29.6.2007

Repudiation of Mediclaim on the grounds that treatment was for cosmetic purposes:: The patient was hospitalised for treatment of swelling at his right breast. The physician after conducting pathological tests and medication, later recommended surgery for 'Gynaecomatia'. The surgery is not of a type of plastic surgery or any operation to improve appearance. It was to held treatment of the illness suffered. To call it Cosmetic is not in order. As such, the repudiation was set aside and the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0208
Mr. S M Parmar
Vs
United India Insurance Co. Ltd.

Award Dated : 29.6.2007

Repudiation of Mediclaim. Mediclaim was repudiated for the reasons 'No record available in Hospital in form of Admission Record or Indoor Treatment record. During the course of the Hearing, the Complainant submitted the Investigation papers, Treatment papers, Discharge Summary, Treating Doctor's Certificate as exhibits. The Documents submitted by the Complainant along with the Claim Form were exhaustive enough to invalidate the ground of repudiation. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0353
Mr. T N Shukla
Vs
New India Assurance Co. Ltd.

Award Dated : 14.5.2007

Repudiation of Mediclaim. The Insured was admitted to a Hospital for treatment of Anaemia. The symptoms noted by the Hospital included "weakness, recurrent anaemia for one year". Iron deficiency was the reason suggested for the anaemia of the Insured. Blood Transfusion was done for nutritional anaemia. Since there was no other disease causing bleeding etc., it was concluded that the Hospitalisation for Blood Transfusion was done to the Insured due to Iron Deficiency Anaemia, which was due to general debility. The same being excluded from the purview of Mediclaim, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-005-0372
Mr. R P Jadhav
vs
Oriental Insurance Co. Ltd.

Award Dated : 14.5.2007

Repudiation of Mediclaim: The Insured underwent Cataract Operation for both the eyes. The Group Policy excluded the Cover for Cataract in the first year of operation of the Policy. Since, the Insured member was included in the scheme only 8 months back, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0382
Sri. M K Pandya
Vs
New India Assurance Co. Ltd.

Award Dated : 14.5.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of "Sle with ITP with AIHA". The Discharge Summary of the Hospital noted 'K/C/O ITP with SLE diagnosed in 2002'. It thus got established that the subject Disease had commenced prior to the commencement of the Policy. As such, the Claim attracts Exclusion Clauses of pre-existing disease. It was also observed that no disclosure of the disease was done while filling up the proposal form for the current Mediclaim policy. Thus, even the allegation of non-disclosure got established. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-005-0010
Mr. C S Bhasin
Vs
Oriental Insurance Co. Ltd.

Award Dated : 18.5.2007

Repudiation of Mediclaim since the subject disease was an Internal Congenital Disease. The Insured was operated for Left VU-Reflux and the surgery undertaken was for Re-implantation of the Ureter. The treatment of the disease had commenced in the first year of the Policy. The Treating Surgeon is the Chief Surgeon (Urology) at a premier Cancer Research Institute. He had noted in his Etiology Report that the Reflux was congenital. There being no history of earlier ailments that might have necessitated an operation only reinforces the aspect of congeniality of the disease. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0322
Dr. J R Purohit
Vs
United India Insurance Co. Ltd.

Award Dated : 23.5.2007

Repudiation of Mediclaim: The Insured was hospitalised to treat morbid Obesity with Hypertension, Joint Pain and Depression. The treatment was done by way of an operation (Laprascopic Gastric Bypass). The Respondent repudiated the Claim stating that the subject surgery was a Cosmetic Surgery. From the papers, it could be ascertained that the Respondent did not even refer the matter for an expert Opinion before repudiating the Claim. The Operating surgeon had noted that the said surgery was done on morbidly obese patients to treat morbid obesity and its complications.

WHO had defined obesity as a disease. Thus the same cannot be concluded to be Cosmetic Surgery. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0359
Mr. S B Purswani
Vs
New India Assurance Co. Ltd.

Award Dated : 23.5.2007

Repudiation of Mediclaim: The Insured, suffered from 'Perthes", a rare Orthopaedical Disease. The issue involved was not interpretation of Policy Conditions or applicability of any decided precedent. The Issue was totally a technical one, which required opinions of a very highly experienced specialist. There was a good amount of debate on the technical inputs on the onset, the regenerations stage, the healing stage and the residual stage of the disease. The debates were done by two Orthopaedic Surgeons of national and international repute. The Forum of Insurance Ombudsman has very limited capacity to obtain yet another opinion. Perhaps an opinion of the Medical Board constituted by Orthopaedics of eminence equal or higher than the two who had opined could be one of the options to be followed to decide the Case. It was hence suggested that the Complainant take up the matter in a Forum/Court considered appropriate for the purpose for proper resolution of the dispute.

Ahmedabad Ombudsman Centre
Case No. 11-002-0004
Ms. J C Das
Vs
New India Assurance Co. Ltd.

Award Dated : 23.5.2007

Repudiation of Mediclaim since Hospitalisation not justified: The Insured complained of severe pain, which led to admission to the Hospital by his treating Doctor. The Respondent repudiated the Claim since no fracture was certified to have occurred in any part of the body and during the course of admission to the Hospital, only primary treatment was given for Trauma in Left elbow and left shoulder, which could have been taken on OPD basis. During the course of Hearing, the Complainant informed that in the same accident, his brother too was injured. He too was admitted in the same Hospital and his Claim had been paid by the Respondent. To deny a similar Claim under the same Policy offends equity. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0367
Mr. A C Thakker
Vs
New India Assurance Co. Ltd.

Award Dated : 24.5.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Piles by K.S. Application. The treating Physician's qualification was M.D.(Ayurveda). The Respondent submitted that the Physician was not qualified to do Allopathic practice and as such did not fulfil the definition of Medical Practitioner as per the Mediclaim Prospectus. K.S. Application is an Ayurvedic Surgical Procedure, which is used in

treating patients in a number of hospitals throughout India. Besides, the Hospital where the operation was done, was registered by the Municipal Corporation under the Bombay Nursing Homes Act. It is difficult to justify non-admissibility of the Claim. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 14-003-0307
Mr. H M Sanghani
Vs
National Insurance Co. Ltd.

Award Dated : 28.5.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of “locked left knee”. The records showed that the Insured was operated for right knee. In such a situation application of the pre-existing Clause to exclude the benefit cannot be sustained. The Claim form however submitted by the Complainant mentioned ‘Accidental Injury’ as the nature of disease/illness and a Complaint was disposed off earlier by the same Forum vide Complaint No. 14-003-0308, pointing out that the due process of Law is desired to be followed in the facts and circumstances of the Case. In view of the same, Orders for payment of Mediclaim shall follow the decision taken on the PA Claim as indicated the Order mentioned above.

Ahmedabad Ombudsman Centre
Case No. 11-003-0312
Mr. A R Moghul
Vs
National Insurance Co. Ltd.

Award Date: 28.5.2007

Partial settlement of Mediclaim: An amount of Rs. 10346/- was not allowed while settling the Mediclaim, being the 15% Service Charges levied by the Hospital where the Insured was admitted for treatment of ‘Ac Small Bowel’. The Service Charge formed a part of the Hospital Bill. Such Service Charges were allowed by the Insurer while settling the Claim for the Insured’s wife in a different case. Taking a holistic view, the Respondent was directed to pay the amount deducted by them.

Ahmedabad Ombudsman Centre
Case No. 14-004-0254
Mr. N S Patel
Vs
United India Insurance Co. Ltd.

Award Dated : 28.5.2007

Repudiation of Mediclaim. The Respondent repudiated the Claim for alleged deficiency of giving necessary documents. The treating Doctor noted that the Insured had Diabetes for the last 18½ years. It was later clarified by the Doctor that the Insured had diabetes only for 1½ years. The Policy had commenced six years back. The Respondent asked for more documents to ascertain the date of onset of Diabetes. While the Respondent can ask for any documents that it considers necessary to decide the case, the Insured can at the best provide what is there in his possession and not more than that. Taking a holistic view, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0360
Sri. S R Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 30.5.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of “Disc Lesion C5-L1”. The Treatment papers noted that the Complainant was operated for P.I.D. L5-S1 4 years back. The Mediclaim Policy commenced only 2 years back. It thus got established that the subject Disease had commenced prior to the commencement of the Policy. As such, the Claim attracts Exclusion Clauses of pre-existing disease. It was also observed that no disclosure of the disease was done while filling up the proposal form for the current Mediclaim policy. Thus, even the allegation of non-disclosure got established. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-012-0363
Sri. A R Sharma
Vs
ICICI Lombard General Insurance Co. Ltd.

Award Dated : 30.5.2007

Repudiation of Claim under Health Insurance Policy: The Insured underwent Hysterectomy in the second year of the Policy. Claim was repudiated by the Respondent since as per the Policy Conditions, the benefit of reimbursement of treatment of Hysterectomy is not payable in the first two years of commencement of the Policy. The Complainant pleaded that the Insured was covered with Mediclaim with United India Insurance Co. Ltd. For five years before switching over to the Respondent Company and as such this Insurance should be treated as ‘Transfer of Mediclaim’. However, since there is no provision in the Health Insurance Policy of the Respondent for treatment of transfer of coverage and since the two Companies or their product conditions not being identical, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0020
Mr. B A Kothari
Vs
New India Assurance Co. Ltd.

Award Dated : 30.5.2007

Partial settlement of Mediclaim: The Insured was hospitalised for treatment due to a Vehicular Accident in Mumbai and was initially hospitalised there. Later, he was medically permitted to be transported to Ahmedabad by Air strictly in Horizontal Position and to be boarded in an Aircraft in a stretcher, lying down while on Flight. An amount of Rs. 23148/- was not allowed while settling the Mediclaim, of which Air Fare of Rs. 19945/-, Rs. 2000/- for Ambulance Charges both of which are beyond the scope of the Mediclaim Policy. Rs. 488/- had been deducted towards medicine bills where purchase went beyond 60 days after hospitalisation. Since, the Insured was declared fit about 90 days after the date of first hospitalisation, the same was allowed. Similarly the cost of Knee Brace, a normal appliance used as a part of treatment for damaged

bones and ligaments costing Rs. 650/- was also found payable. To sum up, the Respondent was directed to pay Rs. 650/- + Rs. 488/- totalling to Rs. 1138/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0374
Dr. R B Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 30.5.2007

Delay in settlement of Mediclaim. The Claim for Rs. 211246/- was submitted on 18-9-2006. A discrepancy letter dated 7-2-2007 was issued by the TPA of the Insurer received and complied by the Insured on 5-3-2007. Subsequently, a cheque dated 14-12-2006 was delivered to the Insured on 5-3-2007 i.e. after a period of 5 ½ months. As per IRDA Regulations, the reasonable time to process the Claim is 37 days. As such, the Respondent was directed to pay interest at 8% simple per annum for 130 days of delay.

Bhopal Ombudsman Centre
Case No. : GI/UII/0407/005
Mr. Dinesh Kumar Jain
V/s
United India Insurance Co. Ltd.

Award Dated : 31.05.2007

Mr. Dinesh Kumar Jain (hereinafter called Complainant) informed that he had taken a Medi Claim Policy No. 191181/48/06/20/00000022 from United India Insurance Co. Ltd., Bhopal (hereinafter called Respondent).

As per the Complainant he had taken the medi claim policy in May 2004 & is continuously renewing the same and in the last policy which was w.e.f. 08.05.2006 to 07.05.2007 a claim was lodged as his wife Mrs. Samta Jain was admitted in Shri Ganga Ram Hospital New Delhi on 07.01.2007 for the treatment of fibroid uterus operation for which he has intimated to the Respondent well before i.e. on 26.12.2006. Treatment was done by Dr. Vivek Marwah and the patient was discharged on 10.01.2007 & as per doctors advice the Complainant has to remain at New Delhi for re-check. The Complainant also stated that he had submitted the claim bill for Rs.51500/- to the TPA of the Respondent on 18.01.2007 for re-imbursement, but their TPA rejected his claim.

The Respondent in its reply-dated 09.05.2007 stated that the Complainant's wife was covered for Sum Insured of Rs. 1,00,000/- w.e.f. 08.05.2006 to 07.05.2007. The Complainant submitted the claim bill to their TPA i.e. M/S Med Save Health Care Bhopal. Claim papers were perused by the experts of their TPA and they concluded that Myomectomy was done for the treatment of infertility. As their policy do not cover any treatment taken for sterility/infertility, the claim was repudiated under policy exclusion clause 4.8 of the medi claim policy by their TPA.

During the hearing the Respondent stated the Complainant's wife was covered for Sum Insured of Rs. 1,00,000/- w.e.f. 08.05.2006 to 07.05.2007. The Complainant submitted the claim bill to their TPA i.e. M/S Med Save Health Care Bhopal. Claim papers were perused by the experts of their TPA and they concluded that Myomectomy was done for the treatment of infertility. As their policy do not cover any treatment taken for sterility/infertility, the claim was repudiated under policy exclusion clause 4.8 of the medi claim policy by their TPA.

Respondent also stated that as per the discharge card of the patient it shows that the patient had undergone IVF in 2002 which was not successful i.e. the patient was suffering since 2002 while he took the first Medi-claim policy in the year 2004 and as such the disease was also pre-existiny and as such the claim is not payable due to policy exclusion clause 4.1 also.

It is observed that the Complainant's wife was admitted in the hospital and the diagnosis was as "Fibroid Uterus" and Hospital discharge Card shows that the operation was done for "Laparoscopic Myomectomy with…….done under GA" i.e. Myomectomy is extirpation of a myoma/tumour. As per policy condition 4.8 excludes such diseases, which is read as " Policy does not cover Convalescence, general debility, 'run down' condition or test cure, congenital external disease or defects or anomalies, sterility, venereal diseases..." and as such the said disease is not covered under the above mentioned policy.

Besides from the discharge summary it is also observed that the complainant's wife had undergone IVF in 2002 which was not successful i.e. the patient was suffering since 2002 while he took the first Medi-claim policy in the year 2004 and as such the disease was also pre-existence and the claim is not tenable due to policy exclusion clause 4.1 also 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 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.

Bhubaneswar Ombudsman Centre
Case No. 11-003-0131
Smt. Sukanti Sahu
Vs
National Insurance Co. Ltd.

Award Dated : 25.05.2007

Insured complainant obtained a mediclaim policy from National Insurance Co. Ltd for sum insured of Rs 15,000/. On 14-02-2004 insured complainant was admitted to U.G.P.H.C. ,Khalikote for treatment of dog bite. Insured incurred an expense of Rs 2764.40 towards her medical expenses. Insured intimated the incident and submitted the bills for re imbursement of medical expenses on 5-7-2004. Insurer repudiated the claim on the ground that claim was not filed within stipulated period of 30 days from the date of discharge as per condition No 5.4 of the policy.

Being aggrieved the complainant approached this forum.

During hearing the complainant stated that being rural illiterate woman she was not aware of the terms and conditions of the policy. Insurer stated that as per policy condition they have repudiated the claim.

Hon'ble Ombudsman directed the insurer to pay Rs 2764.40 to the complainant as the delay was not deliberate and insurer can not absolve his liability on this ground.

Bhubaneswar Ombudsman Centre

Case No. 11-003-0130
Sri A.Kurash Patro
Vs
National Insurance Co. Ltd.

Award Dated 25.05.2007

Insured complainant obtained a mediclaim policy from National Insurance Co. Ltd for sum insured of Rs 15,000/. On 07-06-2004 insured complainant was admitted to Amrita Nursing Home and Pay Clinic,Kabisuryanagar for treatment of fever P.V.O.. Insured incurred an expense of Rs 4882 towards his medical expenses. Insured intimated the incident and submitted the bills for re imbursement of medical expenses on 16-10-2004. Insurer repudiated the claim on the ground that claim was not filed within stipulated period of 30 days from the date of discharge as per condition No 5.4 of the policy.

Being aggrieved the complainant approached this forum.

During hearing the complainant remained absent . Insurer stated that as per policy condition they have repudiated the claim.

Hon'ble Ombudsman directed the insurer to pay Rs 4882/ to the complainant as the disease was not excluded under the policy and insurer can not absolve his liability on this ground.

Bhubaneswar Ombudsman Centre
Case No. 11-003-0155
Sri Manoj Kumar Thebaria
Vs
National Insurance Co. Ltd.

Award Dated 20.06.2007

Insured Complainant obtained a mediclaim policy covering himself and his younger brother Rajesh from National Insurance Co. Ltd, Kolkata D.O.-III. During the policy period Rajesh was hospitalised for his Hernia operation in a Nursing Home. After completion of treatment insured submitted a bill of Rs 9456.25 for re imbursement of his medical expenses. Insurer settled the claim for an amount of Rs 6550/, which the complainant did not accept.

Being aggrieved on the decision of insurer insured approach this forum. During Hearing Insurer stated that insured underwent voluntary vasectomy operation along with hernia operation. Since vasectomy operation was not covered under the policy they have deducted the amount from that claim amount. Insured stated that the deduction made by insurer is arbitrary.

Hon'ble Ombudsman directed the insurer to pay Rs 8616.95 after deduction of Rs 500/ towards surgeon charges on vasectomy operation. Moreover insurer failed to explain the basis of deduction..

Bhubaneswar Ombudsman Centre
Case No. 11-002-0172
Sri Lalitendu Mishra.
Vs
New India Assurance Co. Ltd.

Award Dated : 03.07.2007

Insured Complainant obtained a Universal Health Insurance policy from New India Assurance Co. Ltd covering himself and his spouse. His wife got admitted into popular

nursing home on 19-12-2003 for treatment of left ovarian cyst. Insured submitted a claim of Rs 11027/ for re imbursement. Insurer repudiated the claim on the ground that disease was pre existing.

Being aggrieved the complainant approached this forum.

During hearing the insurer's representative stated that insured was operated after two and half months of commencement of policy. Their medical team has strongly opined that a cyst of 9cm size can not develop within this short period. So, they have repudiated the claim as the disease was pre existing. Insured did not turn up..

Hon'ble Ombudsman directed the insurer to pay Rs11,027/ to the complainant as the insurer failed to produce any opinion of doctors regarding pre existing of that decease.

Bhubaneswar Ombudsman Centre
Case No. 11-002-0157
Sri Krutibash Mishra
Vrs.
New India Assurance Co. Ltd.

Award Dated : 05.07.2007

Insured Complainant obtained a Rasta Apatti Kabacha Policy for himself from New India Assurance Co. Ltd. On 02-02—2005 while the insured coming to his residence near garage chhak two three street dogs ran across the road one after another and dashed against his motor bike as a result insured got injured on his left knee. Insured went to Sanjeevani Nursing Home on 3-2-2005 and took an injection. On 5-2-2005 he was admitted to that said nursing home for his treatment due to his financial problem. Complainant intimated the incident to Lingaraj police station . Insured lodged a claim for re imbursement of Rs 7481.20 towards medical expenses. Insurer repudiated the on the ground that cause of accident mentioned in station diary is different from claim form. Moreover the it was delayed intimation to police authorities.

Being aggrieved of the decision of insurer the complainant approached this forum.

During hearing the insurer's representative stated that complainant stated two different reasons for the cause of accident in claim form and station diary made to police.

Complainant stated that he met with an accident and sustained the injury and admitted to nursing home for treatment.

Hon'ble Ombudsman directed the insurer to settle the claim as the accident is genuine one and repudiation is not justified.

Bhubaneswar Ombudsman Centre
Case No. 14-003-0156
Sri V. Vijaya Kumar
Vs
National Insurance Co. Ltd.

Award Dated : 03.08.2007

Insured Complainant obtained a mediclaim policy from National Insurance Co. Ltd . During the period of insurance insured complainant met with an accident and under went treatment in a hospital and submitted a bill of Rs 61319.90 for re imbursement towards medical expenses .M/s Family Health Plan Ltd .the Third Party Administrator of insurer settled the claim for an amount of Rs 48578 and disallowed Rs 12732 due to non submission of documents . Insured accepted the amount under protest and lodged a complaint in this forum for balance amount.

During hearing complainant was directed to submit the documents desired by TPA and TPA was directed to settle the balance amount. Insured was asked by TPA to submit the documents relating to X ray, Pathology A.O. Instrument Charges, blood test reports ,ECG reports. Insured stated that as the test were conducted by hospital and they have not parted those reports to him he could not submit the same. Regarding instrument charges hospital authorities are better people to high light about the matter. Since the correspondence continued another date was fixed for Hearing. Insurer representative expressed his helplessness as the matter has been handled by TPA.

Hon'ble Ombudsman directed the insurer to pay Rs 12432/ as reports of tests were not handed over to insured by hospital authorities and Rs 300/ has been disallowed since no name has been mentioned in the medicine bills.

Chandigarh Ombudsman Centre
Case No. : GIC/199/NIC/11/08
Ajit Singh
Vs
National Insurance Co. Ltd.

Award Dated : 21.09.07

Facts : Shri. Ajit Singh and his family members were covered under Mediclaim Policy for the period 12.5.04 to 11.5.05 for sum insured of Rs. 3 lakhs for self and wife and Rs. 50,000 each for two children. The complainant's foot slipped from the stairs in his house. As a result of which he had severe pain in his back and leg. He got himself examined from Dr. Survesh Mathur on 14.3.05 who advised him for admission in hospital. He was admitted in Sutlej Hospital, Ludhiana from 15.3.05 to 17.3.05 for medical check up and tests. The tests showed that there was 'Disk Bulge L 4-5 and Disk Protrusion L-5-S1' in his backbone. Despite treatment as advised by the hospital he was unable to move even a single step due to the increased pain. He got himself checked up at Pahwa Hospital on 29.3.05, where he remained admitted from 29.3.05 to 14.4.05. He was given 24 hours Pelvic traction alongwith physiotherapy treatments. On his discharge from the hospital he was advised bed rest and was also referred to Dr. Manoj K Sobti, Neuro Surgeon who treated him from 2.5.05 to 7.6.05. He submitted all the documents to the insurer on 22.8.05 for claim under the policy. However, his claim was rejected on 12.5.06 by the TPA M/s Family Health Plan. It was submitted that he had been having Mediclaim policy since 8-10 years and had never lodged any claim.

Findings : The insurer stated that the TPA had rejected the claim as they felt that no hospitalization was required for physiotherapy treatment and the hospitalization in Sutlej Hospital was for investigations only.

Decision : Held that the tests conducted in Sutlej Hospital had shown the existence of disk bulge L-4-5 and disc protrusion L-5-S1. Thus the tests resulted in the diagnosis of a particular ailment. As far as hospitalization for physiotherapy was concerned, the same was advised by the medical specialist, since the complainant was not in a position to move and was bed-ridden. Hence ordered that the admissible claim amount along with interest @8% w.e.f 1.10.05 till 28.4.06 should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/132/UII/14/08
Lokesh Khanna
Vs
United India Insurance Co. Ltd.

Award Dated : 24.08.07

Facts : Shri Lokesh Khanna had taken a Mediguard Policy from DO-II Ludhiana. He was admitted in Hero DMC Heart Institute, Ludhiana on 1.9.06 and was discharged on 5.9.06 for single vessel disease for which PTCA was done. He submitted all medial records and lodged claim for Rs. 1,62,000/-. The claim was made 'no claim' on the ground of pre-existing diseases of hypertension and chronic smoker., but the insurer did not make any payment to him.

Findings : The insurer informed that the claim was reported by the insured on 8.9.06 for admission in Hero DMC Heart Institute, Ludhiana in connection with heart ailment. Since the claim lodged by the complainant was exceeding their financial authority, the matter was reported to their Regional Office. The Regional Office, Ludhiana deputed Dr. Suresh Kumar, panel doctor for opinion. On 20.9.06 a letter to Medical Superintendent was also written seeking details of the case. As hospital authorities did not respond despite reminders, the insured for approached for requisite information, which was vital for establishing the existence of disease prior to the inception of the policy. But the insured did not reply to their various letters. The claim was repudiated on the basis of discharge summary and DMC clarification letter dated 22.2.07 in which it was stated that the insured was a known case of HTN and chronic smoker. It was stated that these were the major factors for the current ailment. In the absence of any concrete evidence about the periodicity of HTN, it had been concluded that the same is pre-existing disease.

Decision : Held that the discharge summary does not state that hypertension was prevalent before taking the policy. Moreover it states that there was no history of dyspnoea, palpitations, cough, fever or syncope. As far as chronic smoking is considered this cannot be treating as a pre-existing disease. Hence ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/147/OIC/11/08
Satish Kumar Jindal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 24.08.07

Facts : Shri Satish Kumar Jindal and his wife were covered under Mediclaim Policy for sum insured of Rs. 1,50,000/- for the period 23.1.07 to 22.1.08 issued by DO Yamuna Nagar. He felt acute pain in his stomach on 24.1.07 and was under treatment upto 10.2.07, but did not get any relief. He got himself examined again on 10.2.07 at M/s Sachdeva Maternity & General Hospital, Jagadhari where ultrasound and other tests were performed. It was observed that his kidney was not functioning properly. He was referred to M/s Silver Oak Hospital, Mohali for further treatment. He was admitted in M/s Silver Oak Hospital on 19.2.07 for removal of left kidney. The TPA M/s Paramount Health Services was duly informed by the treating doctor, but the cashless facility was denied on 21.2.07 on the ground of 'pre-existing disease not covered'. Despite a report given by the hospital authorities to the effect that the kidney was suddenly damaged with no history of previous ailment of kidney, the request for cashless facility was rejected. An amount of Rs. 1,05,702 was incurred on his treatment. All the bills were available which were not submitted because he was under the impression that once the cashless facility was denied there was no point in lodging the claim with the insurer.

Findings : The insurer stated that the denial of cashless facility by the TPA did not amount to denial of the claim. They had requested the complainant to submit the

necessary documents in March'07, but the same had not been received. Hence the claim was treated as 'no claim'.

Decision : Held that denial of cashless facility by the TPA was not in good taste. The complainant was suffering at that time and he needed help on all accounts. Further, discharge summary clearly states that there was no complaint of kidney during the past ten years. Hence ordered that the insurer should make payment of admissible amount of the claim to the complainant along with interest @8% p.a. w.e.f. 22.2.07 till the date of payment within 15 days of the submission of complete documents in original as required by the insurer.

Chandigarh Ombudsman Centre
Case No. : GIC/168/UII/14/08
Sheel Nanda
Vs
United India Insurance Co. Ltd.

Award Dated : 22.08.07

Facts : Smt Sheel Nanda was covered under Mediclaim Policy issued by BO Samrala. She was undergoing Radio Therapy for knees at Sibia Medical Centre, Ludhiana and a claim for Rs. 61,970/- was lodged with the insurer. She was again admitted in Sibia Medical Centre on 8.8.06 in connection with the movement of her left shoulder. She was again given treatment by Sibia Medical Centre for which she paid Rs. 10,000/-. On 29.12.06 the insurer sent a letter rejecting her claim. She further stated that she sent a letter to the insurer on 2.4.07 informing them that a similar claim had been paid by the Reliance General Ins. Co. Ltd. in the case of Mrs. Raj Kumar Aggarwal. She also enclosed a copy of the order of Ombudsman dated 9.3.07 in the case of Shri Som Nath Gupta, the facts of which she stated were identical to her case and sought intervention of this office for settlement of her claim.

Findings : The insurer stated that the intimation was given 10 days after discharge. So no verification could be done from Sibia Medical centre. The literature of Sibia Medical Centre states that hospitalization is not required. Moreover, Osteoarthritis is a chronic disease and takes a long time to reach the state of restricted mobility and difficulty in walking. The claim file was also taken up with the panel doctor, Dr. T.L. Gupta who submitted report dated 7.12.06 stating that the claim did not fall within the purview of the Mediguard Policy.

Decision : Held that there were documents from Sibia Medical Centre to show that the complainant was hospitalized twice. This was a special treatment where technological advances require special machines and hence such treatment could not be done at home. The complainant has now been able to carry on her normal duties after the treatment thus showing that it was not a chronic disease. Hence ordered that the admissible amount of claim after deducting pre-hospitalization tests of Rs.1,760/- should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/64/UII/14/08
Gayatri Devi
Vs
United India Insurance Co. Ltd.

Award Dated : 24.07.07

Facts : Smt. Gayatri Devi got herself insured under Mediguard Policy from DO, Ludhiana, which was renewed every year. During the third year of the policy she was operated upon on 4.9.06 for sinusitis and all the relevant papers were submitted to the insurer. However, till date no payment of the claim was made to her.

Findings : The insurer clarified the position by stating that the claim had following defects:-

a) There was a break of 5 days at the time of renewal of the policy.

b) The hospital where the treatment took place was not a 15 bedded hospital.

c) No hospitalization was required for treatment of sinusitis.

Hence the claim was repudiated by them in March'06.

Decision : Held that the repudiation of the claim by the insurer on the above grounds was not in order. Firstly, generally seven days grace period is waived automatically for renewal. Secondly, the hospital can either be registered or 15 bedded. In this case the hospital was under the supervision of a Registered Medical Practitioner. Thirdly, regarding hospitalization it was the decision of the treating doctor and not the patient. Hence ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/80/NIC/11/08
Ram Avtar Gupta
Vs
National Insurance Co. Ltd

Award Dated : 18.07.07

Facts : Shri. Ram Avtar Gupta was covered under Mediclaim Policy for sum insured of Rs. 1,25,000/- for the period 8.4.06 to 7.4.07. He was hospitalized in Jaipur Golden Hospital, Delhi from 19.7.06 to 21.7.06, where he was treated for chronic ischaemic heart disease. He lodged a claim with the insurer's TPA M/s Vipul MedCorp Pvt. Ltd. which was kept pending for a long time and finally repudiated vide TPA's letter dated 4.5.07 on the basis of clause 4.1 of the policy regarding pre-existing diseases, as there was a break of 4 days in the policy renewed in 2002. It was submitted that the claim had been rejected on frivolous grounds.

Findings : The insurer stated that the complainant had a Mediclaim policy with the insurer before 2001. The claim was lodged with the insurer in 2001 for heart disease. There was a break of 4 days in continuation of the policy in 2002. The complainant was again treated for chronic ischaemic heart disease from 19.7.2006 to 21.7.2006. The TPA had repudiated the claim since four days period was taken as a break in the policy issued in 2002 and policy issued thereafter was treated as a fresh policy. The claim lodged in respect of present treatment was therefore relating to the disease which was before the break period and hence was treated as pre-existing disease.

Decision : Held that the gap of four days had been treated as the break period. Normally a grace period upto 7 days is allowed for renewal/automatic condonation. Further, no document could be produced by the insurer to substantiate their contention that the grace period was not allowed. Hence ordered that the insurer/TPA should make the payment of admissible amount to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/46/NIA/11/08
Kiran Mehta

Vs

New India Assurance Co. Ltd.

Award Dated : 17.07.07

Facts : Smt. Kiran Mehta had a Mediclaim Policy for sum insured of Rs. 2 lakh. She was treated for fibroid uterus from 23.8.06 to 30.8.06. She filed a claim for reimbursement of expenses incurred by her. The relevant documents as requested by the insurer were submitted by her on 13.10.06. However, the claim was rejected and denied through Raksha TPA Ltd on the ground of pre-existing disease. The complainant's policy was started about 4 to 5 years back and there was a break of 5 months in 2005, before the start of the present policy.

Findings : The insurer stated that the policy had run for less than 1 ½ years and the discharge summary form the hospital had stated that the complainant was suffering from fibroid uterus since 1 ½ years. Moreover the cashless facility was denied by the TPA as the complainant had allegedly stated that she was suffering from the said disease for the last 1 ½ to 3 years. The initial policy was for the complainant and after the break the policy was in the name of the complainant and her husband. Their main contention was that the discharge summary had stated 1 ½ years prior to the surgery which roughly coincided with the revival of the policy in March'2005 whereas 1 ½ years period was over in Feb'05. On a query whether any hospital record for the treatment prior to Aug'06 was available, the insurer could not give a satisfactory reply. On a query whether the complainant was aware of the disease for which she was treated at the time of taking the insurance, no satisfactory reply could be given by the insurer.

Decision : Held that the repudiation has been done mainly because 1 ½ year period started from Feb'05 and policy was revived in March'05. The claim had been repudiated specifically because of gap of 15 -20 days between these two periods. However, taking statement of 1 ½ years as sanctimonious as far as dates are concerned may not be correct. This could be an approximation. No treatment record was available prior to March'05 which could substantiate the contention that the complainant was suffering during the break period of the policy. Hence giving the benefit of doubt to the complainant, ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

Case No. : GIC/92/NIC/11/08

Harbhajan Singh

Vs

National Insurance Co. Ltd.

Award Dated : 10.07.07

Facts : Shri Harbhajan Singh and his family were covered under Mediclaim Policy taken from DO Faridabad for the period 19.10.05 to 18.10.06. His daughter was admitted in Dalip Hospital, Faridabad for treatment. He was also informed verbally by the TPA, M/s Vipul MedCorp Pvt. Ltd. that the hospital is on their panel list. However, when he submitted the claim papers, he was informed by the TPA vide letter dated 14.3.06 that his claim is not admissible as the hospital does not qualify the criteria under clause 2.1 of the policy. It was submitted that the TPA had been approving other claims in respect of the said hospital, whereas his claim had been rejected.

Findings : The insurer stated that the TPA had rejected the claim because the hospital was not meeting requirements under clause 2.1 of the terms and conditions of the policy. On a query whether the hospital was registered, the complainant clarified that it was a registered and was a 15 bedded.

Decision : Held that the repudiation of the claim by the insurer/TPA on the grounds of qualification criteria of Dalip Hospital was not in order. Hence ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/57/UII/11/08
Amanpreet Singh Cheema
Vs
United India Insurance Co. Ltd.

Award Dated : 5.07.07

Facts : Amanpreet Singh was covered under Mediclaim Policy which was valid from 28.3.06 to 27.3.07. Due to urinary retention he was admitted in Emergency of PGI on 4.1.07 and discharged on 10.1.07. He filed the claim with the Family Health Plan Ltd., but the claim was repudiated on the ground that OPD treatment was not covered. The complainant stated that he was discharged from PGI Emergency on 10.1.07 and the hospital authorities do not give any discharge summary unless the patient is shifted to a ward. He was not given any discharge summary, only a discharge card was given.

Findings : The insurer stated that in the absence of discharge summary certificate from the hospital, the TPA had treated the case as an OPD case and hence the same was repudiated.

Decision : Held that the contention of the complainant that he was hospitalized from 4.1.07 to 10.1.07 in OPD emergency of PGI was substantiated by the documents available. Hence ordered that the admissible amount of claim should be paid by the insurer/TPA to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/357/ICICI/11/07
Ashraf Ali
Vs
ICICI Lombard General Insurance Co. Ltd.

Award Dated : 3.07.07

Facts : Shri Mohammad Ashraf Ali was having a Mediclaim Policy named Health Care Family Plan which was valid from 22.3.06 to 21.3.07. He experienced chest pain and cough on 21st February 2007 and was hospitalized on 23.02.07. The claim lodged with the insurer had not been settled so far.

Findings : The insurer stated that the complainant was treated for rheumatic heart disease. Before this he was supposed to have rheumatic fever. This was a pre-existing disease. On a query whether the complainant was aware of the disease before taking the policy, the insurer could not answer satisfactorily. On a query whether any hospital record was available to show that he was treated for rheumatic fever, the insurer replied in the negative. The complainant stated that he was having fever in Oct'06 which was within the policy period. He also stated that blood tests, ECG etc were done before giving the policy and nothing adverse was found. On a query whether any concealment of pre-existing disease was there on the proposal form, the insurer stated that the proposal form was not filled up as the policy was based on information available in the credit card.

Decision : Held that the insurer erred in not getting the proposal form filled and relying on the verbal records. Moreover, there was no record of any hospital treatment before the start of the policy. The tests conducted before the start of the policy were

positive. Hence ordered that the admissible amount of claim amount should be paid by the insurer to the complainant. For future treatments if any, cashless facility should be provided which is the basic feature of the policy.

Chandigarh Ombudsman Centre
Case No. : GIC/379/UII/11/07
Krishan Lal Pahwa
Vs
United India Insurance Co. Ltd.

Award Dated : 3.07.07

Facts : Shri Krishan Lal Pahwa was covered under a Mediguard Policy for the period 04.4.05 to 03.4.06 for sum insured of Rs. One lakh. He suffered head injury due to fall in the bathroom on 27.04.05 and was admitted to Arora Neuro Centre on 29.4.05 where he had to undergo brain surgery. The claim was rejected by the company as per clause 4.2 of terms and conditions of the policy because it had arisen within 30 days of the policy.

Findigs : The insurer informed that the complainant had taken Mediguard Policy for the first time on 04.04.05 for sum insured of Rs. one lakh. He was admitted in hospital in Emergency on 29.04.05 and was operated upon for Aneurysm Rt. Middle cerebral artery bifurcation. As per medical opinion, Cerebral aneurysm is a disease, which may be present from birth. Based on the medical opinion of the panel doctor and keeping in view the fact that the claim occurred within 30 days of the inception of the policy, the claim was rejected as 'no claim'. The insurer also produced a medical opinion from Dr. Singla, based on which the claim had been repudiated.

Decision : Held that medical opinion given by Dr. Singla was general in nature and not specific to the complainant. The rupture in the brain for which the complainant was treated occurred due to fall in the bathroom, which was not disputed by the insurer. Hence ordered that admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/20/OIC/14/08
Kishore Chand Khullar
Vs
Oriental Insurance Co. Ltd.

Award Dated : 22.6.07

Facts : Shri Kishore Chand Khullar and his family members were covered under Mediclaim policy for the period 15.4.04 to 14.4.05 issued by DO-I Amritsar. The policy had run for five years without break. His wife Smt. Rajesh Rani developed sudden convulsions on 31.3.2005. She was admitted to Hartej Hospital, Ajnala Road, Amritsar and was given treatment for more than 16 days. When the claim was lodged with the insurer, the TPA on behalf of the insurer repudiated the claim under clause 2.3 of the policy terms & conditions on the plea that hospitalization was less than 24 hours.

Findings : The insurer clarified the position by stating that the wife of complainant was hospitalized on 31.3.2005 at 3:00 P.M. and was discharged on the same day at 2 p.m. A claim for Rs. 6001/- was submitted to TPA M/s Paramount Health Services and the same was repudiated under clause 2.3, which states that "expenses on hospitalization are admissible only if hospitalization is for minimum period of 24 hours".

Decision : Held that the claim was rejected after about two years, which could have been rejected on the very first day of receipt of case, leading to serious deficiency in service. Secondly, there is a clause, which states that hospitalization for less than 24 hours is reimbursable if due to technological advances in medical sciences hospitalization is required for less than 24 hours. Thirdly, the policy had run for five years and no claim was lodged. The policyholder was entitled to free medical check up without hospitalization for 1% of basic Sum Assured up to a maximum of Rs.3000/-. Therefore, repudiation of claim by the insurer was not in order. Taking a just and fair view, it was ordered that admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/3/NIA/14/08
Sanjay Gupta
Vs
New India Assurance Co. Ltd.

Award Dated : 13.6.07

Facts : Shri Sanjay Gupta's father Shri Mahesh was covered under Mediclaim Policy for the period 08.09.06 to 07.09.07 for sum insured of Rs. one lakh. He was undergoing treatment by Dr. Manmohan Singh. On 26.12.06 he was admitted to Madhu Nursing Home because of chest pain. As advised, he underwent CT Angiogram at GMR Institute New Delhi. Thereafter, he underwent Coronary Angiography on 27.1.07 at Fortis, Mohali. After the test, his father was diagnosed to be suffering from CAD Triple Vessel Disease. All the papers had been submitted to M/s Alankit Health Care, New Delhi, the TPA. He had been given a card by M/s Alankit Health Care for cashless benefits but when the card was shown at Fortis Mohali, it was also not accepted.

Findings : The insurer informed that the complainant was suffering from hypertension before the commencement of the policy i.e in 2002. Hence the TPA repudiated the claim on the ground of pre-existing disease under clause 4.1 of the policy. The complainant stated that his father was suffering from hypertension and this was mentioned in the proposal form. However, the claim was not lodged for hypertension but for coronary Angiography, which was done four years after the commencement of the policy.

Decision : Held that the claim for coronary angiography was not connected with any pre-existing disease. The claim was payable. Hence ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/387/UII/11/07
Karishma Arora
Vs
United India Insurance Co. Ltd.

Award Dated : 13.6.07

Facts : Miss Karishma Arora was covered under Mediguard Policy for the period 19.10.05 to 18.10.06 for sum insured of Rs. 3 lakhs. She fell sick and was admitted in Bombay Hospital from 21.3.06 to 3.04.06. After discharge from the hospital she submitted all the relevant papers to the insurer in time. Her claim was rejected on the ground that it was a disease by birth, which was incorrect. She stated that her doctors

had submitted a clear medical certificate that she was treated for pleural effusion and fever and tubercular and not for epilepsy.

Findings : The insurer clarified the position by stating that the complainant was suffering from congenital epilepsy and was a known case of hypertension, which was not disclosed in the proposal form. If the same had been disclosed in the proposal form, the underwriting of risk would have been different.

Decision : Held that non-disclosure of epilepsy and hypertension was a material fact and should have been disclosed at the time of submission of the proposal form. The non-disclosure of this information had rendered the policy void. The rejection of the claim by the insurer was, therefore, in order. No further action was called for. The complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. : GIC/345/UII/11/07
Kapil Mohan Bansal
Vs
United India Insurance Co. Ltd.

Award Dated : 31.5.07

Facts : Shri Kapil Mohan Bansal had taken a Mediguard policy effective for the period 12.12.05 to 11.12.06 covering four family members, which was renewed from 12.12.06 to 11.12.07. He fell ill due to stomach pain/Cholelithiasis and started getting treatment from Dr. Ravindra Hospital. He was advised operation for Cholelithiasis. He, therefore, got himself admitted in Sama Nursing Home, New Delhi for operation on 19.12.06 and was discharged on 27.12.06. The complainant requested the insurer to pay the expenses incurred, but he got a letter dated 30.01.07 stating that he had been suffering from a pre-existing disease namely Symphotmatic Gall Bladder Disease for the last several months. Since he had taken the policy just one year back, as per policy terms and condition no. 4.1 the claim could not be entertained.

Findings : The insurer informed that the claim papers were referred to panel doctor M/s Satia Nursing Home. As per his opinion it was revealed that the patient was treated for Calculi Cholelethiasis which was due to acute inflammatory processes due to obstruction of bile in Gall Bladder. But for formation of a Gall Bladder Stone, it took many months to several years since it was an ongoing process and the size of the complainant's stone was 17.2 mm. The claim was rejected since in the view of the panel doctor, it was found to be pre-existing. On a query as to whether the complainant lodged any claim before this treatment, the reply was in the negative. On a query as to whether any medical history of treatment before the start of the policy was available, the reply was in the negative. On a query as to whether the complainant was aware of the occurrence of the problem in his body, the insurer could not give any satisfactory reply. On a query as to whether the treating doctor had said anything about the duration of the disease, the reply was in the negative.

Decision : Held that repudiation of the claim based on the opinion of the doctor other than treating doctor was not in order. Moreover, the fact that the complainant knew about the disease or was aware of it before the start of the policy could not be proved. Hence ordered that admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/15/OIC/14/08
Subhash Gandhir

Vs
Oriental Insurance Co. Ltd.

Award Dated : 31.5.07

Facts : Shri Subhash Gandhir was covered under Mediclaim policy issued by BO Panipat for the period 18.2.06 to 17.2.07. He underwent an open heart surgery on 4.4.06 at Escorts Heart & Research Institute, Delhi. He lodged a claim for Rs. 1,80,000 along with all original documents with the insurer on 14.4.06, which were forwarded to the TPA, M/s Genins India Ltd., Chandigarh. The insurer rejected his claim vide letter dated 4.5.07 on the ground of concealment of material facts. He contended that the claim had been denied on false grounds, as he was a regular policyholder since 2002.

Findings : The insurer informed that the complainant had filled up a proposal form in 2004 in which all the columns relating to diabetes were left blank. It was presumed therefore that the answers to all the queries were 'no'. However, in the discharge summary of the Escorts Hospital it was stated that the complainant was suffering from diabetes mellitus for the last ten years. On a query as to whether any documents were available to show that he was suffering from diabetes before taking the policy, the answer was in the negative. On a query as to why the policy was underwritten when the proposal form was not complete, no satisfactory reply could be given.

Decision : Held that the insurer had erred in underwriting and accepting a Mediclaim Policy in 2004 on the basis of an incomplete proposal form which was serious deficiency in service. Moreover, there was no record to show that the complainant was suffering from diabetes except the record from the Escorts Hospital. The policy had already run for four years when the hospitalization took place. The complainant did not have any problem during this period. The repudiation of the claim on the basis of pre-existing disease was not in order as the insurer failed to prove this contention. The claim was payable. Hence ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/389/OIC/14/07
Surinder Kumar Sehgal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 24.5.07

Facts : Shri Surinder Kumar Sehgal was covered under the Mediclaim Policy for the period 31.03.04 to 30.03.05. He got treatment in Kalra Hospital, New Delhi during the currency of the policy and incurred an expenditure of Rs. 15,421.90. All the relevant claim papers including bills and receipts were sent to the TPA, M/s Paramount Health Services, New Delhi on 2.3.05 for settlement of the claim. He stated that despite repeated follow up with the insurer there was no response.

Findins : The insurer informed that the complainant was admitted on 1.3.05 as a case of prolapsed disc. He had undergone MRI spine with other tests and was managed conservatively mainly by oral analgesics. For this hospitalization was not necessary. It was therefore considered hospitalization for evaluation and claim was repudiated under clause 4.10 of the policy.

Decision : Held that the decision for hospitalization does not lie with the patient but with the treating doctor. Since the treating doctor had advised hospitalization and he was admitted in Kalra Hospital, New Delhi as per the discharge slip issued by the hospital, the repudiation of the claim was not in order. Hence ordered that the admissible amount of claim be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/384/NIC/14/07
Usha Goyal
Vs National Insurance Co. Ltd.

Award Dated : 24.5.07

Facts : Smt. Usha Goyal and her daughter Ms. Divya Goyal were covered under Mediclaim Policy with BO Jalandhar for the period 14.4.99 to 13.7.2000. Her daughter met with an accident and was operated upon on 8.3.2000 for fracture of both bones of right legs. The claim lodged with the insurer was duly approved. The policy was subsequently renewed from time to time. Her daughter developed a deflection in the tibia of the right leg and had to undergo operation on 12.8.05 and was hospitalized from 11.8.05 to 14.8.05. The claim for the expenditure incurred was lodged with the TPA on 12.9.05 was not settled.

Findings : The insurer informed that the treatment undergone by the patient from 11.8.05 to 14.8.05 for deformity of right lower limb was in consequence of her earlier road accident in 2000. There was a break in insurance from 13.7.2001 to 2.8.2001 and as per standing instructions of the insurer no break in renewal of policy was to be condoned. Hence the present claim fell under exclusion clause 4.1 regarding pre-existing disease/ailment, and was as such not payable A circular dated 13.6.03 issued by the Regional Office of the insurer in this regard was produced. Para 2 (b) of the circular reads as under:

"If there is a break, a fresh policy may be issued after obtaining a proposal form and this policy will be subject to exclusion of the disease contracted during the expiry policy period and during the break period and such diseases must be specifically mentioned in the Schedule of the policy."

Decision : Held that two conditions which were mentioned in para 2 (b) above were not fulfilled. Firstly, no fresh proposal form was filled up by the complainant. Secondly, the exclusion of the existing disease was not mentioned in the exclusion clause specifically. Also the policy had been renewed periodically giving the reference of initial policy issued in 1999. In view of the above, the complainant had no means to understand or know that this particular disease or treatment was excluded although the insurer was in the know of the same having paid the claim earlier. Thus disease should not be treated as pre-existing. Hence ordered that the admissible amount of claim be paid.

Chandigarh Ombudsman Centre
Case No. : GIC/314UII/11/07
Manmohan Mehra
Vs
United India Insurance Co. Ltd.

Award Dated : 10.4.07

Facts : Shri Manmohan Mehra had taken a Mediguard Policy from BO, Neelam Bata Road, Faridabad. On 27.1.06 his wife Mrs. Shashi Mehra accidentally slipped and her left hand wrist bone was fractured and the same day took treatment from "Veero Devi Memorial Orthopedic and Trauma Centre, Faridabad" and incurred an expenditure of Rs.3220/- The plaster was later removed on 14.2.06. He lodged the claim with the insurer for reimbursement. However, the claim was rejected by the company vide letter dated 09.5.06 on the ground that it was "not admissible as no hospitalization had taken place".

Findings : The insurer clarified the position by stating that as per para 2.3 of the terms and condition of the policy “Hospitalization is a must for passing the claims”. Further, the treatment does not fall under the exclusions provided in respect of clause 2.3. It was a case of treatment like an O.P.D. patient and hence was not covered under the policy.

Decision : Held that there was justification in the repudiation of the claim by the insurer and the action taken by them was in order. The case was dismissed.

Chennai Ombudsman Centre
Case No. 11.04.1459/2006-07
Shri K. P. Chandrahasan
vs
United India Insurance Co. Ltd.,

Award Dated 30.04.2007

The complainant Mr.K.P.Chandrahasan, approached this forum with a complaint against M/s United India Insurance Co. Ltd., City Branch I,Coimbatore, stating that he had taken a Mediclaim policy with M/sUnited India Insurance Co. Ltd. and had made a claim for his hospitalization expenses towards treatment as in-patient at M/s. Kovai Medical Centre and Hospital Ltd., from 29.3.2006 to 01.4.2006 with the diagnosis ISCHEMIC HEART DISEASE, UNCONTROLLED HYPERTENSION AND NEPHROSCLEROSIS WITH RENAL FAILURE and again for for the same case at M/s.K.Govindasamy Naidu Medical Trust from 21.4.2006 to 22.4.2006 and the same was repudiated. Also the representative of the insured stated that only at the time of hospitalization that the insured came to know of having kidney problem , but fully aware of HT earlier.

The representative of the insurer contended that though the insured was having mediclaim policy for many years prior to this, but since there was a break in the insurance during the period 2002 his proposal was treated as afresh and since the insured has stated NIL for the question as to the pre-existing diseases, he was issued a policy by the insurer without excluding any pre-existing disease and it was a Group Mediclaim policy issued to M/s.CMS Educational and Charitable Trust from 2003. The claim was rejected for non-disclosure of pre-existing disease.

The forum perused the documents and confirmed that the insured while shfting his policy to M/s. United India Insurance Co. Ltd., BO I, Coimbatore from United India Insurance Co. Ltd., CBO IV,Coimbatore, had failed to disclose his pre-existing disease which is evident from a Certificate from Dr.R.Subramanyam, M/s.K.G. Hospital, Coimbatore as to the existence of renal problem way back in 2001 itself and hence the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1084/2007-08
Shri Ramakrishnan
Vs
The United India Insurance Co. Ltd.

Award Dated : 6.08.2007

The complainant Shri Ramakrishnan stated his mother is covered under Mediclaim policy with M/s United India Insurance Co. Ltd .His mother was hospitalized at M/s Sooriya Hospital. The diagnosis was Viral Fever, Bronchial Asthma, Acute Exacerbation & GERD. His claim was rejected on the grounds that the present

hospitalization was for the management of a pre existing disease, under policy exclusion 4.1 . He contended that viral fever could not be pre-existing.

The insurer stated that their TPA had repudiated the claim invoking the policy condition 4.1 – pre-existing diseasebecause the patient was primarily admitted for Bronchial asthma,for which she was treated with bronchodilators,and antibiotics . Antipyretics were given only on one day6 as deciphered from the pharmacy bills since he did not have indoor case sheets There had been a similar claim in 2004 and the same had been rejected by this Forum. They have also got a letter from the treating doctor that she was a known case of Chronic Obstructive Pulmonary Disease (COPD) for the last 15 years.

From the scrutiny of the discharge summary and the prescriptions it is evident that the patient was admitted for bronchial asthma and treatment was also given for the same. And there were no convincing documents produced by the complainant to establish that his mother was severely affected by viral fever, which requires infrastructure of a hospital and during the hospitalization active treatment was given for viral fever. On the contrary the insurer established that the insured person was asthmatic patient, admitted for the complaint of breathing difficulty along with other problems viz fever 100 F and the treatment was mainly given for bronchial asthma / COPD, which is a pre existing disease. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.04.1102/2007-08
Shri R Sundarrajan
Vs
The United India Insurance Co. Ltd.,

Award Dated : 13.08.2007

The complainant was covered under mediclaim policy with M/s United India Insurance Co. Ltd., He was hospitalized for the complaint of chest pain and the diagnosis was Systemic hypertension, coronary artery disease etc His claim was rejected on the ground of pre existing disease. He represented to the insurer that he was holding policy for more than 17 years and the insurer had reimbursed his earlier claim for coronary angiogram during 2000.

The representative of the insurer stated that they have not got the details of the claim settled in 2000. They also did not have any records that the insured had policy with them for 17 years. There was continuous insurance policy for 3 years. Their TPA rejected the claim since the insured suffered from Systemic Hypertension which was pre-existing disease, for more than 19 years as mentioned in the Discharge Summary. As per the discharge summary, he is a known hypertensive for the past 19 years on treatment. History of coronary angiogram for coronary artery disease in 1999 stated he had insignificant coronary artery disease.

The Insurer submitted a statement furnishing details of policies issued and claims settled along with discharge summary for the hospitalization during December 1999. However, the complainant has expressed his inability to produce the supporting documents since the relevant documents were lost during the flood in October 2005 . On scrutimy of the cumulative bonus enjoyed it appears that the complainant was holding insurance policy with the present Insurer M/s United India Insurance Co. Ltd., Divisional Office, Ranipet since 1997 onwards. The Insurer contended that they have allowed cumulative bonus of 5% during the policy period 1997-1998, hence the complainant was holding mediclaim policy for 10 years and not for 17 years as claimed. There was recorded evidence available to prove that the patient was suffering from

hypertension since 1987 and Coronary artery problem since 1992. Further, the discharge summary (for the hospitalization during December 1999) revealed that Coronary Angiogram was done 10 years prior to December 1999, hence the first onset of the symptoms for heart ailment might be diagnosed in 1989 itself.

In the light of the above facts, the insurer has clearly established that the patient was suffering from hypertension and Coronary Artery Disease much prior to the inception of the first policy viz 1996-97. On the contrary the complainant failed to establish that he was holding mediclaim policy for more than 17 years and the present hospitalization was not for pre existing disease. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.08.1130/2007-08
Mr C. F. Thomas
Vs
The Royal Sundaram Alliance Ins.Co. Ltd

Award Dated : 22.08.2007

The complainant stated that he has taken Health Shield Insurance policy from M/s Royal Sundaram Alliance Insurance Co. Ltd, Chennai. He was hospitalized from 21.07.2006 to 23.07. He made a claim for the reimbursement of hospitalization expenses of Rs.1,69,210.63 from his employer However, his employer has settled only Rs.1,51,274.25 and disallowed Rs.17,936.38. Thereafter, he lodged a claim with M/s Royal Sundaram Alliance Insurance Co. Ltd. vide his letter dt.21.02.2007 for the reimbursement of balance amount under Health Shield insurance policy. However, the insurer rejected his claim on the ground that the claim documents have been received by them after the stipulated period of 30 days provided under the policy.

The representative of the insurer stated that the insured preferred the claim only after the time limit stipulated under the policy. He contended that as per policy condition that the complainant shall submit the necessary claim documents within 30 days from the date of discharge. In this case, the hospitalization was on 21.07.2006 and the complainant submitted the claim documents on 21.02.2007, much after 30 days time as stipulated under the policy.

On perusal of documents, it was held that the complainants letter dt.07.05.2007 did not reveal extraordinary circumstances or any compelling reasons which contributed to the delay in intimating the claim to the insurer. There are no records to establish that the complainant has intimated the claim to his insurer prior to 21.02.2007. As a prudent person, the complainant should have informed the insurer that he also covered under a policy of his employer and should have obtained insurer's permission for the waiver of policy condition viz., stipulating the submission of documents within a period of 30 days from the date of discharge. It emerges that there was a violation of the policy condition without any substantiating reasons. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.03.1108/2007-08
Shri Suganchand Dhoka
Vs
The National Insurance Co. Ltd.

Award Dated : 21.08.2007

The complainant stated that his family was covered under mediclaim for the past 5 years with M/s National Insurance Co. Ltd., Chennai. His wife Smt Leelabai was hospitalized for the complaint of abdomen pain, swelling abdomen wall and the

diagnosis was Strangulated vertical Hernia with Diabetes Mellitus. His claim was rejected on the ground that the present hospitalization was for the complication of pre existing disease of cholecystectomy operation done done 20 years back, long before the inception of the policy. Hence under exclusion 4.1 the claim is not admissible. He had declared the surgery undergone by his wife in the proposal form. He had mentioned the name of the Doctor and the year in the proposal.

The representative of the insurer stated that the insured did not disclose the adetails of the Cholesystectomy in the proposal form. The current claim was for Strangulated vertical hernia. The claim was made in the third year of the policy.

On perusal of the proposal form etc it is evident that the patient was having the complaint of abdomen pain and swelling abdomen wall only 3 months prior to hospitalization .No other documentary evidence has been produced by the insurer to establish how long the patient had been suffering from present complaint of incisional hernia prior to hospitalization. The insurer also failed to establish by way of documentary evidence that the patient had not been cured by her previous operation for Cholecystectomy done 20 years back that the patient was under regular treatment for the said problem and the present problem viz., Incisional hernia is the complication of the pre existing disease of Cholecystectomy.

In the said case, the scar of the previous incision only was existing prior to inception of the policy and there was no disease or herniation existing at the point of time when the policy was taken. The discharge summary also revealed the patient was developed with the problem of abdominal pain and swelling abdomen wall only 3 months and did not give any history or herniation much prior to inception of the policy viz.,2000, Hence it is evident that the hernia was a new development. It, therefore, emerges that there is no conclusive proof of pre-existence of the disease at the time of inception of the policy. Direction given to insurer to settle the claim. The claim is allowed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.02.1060/2007-08
Shri P Ramesh
Vs
The New India Assurance Co. Ltd.

Award Dated : 12.07.2007

The complainant Mr P Ramesh stated that his family was covered under mediclaim policy from May 2001 to 2004 with M/s New India Assurance Co. After a break of a year, during 2004-05, he had renewed it during 2005-06 for a sum insured Rs.4,00,000/- for himself and his wife and Rs.1,00,000/- for his son. He has taken increased sum insured as his premium paying capacity had increased. In November 2005, his wife suffered from Chronic kidney failure. He had advertised in papers for a kidney donor and fortunately he could get a donor early and the kidney also matched. In December 2005, his wife underwent Kidney Transplantation. He submitted the claim to M/s.TTK Healthcare services who rejected his claim under Clause 4.1 pre existing disease. Hence this complaint.

The representative of the TPA stated that the insured has got admitted on 24.10.2005 in Coimbatore Kidney Care Centre and was treated by Dr.Ramalingam for Chronic Kidney Disease with Chronic Glomerulonephritis. Based on their investigation, they had repudiated the claim under exclusion Clause 4.1 – pre-existing disease. They had also taken an opinion from Dr.Isaac Christian Moses who is a neutral Nephrologist of CMC Vellore. He had opined that the Chronic Glomerulonephritis had led to ESRO necessitating renal transplant. Patient has taken treatment for CRF with.

Dr.Ramalingam for 2 years. Their investigator had obtained the clinical notes of Dr.Vyjayanthi Venkatakrishnan, Gynaecologist, who has stated that the insured " was Known CRF for 2 years". Patient had also been taking homeopathic medicines. The illness was pre-exisitng and hence claim was not permissible.

Documents like Discharge summary, Scan Reports, treating doctor's certificates and Specialist opinions etc were examined. The complainant failed to establish with supporting documents that his wife Smt Vasuki contracted the disease of Chronic Renal failure only after the inception of the policy i.e. after 17.05.2005. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.04.1058/2007-08
Mr V. Balasubramanian
Vs
The United India Insurance Co. Ltd.

Award Dated : 12.07.2007

The complainant Mr V Balasubramanian stated that he was covered under Mediclaim policy for the past 4 years without break with M/s United India Insurance Co. Ltd, During the policy year 31.03.2006 to 30.03.2007 he was hospitalized at M/s Venkateswara Hospitals, Chennai from 10.05.2006 to 16.05.2006 2006 for the complaints of sweating and discomfort. The hospital kept him under observation and finally said that nothing was wrong with him. A 64 slice CT scan was taken. It showed a normal study. After getting discharged from the hospital, he claimed the hospitalisation expenses of Rs.61,450 and submitted claim papers to M/s TTK Healthcare Services (P) Ltd., TPA of the insurer. However, his claim was rejected under Clause 4.1 on the ground that he had a history of DM since 1996, HT since 2001 and CAD since 2000 and dyslipidemia for 20 years and the policy was effective from 31.03.2003, Hence he has approached this forum.

The Insurer sated there was a break in 2002. The policy was renewed after a gap of 171 days and they treated the policy as a fresh policy from 31.03.2003. When the insured had applied for cashless facility, his consultant Cardiologist Dr.Su.Thillai Vallal, had stated that he was a 'known case of Hypertension, Diabetes Mellitus and Dyslipidemia' under the column of past illness. The ECG taken at the hospital showed that he had suffered a Myocardial Infarction and was treated for it .

The extract of indoor case sheet for earlier hospitalization at M/s Apollo Hospital, Chennai during October 2000 revealed that the diagnosis was Coronary Artery Disease (Angiographically – Single Vessel Disease). The insured was unable to disprove that he had not been diagnosed with Coronary Artery Disease prior to 31.03.2003. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.05.1107/2007-08
Shri K Durairaj
Vs
The Oriental Insurance Co. Ltd

Award Dated : 31.07.2007

The complainant was covered under Nagrik Suraksha policy with M/s Oriental Insurance Co. Ltd., Coimbatore for the sum insured of Rs.1,50,000/- (PA for Rs.1,20,000/- and Hospitalization cover for Rs.30,000/-). He met with a road accident on 11.06.2006 near Tiruppur and was treated at Revathi Medical Centre, Tiruppur and

later underwent surgery at M/s Rex Ortho Hospital Coimbatore. Although he had suffered a small injury in his head, it was initially ignored but a few days later he developed headache and profuse vomiting. CT Scan was then taken. He has claimed reimbursement of Rs 30,000/- which is the Sum insured but the insurer offered only Rs.17,500/-, hence this complaint.

The insurer stated that Discharge summary of M/s. Revathi Hospitals had not been submitted and they needed some clarification from M/s Rex Ortho Hospital, Coimbatore. The hospital did not cooperate with the investigator. Further as per their Panel Doctor's opinion, Rex Ortho Hospital had charged excessively and conducted unwanted procedures while giving treatment.

It was held that since Discharge summary was not submitted in respect of the first hospitalization insurer is justified in disallowing the amount of Rs.1750. The contention of the insurer that M/s Rex Ortho Hospital has charged exorbitantly for the treatment is not tenable. However, regarding length of stay in the hospital after the surgery and the type of surgery performed and the costs thereof, since the hospital and the insured have not cooperated with the insurer to submit any additional information and assistance as stipulated under the policy, the insurer is justified in disallowing the amount of Rs.2800/- Direction given to the insurer to settle the claim for Rs.23,800/- as against the original offer of Rs.17,500/- subject to terms and conditions of the policy. Complaint was partly allowed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.05.1511/2006-07
Shri K. S. Renganathan
Vs
The Oriental Insurance Co.

Award Dated : 01.06.2007

The Complainant, an ex-official of M/s Oriental Insurance Co. Ltd, after availing V.R.S from the organization, covered his daughter under Good Health Insurance from 01.04.2004 onwards. His daughter was hospitalized at M/s Sundaram Medical Foundation from 04.05.2006 to 06.05.2007 for ear pain and the diagnosis was MICROTIA and left ear surgery was performed. The claim was rejected on the ground that the hospitalization was for congenital external disease, hence the same is not payable as per policy exclusion 2.1.8. He represented to the insurer that his daughter was covered under the Staff Mediclaim policy since her birth and only recently it was diagnosed that her left ear was not alright. Had he known about her daughter's illness earlier, he would have opted for surgery while he was in service under the Staff Mediclaim policy itself where she had been covered since birth.

The representative of the insurer stated that MICROTA was a congenital disease and pre-existing condition so far as the Good Health policy is concerned. Congenital diseases are covered only for the employees and their family members who were in service under the Staff Mediclaim Scheme. Moreover the claim was preferred in the second year of the policy. Had 3 years been completed they would have allowed the claim.

It was held that In the case of the Complainant's daughter, the 2nd condition for waiver of pre existing disease/injuries under Good Health Policy (viz., (i) four consecutive claim free policy years or (ii) the insured person having been covered under Individual Mediclaim policy or Group Mediclaim policy with Oriental Insurance Company for a continuous period of immediately preceding 48 months without any break) has been

met. Therefore the insurer is not justified in rejecting the claim on the grounds of pre existing disease viz., congenital disease and the complaint was allowed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.02.1059/2007-08
Shri S. Varadharajan
Vs
The New India Assurance Co. Ltd

Award Dated : 11.06.2007

The complainant Mr S Varadharajan, a retired LIC employee submitted a claim for reimbursement of hospitalization expenses of his wife Smt Geetha. She had been suffering from menstruation problem with skin rashes, itching etc., in addition to other problems. But the same was rejected on the grounds that the charges were incurred primarily for investigation purposes which are not consistent with diagnosis, hence falls under policy exclusion 4.10

The representative of the insurer stated that as per the discharge summary it was revealed the patient was not serious enough to be admitted in the hospital. The patient was admitted for the complaint of irregular periods for the past 6 months, however the patient underwent routine investigations like blood sugar random, blood urea, urine sugar, total cholesterol, LDL etc and also Ultrasonography which are no consistent with the diagnosis or ailment, hence they rejected the claim by invoking policy exclusion 4.10. He contended that as per medical opinion also hospitalization was not warranted and the treatment could have been given as outpatient.

On perusal of documents like Discharge summary , It was evident that the patient was not such a serious condition which required infrastructure of a hospital and there were no substantiating reasons for conducting various tests viz Blood sugar, Blood Urea, SR Creatinine, ECHO Report, Ultrasonography Report etc., The complainant failed to establish the condition of the patient was so serious which warranted hospitalization and the basic pre-requisites for hospitalization as per the policy condition have been met with. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.08.1011/2006-07
Shri A Sankar
Vs
The Royal Sundaram Alliance Ins.Co. Ltd.

Award Dated : 07.06.2007

The Complainant obtained through telemarketing , from Royal Sundaram Alliance Insurance Co. Ltd Health Shield GOLD for Rs 1,15,000/-(including Cum Bonus) for the period 11.03.2005 to 10.03.2006. He was hospitalized at M/s Vijaya Hospital for Coronary Artery Disease in addition to other problems in Jan 2006. He underwent Angioplasty and stenting and the expenses were Rs 2,98,811/-. His claim was repudiated by the insurer on the grounds of pre existing disease of diabetes.

On 15/02/2006 he took a Health Shield Premiere, also through telemarketing, for Rs 2,00,000/- and in March 2006 he renewed the Health Shield Gold policy and Cum. Bonus was Rs30,000/- (since the first claim was not entertained). He underwent bypass surgery during March 2006. He submitted a claim for Rs.1,84,811/- under both the policies. This claim was rejected under Health Shield Premiere under waiting period of 30 days and also Health Shield Gold under pre existing exclusion.

The insured's contention was that he had disclosed that he was a diabetic when the policy was sold to him through telemarketing done by Standard Chartered Bank even in 2005 and even on renewal in March 2006 they have collected the same premium, given him cumulative bonus and there were no exclusions. He was under regular treatment for diabetes. No proposal form was ever given to him or signed by him.

The representative of the insurer stated that in telemarketing, disclosures made are recorded and confirmed by the insured later. But they could not produce a copy of the said document to prove that the insured had not disclosed his diabetic condition. As per the Discharge summary, the insured was suffering from Diabetes since 8 years, which was prior to commencement of the policy. Coronary Artery Disease was a direct complication of Diabetes. They repudiated the claims under the first policy on the ground that the ailment of the insured existed prior to inception of the policy. The claim under the second policy was made within 30 days of commencement of the new policy. So claim on the second policy was rejected on the grounds that the hospitalisation falls under the waiting period of 30 days.

However, on perusal of the Attending doctor's certification it was found there were inconsistencies regarding the duration of illness. Besides there is no evidence to the effect that the Insurer has given an opportunity to the proposer to disclose the details pertaining to his health during telemarketing . The insurer could not produce any document to prove that the insured had not disclosed his diabetic condition at the time of telemarketing. Under the circumstances it was held that the insurer is not justified in repudiating on the grounds of pre existing exclusion.

As per Sec.4(4) (Proposal for insurance) of The Insurance Regulatory And Development Authority (Protection of Policyholders' Interest) Regulations 2002, the onus of proof shall rest with the insurer in respect of any information not so recorded where the insurer claims that the proposer suppressed any material information or provided misleading or false information on any matter material to the grant of cover. In this case, the insurer failed to establish their stand by way of documentary evidence that the insured suppressed the material facts of his pre existing disease viz diabetes at the time of proposing for insurance, hence the insurer's argument is not tenable.

The following directions were given to the insurer:

1. To settle the claim for the first hospitalisation from 23.01.2006 to 29.01.2006 under Health Shield Insurance (GOLD) for the period 11.03.2005 to 10.03.2006.
2. To settle the claim for the second hospitalization from 12.03.2006 to 31.03.2006 under the Renewal of the Health Shield (Gold) for Sum Insured Rs 1,00,000/- (Not eligible for cumulative bonus) for the period 11.03.2006 to 10.03.2007.
3. No liablility to insurer under Health Shield (Premiere) .

The complaint was allowed partially.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1008/2007-08
Shri G N Balakrishnan
Vs
The Oriental Insurance Co. Ltd

Award Dated : 19.06.2007

The Complainant was holding mediclaim policy for his family with M/s Oriental Insurance Co. Ltd. with SI of Rs 65,000/- since 1990. During 2002-2003, he claimed for his wife's hospitalization and the same was settled by the insurer. From 2004-2005, he

enhanced the SI to Rs.1,00,000/-. His wife was hospitalised in Nov 06 and out of his claim of Rs.2,00,000/- insurer paid only Rs.65,000/-.

His contention was that the condition on the policy copy given to him stipulated that only in case of a claim under the previous policy, increased SI in the current policy will not apply for claims for the same disease in the current year. In this case, the claim was made in 2002-2003 when SI was Rs 65,000. No claim was made up to 2005-06. Sum Insured was increased to Rs 1,00,000 from 2005-06. In 2006-07 when a claim arose, since no claim was made in the previous policy (2005-06), the enhanced SI of Rs 1,00,000/- was applicable.

On perusal of documents, the Ombudsman pointed out to the insurer that if the policy wordings are more precise and appropriate, dispute would not have arisen. If the policy is issued in an ambiguous manner, it will be interpreted against the insurer, since the policy has been drafted by him. In this case the policy was issued in ambiguous manner, hence it will be interpreted against the insurer.

However, no convincing reasons were given by the complainant regarding (1). reason for waiting for more than 4 years for conducting CABG, although CAD was diagnosed in 2002 (2). maintaining the same sum insured for several years (3).suddenly opting for increase in sum insured from Rs.65,000/- to Rs.1,00,000/- during 2005-2006 (4) accepting the policy 2006-07 without any objection, when the insurer first time incorporated a condition restricting the sum insured for earlier claim etc.

The complaint is allowed on Ex-gratia basis of Rs.15,000/- as a special case over and above the sum insured of Rs.65,000/- available prior to the enhancement of sum insured with cumulative bonus Rs.29,250/- (45% on Rs.65,000/- accumulated in respect of claim free years).

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1009/2007-08
Shri Narayan Kumar
Vs
The New India Assurance Co. Ltd

Award Dated : 21.05.2007

The Complainant Mr N Narayana Kumar stated that he and his family were covered under Medicalim policy with M/s New India Assurance Co. Ltd., for the past 5 years and when the policy was renewed for the period from 13.11.2006 to 12.11.2007, there was a break in insurance of 21 days. His wife was hospitalized at M/s Madras ENT Research Foundation (P) Ltd., from 13.02.2007 to 15.02.2007 and the diagnosis was post cricoids growth. He submitted the claim papers to M/s Medicare TPA of the insurer, but his claim was rejected on the grounds that the present ailment is a pre existing disease.

The insured stated that on 14.02.2007 he was told that his wife was suffering from cancer of third stage in food pipe and voice box. She was also advised immediate surgery. The Insured stated that the first time his wife consulted a doctor regarding her ailment of throat pain was on 27/12/2006 and he has also submitted a prescription of Priyadharshini Clinic establishing the same. In the prescription dated 13.02.2007 also, it has been mentioned that the patient was suffering from difficulty in swallowing only for last 3 months of 2006.

The insurer stated that they received a representation from the insured that his wife was already hospitalised and requested them to consider the current year policy as

renewed policy, however they could not accede to his request to waive break in insurance.

The representative of the TPA stated that in the pre-authorisation form it had been stated that the patient was suffering from dysphagia (difficulty in swallowing) for the last 6 months. But they could not produce the said pre-authorisation request form.

The other documents including Discharge Summary were examined. There were no medical records submitted to establish that the disease had manifested prior to 13.11.2006. The 'pre-existence' of the disease prior to the renewal, ie prior to 13.11.2006, following the break of 21 days, could not be established and so the Complaint was allowed.

Chennai Ombudsman Centre
Case No. IO(CHN) 11.05.1003/2007-08
Mr Naushad Ali
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 30.05.2007

The Complainant represented that his family is covered under Mediclaim policy with M/s Oriental Insurance Co. Ltd., since February 1999 and the policy was renewed for the period from 23.02.2006 to 22.02.2007. His wife Mrs Jasmin Banu developed stomach pain and was hospitalized from 05.05.2006 to 08.05.2006 for hernia. But his claim was rejected on the grounds of pre-existing disease on the ground that the incisional hernia was a result of the caesarian surgery done in 1998 and 2001, much prior to inception of the policy and the present claim was for pre-existing disease which was not admissible under the policy.

The representative of the insurer stated that in the proposal for the year 2002 and 2003, available with them, revealed that the insured failed to disclose LSCS done during 1998 and 2001 and if he had disclosed they would have excluded Hernia. He contented that there was suppression of material facts and they were denied chance of fair underwriting.

The representative of the TPA stated that hernia is a direct complication of LSCS she had undergone earlier. But after seeing the said Discharge Summary, it was admitted by the Doctor, that there was no abnormality in the scar of the surgery done in 1998 during the 2001 LSCS and hence pre-existing disease could not be conclusively established.

The documents like Discharge Summary, Attending Doctors' Certificates have been perused. It is clear that the patient was having the complaint of swelling umbilicus since 2 months prior to operation. It is acknowledged that Incisional hernia can arise only out of a scar of a previous incision and in the present case Mrs. Jasmin Banu having had LSCS in earlier occasions, the present hernia would no doubt have arisen at the place of scar of the previous incision. However it is to be noted that only the scar of the previous incision was pre-existing and not the Hernia. The mediclaim policy excludes pre-existing diseases and not pre-existing scars.

The representative of the TPA accepted that there was no mention about the ailment of hernia in both the discharge summaries of 1998 and 2001. Therefore, the insured and the TPA failed to establish that the patient was suffering from hernia prior to inception of the policy.

It was noted by this forum that the proposal form does not contain any query seeking any information regarding the details of childbirth. It is to be acknowledged that child

birth and its connected procedures are not perceived as an illness and hence the proposer cannot be found fault with for not disclosing the same. In case the insurer wanted to know all material facts regarding child birth also , queries regarding the same should have been included in the proposal form. The complaint was allowed and direction is given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.12.1106/2007-08
Mr K. R. Ananthanarayanan
Vs
The ICICI Lombard Gen. Ins. Co. Ltd.

Award Dated : 13.09.2007

The complainant, a 57 years old, IT professional was covered under Health care policy with the M/s ICICI Lombard Gen. Ins. Co. Ltd. He was hospitalized and the diagnosis was Coronary Artery Disease, Triple Vessel Disease, Mild LV Dysfunction, EF 45%. And underwent bypass surgery. He submitted the claim papers to M/s TTK Healthcare Services P. Ltd., TPA of the insurer. However, his claim was rejected by the insurer on the ground that the present hospitalization was for the pre existing disease hence the claim is not admissible as per policy exclusion C-1.

The complainant stated that he was having diabetes for the last few years. In 2005 when he had been hospitalized for epigastric problem the Doctors suspected renal failure and he was moved to Madras Medical Mission. The diagnosis was Viral Dengue. The Cardiologist had confirmed that he did not have any cardiac problem. He represented to the insurer that his previous hospitalisation never revealed any ailment regarding CAD, TVD, IHD or Inf.Wall Ischaemic and the medicines prescribed were only for viral dengue and suspected acute renal failure and the same were duly resolved. When questioned as to whether he had disclosed that he was suffering from Diabetes in the proposal form, he said that he would have disclosed if he was asked for the details. There was no deliberate suppression. He contended that all persons who have diabetes do not have heart problem.

The representative of the insurer stated that the insured did not disclose details of his health especially Diabetes in the proposal form. He has not mentioned Coronary Artery Disease and diabetes mellitus when he had taken the policy. In the 2005 discharge summary of Madras Medical Mission, it has been very clearly stated that he was suffering from Diabetes. Hence, as per policy condition viz. pre-existing disease exclusion clause they rejected his claim.

On examination of documents it is evident that TPA / Insurer has not produced any substantiating or recorded evidences to conclusively establish that the patient was diagnosed with heart ailment (viz., IHD / Inferior wall ischaemia etc.,) or was under active treatment for the same prior to the inception of the policy. Diabetes mellitus is not the sole risk factor for the ailment of coronary artery disease / Triple Vessel Disease. Nor has it been proved in the present case, that diabetes mellitus was the pre-dominant factor amongst the various other risk factors for the coronary artery disease .

It is to be acknowledged that the complainant also failed to establish by way of documentary evidence that at the time of proposing for insurance, he was free from heart ailment. There was recording of sinus tachycardia in the hospital records during January 2005. As per medical opinion obtained by the Forum, three vessel cardiac disease cannot develop in a few months. In this case hospitalization for the heart

ailment viz., Coronary Artery Disease / Triple Vessel Disease was within a short span 3 ½ months since inception of the policy. Even though the Diabetes Mellitus is not a sole risk factor for Coronary Artery Disease, it is the duty of the insured to disclose all material facts to the insurer at the time of proposing for insurance.

In the light of the above facts the claim was allowed on ex-gratia basis of Rs.80,000/- (Rupees Eighty Thousand only).

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1109/2007-08
Shri S Ranganathan
Vs
The National Insurance Co. Ltd.

Award Dated : 7.09.2007

The complainant's wife was hospitalized at M/s Nethradhama Hospitals P. Ltd. Bangalore from for the complaint of High Myopia – Both eyes. His wife Smt. Shantha was complaining of decreased vision and when they consulted eye doctors she was diagnosed to have Myopia (both eyes). They decided to take treatment at Nethradhama Hospitals at Bangalore. She underwent Zyoptix laser surgery in the hospital. He submitted necessary claim papers to the M/s T T K Healthcare Services P Ltd., TPA of the insurer, for the reimbursement of hospitalization expenses. The claim was rejected by the TPA on the ground of pre existing with an impression that the policy was in force since 2002, whereas the patient was suffering from the ailment for the last 4 years. The complainant produced copies of policy that his wife was covered for the past 6 years (i.e. since 2000) hence rejection was wrong hence this complaint.

The representative of the TPA stated that as per the documents the refractive error in both eyes left-8.50 and right –8.25. The TPA was of the opinion that it would have taken many years for the patient to attain refractive error of –8.50. Hence they sought clarification. The insured did not furnish the same. The TPA had also obtained an Opthalmologist's opinion that it was unlikely that such a high myopia would have developed in 4 years' time. The opining doctor also stated that it could have been present since childhood and the patient might be wearing glasses or contact lens for correction.

Documents like attending Doctors certificate, Discharge Summary, Certificate from Nethradhama Hospitals , Proposal Form etc were perused. It was clearly established that the complainant failed to furnish valid information at the time of proposing for insurance and also not complied with condition number 5.5 of the policy.of assisting the insurer to obtain the necessary documents to enable the TPA process the claim. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1149/2007-08
Mrs.Radhika Ramesh
Vs
The United India Insurance Co. Ltd.

Award Dated : 18.09.2007

The complainant Smt Radhika Ramesh stated that she was covered under mediclaim policy with M/s United India Insurance Co. Lt from 07.11.2006 to 06.11.2007. She was hospitalized at M/s Iswarya Fertility Centre (Test Tube Baby & Research Centre) from 22.11.2006 to 23.12.2006 and the diagnosis was normal uterus with bilateral PCO-puncturing done, bilateral patent tubes and polypoid endometrium. She submitted the

claim papers to M/s Family Health Plan Ltd., TPA of the insurer for the reimbursement of hospitalization expenses. However, her claim was rejected on the ground that the present hospitalizatin is related to the diagnosis / treatment of infertility and the same is not covered under the policy. She represented to the insurer against the same along with a certificate issued by the attending doctor, however her claim was not settled, hence this complaint. She was unable to attend hearing.

The representative of the insurer stated it was a 5th year policy. He stated that the insured had taken treatment for primary infertility. He contended that if the treatment was for irregular periods she would have consulted a Gynaecologist and would not have gone to an infertility center. Her claim was rejected under Sec 4.8 & 4.10.

The representative of the TPA stated that the hospital in which the insured took treatment was primarily a hospital for treatment of infertility. As per the Discharge Summary, the patient was a case of primary infertility, Nature of surgery was Diagnostic Laparoscopy with PCOD-Puncturing with Hysteroscopy. The policy excluded treatment Sterility.

On perusal of the documents it was observed that the clarification letter dated nil, issued by the doctor merely states that the term 'primary infertility' which is mentioned in the discharge summary is to be ignored or omitted. It does not clarify how long insured was suffering from menstrual cycle problem, whether she has been taking treatment and the treatment details. Further, the attending doctor has also not confirmed that the patient had never been treated for infertility or the present hospitalization and treatment was in no way directly or indirectly connected with infertility problem. The complainant failed to establish beyond doubt that the present hospitalization is only for menstrual cycle problem and her hospitalization is no way connected with the sterility (inability to produce offspring) and does not fall under policy exclusion 4.8. or that the present hospitalization is not for any pre existing disease and does not fall under policy exclusion 4.1 and that the present hospitalization is not for any diagnosis purpose and does not fall under policy exclusion 4.10. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. : 11.04.1459/2006-07
Shri K. P. CHANDRAHASAN
vs
United India Insurance Co. Ltd.

Award Dated : 30.04.2007

The complainant Mr.K.P.Chandrahasan, approached this forum with a complaint against M/s United India Insurance Co. Ltd., City Branch I,Coimbatore, stating that he had taken a Mediclaim policy with M/sUnited India Insurance Co. Ltd. and had made a claim for his hospitalization expenses towards treatment as in-patient at M/s. Kovai Medical Centre and Hospital Ltd., from 29.3.2006 to 01.4.2006 with the diagnosis ISCHEMIC HEART DISEASE, UNCONTROLLED HYPERTENSION AND NEPHROSCLEROSIS WITH RENAL FAILURE and again for for the same case at M/s.K.Govindasamy Naidu Medical Trust from 21.4.2006 to 22.4.2006 and the same was repudiated. Also the representative of the insured stated that only at the time of hospitalization that the insured came to know of having kidney problem , but fully aware of HT earlier.

The representative of the insurer contended that though the insured was having mediclaim policy for many years prior to this, but since there was a break in the insurance during the period 2002 his proposal was treated as afresh and since the

insured has stated NIL for the question as to the pre-existing diseases, he was issued a policy by the insurer without excluding any pre-existing disease and it was a Group Mediclaim policy issued to M/s.CMS Educational and Charitable Trust from 2003. The claim was rejected for non-disclosure of pre-existing disease.

The forum perused the documents and confirmed that the insured while shfting his policy to M/s. United India Insurance Co. Ltd., BO I, Coimbatore from United India Insurance Co. Ltd., CBO IV,Coimbatore, had failed to disclose his pre-existing disease which is evident from a Certificate from Dr.R.Subramanyam, M/s.K.G. Hospital, Coimbatore as to the existence of renal problem way back in 2001 itself and hence the complaint is dismissed.

Delhi Ombudsman Centre
Case No. : GI/96/RSA/06
Smt. Yash Verma
Vs
Royal Sundaram Alliance Insurance Company

Award Dated : 29.06.2007

The complaint was heard on 18.06.2007. Smt. Yash Verma was present and the Insurance Company was represented by Shri Ajay.

Smt. Yash Verma had lodged a complaint with this Forum on 19.07.2006 that she had taken a mediclaim policy from Royal Sundaram Alliance Insurance Co. Ltd. effective from 25.03.2004. She had met with an accident on 10.05.2005 and received spinal injuries. Immediately she rushed to nearest clinic where she had been treated by Dr. Attique. After few days doctor advised her to go to specialist and she consulted Dr. Harish Bhargava working in Apollo Hospital. Royal Sundaram Alliance Insurance Co. Ltd. vide their letter dated 20.02.2006 rejected the claim on the grounds that the disease was pre-existing. She further submitted the letter of Dr. Bhargava dated Nil wherein he had mentioned that the disease is not pre-existing. She also confirmed that she had not undergone any treatment for the same, as she had only got injuries on 10.05.2005. She has requested the Forum that her genuine claim be paid.

Royal Sundaram Alliance Insurance Co. Ltd. vide their letter dated 12.09.2006 informed the Forum that Smt. Yash Verma had lodged a complaint under their Health Shield Insurance policy which was valid form 25.03.2005 for expenses incurred by her for treatment of L4/ 5 Disc prolapse with right side radiculopathy for the period commencing from 05.09.2005 to 10.09.2005 for a total claim amount of Rs.120157.75/-. The Insurance Company further informed that the claim for cashless service was submitted by the insured which was rejected by their TPA Medicare Services on the grounds that the ailment was pre-existing in view of the medical records, which revealed the ailment as a chronic case. Hence she approached the Insurance Company by way of a claim for reimbursement of expenses incurred. The Insurance Company not only referred the case to the penal doctors who observed that as per MRI report which shows osteophytes and thickening of ligament this could not have developed over 1 ½ years and is definitely pre-existing. The discharge summary dated 10.09.2005 states that the ailment as L4/ 5 Disc Prolapse with right side radiculopathy and the findings states that the L5 nerve root on right side edematous and badly compressed with protruding disc bulge. Moreover, the MRI Dorso- Lumbar spine report dated 110.05.2005 suggests broad based disc prostrusion with moderate right para-central disc extrusion at L4-5 level causing compression of right L5 nerve roots and that are changes of facetal hypertrophy with mild ligamentum flavum thickening. The Insurance Company further consulted the specialist for his opinion, who opined that “I have gone

through Smt. Yash Verma's policy file, where she was operated for her low back pain, which is 6 months duration. By seeing the reports and complaints the low back pain may be pre-existing one. It is therefore clear from the medical records and opinions of doctors that the ailment for which treatment was undergone by the insured was a pre-existing ailment which could not have developed during the currency of the policy and hence excluded under the terms and conditions contained in the contract of insurance. In view of the medical records and doctor's opinions, they had repudiated the claim of the insured vide their letter dated 20.02.2006 on the grounds that the ailment of the insured takes longer time to develop and would not have developed after the commencement of the policy and further that the present treatment by way of hospitalization was one for treatment of pre-existing disease, outside the policy purview condition D-Exclusion. They further submitted that the present ailment is a prima facie case of pre-existing disease, which is further confirmed by the opinion of the doctors referred above. They have repudiated the claim after due consideration of the medical records of the insured, based on the medical opinion and proper application of mind. The claim was repudiated, as it was not admissible as per the terms and conditions of the policy.

At the time of hearing Smt. Yash Verma informed the Forum that she had slipped from the stair case as a result of which she received spinal injuries and she had never complaints with regard to pain in the spinal cord. She further contested that Dr. H. Bhargava who is renowned Orthopedic doctor has confirmed in his certificate that the disease was not pre-existing as she had no complaint of pain prior to 10.05.2005.

The representative of the Insurance Company contested that as per the various reports of their specialist with whom they have consulted and MRI report which shows osteophytes and thickening of ligament which could not have developed during the period Smt. Yash Verma has been insured. Further, she has developed right L5 nerve roots and that are changes of facetal hypertrophy with mild ligamentum flavum thickening in May 2005, as such the ailment L4/5 disc prolapse with right side radiculopathy was there before the policy was taken. On the basis of the medical records and doctors' opinion they have rightly repudiated the claim as pre-existing disease since as per exclusion clause D of the policy "Pre-existing condition – Such disease /injury which have been in existence at the time of proposing this insurance. Pre-existing condition also means any sickness or its symptoms, which existed prior to the effective date of this Insurance, whether or not the Insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing disease will be considered part of that pre-existing condition". As such as per this condition the disease has been there before the policy was taken in the year 2004.

On examination of the papers submitted and after hearing both the parties the Insurance company has consulted two Orthopedic Surgeons and they have mentioned that the disease may be pre-existing one. Dr. H. Bhargava who has examined Smt. Yash Verma at Apollo Hospital when she was admitted on 05.09.2005 in his report dated Nil has mentioned that "HNP Herniates disc which can be associated with or without DDD. Patient symptoms took place only after the fall hence she had HNP on top of the DDD. So I think her claim is genuine and was none of pre-existing disease". Dr. Bhargava also mentioned that DDD (Degenerative Disc Disease) which is associated with big flarum thickening and facetal hypertrophy and will be found in 70-80% of females above 50 years in MRI scans. Since Dr. Bhargava has mentioned that HNP was a result of fall and DDD could be taken as a pre-existing disease, I therefore pass an Order that Smt. Yash Verma be paid 50% of the admissible claim when she was admitted in Apollo Hospital on 05.09.2005.

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/23/UII/06
Shri Sushil Kumar Jain
Vs
United India Insurance Co. Ltd.

Award Dated : 14.05.2007

The complaint was heard on 14.02.2007 and 07.05.2007 at Jaipur. The complainant Shri S.K. Jain was present. The Insurance Company was represented by Shri B.J.S. Puri.

Shri S.K. Jain lodged a complaint with this Forum on 12.01.2006 that he had taken a mediclaim policy with United India Insurance Co. Ltd. and he had filed a claim for hospitalization of his wife Smt. Madhu Jain. His wife was admitted in Santokba Durlabji Memorial Hospital on 11.02.2005 and was diagnosed for Fibroid Uteruses. But Paramount Health Services Pvt. Ltd., TPA for United India Insurance Co. Ltd. repudiated his claim as per discharge summary duration of present complaint is 2-3 years. As per date available to them, inception of policy is from 19.06.2002 with current policy 2 years 8 months running. Since, pre-existing cannot be ruled out in this case. This claim is declared as no claim. Hence the claim stands repudiated. Shri S.K. Jain contested that he has been continuously insured with the United India Insurance Co. Ltd. since 16.06.2000 till 18.06.2005 and he was entitled to be paid the claim.

United India Insurance Co. Ltd. vide their letter dated 12.02.2007 informed that Smt. Madhu Jain was suffering from Fibroid Uteruses with heavy bleeding for the past 2-3 years prior to the date of Hospitalization. The mediclaim policy was renewed after a gap of four days from 19.06.2002 instead of from 16.06.2002. As per terms of mediclaim policy the captioned policy was treated as a fresh policy and was renewed subject to medical examination and exclusion of existing disease. Since the history of illness is 2-3 years and prior to three years the policy was renewed with break and considering the policy as fresh policy, the claim has been repudiated by their TPA.

At the time of hearing Shri S.K. Jain informed the Forum that he has been continuously insuring himself and his wife since 2000, and there was break in the Insurance Policy for four days as he had not received any renewal notice from the Insurance Company. However, his wife, who had complaint of heavy bleeding 2-3 months before her admission in the Santokba Durlabji Memorial Hospital and her claim is payable as per terms and conditions of the policy.

The representative of the Insurance Company informed the Forum that the break of four days is normally condoned by the Insurance Company, but no condonation was done in this case. The representative of the Insurance Company informed the Forum that this condonation was not possible after the claim is reported. Hence they have rightly repudiated the claim, since, Smt. Madhu Jain was suffering from the disease for the past 2-3 years.

On examination of the papers submitted and after hearing both the parties it is observed that Smt. Madhu Jain was diagnosed for Fibroid Uteruses and was admitted in Santokba Durlabji Memorial Hospital on 11.02.2005 and discharged on 15.02.2005. Shri S.K. Jain has been insuring himself and his family since the year 2000, and there has been a break in the year 2002. However, it is observed that Smt. Madhu Jain is

also enjoying cumulative bonus of 20% on this policy. However, after break in the policy the contention of the Insurance Company based on the discharged certificate that she was suffering from Fibroid Uteruses for 2-3 years could not be treated as pre-existing, since, Smt. Madhu Jain was covered with United India Insurance Co. Ltd. from the year 2000, although there was break of 4 days, which the Company normally condoned as such, the Insurance Company is liable to pay the claim for hospitalization of Smt. Madhu Jain for 11.02.2005 to 15.02.2005 when she was admitted in Santokba Durlabji Memorial Hospital.

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/72/OIC/06
Shri Ajay Dewan
Vs
Oriental Insurance Company Ltd.

Award Dated : 30.04.2007

The complaint was heard on 18.04.2007. The complainant Shri Ajay Dewan was present. The Insurance Company was represented by Shri V.K. Aggarwal.

Shri Ajay Dewan lodged a complaint with this Forum on 25.02.2006 that he had taken a mediclaim policy with Oriental Insurance Co. Ltd. since 1996, and the same was been renewed from time to time without any break for the last 6 years, for himself and his entire family. On 10.05.2005 his son Mast. Tejas Dewan was admitted to the hospital "Upchaar", Delhi, with a complaint of Phimosis Circumcision and discharged on 11.05.2005. The total expenses incurred by him on hospitalization was Rs.8907/-. He filed the claim papers along with the bills in original to the TPA Genins India Ltd. of the Insurance Company. On 10.06.2005 the TPA asked him to file Detail case history with present complaint and its duration. Although he had forwarded the original discharge summary, he again forwarded the copy of the discharge summary along with the Doctor-in-charge Dr. A.S. Chilana, certificate in reply to their letter saying clearly the duration of child's complaint from last 3 months. He kept on reminding the TPA along with his personal visit to their office. On 26.08.2005, the claim was repudiated inspite of his filing treating doctor's certificate. The claim was rejected by the Insurance Company for the reason pre-existing disease exclusion clause 4.1, which means that his son was having this disease before he had taken this mediclaim policy. He contested that his claim has been wrongly repudiated.

Oriental Insurance Co. Ltd. vide their letter dated 21.08.2006 informed the Forum that Mast. Tejas Dewan was admitted in Upchaar Hospital with a case history of inability to retract prepuce. He was diagnosed as a case of Phimosis and treated surgically with Circumcision. On going through the papers their TPA has pointed out that the Phimosis is an external congenital disorder and the present ailment is the complication of that Phimosis, hence, the claim is not falling under the policy terms and conditions. Accordingly they have repudiated the claim under exclusion clause 4.8 of the policy.

At the time of hearing Shri Ajay Dewan informed the Forum that his son Mast. Tejas Dewan was admitted in Upchaar Hospital with a complaint of inability to retract prepuce with mild swelling for the last 3 months and on the advice of Dr. A.S. Chilana, he was admitted in the hospital, he was put on analgesics and anti-biotics but had little relief. Since, the child was having recurrent problems with intermittent relief and he was diagnosed and it was found that he was suffering from inability to retract prepuce and

was advised to under go circumcision, which was done. Since he was operated and his rightful claim has been wrongly rejected by the Insurance Company.

The representative of the Insurance Company informed the Forum that it was an external congenital disorder which was not covered under the policy clause 4.8 as per the advice of their TPA Genins India Ltd and the claim was accordingly repudiated.

On going through the papers submitted and after hearing both the parties, it was observed that Mast. Tejas Dewan 11 year old male was admitted to Upchaar on 10.05.2005 with complaint of inability to retract prepuce with mild swelling since three months. Claimant consulted Dr. Rajeev Gupta, Family Physician three months prior to hospitalization with complaint of swelling of the penis and pain while urination and during retraction of the prepuce which could not be done but with difficulty. He did not have any problem previously. He was put on analgesics and anti-biotics but had little relief. Since the child was having recurrent problems with intermittent relief, he was advised to consult Dr. A.S. Chilana who diagnosed the child as suffering from inability to retract prepuce i.e. a form of acquired phimosis (which is not present since birth) and advised the child to undergo circumcision which was done. Normally if Phimosis is congenital it is detected at birth and is normally treated at an early age since it causes problems during urination and if it is acquired which occurs due to repeated infections (called balano prosthititis) then circumcision is done the treatment for which is payable under the policy. Since, Mast. Tejas Dewan did not suffer from the disease since birth, but acquired it 3 months prior to the date of admission due to infection. Since he suffered from repeated infection there is no other treatment except to excise the prepuce i.e. circumcision and since the policy is in force for the past 6 years and the disease was acquired within the policy period, hence the claim is payable.

I, therefore, pass an Award that Shri Ajay Dewan be paid for the hospitalization of Mast. Tejas Dewan when he was admitted at Upchaar Hospital along with 8% interest from 01.07.2005 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.

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. : 14-003-0119/06-07
Sri Dhruba Bora
Vs
National Insurance Co. Ltd.

Award Dated : 07.06.2007

Facts leading to grievance of complainant

The complainant resents that the claim referred by him under medi claim policy for re-imbursement of the treatment expenses of his father, (now deceased) has not been honoured by the insurer in spite of approaches and legal notice served. The claim is for reimbursement of Rs.9735/- along with Rs.5,000/- for compensation and harassment and delay etc.

Counter-statements from Opp.party/Insurer

The Insurance Company has replied by stating that the claimant had taken a medi-claim policy from Noonmati Branch Office of the insurer w.e.f. 06.03.02 for his family members. That Mr. J. N. Bora, the father of the complainant was treated in Wintrobe Hospital w.e.f. 24/02/2006 to 01/03/2006 on the advice of Dr. Ashim Choudhury for complaint of breathlessness etc. That from the discharge certificate, it is seen that the patient was diagnosed as suffering from “Type II D.M (poorly controlled) /HTN/Acute exerbation of C.O.P.D). That as per the declaration of Dhruba Bora in the proposal form, his father J.N. Bora was a patient of controlled diabetic. That the matter was referred to panel doctor of the insurer to submit his opinion that DM II and COPD is an old disease as stated by Dr. Tridib Barua of Wintrobe Hospital.

Decisions & Reasons

We have considered the views expressed by the parties and perused the contents of the relevant documents forwarded to us. There is no dispute that the proposal was accepted by the insurer in spite of the fact that the insured/propsoser mentioned in the proposal form that the person intended to get cover of medi-claim policy was having a controlled diabetic. Thus, it will be seen that in spite of the declarations given, the insurer issued insurance cover and there is no concealment of facts from the side of the insured. In fact, in the self-contained note, no submission was made by the insurer to opine that claim is not payable. In the self-contained note facts were stated which are not in dispute. Therefore, we find there is nothing to resist the claim as untenable. However, there is no provision to grant compensation as claimed. The only thing that the complainant may claim is reasonable interest as per prevalent bank rate for delay

of settlement of an otherwise genuine claim. The complainant, however, has not enclosed any copy of the voucher, cash memo or payment receipts etc., to justify the amounts mentioned as relief sought in the complaint. There is no provision to give amount on count of legal expenses or other incidental expenses in such complaints.

Order / Award

Concluding thereof, it is hereby directed that the complainant will be reimbursed the expenses incurred for the treatment in question subject to production of vouchers, cash memos, receipts, etc., and other documents in support thereof.

Guwahati Ombudsman Centre
Case No. : 11-011-0150/06-07
Sri Jai Kumar Goyal
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 18.06.2007

Facts

The grievance of the complainant/insured is alleged non-settlement of the insurance claim. It is stated that the complainant was persuaded by Agent of the Insurance Company to purchase insurance policy. That on 25th August, 2006, the complainant felt a chest pain and was admitted into GNRC Hospital, Guwahati. He was discharged on 26th August, '06 with advice to go for Coronary Angiography. That after the discharge from hospital, the claim was preferred by him on 15.09.06. That a part of the claim was settled by the opposite party, but the part under 'Section 3 : Critical illness' has remained unsettled on the plea that a claim – be admissible for 'critical illness' for first heart attack there has to be an 'elevation of cardiac Specific Enzymes'. But on scrutiny of CK-MB report they found the result of the investigation was 8.5. U/L which was within the normal range of 0-16 and accordingly, the claim was untenable. That IU/L even if was normal that would not mean that there was no first heart attack as per medical opinion gathered by the complainant. Accordingly, he is seeking relief from this Institution to the tune of Rs.2,00,000/- as 'Critical Illness Benefit' of policy term.

Contesting the submissions of the complainant, the insurer by its self-contained note would state as follows :

"The Star Package Policy under which the complainant /insured was covered company shall be liable to indemnify the First Heart Attack (Myocardial infraction) when the diagnosis of the Myocardial infraction is evident from the following criteria :

1. History of typical chest pain.
2. New and recent electrocardiographic changes indicating Myocardial infraction,
3. Elevation of infraction specific enzymes.

The aforesaid terms and condition incorporated in the policy under Section III Critical Illness is reproduce below in verbatim :

Section III Critical Illness

If the insured or his family members as shown under section 3 of the schedule is diagnosed as suffering from critical illness which first occurs or manifest itself during the policy period, and if the insured survives for a minimum of 30 dates from the date of diagnosis, the company shall pay a critical illness Benefit.

The limit of indemnity for any policy period for the insured or his family members individually or collectively is shown under Section III of the schedule.

Critical Illness Coverage

1. First Heart Attack (Myocardial Infraction)

   Diagnosis by a physician of the death of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis will be evident by all of the following criteria

   i. History of typical chest pain.
   ii. New and recent electrocardiographic changes indicating myocardial infraction.
   iii. Elevation of infraction specific enzymes

Non-ST segment elevation myocardial infraction (NSTEMI) with elevation of Troponin I or T is excluded.

Specific Exclusion : Angina or Chest pain.

(A copy of the Policy jacket of Star Package under which the complainant/insured was covered is annexed herewith and marked as Document-1).

On careful perusal and scrutiny of all the papers submitted by the complainant/insured it came to our knowledge that the insured was in fact hospitalized from 25-8-06 to 26-8-06 and as such we paid the complainant/insured a sum of Rs.12587/- in respect of his hospitalization claim under policy no. OG-06-2405-9961-00001202. the complainant/insured also accepted the said sum of money and being fully satisfied endorsed his signature in the claim discharge voucher agreeing thereby that the said payment shall be the full and final settlement of his claim preferred under the policy no OG-06-2405-9961-00001202. Moreover a cash less benefit of Rs.170100/- was deposited in Escort Heart Institute Research Centre, New Delhi by cheque bearing no 576169 dated 20-2-07 and was deposited in the said hospital on 21-2-07. As such all the benefits and services to which the insured was entitled was rendered on behalf of the company and no negligence was ever shown in dealing with the claim initiated by the insured."

Referring to this policy condition the insurer would submit that as per the submissions made by the complainant/insured, there is nothing to show that the policy condition was satisfied in so far the 'critical illness/first heart attack' is concerned, notwithstanding the fact that the discharge certificate issued by the GNRC has mentioned final diagnosis as follows :-

> "CAD: ACUTE INFERIOR WALL MI
> ESSENTIAL HYPERTENSION
> PUS."

Thus, there appears to be no clear-cut evidence to show that 'the death of heart muscle as a result of inadequate blood supply to the relevant area' as stipulated in the terms and conditions of the policy.

It is understood that all these symptoms mentioned in the policy conditions must be present simultaneous but the discharge certificate of GNRC Hospital simply mentions CAD : ACUTE INFERIOR WALL MI. Thus, we are of the opinion that no specific and concrete case of 'critical illness' has been brought up from the discharge certificate issued by GNRC along with policy terms and conditions mentioned in the policy jacket.

Concluding, we find that there is no scope on the basis of materials before us to interfere right now with the decision taken up by the insurer. However, there remains a scope for clarification which can be done only by experts i.e., Doctors.

In view of the discussions beforehand, we are of the opinion that the insurer may call for a specific report from the GNRC Hospital by forwarding a copy /extract of the policy

condition of ‘Sec-III Critical illness’ etc and thereafter review the matter within 15 days on the basis of such report.

Guwahati Ombudsman Centre
Case No. : 14-005-0144/06-07
Hiranya Jyoti Bayan
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 22.06.2007

Grievance

The complainant/insured resents that his claim for reimbursement of medical expenses has not been fully settled/paid.

Reply

The insurer/opposite party in its self-contained note states that the complainant has already been reimbursed the medical expenses to the tune of Rs.24,362/- by the UCO Bank (the employer of the complainant) without disputing the quantum of expenses to be reimbursed. The insurer stated that balance of Rs.6474/- out of total expenses of Rs.30,836/- incurred could not be paid as the insured did not respond to some letters issued by the T.P.A. demanding some documents and that is why, the present claim was treated as ‘No Claim’ by the T.P.A. concerned.

Decisions & Reasons

We have gone through the relevant documents placed before us. Although, it is stated that several letters were issued to the complainant, demanding documents, but there is no supporting documentary evidence to show that actually those letters were issued to the complainant/insured demanding certain papers and he wilfully neglected/defaulted in supplying informations or forwarding documents. It appears to us amount now claimed is petty and the major part of the expenses has already been reimbursed by the Bank concerned. We don’t understand why the remaining part should not be paid. It is not understood why the complainant will not send the documents demanded by insurer when it was his own interest to get settlement of the claim. It should be the duty of the insurer to compel production of the documents.

Order / Award

It is hereby directed that the insured/complainant will furnish fresh copy of documents, original discharge summary, original investigation report, original hospital bill etc., if not done already, obtaining receipt thereof from the concerned authority and thereafter within seven days the insurer will take appropriate decision in the matter and make payment of admissible amount, after verification of bills etc., if any.

Guwahati Ombudsman Centre
Case No. : 11-005-0137/06-07
Mrs. Anamika Dutta
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 22.06.2007

Facts (Statements and counter statements of the parties)

The Complainant Smt. Anamika Dutta resents that her medical reimbursement claim was turned down by the Insurance Company on the plea that the disease was 'Pre-existing' on the date of inception of the policy cover notwithstanding the fact that there was nothing to show, as per the treatment documents that the disease of Cholecystitis was 'Pre-existing'.

The Insurance Company in the self-contained note has stated that the policy cover was from 12.04.06 to 11.04.07. The hospitalization of the insured was from 30.04.06 to 05.05.06 and she underwent treatment of Cholecystitis. That the insured was suffering from the disease concerned i.e., Cholecystitis prior to taking the policy and accordingly, the claim is hit by Exclusion Clause 4.1 which goes as follows :-

"All diseases/injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial mediclaim policy taken from any of the Indian Insurance Companies shall be taken, provided the renewals have been continuous and without any break."

Decisions & Reasons

We have examined the record, discharge certificate and other documents produced before us. No documents has been forwarded to us by the Insurance Company to show that the insured consulted any doctor earlier to the date of inception of the policy and had actually knowledge of the same disease before she went for the treatment of Cholecystitis Therefore, the 'Pre-existing' disease Clause is applied in this case without actual materials on record. Therefore, the plea of the Insurance Company is lacking of supporting evidence.

Order / Award

It is hereby directed that the claim should be settled subject to verification of the cash memos, payment receipt documents by payment of actual amount/expenses incurred by the insured.

Guwahati Ombudsman Centre
Case No. : 11-0052-0154/06-07
Sanjoy Kr Dey
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 09.07.2007

Grievance

The grievance of the complainant is that his wife who had mediclaim policy cover above noted had undergone treatment of Vagina Plasty Operation on 18.07.06 but the Insurance Company rejected the claim on the plea that treatment of Vagina Plasty was related to the past history of Fibroid Operation undergone earlier in 2004.

Reply

The insurer in its self-contained note submitted that as per discharge voucher, the treatment was done for Stricture of vagina which as per the opinion of the TPA (M/s. Medsave Health Care Ltd.,) the ailment was due to the previous surgery done for Fibroids etc.

Decisions & Reasons

We have examined the connected documents filed by both the parties. In the proposal form of the connected policy it has clearly been written by the proposer that the insured had Fibroids operation earlier to procurement of the present policy (in the connected policy also it has got a mention). Undisputedly, the present operation was done after about 2 years from the earlier one and no opinion from any doctor or surgeon has been taken by the TPA in order to justify the opinion of the insurer. The question being technical without an opinion of the expert we have nothing to do. A Board of Surgeons /Doctors may examine the matter and give the opinion whether 'Stricture of Vagina' resulted from 'Fibroids' operation. In this context, we may refer to the policy condition nos. 4, 4.1, 4.2 (a) (b), particularly later part of the question no.4.2 (a) (b) :-

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 :

4.1. All diseases/injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial mediclaim policy taken from any of the Indian Insurance companies shall be taken, provided the renewals have been continuous and without any break.

4.2. Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy. This condition 4.2 shall not however, apply in case of the Insured person having been covered under this policy or Group Insurance Policy with any of the Indian Insurance companies for a continuous period of preceding 12 months without any break.

Note : These exclusions 4.1 and 4.2 shall not however apply if,

a) In the opinion of a Medical Practitioner appointed by TPA Company, the Insured Person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the company. and

b) The insured had not taken any consultation, treatment or medication, in respect of the hospitalization for which claim has been lodged under the policy, prior to taking the insurance."

Order / Award

In view of the discussions aforesaid, it is hereby directed that the Insurance Company will appoint a Board of three Surgeons/Doctors, one of whom will be nominated by the insured, to give opinion on the disputed facts and on the basis of the such opinion given by them, the issue/matter will be decided by the insurer.

Guwahati Ombudsman Centre
Case No. : 11-004-0156/06-07
Mr. Raben Kalita
Vs
United India Insruance Co. Ltd.

Award Dated : 09.07.2007

Facts (statements and counter statements of the parties)

The claim of the insured for re-imbursement of the medical expenses under medi-claim policy was rejected by the insurer on the plea that the disease from which he suffered was chronic and accordingly, 'Pre-existing Clause' of the policy will be applied.

Admitting the policy cover, the insurer would submit that as per Medical Officer's Review Report of the Third Party Administrator (TPA), the disease was chronic and pre-existing and hence the claim was inadmissible as per provision of Clause 4.1 of the policy.

Decisions & Reasons

The copy of connected policy conditions and particulars has not been forwarded to us by the insurer. We understand that usually, there is a policy condition of excluding pre-existing disease/ailment from the current policy cover. In the instant case, the insured/complainant had continuous policy cover as per the documents since 10/10/2002 and he had also enjoyed Claim Free Bonus for that . The rejection opinion of the claim exercised by TPA is too brief to understand anything. It may be borne in mind that the connected discharge certificate stated as follows :-

Admitted e a h/o pain in epigastric region for 1 day associated enausea.

The opinion expressed by the TPA (M/s. Heritage Health Services Pvt. Ltd.) goes as follows :-

"4. That sir, as per letter dated 31.08.2006 the TPA i.e Heritage Health Services Pvt. Ltd has informed the complainant about the repudiation of claim on the following Reason :

Clause : 4.1: Pre existing disease not covered in the policy.

Remarks : As per the investigation reports (serum amylase and serum lipase) the disease is chronic and pre-existing in nature : hence the claim is non-admissible."

There are several decisions on the question of 'Pre-existing' by Courts and Commissions. It was held in NIC vs. Bipul Kundu; 2005 CTJ 377 (CP) (NCDRC) that burden to prove Pre-existing Disease is on the insurer. The Commission of Chandigarh while discussing the issue opined as follows :-

"Quite often a person, who might be having some problem with the heart may not be knowing about it and may not go to doctor. The question always, which has to be determined, is was the pre-existing disease within the knowledge of the insured ! This knowledge can be attributed if the person takes some or other treatment from a doctor/hospital. A person –who might be having heart problem may not be knowing about it till he gets it tested."

Similar position is here because the insured/complainant was admitted with Pancreatitis in the Gastritis region for one day associates with Nausea. There is absolutely nothing more than this to affirmatively say that the disease was pre-existing and the insured had knowledge of it. Therefore, we are not in agreement with the opinion expressed by the insurer and are of the considered view that the matter is to be reviewed again by the insurer in consultation with a Board constituted by appointment of three doctors at the cost of the insurer, or alternatively overlooking the diagnosis of chronic Pancreatitis with Gastritis with LAX LES the re-imbursement may be made, particularly in view of the fact that though the insured had cover continuously for more than three years, there was no earlier claim made by the insured.

Order / Award

In view of discussions as above it is hereby directed that the insurer will review the claim again in the guidelines given within thirty days from the date of receipt of copy of this judgement and make appropriate order/payment.

Guwahati Ombudsman Centre
Case No. : 14-004-0146/06-07.
Dinesh Das
Vs
United India Insruance Co. Ltd.

Award Dated : 09.07.2007

Grievance

The complaint of the complainant is that he fell ill on 30/05/2006 and had undergone treatment at Apollo Hospital, Chennai. That he submitted the documents on 21/07/06 to the insurer but till date of this complaint, no settlement of the claim was made.

Reply

As per the insurer, the insured Shri Dinesh Das was admitted into hospital on 23.06.06. That the policy was a fresh one w.e.f. 31.03.06 to 30.03.07 and it was intimated by the insured that he went to Chennai on 30.05.06. Hospital record would show that he was admitted as Out Patient at Apollo Hospital on 03/05/06. That it appears that there were four discharge certificates starting from 23.05.06 and the discharge summary show that he had difficulty in swallowing and pain for the last two months which would confirm that he was suffering from the disease prior to inception of the present policy and accordingly, Exclusion Clause 4 and 4.2 will apply. That it is a clear case of pre-existing disease and the doctor has confirmed the view expressed by the insurer in a letter by submitting his opinion.

Decisions & Reasons

It appears that in the Claim form submitted the insured mentioned the detection of disease on 10.06.06 but from the record we find that his date of admission was 15.06.06. It appears that the insured had submitted bills to the insurer the copy of which were forwarded to us by the insurer and one of those bills is dated 03.05.06 as Out Patient department bill. On scrutiny of the connected discharge certificate the date of admission shown is as 23.06.06 on which date the insured/complainant, as per the contents of the discharge certificate, was suffering from pain and difficulty in swallowing for two months duration which would date back to 23rd April. So, there is a close proximity between the procurement of the policy and the inception of the disease and accordingly, the application of the Exclusion Clause by the insurer may not be unjustified. In the proposal form also, the insured mentioned that his physical condition was good but the circumstances revealed from the connected papers will show that he had already undergone treatment for Carcinoma.

Order / Award

In view of discussions as aforesaid we find no good grounds to interfere and matter stands closed accordingly.

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

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

1.1 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 undergone 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. : 14-003-0078/06-07
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. : G 11.010.294
Sri T. Satish
Vs
IFFCO TOKIO Gen.Ins.

Award Dated : 16.04.2007

The complainant was covered under a Group Critical Illness policy issued to members of Road Safety Club for the period 1.11.2005 to 31.10.2008. He underwent CABG in August 2006. The claim was rejected on the grounds that the insured was hypertensive for the last 5 years (policy incepted on 01.11.2005) and as per exclusion 4.1 of the policy complications arising out of pre-existing condition are not covered.

Decision :

The complainant was given a week's time to convey his responses to the insurer's contentions. He was also advised to submit the treatment papers pertaining to the period prior to admission at Apollo Hospital. However, he failed to submit his entire consultation papers and he did not give any material to contradict the noting in the discharge summary. The complainant's earliest angina was reportedly 7 months prior to the August 2006 surgery thus bringing his related illness into the exclusion. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.005.0312
Smt. Ch. Malathi Rao
Vs
Oriental Insurance Co. Ltd.

Award Dated : 23.04.2007

The complainant and her husband were covered under Mediclaim Policy for floater sum insured of Rs.5,00,000/- for the period 11.12.05 to 10.12.06. She was admitted to hospital in an emergency condition on 29.07.2006. Her claim was rejected on the ground that the disease was pre-existing at the time of inception of policy.

The complainant contended that she maintained good health and had even visited USA in April 2006. The insurers contended that the policy incepted on 11.12.2005 while hospitalization was on 25.07.2006 within 7 months of taking the policy. Since, she was suffering from degenerative disease, the TPA doctor opined that such disease couldn't develop within 5 to 7 months.

Decision :

The TPA doctor opined that the onset of the disease was gradual. There was also no need for hospitalization and could have been treated as outpatient. The complainant was given a week's time to comment on the TPA doctor's opinion. The file was also sent to an independent neurologist for his opinion. The doctor opined that one could remain asymptomatic for a number of years inspite of changes in the spine. The policy does not specifically exclude geriatric/degenerative diseases. Degenerative diseases are bound to be there in every person beyond a certain age. The insurers could not substantiate with documentary proof that the ailment was pre-existing at the time of taking the policy.

The insurers have taken a narrow view of the claim and have not considered the totality of circumstances. The complaint is admitted.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0282
Sri B. Raghava Shetty
Vs
United India Insurance Co. Ltd.

Award Dated : 30.04.2007

The complainant and his wife were covered under Mediclaim policy from 31.03.1994 to 31.03.2005. The policy for the period 2005-06 was renewed with a gap of 12 days on 12.04.2005. His wife was admitted to hospital on 19.06.2006 and incurred an expenditure of Rs. 6837/-. The TPA settled her claim for Rs. 3699/-.

The insurers contended that the amount allowed was for the present ailment and the balance was disallowed for medicines and investigations related to Diabetes and Hypertension as the patient was suffering from DM since 9 years and HTN since 13 years. Both these diseases were in existence as on 12.04.2005, the date of commencement of policy.

Decision :

The insurers are technically correct in considering this policy as a fresh one excluding the expenses incurred for treatment of both DM and HTN which were pre-existing at the inception of policy on 12.04.2005. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G.11.022.0283
Sri K.V. Akileswaran
Vs
New India Assurance Co. Ltd.

Award Dated : 16.05.2007

The complainant purchased Mediclaim policy for the period 31.03.2002 to 30.03.2003. He was continuously covered from 16.11.1998 till 30.06.2002 and from June 2002 to June 2003. He was admitted to hospital on 26.08.2005. His claim for reimbursement was denied by the TPA on the ground that the disease was pre-existing when the cover incepted for the first time. He had a past history of cardiac problem and underwent CABG in 1996.

The insurers contended that the policy taken by the employer with Oriental Insurance Co. Ltd was effective upto June 2003 while the individual Mediclaim policy with New India was effective upto 31.03.2003. Therefore, the latter policy was concurrent and not continuous. It could be considered as additional insurance and deemed to be a fresh policy.

Decision :

The insurers vide their letter dated 14.02.2007 to this office stated that the claim was settled for Rs. 6081/- on 09.02.2007. They added that although the claim was inadmissible they took a sympathetic stand while effecting payment. The insurers took a long time to settle a small claim and are directed to pay interest as per IRDA guidelines for the period 11.05.2006 to 09.02.2007. The complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.005.0287
Sri Y.A. Sridhara Rao
Vs
Oriental Insurance Co. Ltd.

Award Dated : 16.05.2007

The Mediclaim policy for the period 20.11.2005 to 19.11.2006 mentioned cumulative bonus for himself and his wife. However, the renewal Mediclaim policy for the period 20.11.2006 to 19.11.2007 did not carry the cumulative bonus. This deletion was not informed to the complainant. The complainant contended that benefits given as incentives in the contract couldn't be withdrawn or cancelled unilaterally.

The insurers contended that due to modification of the existing policy w.e.f.15.09.2006, the minimum sum insured was fixed at Rs.50,000/- each and Rs. 2541/- was collected from the insured as revised premium. This was informed to the insured prior to issue of the policy and was accepted by him. While calculating the premium the revised rates were applied on the old sum insured of Rs.20,000/-. Therefore, as a one time benefit the complainant and his spouse got the additional benefit of Rs.30,000/- in coverage.

Since the complainant brought out the discrepancy almost immediately after the renewal, the insurers ought to have clarified their stand by way of letter. An amount of Rs.1,000/- is allowed as compensation for deficiency in service. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0302
Sri Arun Kumar Kamath
Vs
United India Insurance Co. Ltd.

Award Dated : 16.05.2007

The complainant was a member of Accident Relief Care (ARC) for the period 08.03.2006 to 07.03.2007 for a sum insured of Rs.1,00,000/-. He met with an accident on 13.08.2006 and was diagnosed to suffer from Bi-frontal Cerebral contusion with seizure disorder and Diabetes Mellitus (Juvenile). Out of his claim for Rs.44,485.88ps, the insurers settled Rs. 32,096/-as the patient received treatment for both accident as well as diabetes during his stay at the hospital.

The complainant contended that deduction of expenses for the treatment of DM was incorrect, as the doctors could not commence treatment for the injuries without controlling the sugar level. Restriction of bed charges to mere Rs. 250/- per day was unfair as he was admitted to one of the listed hospitals. Even consultation charges were deducted from the doctor's consultation charges over which he had no control.

The insurers contended that the room rent was fixed at Rs.250/- per day and hence excess rent claimed was disallowed. Doctor's charges in excess of the amount prescribed were also disallowed.

Decision :

On perusal of the copy of the Certificate of Insurance no mention of any conditions, limits etc., was noted. Even the rate schedule was not handed over to the complainant. As regards room and doctor's visit charges, neither the patient nor his attendants would have any control. Further out of the 10 days stay in the hospital, 6 days were in the ICU, indicating the gravity the situation. The insurers ought to appreciate the seriousness of the case and should look into the totality of circumstances. The insurers and directed to pay the balance amount of the claim as per bills submitted after deducting premium towards reinstatement and excess as per policy. The complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0313
Sri R. Subhash Chandra Bose
Vs
National Insurance Co. Ltd.

Award Dated : 22.05.2007

The complainant renewed his Mediclaim policy on 29.01.1999. The earlier policy expired on 10.09.1998. He was hospitalized from 31.01.1998 to 07.02.1998 for heart ailment and received claim of Rs. 93,000/- from the insurers. He was hospitalized again in May 2006 for heart ailment and his claim was rejected on the ground that the disease was existing prior to the earliest date of continuous insurance without break i.e. 20.04.2000.

The complainant contended that gaps in insurance arose due to non-receipt of renewal notices.

Decision :

As per current practices, pre-existing diseases are excluded if there is no continuous insurance after the onset of the said illness. The reason for the gap in renewal is not convincing especially as the insured received claim benefits of Rs. 93,000/-. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0307
Sri M.S. Balasubramanya
Vs
New India Assurance Co. Ltd.

Award Dated : 16.05.2007

The complainant renewed his Mediclaim policy for the period 2005-06 with a gap of 7 days. He was admitted to hospital on 19.07.2006 for Left Indirect Inguinal Hernia and discharged on 21.07.2006. His claim was rejected on the ground that the disease was first year exclusion.

The complainant contended that the lapse was unintentional and the delay ought to be condoned. The insurers contended that the complainant gave a letter that he was agreeable for disallowing cumulative bonus. The insured was informed that the policy for 2005-06 was a fresh one. The hospital records state that the problem was in existence since one week which comes under the twilight zone of the break period.

Decision :

The insurers have rejected the claim in accordance with the terms and conditions of the contract. No convincing reason was put forth by the complainant for the delay in renewal. He has made earlier claim for his wife and therefore cannot plead ignorance of the policy terms and conditions. He also did not dispute the fact that the insurers explained to him that the policy for 2005-06 was a fresh contract at the time of renewal. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0340
Sheikh Abdul Farooq
Vs
United India Insurance Co. Ltd.

Award Dated : 18.06.2007

The complainant was admitted from 07.06.2005 to 18.06.2005 following dislocation of his right shoulder. As per the documents, he initially suffered an injury at Ghaziabad on 29.05.2005 which got aggravated on 04.06.2005 when he lifted some heavy items. His claim was rejected on the ground that the cause of loss was not clearly established, cash receipt was not in order and some receipts showed that doctor made payment to the hospital.

Decision :

The hospital has on its letter head given the break-up of the total Rs. 21,000/- received by them. All the objections raised by the insurers are misplaced. There is no sense in their stand especially when the investigator had reported that the insured had taken treatment at the hospital and claim submitted was genuine. The insurers are directed to process and settle the claim. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.005.003
Sri Balaji Ratnam
Vs
Oriental Ins. Co. Ltd.

Award Dated : 29.06.2007

The complainant and his wife were covered under individual Mediclaim policy for the period 13.01.2006 to 12.01.2007. The earlier policy was valid for the period 18.10.2004 to 17.10.2005. There was a gap in renewal of the policy as the complainant and his wife were out of the country from 18.10.05 to 03.01.06. The policy for the period 2006-07 was renewed only on 13.01.06. The complainant underwent a prostate surgery on 02.11.06and his claim was rejected by the insurers on the ground that there was a gap in renewal of the policy of 87 days. The complainant contended that his first policy was from 18.10.03 to 17.10.04, which was renewed without a break for the period 18.10.04 to 17.10.05. They purchased Overseas Travel Insurance Policy from Tata AIG for the period 31.07.05 to 26.01.06 (180 days). The insurers contended that although there was a provision of extending the policy period for the number of days the policy holder was away from India, the complainant did not inform them either while leaving the country or immediately after arrival in the country. This fact was informed only at the time of claim intimation.

Decision :

In this case the individual Mediclaim policy was valid for the period 18.10.04 to 17.10.05 and the overseas policy for the period 31.07.05 to 26.01.06. The complainant and his wife left India on 01.08.05 and returned on 03.01.06. Therefore the individual Mediclaim policy runs for 288 days from 18.10.04 to 01.08.05. The balance unutilised period was 77 days.

It is clear from the letter and spirit of the circular that the Indian policy need not be in force when the person is outside India with an Overseas Mediclaim policy. The 77 days balance is to be reckoned from 03.01.06 the date of arrival in India. The insurer's explanation that the 77 days balance is to be reckoned from 17.10.05 and ceases on 02.01.06 is in correct. The insurers are directed to consider the policy as a continuous one and allow all the renewal benefits due to the complainant and his wife. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.004
Sri Balaji Ratnam
Vs
New India Ass. Co. Ltd.

Award Dated : 29.06.2007

The complainant was insured under an individual Mediclaim policy for the period 23.07.06 to 22.07.07. He was admitted on 27.11.06 with Bladder Neck Obstruction. His claim was rejected on the ground that the problem for which the treatment was taken

was present since 2005. The complainant contended that this operation was in no way connected to the earlier hospitalisation which was for prostate. The insurers contended that this was the first year policy. Prostate was specifically excluded during the first year of operation of the policy as per clause 4.3.

Decision :

Since continuity of insurance policy has been established since 2003, this policy cannot be termed as a fresh one. The complainant is directed to submit copies of earlier policies and copy of the order No.G-33/2007-08 dated 29.06.2007 to the insurers to facilitate

settlement. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 12.012.010
Sri C.K. Manoharan
Vs
ICICI Lombard General Insurance Co. Ltd.

Award Dated : 02.07.2007

The complainant and his wife were covered under a Healthcare policy for the period 15.09.06 to 14.09.07. His claim for treatment undergone for neck and shoulder pain was rejected on the ground that treatment was taken as out-patient and there was no hospitalisation. He was shocked to receive cancellation endorsement which read “at the request of the insured....” The complainant contended that the insurer assured him that the policy covered hospitalisation expenses, out-patient treatment expenses and cost of regular health check-up. He was informed that bills for out-patient treatment for minor ailments like cold etc., could be accumulated and a single claim lodged with the insurer. An amount of Rs. 7,200/- was recovered towards premium in instalments. The insurers contended that the policy was cancelled on request of the customer and refund of Rs.2,400/- was made after applying the refund grid.

Decision :

There is no request for cancellation of policy from the complainant in writing. The complainant only expressed his anguish that he would be constrained to cancel the policy in the event of his claims being rejected. The insurers cancelled the policy on 26.02.2007 which means the actual policy period was 15.09.2006 to 26.02.2007 (164 days or approximately 5½ months). In this case the insurers collected further premium upto 14.06.2007, i.e. another 108 days extra. This is not correct as there was no policy in existence with effect from 26.02.2007. The insurers are therefore directed to refund the premium for the period 26.02.2007 to 14.06.2007 in addition to Rs.2,400/- already paid to him. They are directed to pay Rs. 3,000/- as compensation to the complainant for leading him to believe that he was covered under the policy even for out-patient treatment. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0016
Sri Suleiman Sharif Khwaja
Vs
United India Ins. Co. Ltd.

Award Dated : 02.07.2007

The complainant and his family were covered under Mediclaim policy for the period 01.08.2006 to 31.07.2007. His wife was admitted to hospital with complaints of chest pain and underwent CAG + stent implant. Her claim was rejected on the ground that as

per the treating doctors certificate, patient was a known case of hypertension since 7 to 8 years. Since hypertension was the main pre-disposing cause for heart disease, the ailment was treated as pre-existing disease and rejected under 4.1 clause. The complainant contended that his wife was continuously covered under Mediclaim policy since 2002-03 and this was the first claim. She was diagnosed to suffer from HTN only in 2006-07 and she was not aware since when she actually had the ailment as she never took any specific treatment for HTN. The insurers contended that in the proposal form the complainant replied in the negative to the question regarding Blood Pressure. Therefore, she suppressed material facts about her health.

Decision :

The complainant's first policy was for the period 2003-04 and she underwent surgery in November 2006. She would not have postponed the treatment for 2 years just to avail insurance benefits. It was possible that she was unaware of the existence of her HTN or its severity and hence did not fill in the reply. The certificate from the treating doctor clearly mentions that the patient had no past history related to this problem. The insurers did not bother to seek clarifications from the cardiologist before rejecting the claim. They ought to keep in mind the insurance history of the complainant and should consider the said certificate of the treating doctor in full and not choose what is convenient to them. Hence repudiation of the claim cannot be sustained. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0017
Smt. Mutahera Habibullah
Vs
United India Ins. Co. Ltd.

Award Dated : 02.07.2007

The complainant's claim for reimbursement of Rs. 2,06,788/- towards expenses for total replacement of left knee was rejected by the insurers on the ground that there was a gap of 30 days in renewal of the policy during 2003-04. The disease was pre-existing at the time of inception of the policy. The complainant contended that she was covered under Mediclaim policy since 1997 and she was out of town during the renewal of policy for 2003-04. The renewal was accepted by the insurers after submission of medical certificates.

Decision :

The insurers gave a commitment during the hearing that the claim would be settled within one week of submission of all bills duly certified. They also agreed in principle to overlook the gap of 30 days and treat the policy as continuous. The complainant is directed to submit the entire claim related documents duly attested to the insurers. The insurers are directed to abide by their commitment and pay the claim. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0031
Sri K. Suryanarayana Murthy
Vs
New India Assurance Co. Ltd.

Award Dated : 12.07.2007

The complainant's sister's claim for reimbursement of expenses for 2 hospitalisations were rejected by the TPA as the patient was having the symptoms for 4 years, before

the inception of policy on 01.09.2000. The complainant contended that the same hospital made note that the patient was having the symptoms since 2 years. Actually she had the problem only one year prior to the date of first admission. The insurers contended that they requested the complainant to submit past medical records for the period 2000 to 2004.

Decision :

Since the complainant was unable to produce the medical records the insurers were directed to verify the hospital records. They enclosed photocopies of treatment and progress notes of the treating doctor at CMC, Vellore. In almost every page it is recorded that the disease was present since 4 years. The insurers ought to go by the medical records submitted. They were well within their rights in rejecting both claims. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.020
Sri B.V. Sridhar
Vs
New India Assurance Co. Ltd.

Award Dated : 17.07.2007

The complainant's mother was admitted to hospital on 20.09.2006 with fracture of the shaft of the right femur and underwent hip replacement on 05.10.2006. As against the total claim bill of Rs. 84,898/-, the TPA settled Rs. 27,410/- and disallowed Rs. 57,488/- as the entire sum insured under the policy for the period 01.10.2005 to 30.09.2006 was exhausted. The complainant contended that this policy was promptly renewed for one more year under the automatic renewal scheme of Citibank from 01.10.2006 to 30.09.2007. The TPA approved an amount of Rs. 65,328/- as cashless facility from the total claim bill of Rs. 1,50,226/-. He had to pay Rs. 84,988/- to the hospital over and above the authorised amount. Since his mother underwent surgery on 05.10.2006, the new policy period, he was entitled to receive the balance. The insurers contended that at the time of hospitalisation the available sum insured was Rs. 98,744/- as some other claims were settled earlier. After all the claims, there was a clear balance of Rs. 27,410/- which was sanctioned to his mother. It was not possible to consider the claim for the balance sum insured under the new policy as per clause 2.5 of the policy according to which "…. Claims if more than one will be treated as a single claim for the purpose of the policy." In no case, the expenses incurred beyond the available sum insured, even if the policy is renewed without a break will be reimbursed / paid as there is no fresh admission to hospital. It is only a continuation of the hospitalisation period.

Decision :

The insurers ought to appreciate the fact the claimant was insured continuously for over a decade and her policy was renewed for 2006-07 also. Although rejection may have been done on a strict technical interpretation of the terms and conditions, the arguments are against the spirit of the policy terms as a whole. Considering the peculiar predicament of the complainant, which as it appears has arisen only due to the reckoning of the date of admission, I am inclined to award Rs.3,000/- as ex-gratia. The complaint is partly allowed as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0043
Sri Sastry Chandrasekhar

Vs
United India Ins. Co. Ltd.

Award Dated : 17.07.2007

The complainant was covered under Aarogyadaan Policy. He was admitted in hospital for shortness of breath and fever. His claim was rejected on the ground that the present hospitalisation was for management of an ailment which is related to a pre-existing condition clause 4.1. The insurers contended that the insured was a known DM since 10 years, HTN since 10 years, Heart Disease since 4 years and COPD since 2 years as per the admission request note. He was admitted within3 months of taking the policy.

Decision :

It is noted that apart from the treatment of pre-existing diseases, the complainant was diagnosed as having other ailments like anaemia, urinary tract infection during the hospitalisation for which the claim was made. Since not all diseases for which treatment was taken and claim was lodged can be termed as pre-existing, Rs. 10,000/- is awarded as ex-gratia. The complaint is allowed as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0060
Sri M. S. Prabhakara Rao
Vs
United India Ins. Co. Ltd.

Award Dated : 17.07.2007

The complainant purchased Mediclaim policy for the period 24.10.2006 to 23.10.2007. He underwent Lasik treatment to left eye on 02.02.2007 and right eye on 09.02.2007. His claim was rejected on the ground that correction of myopia or refractive errors were not sought to be covered under the policy.

Decision :

During the course of hearing it was brought to my notice that the complainant filed a complaint before the Consumer Forum, Hyderabad on the same subject matter. However, he gave a declaration that his complaint to this office is not on the same subject matter for which any proceedings before any Court or Consumer Forum or arbitrator are pending settled or were so earlier. This complaint is therefore non-entertainable as per Rule 13(3) (c) of RPG Rules, 1998.

Hyderabad Ombudsman Centre
Case No. : G 11.008.064
Smt. Sagi Usha Raju
Vs
Royal Sundaram Alliance Ins Co. Ltd.

Award Dated : 23.08.2007

The complainant's husband was insured under a health insurance policy of Royal Sundaram Alliance Ins. Co. Ltd. from 10.03.2003. He was hospitalised on 04.12.2006 with complaints of breathlessness and fever which was diagnosed as broncho-pneumonia and pulmonary embolism. Subsequently he died. A claim was lodged, which the insurer rejected recalling that they had earlier rejected the claim for hospitalisation expenses in December 2003. That claim was for kidney transplantation. The insurers contended that the present claim arose out of the kidney transplant which itself arose out of pre-existing conditions.

Decision :

The complainant submitted that her husband was diagnosed as having diabetes and hypertension only in the middle of 2003 i.e after taking the policy. This is supported by the discharge summary of December 2003 which notes that the patient had DM and HTN for 6 months. The policy exclusion states that for the first year of operation of the policy the expenses on treatment of kidney disorders were not payable to insured persons suffering from DM/HTN. The insurers could not establish that the patient had symptoms of DM & HTN prior to March 2003. The wording of the exclusion shows that even if the patient had suffered from these ailments prior to March 2003, the expenses on kidney disorder were not payable only during the first year. The insurers could not establish that the kidney ailment existed prior to March 2003.The complainant stated that she did not question the rejection of the first claim as she had to tend to her ailing husband. The rejection of the claim stating that use of immuno-suppressives, which lead to present ailment was in consequence of kidney transplant is not justified when it is not proved that kidney ailment existed prior to taking the policy. In fact these medicines were used much after the commencement of insurance cover. The insurers are directed to pay Rs. 2,17,500/-.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0102
Sri K. Srinivasulu Reddy
Vs
United India Ins. Co. Ltd.

Award Dated : 27.08.2007

The complainant was covered under a Mediguard Policy of United India Insurance Co. Ltd. from 27.09.2004 which was subsequently renewed from 27.09.2005 to 26.09.2006. He was hospitalised on 22.07.2006 and again on 23.09.2006. He lodged two claims for Rs.8,608/- and Rs. 76,450/- which were settled for Rs.3,874/- and Rs. 68,550/- respectively. Post hospitalisation claim for Rs.6667/- which was also lodged with the insurer was not settled yet.

Decision :

The complainant during the course of hearing confirmed that the insurer's Branch Manager called him and offered to settle the balance in first claim and he was agreeable to that offer. The insurer had not given any clarifications for the short settlement of the second claim. The insurer agreed to review the claim after obtaining clarifications from the complainant. The insurer also agreed to consider the post hospitalisation claim towards the expenses incurred for 60 days from the date of discharge. The insurer was directed to consider the claims as per the terms and conditions of the policy and dispose the claims within one month from the date of the order.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0101
Smt. K. Padmavathi
Vs
United India Ins. Co. Ltd

Award Dated : 27.08.2007

The complainant was insured under a Mediguard policy of United India from 27.09.2005 to 26.09.2006. She was admitted in the hospital for treatment of gall bladder polyp on 27.01.2006. The complainant's husband was an employee of the State Road Transport

Corporation and the employer had reimbursed the hospitalisation expenses. A claim for Rs.5,360/- towards post hospitalisation expenses was lodged with the insurer. The claim was repudiated stating that the disease was pre existing. She represented to the insurer who asked for certain clarifications on the amount settled by the RTC, but the insurer did not send any further communication even after the clarifications were given.

Decision :

The discharge summary of the hospital stated that the ailment was in existence for four months whereas the insurance cover extended for barely 4 months. Thus the ailment was pre existing and the insurers were within their right to repudiate the claim. There was considerable delay in processing the claim. Firstly the insurer had taken 6 months to convey their decision on a fact which was within their knowledge once the claim was lodged. Secondly they have sought clarifications from the complainant after the claim was repudiated thereby sending signals that the claim was being reviewed and thereafter no decision was taken for 9 months. All this constitutes deficiency of service for which a compensation of Rs 1000/- is awarded and the complaint against repudiation is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.072
Sri V Giridhar
Vs
New India Assurance

Award Dated : 31.08.2007

The complainant was insured along with his family members under Medical insurance since 24.12.2001. He was hospitalised on 3 occasions between May'06 and July'06 for ailments diagnosed as Pancreatitis, Chronic liver disease, Oesophageal ulcers and portal vein thrombosis. The claims for Rs.2,03,595/- were lodged which were repudiated stating that the hospitalisation was related to management of an ailment which resulted from alcohol intake.

Decision :

The insurer referred to an earlier hospitalisation in March'06 in the discharge summary of which the diagnosis is mentioned as alcoholic gastritis and contended that the present hospitalisations were a continuation of the same treatment. They further stated that the liver ailment and pancreatitis arose out of alcoholism and the claim was repudiated under clause 4.8 of the policy. The complainant argued that in the discharge summaries of present hospitalisations there was no mention that the hospitalisations were a result of an ailment which was due to intake of alcohol. The insurer submitted the progress notes (hospital case-sheets) pertaining to the three hospitalisations wherein it is clearly noted at many places as "ethanolic" and "ethanol related". The independent medical opinion obtained also stated that these disorders are likely due to long term alcohol abuse. Therefore the complainant is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.073
Sri Anant Shivram Bhat
Vs
New India Assurance Co.

Award Dated : 07.09.2007

The complainant obtained a Mediclaim policy from New India effective from 16.08.2005 which was renewed from 16.08.2006 to 15.08.2007. He was admitted to hospital for

eye surgery (cataract) on 16.10.2006. The TPA approved cash less facility for Rs. 18,000/- and after discharge from hospital, a claim was lodged for Rs.23,233/- The claim was repudiated stating that the ailment was pre-existing and even the cash less facility was withdrawn.

Decision :

The insurer stated that the discharge summary recorded the existence of the ailment for 2 years and therefore it was pre existing. The complainant stated that the records of the hospital record the pre existing condition as one year only and the mistake was done by billing section. The corrected discharge summary was obtained and even a certificate from the treating doctor was submitted. The insurers had the opportunity to investigate and also to verify with the treating doctor about the facts. Instead they kept harping on a single point that they would rely on the first discharge summary and would not consider the doctor's certificate and second discharge summary. They deprived themselves of an opportunity to investigate when they claim that records submitted were contradictory. The complainant was justified in his contention that pre-existing condition was wrongly recorded in the first discharge summary and insurers were directed to settle the claim.

Hyderabad Ombudsman Centre
Case No. : G 11.004.083
Dr. N Basavaraja
Vs
United India Ins.Co.Ltd.

Award Dated : 14.09.2007

The complainant was covered under a Mediclaim policy since 21.11.2002. It was renewed with a gap of 39 days in 2004, effective from 29.12.2004. He was hospitalised on 10.04.2006 with pain in the back which was diagnosed as sciatica. The discharge summary stated that the patient suffered from back pain for one and half years and the treating doctor also certified that ailment was exiting for 2 years. The claim was repudiated stating that the disease was pre existing.

Decision :

The complainant stated that no notice was given for renewal and also the policy does not contain the effects of break in renewal. As per clause 3.9 of the policy, the insurers were not bound to give notice of renewal and clause 4.1 states that the policy would be continuous only when it is renewed without break. The insurer pointed to the MRI reports which state that posterior and right para-central protrusion of L4-L5 disc had increased compared to the pervious scan dated 17.10.2002 and contended that the disease existed even before the cover incepted for the first time on 21.11.2002 The insurers were justified in rejecting the claim. The complainant was not guided properly as mentioned in the IRDA guidelines which amounted to deficiency in service. The complaint is dismissed and compensation of Rs 2000/- is awarded for deficiency of service.

Hyderabad Ombudsman Centre
Case No. : G 11.002.084
Sri Vijay Rajan
Vs
New India Ass. Ins.Co.Ltd.

Award Dated : 17.09.2007

The complainant was covered under a Mediclaim policy since 01.11.94. She was covered for a Sum insured of Rs. 1,00,000/- upto 31.10.99 and for a Sum insured of Rs.2,00,000/- since 01.11.99. She was admitted to hospital on 24.09.06 for bilateral Osteo-arthritis and total knee replacement was done. The claim was settled for Rs.1,00,000/- and the balance was rejected stating that for enhanced sum insured the ailment was pre-existing.

Decision :

The complainant stated that though there was mild pain, the symptoms deteriorated only one year prior to surgery and she visited Institute of Aerospace Medicine for Resonance Therapy. The pain subsided for some time and reappeared for which surgery was done. The insurer pointed that as per discharge summary the patient had pain in both knees 8 years prior to surgery. The insurer could not explain how they concluded that pain was due to existence of the ailment only. They could neither submit any further information on which the conclusion of pre-existing disease was arrived at. The pain as mentioned in discharge summary was not conclusive proof of existence of ailment. The insurers were directed to pay the balance claim of Rs.1,00,000/-.

Hyderabad Ombudsman Centre
Case No. : G 11.012.0145
Sri Varadharajan Ravi
Vs
ICICI Lombard Gen. Ins. Co. Ltd.

Award Dated : 20.09.2007

The complainant insured himself and his family under a Health Care Policy for the period 20.07.2006 to 19.07.2007. The complainant's son was admitted to hospital on 19.01.2007 for an ailment diagnosed as "neurocysticercosis". A claim for Rs 9238/- was lodged. The claim was rejected stating that as per policy conditions the expenses incurred for treatment of any kind of tumours, cysts, nodules and polyps were not admissible for first two years of insurance.

Decision :

The complainant stated that the primary cause of his son's ailment was only tape worm infestation and not a cyst. The insurers stated that the claim was rejected as neuro-cysticercosis which affected the complainant's son was due to formation of cysts. The insurance policy excludes cysts, which would only mean the cysts manifesting on the insured anywhere in the body. It is clearly not established from the treatment papers as to where any cyst has occurred. The extract from book on parasitology submitted by the insurer states "In cysticercosis of brain, the symptoms are more often due to dead and calcified larvae". The insurers relied on research paper by Dr De Gorgio which noted that tape worm eggs turn into larval cysts and migrate to the brain causing neurocysticercosis. The insurers may be technically correct, but a broader view ought to be taken. The probability of insured's ailment arising out of tape worm infestation only cannot be ruled out. In view of above an amount of Rs.5000/- is allowed as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0163
Smt K Bhulaxmi
United India Ins. Co. Ltd.

Award Dated : 28.09.2007

The complainant was insured under a Mediclaim policy since 3.10.2001 for a Sum insured of Rs.1,00,000/-. She took treatment for hearing problem and lodged a claim for Rs.12,750/-. The claim was repudiated stating that the cost of hearing aid was not payable as per the policy .

Decision :

The insurer stated that the insured had undergone tests only and lodged a claim towards cost of hearing aids which was repudiated as per exclusion 4.6 of the policy. The said condition of the policy excludes the cost of spectacles contact lenses and hearing aids. Therefore the complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11-003-270/2006-07
Smt.Margaretha Parathara
Vs.
National Insurance Co.Ltd.

Award Dated : 18.04.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of partial repudiation of a medical claim by the insurer under Policy No.570704/48/06/8500000517. The complainant's son was treated in an Ayurveda Hospital and preferred a claim for Rs.33164/-. However, the insurer allowed only Rs.3000/- being 20% of capital sum assured. The Divisional Office of Insurance Co. also reviewed the case and they also upheld the decision of limiting the claim amount to 20% of insurance amounts. The annual limit for Ayurveda treatment was limited to 20% of sum assured, by an endorsement made by way of a rubber stamp on the policy. The complainant was not convinced of the validity of the endorsement by way of a rubber stamp as the same was not authenticated by way of insurance officials signature and also there was no mention of the same on the proposal form. On verification of records it was observed that the limit for Ayurveda treatment was limited to 20% of sum assured by an endorsement by way of a rubber stamp. Though the endorsement was not signed by officials of the insurer and there was no mention of the same in the proposal form, the general principle regarding endorsement on insurance policies implies that a rubber stamp overrides the printed matter on the face of the policy. Hence the endorsement of limiting the reimbursement to 20% of sum assured for Ayurveda treatment was valid and hence the complaint was dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-011-315/2006-07
Sri.Sahil Ismail
Vs.
Bajaj Allianz General Insurance Co.Ltd.

Award Dated : 27.06.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of Hospital Cash Daily Allowance policy taken by the complainant from Bajaj Allianz General Insurance Co.Ltd. he had been admitted to Amrita Hospital for 7 days from 23.11.06 to 30.11.06 and his claim for compensation was repudiated on the ground of existence of pre-proposal illness. He also did not get any proper reply or response to many of his queries. Even his personal visit to offices has no effect. The insurer put forward the following arguments. In the proposal form it was reported that he does not have any pre-existing disease. However from the medical report presented by the insured it was evident that he has been presented with complaints of intermittent

diplopia since birth and head ache for a long duration. For head ache and diplopia he has been consulted various hospitals and referred to Amrita Hospital for further evaluation and management only. As per policy condition sickness which manifest during policy period and got admitted and treated during policy period will only cover under the policy. As the insurer was able to prove pre-proposal illness with clinching evidence, this Forum find no reason to interefere with the decision of insurer and repudiating the claim.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11-004-336/2006-07
Sri. Vinayan T.
Vs.
United India Insurance Co. Ltd.

Award Dated : 28.06.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of repudiation of medical insurance claim under the insurance policy held by the complainant with United India Insurance Co.Ltd. He has insured himself and his family members under medi claim insurance policy since 12.6.98 and has been renewing the same for 9 years. The first policy was taken from National Insurance Co.for an insured value of Rs.15000/- for each member and then increased to Rs.20000/-. He has transferred the policy to United India Insurance Co. on 23.5.01 and also increased the SA to one lakh for his parents and Rs.50000/- each for himself and his spouse. During the tenure of insurance with United India his father has been hospitalized 3 times and in the first 2 occasions the bills were settled without any objection and in the third occasion the claim was rejected on the ground that previous illness particulars are not disclosed in the proposal forms and relevant columns in the proposal was left blank. The claim in question was for treatment taken from Amrita hospital and later in Lourde Hospital. As per hospital reports he was detected to have Renal disease from march 2001, i.e., 2 months before renewing the policy with United India Insurance Co., Coronary disease from Sept.2001, and diabetes Mellitus from 2002. These three diseases have equally contributed to hospitalisation and only the first disease, renal disease was detected previous to renewal with United India Insurance Co. As per policy condition in case the insured has a policy under the same scheme or Group insurance scheme with any of the Indian Insurance companies for a continuous period of proceeding 12 months without any break then the exclusion clause is not applicable. Here he was renewing the policy for the last 9 years without any break. The argument of the insurer that some columns in the proposal form was left blank also does not carry conviction since the same was overlooked at the time of underwriting in 2001 itself and the policy was renewed. There is no convincing reason for the insurer to repudiate the claim, since the insured has renewed his policy for 9 years albeit with two insurance companies. The policy condition does not permit the insurer to reject the claim under the pre-existing disease and in view of this complaint is allowed and insurer is directed to settle the claim.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/11-002-351/2006-07
Sri. P. K. Valsappan
Vs.
The New India Assurance Co. Ltd.

Award Dated : 17.07.2007

The complaint is against partial repudiation of a claim under medi claim insurance policy taken by LIC of India for the benefit of their employees. The complainant, an employee of LIC of India has undergone Ayurvedic treatment in a nursing home for cervical and lumber spondilosis from 28.10.06 to 11.11.06. He made a claim for Rs.17300/- supported by necessary bills. Initially Rs.6100/- was alone allowed and the rest of the claim was rejected. On following it up an amount of Rs.6900/- was also allowed disallowing the balance of Rs.4300/-. Aggrieved by this he approached this Forum. It was submitted on behalf of the insurer that according to their panel doctor all the treatment as taken by the claimant cannot be taken at the same time. On getting the complaint they referred the matter with the opinion of panel doctor to the treating doctor. On getting clarification from treating doctor they again sought the opinion of panel doctor and as per his advice they settled Rs. 14600/- out of claim amount of Rs.17300/-. On going through the records it was observed that the panel doctor has opined that all the treatment cannot be taken at a time. However he has opined that all the depicted treatment can be done for the diagnosed disease. It can be noted that the panel doctor who has initially stated that all these treatment cannot be taken at the same time has later recommend 10 days reimbursement. This means that 10 days treatment is possible. The advice given by panel doctor appear to be contradictory. Hence there is no justification in denying the full claim. During the course of hearing it was also submitted that after filing the complaint an amount of Rs.1600/- was also sanctioned and the rejected claim amount is only Rs.2700/-. An award is therefore, passed directing the insurer to pay the balance amount of Rs.2700/- along with a cost of Rs.250/-.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-375/2006-07
Sri.Sojan K. J.
Vs.
United India Insurance Co.Ltd.

Award Dated : 25.07.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim under Medi Guard policy. The policy was issued to Sri.K.J.Sojan covering himself and his family members w.e.f.3.9.04. His father was admitted in Lourdes hospital, Ernakulam on 18.2.06 for treatment of basal pneumonia and acute respiratory failure. The claim was repudiated on the ground that the ailment for which treatment was taken was pre-existing and was not disclosed while proposing for insurance. It was submitted on behalf of the insurer that their enquiry at the hospital revealed that the patient made his first visit to the hospital on 6.8.02 and the problem presented by him was respiratory problems. The illness was diagnosed as Chronic Obstructive Pulmonary Disease (COPD). He was also found to be suffering Bronchial Asthma, wheezing and cough. But it is pertinent to note that though the insurer has verified the hospital records no documents have been produced as to any prior treatment. They produced only on investigation report through their officers. Hence it can very well be presumed that pneumonia would not have been there before taking policy. Even if he has undergone treatment in 2002, insurer was not able to prove that it was for like ailment which occurred in 2006. Hence this Forum finds that the material available is not sufficient to substantiate repudiation and the insurer is directed to settle the claim with 9% interest.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-003-356/2006-07
Sri.M.S.Narayanan Nair
Vs.
National Insurance Co.Ltd.

Award Dated : 01.08.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.Narayanan Nair has taken the medi claim policy for himself and the family members w.e.f. 5.9.02. His claim for reimbursement was repudiated on the ground that in the application before TPA for cash less facility the insured has declared that he was suffering diabetes mellitus for the last four years, and the declaration was signed by the applicant himself and the doctor. As the existence of Diabetes Mellitus was not disclosed in the proposal for insurance, the claim was repudiated on the ground of non-disclosure of preproposal illness. It was submitted by the insured that though the declaration was signed by him it was prepared by somebody else at the time of taking Angiogram and he was not in a position at that time to make such a statement. On verification of all records it can be seen that this declaration is as vague as anything. The period is stated approximately as 4 years and it is possible that the statement is only by the bi-stander. Insurance company has not produced any proof other than this declaration that the patient was diabetic while proposing for insurance. The declaration was countersigned by somebody on behalf of the attending doctor. It is not known who has signed on behalf of the attending doctor. The claim for reimbursement is for cardiac disease and not for diabetes mellitus. Hence there is no reasonable ground for the insurer to repudiate the claim. The insurer is directed to pay a sum of Rs.50,000/- to the claimant with an interest of 8% from date of claim till payment.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-002-027/2007-08
Sri.Udayan N Lalan
Vs.
The New India Assurance Co.Ltd.

Award Dated : 02.08.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant has taken a medi claim policy for a sum of Rs.1.00 lakh. While the policy was inforce he was admitted in Krishna Hospital, Ernakulam for 1 day and the claim for reimbursement of expenses was repudiated as only OP treatment was given in the hospital. It was submitted by the insurer that the patient was admitted on 2.5.06 and disposed on the next day. No specific treatment was given or any medicine was administered during the period of stay at hospital. The claim amount consists of scanning charges, rent and doctors fee only. The stay in hospital is for diagnostic purpose only and after diagnosis he was discharged with the advice to regular exercise and physiotherapy. A copy of policy document is produced. Policy condition is very specific that expenses incurred primarily for diagnostic purpose such as X-ray, Laboratory tests etc. not consistent and incidental to disease are not covered under the policy. As decision of insurer in repudiating the claim is based on facts the repudiation is upheld and complaint is dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-005-379/2007-08
Sri.Timi Issac Mathai
Vs.

The Oriental Insurance Co.Ltd.

Award Dated : 30.07.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim in respect of Good Health Policy No. 441702/48/ 2007/03132. The complainant has taken a Good Health policy on 29.8.05 for himself and his family members. The claim for reimbursement for a cataract operation for his wife was repudiated by the insurer on the ground that the operation was within 2 years of policy, and reimbursement for cataract operation for first 2 years is excluded as per policy condition. As per policy document issued policy was commenced on 29.8.05 and later renewed on 28.8.06. The cataract operation was done in November 06. Policy condition is very specific about its exclusion clause that reimbursement of cataract operation is excluded for the first two years of policy. As the operation was done within two years of commencement of policy, there is no reason to interfere with the decision of insurer and the complaint is dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-088/2007-08
Sri.Reji Jose
Vs.
United India Insurance Co.Ltd.

Award Dated : 07.08.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim for reimbursement under a medi guard policy. The complainant Sri.Reji Jose took the Medi Guard Policy from 1.12.05 to 30.11.06 covering himself, his wife, parents and children. His father was admitted in hospital on 17.7.06 and treated as inpatient upto 21.7.06 for Cervical spondylosis. The claim was repudiated by the insurer on the ground that the policy was taken after diagnosis of ailment and it was not mentioned in the proposal form. The copy of the case sheet from Cherupushpam hospital where treatment was taken was produced which shows that he had taken treatment from that hospital in the month of July/August.05. In September 2005, he was directed by the Orthopaedician, X-ray of spine was taken and thereafter medicines were prescribed as if he was having vertebral prolapse and found that there was Lumbago or lower spondylosis. Hence it is clear that spondylosis was diagnosed, as early as Sept.05 and while taking the policy in 12/05 the ailment existed. As all pre-existing illness was excluded from the purview of the policy the insurance company is not liable to make any payment under the policy and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-019/2007-08
Dr.Jose Elenjikkal
Vs.
United India Insurance Co.Ltd.

Award Dated : 14.08.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of claim under a medi claim insurance policy. A group medi claim policy for members of IMA and their family was issued on the application of IMA. The complainant, his wife and 2 daughters were covered under the policy. While so, the complainant's daughter was admitted at Lisie Hospital on 28.4.04 for lower back ache and discharged on 29.4.04. The claim was repudiated on the ground that the patient

was hospitalized for one day only for clinical observation and no specific treatment was given. The discharge summary shows that the complainant's daughter was admitted on 28.4.04 and discharged on the next day. Investigation done are shown as MRI of cervical spine. The treatment is shown as bed rest for 2 weeks and prescribed some oral tablets. From the expenses claimed also it can be seen that, the expenses are mainly for diagnostic studies only and no confinement is required after investigation. On account of specific exclusions clause as per policy condition the insurer justified in repudiating the claim and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-003-374/2006-07
Sri.Shiju Joseph
Vs.
National Insurance Co.Ltd.

Award Dated : 30.07.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim under medi claim policy. The complainant Sri. Shiju Joseph had taken a medi claim policy covering the family members w.e.f. 16.6.05. During the currency of policy his wife was admitted in hospital and the claim for reimbursement was repudiated by the insurer on the ground that she was admitted only for evaluation, which requires only outpatient treatment procedure. The total amount claimed is Rs.7901/30 out of which Rs.825/- is for hospital bill, Rs.500/- doctors fee for hospital visits, Rs.151.30 for medicines during hospital stay and Rs.4600/- for test report from Mangalore during hospital stay, Rs.25/- for medicine after discharge and Rs.1800/- for test report after discharge. The contention of insurance company is that hospitalisation was done only for conducting test and as such insurance company is not liable to pay the claim amount. In the claim statement and hospital report the ailment was shown as hypertension and in the medical certificate of Dr.Srinath of Kottachery hospital dated 27.10.05 also the ailment is shown as hypertension and treatment imparted is shown as "conservative' and is also stated that the hypertension was diagnosed on 10.10.05 itself. It looks that these tests were conducted only after diagnosis. The test conducted an MRI scan and Renal Arterial Doppler study, which has nothing to do with hypertension. Though she was admitted on 10.10.05 in City Nursing Home, Kanhangad, it was stated that the insured was present in Mangalore on 11.10.05 for conducting MRI scan and Renal Arterial Doppler study. Hence it can be seen that no hospitalisation was required and only conservative treatment was given for hyper tension and hence the claim for hospitalisation is not sustainable and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-002-035/2007-08
Sri.Joseph G Nellikkal
Vs.
The New India Assurance Co.Ltd.

Award Dated : 06.08.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim under medi claim insurance policy. The complainant has taken a medi claim insurance policy covering himself and his family members. His daughter Ms.Mary Vineetha who was covered under policy had taken treatment in Ranjini Eye Care hospital for Myopia from 14.11.06 to 24.11.06 and subsequently took lasik

treatment from 17.1.07 to 23.1.07 from Media Lasic Centre. The claim was repudiated on the ground that Myopia was not a disease and only a defect in vision and also lasik treatment is a cosmetic treatment which is not covered under the policy. In the preamble of the policy regarding risk coverage it was specifically stated that the risk is covered only for the disease contracted or injury sustained during the currency of policy. It looks that expenses are incurred for correcting the defect or eye sight – Myopia. Myopia is only a defect of eye and not a disease. Lasik treatment is taken only to avoid using spectacles or lenses which is in the nature of a cosmetic treatment. Cost of spectacles and contract lenses are excluded from the policy. No treatment records were produced to show that she had any disease. Admission and discharge certificate from hospital also was not produced. At the time of hearing the complainant has submitted that there was no IP treatment and his daughter was going for treatment regularly from her house. It can be seen that the entire treatment was for rectification of defects of vision and the complainant had incurred expenses only for rectification of defects in vision and hence the claim is unsustainable and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-036/2007-08
Sri.Laiju George Kodiyan
Vs.
United India Insurance Co.Ltd.

Award Dated : 05.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998 is against repudiation of a claim under a Family Health Plan Limited Policy covering the aged parents of the complainant. On 18.6.05 complainant's mother consulted a doctor as a lump was found on the breast and on 30.6.05 she was admitted for surgical operation. The claim was repudiated on the ground that the disease was pre-existing. The decision of insurer is mainly based on the hospital report that the lump was present one week before consultation on 18.6.05. The policy was issued with commencement date as 13.5.06. As per policy condition any disease contracted within 30 days of commencement of policy is not covered under the policy. It was submitted on behalf of the insurer that as the disease was existing before one week of consultation on 18.6.05. They are justified in repudiating the claim. But the fact remains that though the illness was existing one week before consultation on 18.6.05, the patient was not aware that the lump was Carcinoma. It is evident from the report that the patient has not taken any treatment before 18.6.05. Hence the contention of the insurer that the decision was pre-existing is not sustainable and there is no valuable ground for repudiation of claim. The complaint is allowed and the repudiation is set aside and an award is passed directing the insurer to pay a sum of Rs.40,000/- with interest at 8% since date of claim till payment.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-119/2007-08
Sri.Biju George
Vs.
United India Insurance Co.Ltd.

Award Dated : 07.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant had taken a medi guard policy covering himself and his wife. During the

coverage of the policy his wife was admitted in a homeopathic hospital for 2 days for treatment of Oedemateous inflammation. The claim was repudiated on the ground that no active line treatment requiring hospitalisation was there and entire treatment could have been taken as outpatient. As per policy condition only expenses which are reasonably and necessarily incurred only is to be reimbursed, and as in this case the entire treatment can be taken as an outpatient, the insurer is justified in repudiating the claim. It was submitted by the complainant that due to acute pain the patient was not in a position to stand or lie down and hence the doctor advised inpatient treatment. In the medical certificate there is absolutely nothing to show that inpatient treatment was not necessary. Since doctor of a recognized hospital has prescribed the treatment as inpatient and had given inpatient treatment, it is to be taken that inpatient treatment was necessary. The petitioner's case is that due to acute pain the patient could not sit or lie down. In such a situation it is proper to advice inpatient treatment. Hospital bill includes charges for nursing care also. Hence the repudiation is found to be faulty and insurer is directed to pay the claim amount with 8% interest.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-096/2007-08
Sri.Sunil Kumar S
Vs.
The New India Assurance Co.Ltd.

Award Dated : 07.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant had taken a medi claim policy covering himself, his wife, son and daughter. During the currency of policy Smt.Deepthi Sunil, W/o. of the complainant had taken Root Canal treatment and claimed an expenses of Rs.3550/-. The insurance company partially repudiated the claim disallowing the amount spent for amalgum filling, interim crown charges and ceramic crown charges as theses charges are related to cosmetic treatment. The claim for RCT taken for a dental clinic for periapical infection is admissible as per policy condition. Out of a bill of Rs.3550/- only Rs.1200/- towards RCT was allowed disallowing expenses towards amalgum filling, interim crown and ceramic crown. It looks that RCT was taken only to correct the defect and cure the disease. As there was a cavity amalgum filling was required. After amalgum filling crown is applied only to preserve the tooth. Hence it looks that amalgum filling and applying crown is only part and parcel of RCT. If it was not done there would be no use of RCT. Hence the partial repudiation made by the insurer is not correct and insurer is directed to allow the balance amount of Rs.2350/- with 8% interest since date of claim till payment.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-005-047/2007-08
Sri.A.S.Gopinatha Pillai
Vs.
The Oriental Insurance Co.Ltd.

Award Dated : 18.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complaint is against repudiation of a claim under Universal Health insurance policy issued by the Oriental Insurance Co.Ltd. The complainant, Sri.A.S.Gopinatha Pillai has taken the policy for the benefit of himself and his family members for the period covering 22.6.06 to 21.6.07. During the currency of policy he was admitted in hospital

for treatment of compressive myelopathy for the period from 26.9.06 to 9.10.06. The claim was repudiated on the ground that the illness was pre-existing one and at any rate the disease was contracted within one month of commencement of policy. The case summary from SCTIMS reveals that he was having pain neck with both upper limbs for one year and difficulty in walking for more than 2 months. He was referred to SCTIMS by Dr.S.K.Ajaiyakumar. The OP summary details furnished by Dr.Ajaiyakumar on 15.7.06 shows that he was consulted on 15.7.06 and having the symptoms on 15.7.06 itself. Hence it is clear that the patient was aware of the illness on 15.7.06 itself that is within one month taking policy on 22.6.07. It was submitted by the complainant that the proposal and necessary premium was submitted to the hospital for onward transmission to insurer as early as on 15.4.06 and date of commencement must be taken as 15.4.06 and hence the disease was contracted only after one month of taking policy. But the insurer has submitted that the proposal was submitted and first premium was remitted only on 22.6.06. The insurance company produced copy of proposal form, the proposal was an undated one. It looks that proposal was initiated on 22.6.06 acknowledging the receipt of the same. The first premium receipt no.3427391 was also issued on 22.6.06. Hence it is very clear that the policy was issued pursuant to proposal dated 22.6.06 and the disease was contracted within one month of taking policy. The repudiation made is correct and it is liable to be upheld.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-005-089/2007-08
Sri.Hitesh M Kothari
Vs.
The Oriental Insurance Co.Ltd.

Award Dated : 06.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant Sri.Hitesh M Kothari had taken a medi claim policy covering his mother Smt.Indira Kothari. During the currency of the policy Smt.Indira Kothari was admitted in hospital and on 13.9.06 knee Arthroplasty was done. The claim was repudiated on the ground that the hospitalisation was for the management of an ailment relating to a pre-existing condition. The complainant has contended that the medi claim policy was taken as early as 10.8.04. The cheque for renewal w.e.f. 10.8.05 was tendered on 25.8.05 which was dishonoured and ultimately the renewal of policy was effected w.e.f. 12.9.05 by remitting premium with necessary bank charges for dishonoured cheque. Hence it was submitted by the complainant that the policy must be treated as continuing w.e.f. 10.8.04 without any break. But the insurer has submitted that there was about 34 days delay in renewing the policy and hence the policy issued on 12.9.05 to be treated as a new policy as they allow only 7 days to renew the policy. In the discharge summary issued from Tejaswini Hospital from where treatment was taken it was stated that the disease has set in 2 years back, that is as early as Sept.04. As the policy was renewed on 12.9.05 after a break of 34 days it cannot be taken as that there was insurance coverage from 10.8.04 and policy issued on 12.9.05 is a new policy and hence the insurer has every reason to repudiate the claim on the ground of pre-existing illness and hence the complaint is liable to be dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-108/2007-08
Sri.A.Keshavan Embrandiry
Vs.
United India Insurance Co.Ltd.

Award Dated : 26.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. Sri.Keshavan Embrandiry was issued with a medi claim policy covering the period 28.2.06 to 27.2.07 covering himself and his family members. During the currency of policy he was admitted to Nithyananda Ayurveda hospital, Quilandy from 9.7.06 to 15.7.06 for treatment of "gridrasi" and incurred an expense of Rs.12836/-. His employer has sanctioned an amount of Rs.7208/- on 27.11.06 and his claim for balance amount of Rs.5628/- was repudiated by the TPA on the ground that the entire treatment could have been taken on an O.P. basis and no hospitalization was required. It was also submitted by insurer that the treatment imparted was not that of "Panchakarma"; as panchakarma treatment takes from 15 to 30 days. It was submitted by the complainant that he was suffering from severe low back ache and treatment was taken for the same. According to him the course of treatment includes uzhichil, pizhichil and navarakizhi from 7 to 11.30 in the morning and after noon he was having shirovasthy and after that medical bandage was applied till 7'0' clock the next morning. During the treatment the bone will become tender and any bodily movement may lead to joint displacement. Hence it is virtually impossible to undergo treatment on an OP basis. From the course of treatment it is very clear that the patient has to be in hospital through out the day. The insurer has not disputed that such treatment was taken. Their contention was that as panchakarma treatment requires 15 to 30 days, a treatment for 7 days is not at all admissible. They have not produced any proof to show that 15 to 30 days treatment is required for such a treatment. Hence there is no material in the argument of insurer and hence the insurer is directed to pay the balance amount of Rs.5628/- with interest at 8% and a cost of Rs.1000/- to the complainant.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-002-145/2007-08
Sri.P.B.Kunjumuhammed
Vs.
The New India Assurance Co.Ltd.

Award Dated : 28.09.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant had taken a policy covering the risk of himself and his wife and children for the period 11.12.06 to 10.12.07. While the policy was in force he was admitted in hospital on 23.11.06 and was discharged on 24.11.06. The claim was submitted for reimbursement of Rs.6444/- which was repudiated on the ground that there was no active line of treatment from hospital and he was admitted only for diagnostic purpose which is a specific exclusion as per policy condition. The discharge card from hospital shows that he was admitted on 23.11.06 and was discharged on 24.11.06. Course undergone in the hospital are bed rest and MRI scan. It looks that only on discharge from hospital medicine was prescribed. No medicine was given from hospital during admission time. He has produced bills and copy of MRI scan before insurer which shows that MRI scan was done on 23.11.06, i.e., on the date of admission. The bill of MRI scan was paid on 22.11.06 i.e., one day prior to date of admission out of total expenses of Rs.6440/-. Rs.5880/- is for MRI scan. No bills are produced for medicines purchased during his stay at hospital. The discharge card also shows no treatment taken during his stay at hospital. Hence it is clear that admission is only for diagnostic purpose and hence repudiation is to be upheld.

Kolkata Ombudsman Centre
Case No. 296/11/002/NL/08/2006-07

Shri Sudarsan Dhar
Vs
The New India Assurance Co. Ltd.

Award Dated : 5.4. 2007

Facts & Submissions :

This petition was filed against repudiation of a claim on the ground of pre-existing disease under Mediclaim Insurance Policy.

The complainant stated that he along with his wife was covered under a mediclaim insurance for the period 22.05.2004 to 21.05.2006 in continuity to his earlier policy. The complainant further stated that he was a Service Holder under Asansol Municipal Corporation from 01.03.1968 and had never enjoyed long leave due to his illness. He suffered prostate problem on or from 08.01.2005 and immediately consulted Dr. B.D.Mukherjee, MS (Surgeon) at Rambagan, Searsole, Ranigunj, Burdwan who advised him for treatment at Kolkata under Dr. Dipak Mukherjee the Consultant Urologist and accordingly he was admitted at Microlab Nursing Home, 24, Bipin Pal Road, Despriya Park, Kolkata on 17.01.2005 for micro surgery on 18.01.2005 and released from the nursing home on 22.01.2005. All the related papers were submitted to the insurance company, Asansol Division. On receipt of the claim papers the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. issued a letter dated 07.04.2005 repudiating his claim on the ground that “the size of the Prostate indicates the disease was pre-existing as the policy is 1 year 7 months old. So, the claim is not payable”. On receipt of such repudiation letter the complainant represented to the TPA on 16.05.2005 and thereafter to the insurance company on 24.11.2005 stating his following views against repudiation of his claim: -

a) That the complainant was 100% medically fit before 22.05.03 as per Insurance Company’s opinion;
b) that it is sure that as per statement, his Prostate enlarged after receiving membership;
c) that the Insurer have found him all clear medically when they issued the policy on 22.05.03 ;
d) that the complainant is not at all a medical man that he can medically check himself ;
d) that he thinks that the Insurer have maintained all your official forms and norms before accepting his prayer of Mediclaim Member ;
f) that Prostate disease is such type of disease which cannot stay a long time in disguise of (as per Doctor’s opinion) .

Therefore, he requested the insurance company to allow his claim but as it yielded no result, he filed this petition for redressal seeking relief of Rs.30,000/- plus 10,000/- interest and other charges.

The insurance company in their self-contained note stated that in the second year of mediclaim policy the Insured submitted a claim for reimbursement of cost of treatment for prostate operation and the entire claim papers were forwarded to their TPA for settlement.

After processing of the claim, the TPA repudiated it as “No Claim” and they issued repudiation letter dated 07.04.2005 stating the reasons for repudiation as “the size of prostate indicate, that the disease was pre-existing as the policy was 1 year 7 months old and therefore, the claim was not payable.” They further stated that as a matter of fact in respect of mediclaim all the decisions were taken by their TPA and the files

were kept and handled by them and this decision of repudiation was taken by the TPA's Claim Adjudication Department and the doctors panel as constituted by them.

Decision :

On going through the available records and guidelines, it was observed that the Insurance Company did not take any medical opinion with regard to the duration of prostrate problem and its size from the date of operation. The prescription of Dr. P. Banerjee dt.10.1.2004 indicated that the patient was suffering from acute retention of urine; catheterization and USG indicated weighing of prostrate 76.4 gms. The complainant stated that the date on prescription was wrongly written as 10.1.2004, which should be 10.1.2005 and therefore, the disease was only detected just before the policy cover coming to an end. This office found that the facts were contradictory in nature. As there was a confusion with regard to the duration of the prostrate gland owing to its size, it was decided that both the parties should get an opportunity to finally arrive at a decision whether the disease was a pre-existing nature or not. Therefore, Hon'ble Ombudsman directed the Insurance Company to appoint a specialist doctor of repute outside their panel of doctors, who was also acceptable to the complainant to have his expert opinion on the subject claim. The specialist doctor's decision would be final and based on that expert opinion; the Insurance Company should take their final decision by reviewing their decision of repudiation of the claim.

Kolkata Ombudsman Centre
Case No. 306/11/002/NL/08/2006-07
Shri Shyamal Kumar Sengupta
Vs
The New India Assurance Co. Ltd.

Award Dated : 05.04.2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a hospitalization claim under mediclaim insurance policy.

The complainant stated that he took mediclaim insurance policy from The New India Assurance Company Limited and was subsequently renewed for the period 29.01.2005 to 28.01.2006. The policy was still in force. He did not suffer any low back pain at the time of taking the insurance policy but due to heavy jerky episode caused by lifting of household articles, he suffered an acute back pain in his hip joint region with numbness in both the legs in October 2005. He was first treated at Peerless (OPD Section) Hospital from 17.10.2005 until 02.12.2005 and finally disectomy was done at Park Clinic, Kolkata on 09.12.2005. During his hospitalization he applied for cashless facility to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd., but the same was rejected by them on 08.12.2005 and subsequently his claim for reimbursement was also repudiated on 30.03.2006 on the ground that "As per MRI report – the disease is de-generative disc disease which is of long standing nature. Acute jerky episode has aggravated the symptoms of the disease. Hence the adjudication department and the doctors panel has decided this as no claim". The complainant represented to the insurance company against such repudiation on 22.05.2006 followed by reminder in July 2006 contending that he did not suffer any such complaint at the time of inception of the policy and such illness occurred due to jerky episode after 18 months from the inception of the policy. He, therefore, categorically did not agree to the illogical decision of the insurance company in repudiating his claim. The insurance company reiterated their earlier stand of

repudiation of his claim and therefore, he filed this petition to us for relief of Rs.59,500/-.

The insurance company in their self-contained note stated the following points in defence in favour of their decision in repudiating the claim.

The complainant had taken a Mediclaim Policy No. 510500/48/03/03860 which was subsequently renewed vide Policy No.510500/48/04/78185 for the period from 29.01.2005 to 28.01.2006. The complainant was admitted to Park Clinic on 07.12.2005 under Dr. Saumyajit Basu with a complaint of Low back pain with bilateral leg pain and neurogenic claudication started after an acute jerky episode and after clinical examination he was diagnosed suffering from L4/5 PID with gross neural compression on the left > right side. He applied to the T.P.A, M/s Medicare T.P.A Services (I) Pvt. Ltd for cashless facility. But the same was not approved by the said T.P.A.

The medical management was given to him for L4/5 decompression & discectomy on 09.12.2005 L4 Laminectomy (nearly full) had done and a large free fragment could be delivered out from the right side. The patient was discharged on 18.12.2005 after being declared fit by the doctor. The complainant submitted his claim for Rs.59,500/- to the insurance company on 04.01.2006 and it was forwarded to the T.P.A for their necessary adjudication of the claim. Based on opinion of claim adjudication department and doctor's panel the TPA repudiated the claim on 30.04.2004 on the grounds that as per MRI Report – the disease is degenerative DISC Disease, which was long standing, the acute jerky episode aggravated the symptoms of the disease. Hence, the adjudication department and the Doctors' panel decided this as no claim and the complainant was duly informed. On receipt of the repudiation letter from T.P.A, the complainant represented to the insurance company for a review of his claim on 22.05.2006 and the T.P.A, did not alter its previous decision and set aside the claim.

Decision :

As the action taken by the Insurance Company was not on all fours the oral directions given by the Insurance Ombudsman during the course of hearing, the Insurance Company was directed to request to the complainant to go to the same doctor, as indicated in their letter or if he declined, the insurance company should appoint a specialist doctor outside their panel, who was also acceptable to the complainant to obtain a fresh opinion particularly with regard to the opinion; the Insurance Company should review the claim and based on that opinion, they should take their final decision.

Kolkata Ombudsman Centre
Case No. 307/11/005/NL/08/2006-07
Shri Badal Samajdar
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 5.4.2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a hospitalization claim under individual medicalim insurance policy due to violation of policy condition no. 5.3 & 5.4.

Shri Badal Samajdar stated that he had individual mediclaim insurance with the Oriental Insurance Company Limited since 22.02.2000 and had renewed it from time to time and had never made any claim before 26.10.2005.

The complainant suffered retinal detachment on his right eye and subsequently operation was done at Disha Eye Hospital & Research Centre Pvt. Ltd. on 14.07.2005 and the doctor advised him to stay in “PRONE POSITION” for 12 hours per day for 7 days and the next check up was after 13 to 14 days and final check up was on 27.08.2005. Actually, as he was confined and refrained from all normal activities for 45 days he took some time to arrange all papers required to maintain the insurance formalities for submission of the claim. But the TPA of the insurance company, M/s Heritage Health Services Pvt. Ltd. repudiated his claim on 30.10.2005 on the ground of violation of conditions no. 5.3 & 5.4 of the policy due to delay in intimation and in submission of the claim documents. The complainant made an appeal to the insurance company stating the cause of delay. Since his appeal was not considered by the insurance company the petitioner filed his complaint to this forum for relief of Rs.20,700/-.

The insurance company in their self-contained note dated 26.09.2006 stated that the complainant was admitted to Disha Eye Hospital & Research Centre for undergoing an operation of his right eye for retina detachment on 14.07.2005 and thereafter he submitted all relevant documents to the insurance company on 26.10.2005 and the claim intimation in this regard was also given to the TPA on 24.10.2005 whereas he was discharged from the hospital on 15.07.2005 which resulted in unreasonable delay in giving claim intimation and the claim documents to the TPA for settlement of his claim.

It was further stated that as per the policy condition no. 5.3 upon happening of any event which may give rise to a claim immediate intimation with full particulars like ID Card No., nature of illness, name of the hospital where treatment was taken etc, should be given to TPA and as per condition no. 5.4 all supporting documents relating to the claim to be submitted to the TPA within 7 days of discharge from the hospital. The insurance company also stated in the self-contained note that no effort was made by the complainant in the instant claim to justify the delay and even if the complainant was under post operative guidelines of his doctor he could submit the documents to the TPA through somebody on his behalf.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. It was observed that the complainant, Shri Badal Samajdar was admitted to Disha Eye Hospital & Research Centre Pvt. Ltd. for the period 12.7.2004 to 13.7.2004 and again from 14.07.2005 to 15.7.2005 and the doctor declared him fit to resume his normal duties from 28.8.2005. In reality, the intimation of claim and submission of the claim documents to the TPA of the Insurance Company were done on 24.10.2005. Hence, there was a delay in intimation of the claim and submission of the claim papers pertaining to hospitalization by 3 months and 11 days after the second time discharge from the hospital on 15.7.2005. Even, if we consider the rest period of 45 days, as suggested by the doctor, still there was a substantial delay in intimation on the part of the complainant, which ought to have been done immediately on hospitalisation, according to the policy condition no.5.3. As far as submission of the claim documents was concerned, he should have submitted the same within 7 days from the date of discharge from the hospital, otherwise it would attract the policy condition no.5.4. As it can be seen in this particular case both the policy conditions were violated. The complainant did not justify by reasonable cause the delay, consequent to which repudiation was made by the Insurance Company. In short, he did not put forth any reasonable ground in favour of waiver of delay in intimation or delay in submission of claim documents.

Accordingly, this office agreed with the views of the insurance authorities in repudiating the same. Keeping in view, the monetary hardship suffered by the patient, it was felt that an ex-gratia payment of Rs.7,000/- might be granted which, would meet the ends of justice. Therefore, Hob'nble Ombudsman directed the Insurance Company to pay Rs.7, 000/- as an ex-gratia in this case. The petition was disposed of accordingly.

Kolkata Ombudsman Centre
Case No. 330/12/004/NL/08/2006-07
Smt. Dayavati Tantia
Vs
United India Insurance Co. Ltd.

Award Dated : 5.4.2007

Facts & Submissions :

This petition was against excessive loading on renewal premium under Individual Mediclaim Policy.

In her complaint, the complainant stated that she and her husband, Shri Vishwanath Tantia, were covered under mediclaim policy since 2001 for a sum insured of Rs.1 lakh each. At the time of renewal of the said policy on 29.07.2006, the insurance company loaded the renewal premium by more than 500% over the previous year's premium and demanded Rs.27,183/-. In addition, they imposed an excess of Rs.10,000/- on each and every claim. On representation, the insurance company reduced the renewal premium to Rs. 15,935/-, which still was more than 300 % over the previous year's premium. However, they removed the excess clause. The complainant did not agree to pay the increased premium even on the reduced scale and sent a bank pay order for Rs.5,474/-, being the renewal premium based on the last year's figure. However, the insurance company did not accept the said cheque and returned it to the complainant.

The complainant further stated that she filed two claims for Rs.11,695/- in 2002 and for Rs.1,15,000/- in 2006, the latter being for knee operation. The complainant contended that it was natural to have claims sooner or later in the old age and this was the only reason for taking mediclaim policy. Both complainant and her husband were senior citizens. The complainant agreed to file an undertaking that in case the premium increased by IRDA or a Court of Law, she would pay the difference. Despite representation to the insurance company, they did not withdraw the loading. Being aggrieved, the complainant approached this forum seeking relief in the form of renewal of mediclaim policy as per old premium rate.

In their self-contained note, the insurance company stated that the complainant and her husband came under cover when their respective ages were 63 and 68 years as per proposal-dated 30.07.2001. The first policy issued for the period 30.07.2001 to 29.07.2002 excluded cataract for Shri V.Tantia and the sum insured was Rs.1 lakh each. Under the first year policy, a hospitalization claim for Smt. Tantia was filed for knee joint pain in June 2002. The said claim was settled for Rs.11,695/-. The proposal form did not mention about any pre-existing disease and the insurance company apprehended that in near future a knee replacement claim could be filed. Eventually, on 24.02.2006 Smt. Tantia did undergo a total knee replacement operation of her left leg. The nature of illness confirmed by the TPA (Heritage) was "Left Knee Tricompartmental Osteoarthritis with Mild Hypertension". Since, the first claim relating to knee pain was settled in the first year itself, the TPA settled the claim for total knee

replacement as well. The insurance company also expressed their apprehension that the second knee replacement claim is imminent.

The insurance company contended that the entire exercise of loading the premium against the complainant's mediclaim policy was done in view of the abnormally high claim ratio of 1234% - total claim of Rs.1,26,695/- was paid against total premium of Rs.10,262/-. On receipt of the complainant's representation regarding loading of premium, the Insurers' Regional Office Grievance Cell reviewed the whole matter and they scaled down the initial loading of 400% and also exempted the excess imposed. Accordingly, the revised renewal premium of Rs.15,935/- was sought from the complainant for the period 30.07.2006 to 29.07.2007. But, the complainant sent a Pay Order for Rs.5,474/- without paying for the loaded premium. The Pay Order was returned back by the insurance company as its acceptance would amount to violation of Section 64 VB of the Insurance Act.

Decision :

This office considered the facts and circumstances of the case, the materials available on records and the submissions made at the time of hearing. The insurance company already partially reviewed the case with regard to imposition of loading on premium by withdrawing additional premium asked in the case of Shri. Vishwanath Tantia. Moreover, they also withdraw the 'excess' imposed under the policy. However, they did not review the loading made on the premium in respect of Smt. Tantia. On going through the available records and guidelines, this office felt that a loading of 200% on Smt. Dayavati Tantia's premium, instead of 400%, would meet the ends of justice. Therefore, Hon'ble Ombudsman directed the insurance company to reduce the loading accordingly, if the policy was actually renewed. However, the renewal if already not done, would be done according to law. The petition was accordingly disposed of.

Kolkata Ombudsman Centre
Case No. 356/11/003/NL/09/2006-07
Sri Subrata Sen
Vs.
National Insurance Co. Ltd.

Award Dated : 21.5. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim under Mediclaim Insurance Policy.

The petitioner, Shri Subrata Sen stated that he took a family mediclaim policy for self, Shri Soumya Suvra Sengupta, son along with other family members issued by National Insurance Company Ltd. for the period from 16.03.2005 to 15.03.2006. Shri Soumya Suvra Sengupta, an engineering student studying and staying at Nagpur felt some gastritis problem in the first week of January 2006 and upon advice of some of his friends, Shri Soumya Suvra started self-medication for relief of pain, which ultimately did not help him, and his condition further deteriorated. Then he was admitted to Central Avenue Critical Care Hospital and ICCU Unit, Nagpur for the period 08.01.2006 to 10.01.2006 wherein he was treated for drug overdose with acute gastritis.

The complainant submitted his claim to the insurance company's TPA for reimbursement of hospitalization claim, but the TPA, M/s Family Health Plan Ltd. vide their letter dated 10.02.2006 rejected his claim on the grounds that the hospitalization was pertaining to the treatment for self intentional injury which was not covered under standard mediclaim policy. The petitioner on receipt of the repudiation letter represented to the Insurance Company's Regional office at Kolkata on 10.03.2006 and

also M/s F.H.P.L, the TPA on 22.03.2006 stating his contention about denying the decision of the TPA.

The petitioner in his petition dated 22.08.2006 to this forum further stated that during hospitalization while verbally asked by the doctors about the medication prior to admission they were informed about the consumption of some tablets which was recorded in the Discharge Summary.

According to the complainant, the unknown tablets were neither intoxicating nor were taken to cause any so called self-injury and hence it does not come within the purview of the policy exclusion no. 4.8 in repudiation of his claim.

Further, according to him, had the Insurer been sure about self-injury they could have investigated the case and in the event it was a case of self-inflicted injury then there would have been a police case or had it been a case of intentional overdose to harm one-self the hospital authority would have recorded in that way. It was further stated that he had complained to the higher authority with no result excepting advising their TPA to review the case, which in turn asked the complainant to provide Medico Legal Copy done by the hospital authority at the time of admission. If MLC was not done then explanation for the same from the treating doctor and a copy of indoor case paper of hospitalization were sought. It was surprising from the contents of the letter that the TPA instead of obtaining such report from the hospital authority they had written to the Insurer, which showed the mind, set of their TPA. However, since his pursuing of the claim through his representation to the insurance company/ TPA yielded no result, he ultimately approached this forum for relief of Rs.20, 644/- plus interest.

The insurance company submitted their self-contained note dated 16.10.2006 followed by their further correspondence dated 26.10.2006. In the self-contained note they mentioned that they sold a mediclaim insurance policy to Shri Subrata Sen initially for the risk period from 16.03.2004 to 15.03.2005 covering himself his wife and two sons with sum insured of Rs.65, 000/- for self and wife and 50,000/- for the 2 sons. The said policy was subsequently renewed upto 15.03.2007 and in the current policy the sum insured was increased to Rs.1, 15,000/- for the first two insured persons and for remaining two Rs.75, 000/- each.

In the complaint part vis-à-vis the steps taken by the insurance company they stated that on receipt of a letter dated 18.05.2006 along with a copy of another letter dated 10.03.2006 written by Shri Sen to the TPA Cell of the Insurer's Regional Office, Kolkata enclosing therewith a doctor's certificate dated 18.02.2006 issued by Dr. R.G. Chandak. Later, they took up the matter with M/s F.H.P.L, the concerned TPA under their letter-dated 28.06.2006. The insurance company also stated that Shri Sen did not lodge any claim directly with the insurance company as yet and he did not send his response to the insurance company's letter dated 28.06.2006 which was originally addressed to M/s F.H.P.L. Shri Sen also did not submit evidence against repudiation of his claim by M/s F.H.P.L, as yet. The claim was not even repudiated by them any time in the past and in the meantime the complainant preferred an appeal before the Insurance Ombudsman. However, they sent reminder to their TPA dated 27.09.2006 requesting them to furnish the latest status of the claim, the reply to which was not yet received.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. It was observed that during the course of hearing, the representative of the insurance company categorically stated that they did not yet repudiate the claim. He also stated that TPA, M/s Family Health Plan Ltd. did not yet respond to their correspondences exchanged between the insurance company and their

TPA with regard to the above claim. It was surprising to note that the TPA of the insurance company was not looking after the policyholder with regard to claims. The dismal service to the client by the TPA was unacceptable. The TPA was directed to respond immediately to the correspondences exchanged by the Insurance Company to arrive at a resolution of the case.

Further, the representative of the insurance company stated that the case might be referred to a specialist doctor for his opinion.

Under the circumstances, Hon'ble Ombudsman directed the insurance company to appoint a specialist doctor to have his opinion and the complainant might be given an opportunity to defend his case or to explain his case before the specialist doctor, so appointed and then obtained an opinion with regard to admissibility of the claim. If the claim was admissible, the insurance company was directed to settle the claim based on that opinion. It was also suggested that if the complainant was not satisfied by the decision of insurance company, he might seek redressal from any other forum or he should revert back to this forum for redressal.

Kolkata Ombudsman Centre
Case No. 440/11/002/NL/10/2006-07
Shri Sanjib Chandra Ghosh
Vs.
The New India Assurance Co. Ltd.

Award Dated : 4. 6. 2007

Facts & Submissions :

This petition was filed by the petitioner against repudiation of a claim under Mediclaim Insurance Policy due to 'Pre-existing' disease.

The petitioner, Shri Sanjib Chandra Ghosh stated that he took a Mediclaim Insurance Policy from the New India Assurance Co. Ltd. covering the complainant, his wife Smt. Mita Ghosh for the period 06.01.2005 to 05.01.2006 in continuity of the previous insurance and was subsequently renewed for the period 06.01.2006 to 05.01.2007.

The complainant's wife Smt. Mita Ghosh met with a road accident and got her admitted into the nursing home for treatment on 24.03.2005 and the doctor on 25.03.2005 duly discharged her, as there was no major injury.

Afterwards, the patient was continuously suffering from urinal problem due to infection of urine and was treated by 3 doctors, Dr. Santanu Roy, Dr. Subir Aditya and Dr. Rupak Dutta.

Besides above, as per suggestion of Dr.Subrata Ghosh and Dr. M.M.Roy (both family doctors of the complainant) the patient was admitted to Care And Cure Nursing Home, Burdwan on 05.05.2005 under Dr. Sujan Sarkar and was treated there upto 13.05.2005.

Although, the treatment was going on as the condition of the patient was deteriorating day by day, the complainant had no alternative, but to proceed to Chennai Apollo Hospitals for detection of disease and the patient was then admitted to R.G.Stone Urological Research Centre, Chennai for operation of left kidney. The operation was done by a group of doctors on 11.07.2005 and she was released from the hospital on 28.07.2005.

The complainant submitted his first claim for Rs.14, 805.19 to the Insurer on 23.06.2005 for hospitalization at Care And Cure Nursing Home, Burdwan and the claim was settled by the Insurance Company's TPA, M/s. Medicare TPA Services Pvt. Ltd. on 20.12.2005 for Rs.13,955/-. The complainant submitted his second hospitalization claim for treatment of his wife at Chennai on 30.09.2005 for Rs.35,410/-, but his

second claim was rejected by the TPA of the insurance company M/s. Medicare TPA Services(P) Ltd. vide their letter dt.16.11.2005 on the ground that it was not possible that a hydronephrotic & non-functioning kidney developed within just 18 months of policy inception, particularly when they considered that the kidney was densely adherent to the parities. Hence, the disease was 'pre-existing' and the claim was not tenable. The insurance company on 13.03.2006 further communicated this decision to the complainant.

After such repudiation, the complainant took up the matter both with the TPA and the insurance company on several occasions arguing for the admissibility of the claim with documentary evidences in support of his contention, but the TPA ultimately confirmed their repudiation decision vide their letter dt.25.04.2006 on the ground that the patient had severe anemia secondary to chronic renal disease and considering the reports to the extent and requiring nephrectomy could not develop within this short period. Ultimately, the complainant filed his petition to this forum for relief of Rs.40,000/-.

The insurance company submitted their self-contained note dt.31.01.2007 in defence of their repudiation decision.

The following points in defence in repudiation of the claim mentioned in the self-contained note: -

1. The insurance company's Burdwan Branch Office issued Hospitalization and Domiciliary Benefit Policy bearing No.512502/48/04/75493 to the complainant including his wife Mita Ghosh and son Chandan Ghosh for the period 06.01.2005 to 05.01.2006 on the basis of proposal form.
2. The complainant gave intimation on 03.08.2005 with regard to the hospitalization of his wife Smt. Mita Ghosh who was admitted to R. G. Urological Research Institute, Chennai on 10.07.2005 and discharged on 28.07.2005 after operation of Kidney.
3. Subsequently, the claim was submitted on 31.09.2005 for Rs.35,330/- against medical expenses for treatment and operation of Kidney and the insurance company sent the claim papers to the TPA, M/s. Medicare TPA Services (I) Pvt. Ltd.
4. After receiving the claim file the TPA wrote a letter to the complainant requesting submission of some relevant documents, which were urgently required in settlement of the claim, and the complainant ultimately deposited the required documents to the TPA. The TPA thereafter decided to reject the claim as per the opinion of their doctors' panel on the ground that a hydronephrotic and non-functioning of kidney could not have developed within just 18 months of policy inception. Therefore, it was decided that the disease was 'Pre-existing' disease and the claim was not payable and the complainant was duly informed on 16.11.2006, 22.02.2006 and 25.04.2006.
5. Moreover, the TPA being the adjudicating authority finally repudiated the said claim as 'no claim' and held as not payable. Therefore, The New India Assurance Co. Ltd. did not have any other alternative, but to repudiate the same.
6. According to the insurance company, the insured obtained the Mediclaim Policy under certain false statements made in the proposal form. This was to say that the said policy was obtained by non-disclosing some material facts which were necessary to be furnished at the time of insurance. Hence the insurance company stated that they did not have any liability to pay any compensation in the instant claim.
7. In the concluding paragraph the insurance company defined the Exclusion Clause No.4 (1) in order to substantiate their repudiation decision.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. On going through the details of the Discharge Certificate, it was found that the patient had a history of chronic Pyelonephritis, type – II Diabetes Mellitus, severe anemia, mild renal impairment and acute Hydronephrotic for which the insurance company repudiated the second claim. On the strength of this certificate, the TPA of the insurance company repudiated the claim after taking into consideration of the medical opinion of their panel doctor. However, the Discharge Certificate, which indicated the same disease in the case of the first claim, did not arise any suspicion of the TPA and settled the claim. The insurance company did not have any knowledge whether any medical opinion had been obtained or not in the case of the first claim. Mere statement that the first claim was paid erroneously was not sufficient for confirmation of repudiation of the second claim. The insurance company ought to have proved that the TPA made an error after coming to a conclusion that the disease was pre-existing. The evidences indicated clearly that the TPA even after going into the Discharge Certificate felt that the claim was payable, did not indicate any error in the judgment. The panel doctor's opinion should have been obtained for the first claim. That had not been done in this case. Further, it was observed that the renewal policy did not contain any exclusion clause imposed after the insurance company had knowledge that repudiation of one claim was made for a pre-existing disease.

Under the circumstances, Hon'ble Ombudsman was unable to agree with the arguments made by the insurance company and therefore, he directed the insurance company to settle the claim, as per policy conditions within 15 days. Further, the complainant claimed interest on the amount receivable by him from the insurance company. However, it was observed that the insurance authorities had to rely on the medical opinion given by their panel doctor and they could not take suo moto decision of their own to avoid the decision of repudiation of the claim. Under the circumstances, it was found that the interest sought was not exigible. Therefore, Hon'ble Ombudsman was unable to grant interest on the claim to the complainant. The order was accordingly disposed of.

Kolkata Ombudsman Centre
Case No. 422/11/002/NL/10/2006-2007
Shri Tapan Kumar Ganguli
Vs.
The New India Assurance Co. Ltd.

Award Dated : 04.06.2007

Facts & Submissions :

This petition was filed by the complainant with regard to repudiation of a claim under an individual Mediclaim Insurance Policy.

From the petition dt.25.9.2006 filed by the complainant and from the subsequent 'P' form dt.15.11.2006, the following facts emerged:-

The complainant himself stated that he was suffering from various ailments since December 2005 and was treated by several doctors from time to time. He further stated that suddenly in the morning of 02.01.2006, the complainant's condition became critical and with the help of his relatives and neighbours he was taken to Ramkrishna Mission Seva Pratisthan where he was treated at the outdoor department and was released. He further stated that on 10.01.2006 he was suffering from extreme stomach pain and was admitted to Saviour Clinic and underwent an operation. Further, the patient was detected as suffering from cardiac problems and was treated in the ICCU.

Further, the complainant thereafter lodged a claim to the insurance company's TPA for Rs.43,918/- on 05.04.2006 along with all original treatment papers and relevant bills.

The TPA in turn repudiated the claim vide letter dt.01.06.2006 received by the complainant in the middle of July, 2006 on the ground that as per opinion of the claim adjudication department, the doctors' panel, and as per OPD Card dated 2.1.2006, the patient was suffering from diabetes for last 18 yrs before the inception of policy. Further according to the TPA, all his present ailments were complications of long standing diabetes and according to the doctors' panel of the TPA, Gastropathy and Neuropathy were the causes of acute dilation of stomach and pain. Further, the doctors stated that the diabetic condition also leads to CAD resulting in decrease in LV function. Therefore, it was held that the disease was pre-existing, and as per clause 4.1 this claim was not payable.

In the petition the complainant stated that as a matter of fact he was taken to hospital in a critical condition and anyone of his relatives or neighbours who had accompanied him might have mistakenly told some erroneous information which was recorded by the hospital in the OPD Card dt.02.01.2006. Actually, the complainant had been suffering from Diabetes for the last 4/5 years. Secondly, the Doctors Panel of TPA admitted, Diabetes also leads to CAD resulting in decrease of LV function, which meant besides Diabetes there may be several other factors for the ailment in question. So the rejection of his claim on the plea of Diabetes was illegal and intended to deprive a genuine claim. The complainant submitted his representation to the insurance company dt. 01.05.2006 against repudiation of his claim but it yielded no result. Therefore, he filed this petition for relief of Rs.43, 918/-.

According to the self-contained note, Shri Tapan Kumar Ganguli, complainant first visited Ramakrishna Mission Seva Pratisthan (R.M S.P.) as an outdoor patient and the OPD card dt.2.1.2006 indicated that the patient was suffering from Diabetic Mellitus (D. M.) for the last 18 years. The second hospitalization of the patient was at Saviour Clinic on 10.1.2006 and was operated for Gastrostomy. The Discharge Certificate of the Nursing Home indicated that the patient was suffering from DM (Neuropathy + Gastropathy) HTN, IHD and poor LV function. Due to acute dilation of stomach, Gastrostomy was done. The claim was repudiated on 21.2.2007 based on the opinion of their panel doctor that the patient's long ailments were the complications of long standing diabetes and Gastropathy and Neuropathy.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. To be fair in judgment in respect of both the complainant and the insurance company, Hon'ble Ombudsman directed the insurance company to appoint a specialist doctor outside their panel as well as TPA's panel who was also acceptable to the complainant to have his opinion after going into the details of evidences available with the insurance company. The complainant should have an opportunity to represent his case or to explain his case before the specialist doctor, so appointed by the insurance company, to obtain an opinion with regard to pre-existing nature of the disease, keeping in view that the insured was having the said policy even before 1999.

It was also advised that this exercise had to be completed within 30 days. If the complainant was not satisfied with the decision of the Insurance Company, he should to seek redressal from any other forum including this forum.

Vs

The New India Assurance Co. Ltd.

Award Dated : 13.7. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim under Mediclaim Insurance Policy.

The complainant, Shri Ashok Bhattacharya stated that he was covered under a Mediclaim Policy for the period 25.03.2005 to 24.03.2006 along with his family members, and he lodged a hospitalization claim to the insurance company on 20.12.2005 for Rs.1,45,461/-. The claim was for two hospitalizations one for the period 06.04.2005 to 11.04.2005 for Rs.68,495/- and another for the period 22.09.2005 to 27.09.2005 amounting to Rs.76,966/-. All the necessary hospital reports, hospital bills and forms along with other reports were submitted to the TPA of the insurance company, i.e. Medicare TPA Services (I) Pvt. Ltd. towards his treatment in the hospital.

The TPA rejected the claim on 29.03.2006 on the ground that the date of inception of policy was 25.03.2004 and the complainant visited to the doctor on 24.01.2003 before inception of the policy. As per paper with features of Ascities and also received treatment Peritoneal Tap that suggest the present ailment CLD with Ascities was pre-existing and as per clause 4.1 the claim was not payable.

The complainant on receipt of repudiation letter represented against the decision of the insurance company on 03.04.2006 denying the facts that he had visited the doctor on 24.01.2003 as stated in the repudiation letter and challenged that there was not a single document which suggested such consultation with the doctor on 24.01.2003 and he also contended that chronic disease could start at any time during the tenure of the health policy. The complainant further stated that insurance company's doctors examined him and certified that he was in good health to accept the policy and renew it and there was no claim in the first year of operation of the policy.

In the Self Contained Note dt.27.12.2006, the insurance company stated that M/s. Medicare TPA Services (I) Pvt. Ltd. repudiated the claim for the reasons that the patient was having CLD with Ascities, which was pre-existing and the claim was not payable as per exclusion Clause 4.1 of the policy. It is also stated in the Self Contained Note that the inception of the policy was from 25.03.2004 and the patient visited the doctor on 24.01.2003 i.e. before the inception of the policy and therefore the claim was repudiated.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. On going through the various documentary evidences, it was found that the complainant was not agreeable to the opinion given by the specialist doctor, so appointed by the insurance company in which it was stated that the patient was suffering from Ascites for one and half years and Haemetemesis for the last 8 years, consequently holding that the instant ailment being CLD was definitely due to pre-existing nature of the above two ailments. There was some strength in the argument put forward by the complainant and her daughter that an ailment known as Haemetemesis suffered 8 years back, not treated, could not be held responsible for this onset of the disease of CLD of the patient.

Under the circumstances, it was felt that insurance authorities should obtain an opinion of a specialist doctor whether there was a relationship between Haemetemesis and Ascites with CLD. The insurance authorities were directed to appoint a specialist doctor and might recommend at least the names of three specialist doctors, out of

which the complainant might select a doctor before whom both the parties could put up all the evidences available with them and the complainant had right to defend before the specialist doctor. The opinion of the specialist doctor must be final and based on that opinion the insurance company was directed to review the decision of repudiation, already made by them.

If the complainant was not satisfied with the decision of the Insurance Company, he should have liberty to seek redressal from any other forum including this forum.

Kolkata Ombudsman Centre
Case No. 481/11/003/NL/11/2006-2007
Smt. Panna Sengupta
Vs
National Insurance Co. Ltd.

Award Dated : 13.7.2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim under individual Mediclaim Insurance Policy due to pre-existing disease.

The petitioner, Smt. Panna Sengupta stated that her mother Smt. Bithika Sinha was covered under a Mediclaim Insurance Policy for the period 09.04.2005 to 08.04.2006 in continuity of her previous insurance. Smt. Bithika Sinha was hospitalized at Merry land Nursing Home on 17.07.2005 for treatment of HTN, Uncontrolled DM, Low Back Pain, Acute LVF and Chronic Liver parenchymal disease and was discharged on 01.08.2005. The claim for reimbursement of hospitalization expenses of Rs.43,881.25 was submitted to the insurance company's TPA M/s. Family Health Plan Ltd. But the TPA rejected the claim on 22.12.2005 on the ground of 'pre-existing' disease.

The complainant submitted her representation to the insurance company on 12.07.2006 against such repudiation contending the following points: -

i) That her mother Smt. Bithika Sinha took Mediclaim Policy in April 2001 and renewed up to April 2006 without having a single claim and earned cumulative bonus of Rs.15,000/-upto April 2006.

   Since her mother was a Diabetic Patient, this disease was excluded from the policy besides standard exclusion since inception of this cover;

ii) That the patient was admitted in the Merryland Nursing Home, Kolkata as per advice of the consulting physician for better treatment and control as the patient was suffering from various disorders.

iii) That the insurance company couldn't say that the ailments for which the patient was admitted in the hospital originated from diabetes and her mother was covered under the mediclaim policy for last 5 years without any claim;

iv) The complainant's, widow mother did not have sufficient money to continue her treatment due to refusal of the claim and ultimately, she died on 17.09.2006 for which Insurance Company, according to her was directly responsible;

v) The complainant's mother was a senior citizen and pension holder. Normally a Senior Citizen took a Mediclaim Policy because she was more prone to disease and Insurance Company knowing fully about it accepted such policies. Therefore, it was not justified to refuse claim on flimsy grounds.

But even after her representation to the insurance company, they did not settle the claim Rs.43,881.25 being the hospitalization cost refused by National Insurance Co. Ltd.

The insurance company submitted their Self-Contained Note on 11.07.2007.

On receipt of the proposal form the deceased insured Bithika Sinha on 09.04.2001, the insurance company accepted the risk under Mediclaim Insurance Policy excluding the disease on heart ailment and diabetis in addition to routine exclusions after taking panel doctor's opinion.

In the proposal the insured Bithika Sinha declared against question No 13(b) i.e. "Slip disc and other spinal disorder" she had a fainting once in July, 2000 and against question No.13(c) she declared to be a patient of IHD and against question No.13 (j) it was declared that the proposer already had the Pace-maker implanted. Therefore, the insurance company issued the policy with the aforesaid exclusion for a sum insured of Rs.75,000/- which was continuously renewed up to 08.04.2006.

The deceased Insured, Bithika Sinha submitted her hospitalization claim for Rs.43, 881.25 to the insurance company's TPA. i.e. Family Health Plan Ltd. on 29.10.2005. She was admitted in the hospital from 17.07.2005 to 01.08.005 for treatment of HTN, uncontrolled DM, low back pain etc.

On scrutiny of the claim file the insurance company confirmed the repudiation of the claim done by their TPA i.e. Family Health Plan Ltd. based on their medical opinion since the treatment taken in the hospital related to an excluded disease under the policy and further it was also "Pre-existing" as per the certificate of Dr. T. K. Chaudhury dt.01.08.2005 which stated the insured was suffering from that disease since 10 years.

Decision :

Since the Discharge Certificate clearly stated that the patient was treated in the hospital for the diseases, which were specifically excluded in the policy, and there was no indication for treatment of Osteoporosis in the Discharge Certificate, Hon'ble Ombudsman was unable to agree with the views of the complainant. Therefore, Hon'ble Ombudsman upheld the decision of the insurance company in repudiating the claim due to exclusions made at the time of issue of the policy. Hence, the complaint was disposed of without giving any relief to the complainant.

Kolkata Ombudsman Centre
Case No. 550/11/004/NL/11/2006-07
Shri Tapan Kumar Mandal
Vs
United India Insurance Co. Ltd.

Award Dated : 13.7. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim under individual Mediclaim Policy.

The petitioner, Shri Tapan Kumar Mandal, stated that the complainant's wife Smt. Rekha Mandal was covered under a Mediclaim Policy taken by his daughter Ms. Sujata Mandal including the complainant for the period 02.09.2005 to 01.09.2006 and the complainant submitted a hospitalization claim in respect of his wife Smt. Rekha Mandal, to the Insurance Co.'s TPA, M/s. Medicare TPA Services (I) Pvt. Ltd. on 18.05.2006, who underwent an operation of Cystoscopy and Urethral dilation under

G.A. on 05.05.2006 by Dr. K. Pradhan at Sri Aurobindo Seva Kendra, Kolkata and the total claim was for Rs.8,794.37 The TPA on receiving the claim documents rejected his claim on the plea that the Urethral Stricture was due to previous Hysterectomy operation. The complainant on receipt of such rejection letter submitted his representation to the TPA enclosing therewith Certificate dt.26.06.2006 issued by his attending doctor Dr. K. Pradhan in support of his claim which clearly stated that the disease was due to hormone deficiency following Menopause and in no way was related to previous Hysterectomy which was a gynaecological disease. But the TPA did not change their earlier decision of refusal of claim and therefore the complainant filed this petition for relief of Rs.5,000/- plus Claim amount of Rs.8,794.37

The insurance company submitted their self-contained note dt.04.06.2007 with respect to the subject complaint.

The insurance company while endorsing the self-contained note dt.09.03.2007 submitted views of the TPA, M/s. Medicare TPA Services(I) Pvt. Ltd. with regard to the repudiation of the claim, in which they mentioned that the Mediclaim Policy issued to the complainant was with an exclusion of any disease related to Hysterectomy and gallbladder with respect to the insured patient Smt. Rekha Mandal, wife of Shri Tapan Kumar Mandal who was hospitalized at Sri Aurobindo Seva Kendra, Jodhpur Park, Kolkata and was finally diagnosed as Urethral Stenosis with chronic retention and therefore the claim was repudiated under the said policy exclusion as per opinion of the Claim Adjudication Department and doctor's panel of the TPA. The TPA on 04.06.2006 duly communicated the decision of repudiation to the complainant.

Decision :

On going though the various documentary evidences, as stated above, it was clear that there were two conflicting opinions that prevail in this particular case. One opinion given by Dr. K. Pradhan who clearly stated that the disease was due to hormone deficiency following menopause and not connected with Hysterectomy operation. Dr. A. M. Rangarajan, panel doctor for the TPA of the insurance company considered this opinion, and clearly stated that they were not satisfied with the reasons that the present ailment was due to post menopause hormonal changes. According to him, Urethral Stenosis was known to be due to insult on urethral wall either procedural or infection. He confirmed that the present ailment was related to Hysterectomy done in the past.

Due to these conflicting opinions that prevail in this case, it was felt that an expert opinion from a specialist doctor should be taken before repudiating the claim. Therefore, Hon'ble Ombudsman directed the insurance authorities to appoint a specialist doctor outside the list of their panel of doctors and suggested at least the names of three specialist doctors, out of which the complainant might select one specialist doctor. The opinion of the specialist doctor was final. The specialist doctor was requested to give his opinion whether Urethral Stenosis for which the claim was made, was due to previous Hysterectomy operation or not. The complainant was requested to co-operate with the insurance authorities while processing the claim and had the right to defend his case before the specialist doctor. This exercise had to complete within 30 days from the date of receipt of the consent letter from the complainant. The complainant was free to go to any other forum including this forum, if he was not satisfied with the decision of the insurance company.

Vs

The New India Assurance Co. Ltd.

Award Dated : 6.8.2007

Facts & Submissions :

This petition was filed by the complainant against partial repudiation of a claim under Mediclaim Insurance policy.

The petitioner, Sri Baidyanath Ghose stated that he took a Mediclaim Insurance Policy covering self and his wife for the period 01.10.2005 to 31.09.2006. The complainant claimed for hospitalization expenses for treatment of his wife Smt. Basanti Ghose at AMRI Hospital for the period 04.02.2006 to 08.02.2006 to the insurance company's' TPA, i.e. M/s. Medicare TPA Services (I) Pvt. Ltd. as she was suffering from Pneumonia and urinary track infection. The insurance company paid a part of the claim amounting to Rs.17, 118/- against a total claim of Rs.33, 078.09. The balance amount of Rs.15,960/- was not paid due to the reason that the pathological test report, x-ray etc. were not attached to the claim but the bill for these tests was raised. The complainant later submitted all the test reports on 17.07.2006, but the insurance company did not pay him balance amount on the plea that the claim has been full and finally settled. Although, the complainant pursued the matter with the insurance company but the balance amount was not paid and therefore he filed this petition for relief of Rs.15,960/- towards cost of pathological and other tests done by the hospital authority.

The insurance company submitted their self-contained note dt.28.05.2007 enclosing therewith their consent to the Ombudsman to act as a mediator between the complainant and the insurance company and give his recommendation for the resolution of the complaint.

The insurance company stated that their TPA settled the claim at Rs.17,118/- on 27.05.2006 and issued Cheque, based on the available papers submitted to them. They stated that although the complainant's claim was for Rs.33,078/-, but as the investigation/pathological reports, against which the bill was raised, were not submitted with the claim documents, therefore, there was a deduction of Rs.15,960/- from the claim amount. The complainant after a lapse of 1 ½ months from the date of full and final settlement of his claim submitted the above reports on 17.07.2006 and as the claim was already settled in full and final the balance amount could not be paid.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. Hon'ble Ombudsman was not agreed to with the decision of the insurance company that they decided not to pay the remaining amount as the original claim amount had already been paid, as it was a full and final settlement. Only the question of non-filing of certain documents remained and repudiating the claim on flimsy grounds that the full and final settlement was made, was not tenable.

Therefore, the insurance company was directed to pay the remaining amount after submission of documents by the complainant. The complaint was disposed of accordingly.

Kolkata Ombudsman Centre

Case No. 634/11/002/NL/01/2006-07

Shri Samya Chattopadhyay

Vs

The New India Assurance Co. Ltd.

Award Dated : 22.8.2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a hospitalization claim under mediclaim insurance policy.

The petitioner, Shri Samya Chattopadhyay stated that he took a Mediclaim Policy covering selfand his mother Smt. Sikha Chattopadhyay for the period 24.03.2005 to 23.03.2006 in continuity of the previous insurance for a sum insured of Rs.50,000/- each with necessary cumulative bonus which was further renewed up to 23.03.2007..

The complainant submitted a claim for Rs.23,371/- to the insurance company on 18.04.2006 towards hospitalization expenses incurred for treatment of his mother. On receipt of the claim the TPA of the insurance company wrote a letter to the Insured on 21.04.2006 demanding submission of Histopathology Report and previous treatment papers in order to come to a logical conclusion with regard to the settlement of the claim by the adjudication department and the doctors' panel of the TPA. In reply, the complainant vide his letter dt.02.05.2006, to the TPA informed the reasons as to why the Discharge Certificate could not be sent to the TPA, and he sent Histopathology Report in original and photocopies of the Discharge Certificate dt.05.09.2005, 30.09.2005, 22.10.2005, 22.01.2006, 16.02.2006 and 10.03.2006. The TPA further requested the complainant on 27.05.2006 for submission of the photocopy of the Discharge Certificate for treatment in the hospital in August 2005 when the patient had undergone surgery. Complainant also stated that while the TPA asking for some documents on 21.04.2006 they should have also asked for this document at that time. In the representation the complainant stated that his mother Smt. Sikha Chattopadhyay was admitted in the Government Hospital in August 2005 for surgery and question of advice for admission does not arise in this particular case as the admission advice in Govt. Hospital is never provided to the patient and the claimant wanted that TPA should clarify whether all patients who take admission in the Govt. Hospital for their treatment, their claims are also denied for not having the admission advice and if so, under what rule and non-availability of the Discharge Certificate for first admission can not be a ground for denying a claim. Even though, the complainant made several correspondences with the insurance company in fulfillment of their requirement, the insurance company's TPA ultimately rejected the claim vide their letter dt.29.06.2006 on the ground that after going through the papers available in the file they find that the advice for admission when the patient was first admitted is not available. They also required the discharge certificate for the first admission without which they were unable to come to a conclusion about admissibility of the claim.

On receipt of the repudiation letter, the complainant made a representation to the insurance company stating his inability to submit the required documents, as he did not receive the same even after writing to the hospital authority on 05.09.2006 and on 12.10.2006. But the insurance company did not consider his representation and upheld their previous repudiation decision vide their letter dt.30.1.2006 mentioning that the case had been reviewed and they reiterated their previous decision of "No Claim". Being aggrieved by the above decision the complainant filed the petition for relief of Rs.23,371/- with interest @ 9% p.a. from the date of making the claim till the payment of the same.

The insurance company in their self-contained note dated 25.04.2007 stated the following points of defence in favour of their decision in repudiation of the claim: -

i) The instant claim pertains to Smt. Sikha Chattopadhyay, mother of the complainant who was admitted to S.S.K.M. Hospital on 22.03.2006 with "Carcinoma of Ovary" and the treatment given was Chemotherapy;

ii) As per letter dt.18.04.2006 of the complainant, Smt. Chattopadhyay had undergone surgery in August 2005 when she was diagnosed “Cystadino Carcinoma of Ovary”;

iii) The claim papers submitted to the TPA did not contain any treatment paper relating to the patient’s hospitalization in August 2005 and accordingly, the TPA asked for the document vide their letter dt.21.04.2006. In reply, the complainant vides his letter dt.02.05.2006 forwarded Histopathology Report of August 2005 along with copies of the Discharge Certificate of S.S.K.M. Hospital dt.05.09.2005. 30.09.2005. 22.10.2005, 22.01.2006, 16.02.2006 & 10.03.2006;

iv) Since from the available documents, the TPA could not determine the period of the commencement of the disease they again sent letters dt.09.05.2006 and 27.05.2006 to the complainant asking submission of the remaining treatment papers along with discharge certificate relating to the hospitalization in August 2005. It was also stated that the complainant Mr. Samya Chattopadhyay in his letter dt.02.05.2006 addressed to the TPA stated that the related discharge document have been submitted in original to Government of West Bengal for getting free treatment and hence, no paper was available. But the second letter dt.02.06.2006 of the complainant contradicts his earlier statement that due to unavoidable circumstances and since the previous treatment papers were lost or misplaced, the same could not be furnished;

v) The insurance company also stated that the concerned TPA already informed the complainant on 29.06.2006 that the relevant claim had been adjudicated as no claim as they could not arrive at any conclusion regarding the admissibility without verifying the admission advice and the Discharge Certificate for the original admission in August 2005. On receipt of the representation from the complainant the insurance company took expert’s opinion from their panel doctors and reviewed the claim and as per panel doctor’s report dt.22.04.2007 the insurance upheld the decision taken by their TPA in not allowing the claim for want of requisite documents.

The insurance company while giving their self-contained note also enclosed their panel doctors’ opinion dt.22.04.2007 along with observations of their TPA in the claim.

Decision :

From the available records, it could be seen that the insured’s patient, Smt. Sikha Chattopadhyay was first admitted in Sambhu Nath Pandit Hospital, Kolkata in August 2005 where she was diagnosed as suffering from “Cystadino Carcinoma of Ovary” and the Histopathology Report dt.08.08.2005 suggested the same. Therefore, it was found that the Chemotherapy treatment was undertaken. As she did not respond to the cycle of Chemotherapy, she underwent another surgery in November 2005 and later she was advised to take Chemotherapy treatment in S.S.K.M. Hospital. The father of the complainant was a former West Bengal Government Official and most of the treatment was free of cost excepting for cycles of Chemotherapy. Therefore, he made a claim for Chemotherapy treatment and did not make any claim for previous hospitalization. The insurance company could not determine the admissibility of the claim, as the original hospital treatment papers for August 2005 were not provided. It is surprising to note that the insurance company did not investigate with the hospital authorities for obtaining the treatment particulars for hospitalization in August 2005. For non-submission of these documents, the claim should not have been repudiated. However, once the detection of Cystadino Carcinoma was made, the question of postponing of Chemotherapy could not arise. Therefore, if the disease existed before the inception of the policy (before 24.3.2003), even then Chemotherapy treatment would have been started. However, in the interest of justice, Hon’ble Ombudsman gave an opportunity to

the insurance company to institute an investigation for getting the treatment particulars, such as admission advice, discharge summary and other documents to arrive at a decision and review the decision of repudiation on the strength of such documents, so obtained. After obtaining such documents, the insurance company should come to a definite conclusion with regard to whether the insured was having the knowledge of the disease or not before the inception of the policy. The complainant was disposed of accordingly.

Kolkata Ombudsman Centre
Case No. 692/11/002/NL/02/2006-07
Shri Shrawan Kumar Banka
Vs
The New India Assurance Co. Ltd.

Award Dated : 24.8.2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a hospitalization claim on the ground of pre-existing disease under mediclaim insurance policy.

The petitioner, Shri Shrawan Kumar Banka stated that he had been continuing his medical policy with the insurance company for the last 5 years since March 2001 and no claim had so far been made by him except for the instant claim and there was no exclusion clause mentioned at the time of issuance of the policy and thereafter.

In August 2006, the complainant underwent Angioplasty during his hospitalization at Narayana Hrudayalaya, Bangalore for the period 04.08.2006 to 09.08.2006 and the complainant wanted to avail cashless facilities under Mediclaim Policy which was denied by the insurance company on the ground that the patient had been suffering from diabetic and hypertension prior to inception of the policy. But the complainant did not agree to this contention, as heart disease was never pre-existing. It was also stated that he had declared about his hypertensive and diabetic condition when he took the policy five years back and the insurance company did not mention about any exclusion at the time.

After denial of such cashless facilities by the insurance company, the complainant had to meet the cost of expenses after borrowing loan to the tune of Rs.4 to 5 lacs and he was forced to go for reimbursement of the hospitalization expenses for surgery. Therefore, he submitted a claim to the insurance company's TPA, M/s. Medicare TPA Services (I) Pvt. Ltd., who rejected the claim on 19.08.2006 on the ground that the patient was hypertensive and diabetic for the last 20 years and the ailments for which he was admitted, was directly related to the disease which was pre-existing. After the TPA rejected the claim the complainant approached to the insurance company's Divisional Office at Patna and pleaded for their intervention. A letter was also sent to the
TPA to reconsider the case in the light of a letter dt.04.08.2006 of Dr. Sanjoy Mehrotra M.D. (Med.), D. M.(Card.), Consultant Interventional Cardiologist of Narayan Hrudayalaya, Bangalore addressed to the insurance company and their TPA wherein the doctor stated that –

"Shri Shrawan Kumar Banka, aged 53 years residing at No.10, Rajiv Nagar, Keshari Nagar PO, Patna Bihar had consulted the undersigned for his heart ailment. He underwent coronary angiogram which is suggestive of coronary artery disease requiring angioplasty + stent at the earliest to prevent irreversible damage to the vital organs of his body as opined.

The presence of diabetes and hypertension may be associated with coronary artery disease but cannot be used as a means to deny insurance for new onset coronary artery disease (CAD) treatment. The CAD is a multifactorial disorder and not necessarily because of hypertension and diabetes.

If you require any further information/clarification with regard to this patient, please do contact/write to us."

It was further reiterated by the complainant that as per the doctor's letter and also since there was no exclusion made in the policy since 2001 even after his declaration of the ailments in the proposal form the insurance company had no reason to repudiate his claim. However, as his claim was not considered he filed this petition for relief of Rs.2.4 lacs for medical coverage and Rs.2.10 lacs for harassments.

The insurance company's Regional Office submitted their self-contained note dated 27.06.2007 mentioning the following points in support of their repudiation of the claim: -

i) First insurance coverage for Mediclaim Policy was given to Mr.Shrawan Kumar Banka on the basis of declarations given in the proposal form w..e..f. 23.03.2001 to 22.03.2002 and subsequently it was renewed for the period from 25.03.2006 to 24.03.2007 under Policy No.540102/48/05/20/70000009;

ii) While verifying the proposal form submitted by the Insured for the above years, the insurance authorities observed that the Insured, Sri Shrawan Kumar Banka was well aware about the disease that he was suffering from Hypertension and Diabetes Mellitus for the past few years. The claimant, Shri Banka submitted the Mediclaim Form on 11.08.2006 for Rs.4, 24,620.04 to the TPA in settlement of his medical expenses towards treatment of his heart ailment. The complainant also gave his declaration authorizing the TPA to seek medical information from any hospital/medical practitioner at any time, who had attended him and also authorized the TPA to make payment of claim timely as per terms, conditions and limitation of the policy;

iii) While processing the claim file it was observed by the TPA that the Insured was directly admitted to the hospital at Bangalore without reference of any doctor and therefore it proves that the patient was well aware of his disease for which he had taken admission immediately for treatment, as suggested by the expert medical practitioner who is well known about his symptoms. The heart disease could not develop in a short period. Mr. Banka was treated by Dr. Sanjay Mehrotra and he also mentioned in the discharge summary dt.09.08.2006 that the presence of diabetes and hypertension of 20 years duration and was on treatment. Doctor Certificate dt.04.08.2006 also stated that the presence of diabetes and hypertension may be associated with coronary artery disease, i.e. heart disease;

iv) It is also stated by the insurance company that since any disease which is pre-existing at the time of inception of the policy, whether the insured declared it or not in the proposal form about such illness, even if the same is not tallying with the terms and conditions of the mediclaim policy and the repudiation of the claim was based on the opinion of doctors' panel of the TPA that the patient was hypertensive and diabetic for last 20 years and had undergone treatment in the hospital for the same diseases.

On receipt of the representations from the complainant dt.07.09.2006 and 28.09.2006 the insurance company's TPA reviewed the case and they upheld their previous decision of repudiation and issued letter dt.07.12.2006 to the complainant.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. It was observed that the complainant had already declared earlier about the existence of hypertension and D. M., which was mentioned in his letter dt.07.09.2006. The insurance company did not have the proposal form pertaining to the original policy. Therefore, it was reasonable to presume that the insured had informed the insurance company and that they decided not to exclude any disease pertaining to hypertension and D. M. Therefore, it was presumed on the part of the insurance company that they had no objection to accept the risk with such pre-existing diseases. Further, it was clear that the existence of hypertension and D. M. for the last 20 years did not prove that the complainant was having a pre-existing disease as per the claim prior to inception of the policy. We couldn't say that the onset CAD existed due to mere symptoms like hypertension and D. M.

Considering all these aspects, it was directed that the insurance company should settle the claim after reviewing the decision of repudiation. However, since the insurance company had written letters to the employer, it was requested to the complainant to expedite reply of those letters so that the insurance company could come to know the extent of the claim that could be settled. The representative of the insurance company was requested to hand over the copies of those letters so that the complainant could expedite the reply.

Kolkata Ombudsman Centre
Case No. 693/11/002/NL/02/2006-2007
Sri Sree Gopal Modi
Vs
The New India Assurance Co. Ltd.

Award Dated : 12 .09.2007

Facts & Submissions :

This petition is against partial repudiation of claim under Mediclaim Insurance Policy.

The petitioner, Shri Sree Gopal Modi in his petition dt.24.01.2007 stated that he along with his wife were covered under individual Mediclaim Policy No.512800/48/06/20/70000332 for the period 21.04.2006 to 20.04.2007 for a sum of insured of Rs.2,50,000/-and Rs.1,50,000/- for him and his wife respectively with necessary cumulative bonus. The petitioner was admitted at Belle View Clinic for the period from 17.07.2006 to 23.07.2006 for treatment of Hemorrhoids and for this treatment hospital authority allowed cashless facility for Rs.50,000/- and balance amount of Rs.37,709/- paid to the hospital authority by the petitioner had to be reimbursed by the insurance company's TPA M/s. Medecare TPA Services (I) Pvt.Ltd. But the TPA sanctioned Rs.18,279/- which the complainant did not accept. The complainant stated that the deduction in claim for doctor's fees and hospital charges was not justified. On receipt of the discharge voucher along with Cheque for Rs.3,038/- apart from the cashless amount the complainant did not accept it and sent it back to the TPA on 12.09.2006 and a representation was sent to the insurance company. After the complainant's representation the insurance company's TPA reviewed the claim and issued a Cheque for Rs.18,279/- deducting Rs.19,430/- from the total claim. Since the petitioner disagreed to this settlement, he again returned back the cheque with protest and issued Advocate's Notice to the TPA to settle his claim for the full amount of Rs. 37,614/- with 18% accrued interest plus other relief. The insurance company's TPA replied to the Advocate's Notice stating therein the details of deduction made in the claim apart from the cashless benefit of Rs.50,000/-. The complainant not being satisfied about such decision of the insurance company filed this petition for relief of Rs.37,709/- plus interest.

The insurance company filed the details of the claim along with their self-contained note at the time of hearing held on 10.09.2007. According to them, the TPA of the Insurance Company limited certain payments as per the guidelines issued by the insurance company. According to the insurance company, though the total claim was for Rs.90,946/-, the TPA settled the same at Rs.87,709/- . Out of this amount of Rs.87,709/-, Rs.50,000/- was paid directly to Belle Vue Clinic as cashless facility and out of the remaining of Rs.37,709/-, they offered to settle the claim for reimbursement at Rs.18,279/- towards hospital expenses. Hence, there is a deduction made by the TPA which is as under :-

i) Rs.15,375/- deducted from the total claim amount of Rs. 35,375/- in respect of Physician and Surgeon fees ;

ii) Rs. 1,360/- deducted towards investigation due to non-submission of bill by the complainant;

iii) Rs. 1,595/- deducted against miscellaneous expenses which included Omni care Monitor Charges, Razor Charges and Telephone charges;

iv) Rs. 1100/- deducted against O.T. charges.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. Under the circumstances, Hon'ble Ombudsman agreed with the arguments put forward by the insurance company in support of their various deductions made from the claim amount.

Therefore, the insurance company was directed to pay the following amounts, already deducted from the claim amount: -

i) Rs.15,375/- in respect of Physician and Surgeon fees ;

ii) Rs.1,100/- in respect of O.T. claim charges;

iii) Rs.1,360/- towards investigation on filing of the bill by the complainant.

However, miscellaneous expenses of Rs.1,595/- were not paid. No interest was paid as the insurance company did not pay the full claim bonafide, as per their guidelines.

Kolkata Ombudsman Centre
Case No. 789/11/008/NL/03/2006-2007
Shri Bimal Kandoi
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 19 .09 2007

Facts & Submissions :

This petition was filed against repudiation of a claim under Health Shield Insurance Policy due to 'Pre-existing' disease.

The petitioner, Shri Bimal Kandoi stated that he took Health Shield Insurance Policy of Royal Sundaram Alliance Insurance Co. Ltd. for the period 31.10.2005 to 30.10.2006 and the policy was renewed for the period 31.10.2006 to 30,10.2007 covering the petitioner and his family members. The petitioner submitted a hospitalization claim on 04.12.2006 towards treatment of his 13-year-old son Master Harsh Kandoi for operation of enlarged Adenoid and Nasal Polyp on 04.11.2006 at Bhagirathi Neotia Woman & Child Care Centre. The claim of the petitioner was repudiated by the insurance company vide their letter dt.26.12.2006 on the ground that as per claim papers and the opinion of the expert doctors the gross hypertrophy of adenoids along with blocked

osteomeatal complex by thickened polypoidal mucosa having polyp with nodular thickening of mucosa is a chronic ailment could not have developed over the period of 13 months and was pre existing. As per exclusion under the policy the company would not be liable for any claim in connection with or in respect of pre-existing disease and any disease, illness medical condition, injury, which was a complication of the Pre Existing Disease or any heart, kidney and circulatory disorder in respect of the insured persons suffering from pre-existing Hypertension/Diabetes. These disease should however be covered after 5 years of consecutive insurance of this policy with the insurance company.

The petitioner thereafter submitted his representation dt.08.02.2007 clarifying that there was no question of pre-existing disease as had been contained in the repudiation letter of the insurance company and in support of his defence in payment of the claim he also submitted a Certificate dt.29.12.2006 of the attending doctor, Dr. Sarmishtha Bandyopadhyay and the insurance company after reviewing the claim opined vide their letter dt.21.02.2007 that as per medical records the symptoms of the disease started within 30 days of the policy inception, and as per their panel doctor's opinion the ailment would not have been developed after the policy inception. Hence, the ailment was pre-existing. In support of their decision the insurance company also mentioned in their letter to the complainant that their policy excludes any pre-existing disease and complication of preexisting disease /condition whether the insured was aware of the same or not. Hence, the current admission was outside the scope of the cover. The petitioner not being satisfied about above review decision of the insurance company, filed this petition for relief of Rs.45,231/- towards monetary loss and Rs.15,000/- for damages.

The insurance company instead of giving their self-contained note they submitted a letter dt.27.07.2007 to this office mentioning therein that they were ready to settle the claim amount of Rs.37,426/-provided if the complainant was ready to produce the proper money receipt for Rs.18,000/-. The insurance company had already spoken to the Insured to produce proper receipt. But the insured was not willing to produce the same and he told the insurance company that he would go to Ombudsman. In the letter the insurance company had also mentioned that the complainant had already produced the computerized bills of all expenses except for the amount of Rs.18,000/- and if insured could submit the proper bill for Rs. 18,000/- the same would be paid by the insurance company, otherwise, they could pay only Rs.19,426/- from the total claimed amount.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. After going through the details of the receipt submitted by the complainant with regard to the admissibility of the amount of Rs.18,000/-, this office opined that it was the normal practice of the doctors who attended various hospitals/nursing homes for surgeries or consultations did not have any pre-printed stationery for issuing bills/receipts. The insurance company was directed to accept the money receipt given by the complainant and pay the claim.

With regard to the deductions made by the insurance company, Hon'ble Ombudsman was satisfied with the explanation given by the representative of the insurance company. Therefore, it was held that they correctly restricted the total claim payable to Rs.
37,426/-. Hence, this office directed the insurance company to pay the entire claim of Rs.37,426/- after accepting the receipt already submitted by the complainant for Rs.18,000/-.

Kolkata Ombudsman Centre
Case No. 831/11/003/NL/03/2006-2007
Shri Tapas Kumar Bhattacharjee
Vs
National Insurance Co. Ltd..

Award Dated : 26 .09 2007

Facts & Submissions :

This petition was filed against repudiation of a claim under Individual Mediclaim Insurance Policy.

The petitioner, Shri Tapas Kumar Bhattacharya stated that he along with his family members were covered under Mediclaim Insurance Policy No.102000/48/05/8500001321 for the period 09.11.2005 to 08.11.2006 in continuity of his previous policies.

Having felt a sense of vertigo the family members of the complainant consulted the local physician who advised hospitalisation for thorough check up. Accordingly, on the same date on 01.04.2006 the patient got admitted to Apollo Gleneagles Hospitals where permanent Pacemaker (Double Chamber) implantation was done. However, prior to said admission the petitioner got admitted to the same hospital on 30.01.2006 and Holter Monitoring test was undertaken, but nothing serious was identified and hence he was released on 03.02.2006. According to the petitioner, the comments of the physician might be judicious from medical stand point but the insurance company's comments on LOC and Diabetic were not correct, since LOC occurred 2 months back, i.e. on 31.01.2006 and no diabetic symptom was diagnosed10 years back. The petitioner also contended that he was admitted to hospital on 31.01.2006 and that how could insurance authorities diagnose that the complainant suffered from Type 2 Diabetics Mellitus 10 years back without having any supporting papers to that effect. Therefore, according to him the TPA and the insurance company rejected his claim on 04.05.2006 without ascertaining the truth, and therefore were not justified. Although he made repeated representations to the various authorities of the insurance company, he did not receive any positive reply from them and therefore, he filed this petition for relief of Rs.90,000/- plus cost of harassment and interest.

The insurance company submitted their self-contained note dt.10.09.2007 giving details of insurance since 1996 to 2006 wherein they have mentioned that the petitioner was covered under a Mediclaim Insurance Policy of the New India Assurance co. Ltd. w.e.f. 30.09.1996 to 29.09.2000 without interruption. After that the petitioner was covered under a Group Policy of GTFS for the period from 01.09.2001 to 31.08.2004. Thereafter, the petitioner was covered under Mediclaim Insurance Policy of the present Insurer w.e.f. 09.11.2004 to 08.11.2006. The insurance company therefore stated that from the above details it could be seen that the policy was not continuous since 1996 as stated by the petitioner. They have also stated that in the proposal form neither the Insured had mentioned about the previous insurance details nor declared about the disease that he was suffering since last 10 years, while taking insurance coverage from the present Insurer.

Regarding the claim the insurance company, while giving details of hospitalisation, have stated that the reasons for repudiation were based on medical opinion of the medical officer of the TPA, which stated that the present hospitalisation was for the management of the ailment, which was related to the pre-existing condition. The claim was repudiated as per policy condition No.4.1 (DM 10 years and LOC for few years) supported by the Case Sheet of the hospital in support of such observations of the TPA. The insurance company mentioned that sinusitis and related disorder is an

exclusion clause in the 1st year of the policy but if it were a pre-existing disease before the inception of the policy the same would never be covered as per rule.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. The medical officer of the TPA of the insurance company came to the above-mentioned conclusion keeping in view the fact that DM was there for 10 years and LOC existed for few years. The existence of DM even before the inception of the policy could not be treated as pre-existing disease as it was only a symptom and there was no manifestation of any disease. However, in the case of recurrent loss of consciousness for few years (LOC) did not indicate that the disease existed even prior to inception of the policy i. e. in this case before 9.11.2004. Therefore, Hon'ble Ombudsman was unable to agree with the findings of the panel doctor of the TPA.

Keeping in view of the above facts, it was recommended that the insurance company should appoint a specialist doctor outside their panel and after submitting all the documents to the specialist doctor, he might be requested to give an expert opinion on the subject whether LOC had existed before 9.11.2004 including Symptoms of Sick Sinus Syndrome and Atrial Fibrillation. On the strength of that opinion, the insurance authorities were directed to review the decision of repudiation of the claim.

Lucknow Ombudsman Centre
Award No. IOB/LKO/04/39/02/07-08
Shri N.K. Sharma
Vs.
The New India Assurance Co. Ltd.

Award dated 07.08.2007

Brief Facts :

Shri N.K. Sharma (Complainant) was covered under the staff Mediclaim Policy of The New India Assurance Co. (Respondent). During the currency of the policy, his wife Mrs. Manorama Sharma was admitted in a Nursing Home for the period 01.10.04 to .6.10.04 for treatment of Urinary Tract infection (UTI). All relevant bills / diagnostic reports were submitted by the complainant. However the claim was repudiated on the grounds that admission was not warranted for management of UTI illness and that case was manipulated to justify admission so as to convert medical diagnosis and treatment into hospitalization claim.

Issue :

Whether based on the papers on record, her admission to the hospital was justified in terms of medical requirements.

Findings :

The respondent company has relied upon the opinion of an Independent doctor of Appollo clinic Dr. Deepak Rao who in his opinion has stated that admission was for management of high fever & UTI. He however adds that as per hospital record there are no tests relating to urine culture and no data to suggest monitoring of temperature during her stay in hospital – two important aspects of management of her illness. The doctor's opinion also pointed out some more irregularities & inconsistencies about drug administration and medical prescription etc. which casts doubt on the requirement of her admission to nursing home for treatment of her illness. The independent doctors professional medical opinion was relied upon by the respondent company in rejecting the claim

Decision :

Finding no reason to doubt the veracity of the Doctor's Professional Medical opinion which led to suspicion with regard to requirement of her admission to a nursing home for treatment, the hospital record proving beyond doubt that no Urine culture test and monitoring of temperature were conducted, the decision of repudiation of claim by the respondent company was upheld.

Lucknow Ombudsman Centre
Award No. LKO/04/49/02/07-08
Swapnil Kasera
Vs.
The New India Assurance Co. Ltd.

Award dated 05.09.2007

Facts :

The complainant had taken out a Mediclaim Policy with the respondent company for the period 02.05.06 to 01.05.07 for a sum insured of 1 lac. On 05.1.06 he was admitted in Suraj Hospital, Kanpur for treatment of back pain and discharged on 06.12.06 after the alleged treatment. He submitted a bill for Rs.13291/- for MRI dorsal spine which is only a diagnostic test and no other expenses towards medicines / drugs / pathological test were mentioned. The complainant contended that medicines / injection were taken by him but no bills / prescriptions could be produced by him.

The respondent company rejected the claim under clause 4-10 of the policy which reads as under

"Charges incurred at Hospital or Nursing Home for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment sickness or injury, for which confinement is required at a Hospital/Nursing Home."

Issue :

If repudiation by the respondent company under clause 4.10 of the policy is justified.

Findings :

Based on the documents available on record i.e. the bill showing charges only towards an MRI which is a diagnostic test and does not require hospitalization, the Dr's prescription which also stated "hospitalization for evaluation" it can safely be concluded that admission in hospital was only to meet the cost of conducting the MRI test and the case was well within the scope of above exclusion, and that the respondent company was well within its rights to repudiate the claim.

Decision :

The repudiation of the claim under clause 4-10 of the policy was justified.

Mumbai Ombudsman Centre
Case No. : GI-88 of 2006-07
Shri Manoj V. Shah
V/s.
The New India Assurance Co. Ltd.

Award Dated : 23.04.07

Shri Manoj V. Shah was covered under Mediclaim Policy issued by DO 110900 since 26/7/1989 as reported by the Complainant. Company vide their letter dated 17/8/2005 to the Complainant have stated that "you are covered under Policy cover sine 7/7/199". However, the policy copy of 2004 shows that Shri M.V. Shah is enjoying the maximum

cumulative bonus of 50% which indicates that he was covered atleast since ten years which is definitely before 1999. He was hospitalized for acute viral hepatitis at Joy Hospital on 10/2/2005 to 17/2/2005. Post discharge he developed RLL weakness for which a neurologist was consulted who advised MRI and thereafter the Insured took necessary treatment and follow up. When he lodged a claim for Rs.14221/- the Company settled the claim for Rs. 3671/- disallowing Rs. 10,550/- (towards MRI scan Rs.5000/- which was done after discharge, consultation fees of Dr. Atul Shah Rs. 1500/- and Rs. 1800/- visit charges of Dr. Samir J. Shah and Rs. 2250/- towards physiotherapy). The Complainant approached the grievance cell for reconsideration of the claim but not getting any favourable reply, he approached the Office of the Ombudsman pleading for full settlement. Parties to the dispute were called for personal hearing on 26th March, 2007.

As per the commitment by the Sr. Divl. Manager during the hearing, a meeting was held at the Company's Divl. Office on 28/3/2007 in the presence of officials of the Company, Dr. Nilam of the TPA and the complainant, during which it was agreed by the Company, TPA and the complainant to resolve the matter by paying Rs. 5,000/- towards scanning charges and Rs. 2250/- towards physiotherapy charges. The TPA was asked to pay an amount of Rs. 7,250/- in addition to the amount of Rs. 3671/- originally paid. The Company today i.e. on 20th April, 2007 submitted to this Forum a copy of a letter from the complainant agreeing to resolve the dispute by accepting the amount of Rs. 7,250/- as full and final settlement. Since the grievance of the Complainant has been redressed, the Complaint is filed as closed.

Mumbai Ombudsman Centre
Case No. : GI-117 of 2006-2007
ShriJitendra Tanna
V/s
National Insurance Co.Ltd.

Award Dated : 31.05.07

Shri Jitendra Harilal Tanna along with his family members was insured under the mediclaim policy of National Insurance Co.Ltd. since 1998 for Sum Insured of Rs.1 lakh for himself and increased to Rs.2 lakhs in the year 2004. Shri Jitendra Tanna was admitted to Sir Hurkisondas Nurrotumdas Hospital on 15.09.2005 with complaints of pain in (L) side of chest associated c perspiration ·· 2 days |ed significantly at rest. The diagnosis made at the hospital was Acute Anteroseptal Infarction. PTCA was done on 15.09.2005 by Dr.Mashru and after getting treatment he was discharged on 19.09.2005. After hospitalisation when the claim was preferred by Smt.Gita Tanna for Rs.2,58,535/-, the claim was partially settled by M/s Medsave TPA Services for Rs.1,43,100/-. Not satisfied with the settlement, Smt.Gita Tanna represented to the TPA requesting to settle her full claim. The TPA informed Shri Jitendra Tanna that the claim has been restricted to Rs.1,00,000/- +Cumulative Bonus Rs.43,100/- and the enhanced Sum Insured of Rs.1,00,000/- cannot be considered since it was from 03.12.2004. They also stated the Chronic Artery Disease (CAD) is a chronic disease and it takes years to develop. she approached the Insurance Ombudsman with her grievance and requested to settle her claim in full.

In the case of Shri Jitendra Tanna, the original cover of Rs. 1,00,000/- incepted in 1998 and the additional cover of Rs. 2,00,000/- incepted in 2004. If we observe the facts of the case, we will see that the sum insured was increased in the year 2004 and within 9 months from renewal he was admitted in the hospital and the claim has arisen. Shri Jitendra's contention that at the time of enhancement of the sum insured he had

submitted ECG and Blood sugar report to the company, which was normal only then the Insurer has granted additional Sum Insured of Rs.1 lakh. No past history of Hypertension and Diabetes Mellitus was recorded in the discharge card, however, the hospital has issued a letter dated 19.09.2005 stating ' No H/o HT/DM/IHD in the past, no H/o any similar episodes in past.' The B.P. reading recorded at the time of admission was 240/120mm/Hg. The Complainant has also submitted a certificate dated 30.12.2005 from his family doctor stating that the patient has never suffered from Hypertension or IHD, he got Hypertension recently on 14.09.2005. This certificate is not much of use as it did not gives any BP reading or the medicines given and not supported by any past prescription. It has been issued after rejection of claim. The Insurer has not produced any evidence to support their point, they have merely rejected the claim on the basis of a hypothesis. The Insurer while granting the increased sum insured has obtained ECG and Blood sugar report and if there was any doubt they should have asked for some more reports depending on their underwriting standard. In view of the foregoing analysis, the insurer is not justified in disallowing the claim for the increased sum insured of Rs.1 lakh. The benefit of doubt goes in favour of the Insured.

Mumbai Ombudsman Centre
Case No. : LI-025 of 2006-2007
Shri Nilesh N. Chopada
V/s.
ICICI Prudential Life Insurance Company Ltd.

Award dated 31.5.2007

Shri Nilesh N. Chopade had a Policy from ICICI Prudential Life Insurance Company Limited bearing No.02680318 under Health Assure Policy with cover against six critical illnesses with a waiting period of 6 months from date of issue of policy. The critical illnesses covered were: Cancer, Heart attack (Myocardial Infarction), Stroke, Coronary Artery By-Pass Graft Surgery (CABGS), Kidney failure and Major Organ Transplant.Shri Nilesh N. Chopade lodged a claim on 26.11.06 with the Company stating the cause of claim as "Critical illness – Both kidney failure". The claim was repudiated by the Insurer stating that since the Life Assured was diagnosed to be suffering from one of the critical illnesses covered under the plan within six months from the issue of the policy, the Company returned the premium (excluding extra premiums) paid and the policy was terminated. On representation to the Grievance Redressal Committee of the Company, they informed him that rejection of the liability by the Company was justified.

The oral and written submissions made by the parties have been analysed. It is not disputed that the insured was suffering from kidney failure which is covered under the policy. As per the Insured's statement dated on 12.10.2006, he had developed burning sensation while passing urine. Further he consulted Dr.V.B.Warade on 13.10.2006 in Life Line Hospital, Malkapur. He was referred to Dr.Nikhil Kibe and the Final Diagnose given as End stage Renal Disease Stage V, CRF + Hypertension and treatment details was given as Administration & Emergency Dialysis He was asked to undergo various tests which were taken on 16.10.2006. His Haemoglobin was 3.0 gm% (Normal value for males:14-18gm%). His Liver Function test was also abnormal. A letter from Dr. Nikhil Kibe, Consultant Nephrologist, Specialist in Kidney and Hypertension dated 16.10.2006 certifies "Shri Nilesh Chopade is suffering from Chronic Kidney Failure and he has come with S. Creatinine of 33 mg% and is serious. Patient is admitted for daily dialysis". The discharge card from Cotton City Hospital gives the diagnosis as Single Kidney, ARF with CRF (Acute Renal failure with Chronic Renal Failure) on

Hemodialysis. The Order Sheet dated November 20, 2006 from PKC Hospital & Medical Research Centre, Vashi states that Patient k/c/o kidney failure since 7-8 months and on regular Hemo Dialysis twice a week but the same has been cancelled subsequently. A letter from Dr. A.V. Ingale, Vashi dated 20.11.2006 certified that he was a known case of CKD (Chronic Kidney Disease) Stage V, Severe anemia, twice a week on HD (Hemo Dialysis), Cough, hemoptysis on lying down.

In the policy terms and conditions, the benefits payable subject to policy in force under 1(iv) reads as "In the event of the life assured being diagnosed to be suffering from any one of the Critical illnesses as mentioned in Clause (2) of the policy where the diagnosis is within six months from the issue of the Policy, the premiums (excluding any extra premiums) paid shall be returned and the policy will terminate". The said policy was issued on 17.04.2006 and hence the six months waiting period ended on 16.10.2006. In the order sheet of PKC Hospital history has been noted on 20.11.2006 as Pt k/c/o kidney failure" – 7-8 months on regular H.D. twice a week", but the same was cancelled on 22.01.2007 with the remark "previous illness record verified". The LA disputed this statement of 7-8 months and produced a certificate signed by Dr. Dileshkumar Bharambe stating that he was working in PKC hospital ICU on 20.11.2006 when Shri Nilesh Chopade was admitted and while taking the history of the patient he misinterpreted his symptoms for 7/8 months instead of 1 month. The insurer has stated that on receipt of the said documents alongwith the representation of the LA, the officials of the Insurance Co. sought a meeting with Mr. S.K. Kapoor, the Director of PKC Hospital on 12.02.2007 for seeking clarification on the letter purported by Dr. Dileshkumar Bharambe regarding the changes made by him on the said Order Sheet. It is submitted by the Company after hearing the company's representatives and after examining the records, Mr. Kapoor stated that no doctor would give a letter stating that the history was misinterpreted and Mr. S.K. Kapoor also confirmed that the original Order sheets are in safe custody and have not been altered i.e. the earlier history of kidney failure since 7-8 months and hemo dialysis as recorded by the Hospital remain unchanged. An opinion was also sought from a Medico – Legal Consultant, Dr. M.S. Kamath, M.B.B.S., L.L.M, on change in history of patient post facto. As per his opinion the history as first taken down by the attending doctor could be equated to First Information Report which is an important, significant legal document and its contents are binding in fact and in law and repudiation based on the history written in the Discharge Card is bonafide and cannot be over-ruled by subsequent certificates/opinions. According to medical science the condition of chronic kidney failure occurs over a long period of time.

Result : The complaint is not allowed.

Mumbai Ombudsman Centre
Case No. : GI-190 of 2006-07
Shri Rohit Lamba
V/s.
Cholamandalam General Insurance Co. Ltd.

Award Dated : 04.05.07

Shri Rohit Lamba , the complainant had taken an Individual Health Policy from Cholamandalam Gen. Insurance Company w.e.f. 27/4/2005 valid till 26/4/2006 in the name of himself and his wife, Smt. Sheetal Lamba for SI of Rs. 4 lakhs each. During the currency of the policy, the Insured lodged a claim for Rs. 73,186/- for the treatment of his wife for Amoebic Liver Abscess with Sub diaphragmatic collection at Jaslok Hospital from 10/5/2005 to 13/5/2005. The Company repudiated the claim under clause C1 under General Exclusions of the policy

It was pointed out to the company that the complainant in his letter dated 20th June, 2006 to this Forum, has mentioned that the policy should be considered as a continuous policy as the earlier cover was with Oriental Insurance Company since 27.4.2001, without any exclusion and the policy was renewed thereafter with Cholamandam General Insurance Company on 27.4.2005.

Analysis of the case reveals that the Company repudiated the claim on the basis of the opinion of their TPA's panel doctor who opined that "on scrutiny of the claim documents it was seen that the patient was admitted with complaints of left shoulder tip pain since two weeks and fever with chills since last 20 days and loss of appetite. C.T. Scan of abdomen,Chest & Pelvis showed left sub diaphragmatic and splenic abscess and amoebiasis. Hence claim was not admissible as treatment is carried out for sub diaphragmatic abscess complaint which were present prior to inception of the policy hence pre-existing as per policy exclusion clause C-1".

On scrutiny of the proposal form filled up by the Insured of Cholamandam General Insurance Company, it is observed that the Insured has mentioned the details of his earlier insurance with Oriental Insurance in the column "details of other insurance policy". The Sum Insured under his policy then was Rs. 2 lakhs each for himself and his wife and the expiry date of the last policy was 26/4/2005. He shifted his Mediclaim Insurance to M/s. Cholamandalam General Insurance from 27/4/2005 and the Company accepted the renewal maintaining the continuity which is clear from the fact that they have given the benefit of the CB accrued under his earlier Thus it is clear that the present policy of Cholamandalam Gen. Insurance was issued in continuation with the earlier policy from Oriental and therefore was in operation for the past 4 years. It is, therefore, held that the repudiation of the claim by Cholamandalam General Insurance Company as per excl. clause C-1 is not sustainable.

Mumbai Ombudsman Centre
Case No. : GI-849 of 2006-07
Smt. Meenaxi Mukherji
V/s.
National Insurance Co. Ltd.

Award Dated : 09.05.07

Shri Jayjeet Mukherji took an Individual Mediclaim policy for himself and his parents for the first time on 18/7/2005 . The policy was valid till 17/7/2006. During the currency of the policy, his mother, Smt. Minaxi Mukherji was admitted to Sujoy Hospital on 14/4/2006 for right breast lump. She was operated and discharged on 15/4/2006. Claim submitted to the Company's TPA - E Meditek Solutions Limited was rejected under exclusion 4.2 of the policy.

On scrutiny of the papers submitted by the Complainant and the Company, it is revealed that Smt. Meenaxi Mukherji consulted Dr. Dr. Vijay Udas, Consultant Surgeon of Sujoy Hospital on 4/4/2006 for complaints of lump in right breast. The history of the lump noted in the said papers was since 8 months. If back-calculated the origin of the lump falls on 4/8/2005. She was advised Mammography which revealed well defined solid lump. She was admitted to Sujoy Hospital on 14/4/2006 for excision of the lump and the same was sent for histopathology which revealed " Right Breast - Invasive Ductal Carcinoma" vide report dated 22/4/2006. She was then referred to Tata Memorial Hospital on 26/4/2006 for further treatment. The Tata Memorial Hospital

papers noted the history of lump in right breast as 'since July, 2005' and the first policy was also taken in the month of July 2005. Going by this recordings of the hospital, the claim falls under excl. 4.2.

There is a certificate from Dr.D.M. Kalambi, ENT Surgeon. The said certificate gives a contradictory history of the origin of the lump as against the history noted in both the hospital papers. However, the certificate is dated 1st Sept. 2006, which might have been obtained by the Complainant subsequent to the rejection of the claim, to strengthen her case and hence an after thought.

From the history recorded at hospital, it can be reasonably drawn that the hospitalization was done for a growth/lump which was within the knowledge of the Insured. The complainant contended that the lump was actually diagnosed to be malignant/cancerous only on 22/4/2006 and hence the Company's decision to reject the claim under excl. 4.2 is incorrect as she felt that there was a clear gap of nine months after commencement of the policy. The Insured had the knowledge of the existence of a lump but she may not be aware of it seriousness in the absence of the pain, as stated earlier. In view of the above, this Forum does not find any justifiable reason to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-434 of 2006-07
Smt. Sukanya S. Chhabra
V/s.
The New India Assurance Co. Ltd.

Award Dated : 10.05.07

Smt. Sukanya Chhabra was covered under Mediclaim Policy issued by The New India Assurance CompanyLimied . When Smt. Chhabra preferred a claim with the Company for her hospitalization at P.D. Hinduja Hospital for multi-obulated ganglion right wrist joint – Lipoma, the Company repudiated the claim under condition 2.3. Not satisfied with the decision of the Company, Smt. Chhabra represented to the Company which was also turned down. Her contention was that many surgeries nowadays are done on a day care procedure like cataract, gastroscopy, colonoscopy and some fracture surgeries which requires anaesthesia are also treated within 24 hours. Hers was a similar case of surgery which required anaesthesia but less than 24 hours stay.

The Company was asked to refer the case to a well known Surgeon and submit his opinion whether hospitalization and anaesthesia was necessary in this case. The complainant was asked to submit inpatient record from the hospital regarding general anaesthesia and the quantity of anaesthesia administered and when the patient came back to consciousness and also a copy of the letter signed by the relative of the patient given to the hospital consenting for administration of general anaesthesia. The Company and the Complainant were asked to submit the requirements within 10 days to this Forum. The documents as called for, were received by the Company as well as the complainant Smt. Chhabra was admitted to P.D. Hinduja Hospital with complaints of swelling over right wrist region since 4-5 months. and she was diagnosed to have multi-obulated ganglion right wrist joint – Lipoma. She was discharged the same day. However, the complainant's contention was that she had undergone surgery which required anaesthesia

Subsequent to hearing, the Complainant submitted the consent form for anaesthesia and the anaesthesia chart of the Hinduja Hospital . It is revealed from the said papers that excision was done under local anaesthesia. The Company also forwarded the

opinion of an independent surgeon which stated “The Claimant had a lipoma on wrist which was operated under Bier’s block. This is a type of intravenous regional anesthesia wherein on the distal limb is anaesthetized. The claimant was not operated under general anaesthesia as per her claim as the discharge card shows she was operated under Bier’s block. Also post operatively she was advised full diet which is not done if GA is given There is no bill of medicines used for GA which again proves the same. Hence it is clear that in the present case the basic criteria for admissibility of the claim has not been fulfilled and this case is not fit for waiver of minimum 24 hours stay in the hospital also.

Mumbai Ombudsman Centre
Case No. : GI-163 of 2006-07
Chander Saigal
V/s.
The New India Assurance Co. Ltd.

Award Dated : 10.05.07

Shri Chander Saigal and his wife were covered under Mediclaim Policy since 1992 for a sum insured of Rs. 1 lakh each. The sum insured under the policy was enhanced to Rs. 3 lakhs each in the year 1999 and the policy was issued with a specific exclusion for any treatment related to prostate glands/spinal cord and HT in respect of Shri Chander Saigal. He reported three claims in the year 1999, 2000 and 2003 for vatha vyadhi, chronic fissure and acute laryngitis which were all settled by the Company in full. In the year 2005-06 Shri Saigal preferred a claim Coronary Artery Disease for which he was hospitalized at Breach Candy Hospital. The claim was partially settled by the Company for Rs. 1,05,000/- as against his claim for Rs. 3,53,521/- which was accepted by him under protest.

Analysis of the case reveals that Shri Chander Saigal was admitted to Breach Candy Hospital 20/5/2005 with Left sided back pain. Past history recorded in the hospital papers were h/o of bronchial asthama , Hypothyroidsm , operated for Prostate Enlargement in 1996 and operated for fissure in the Ano. His CAG revealed critical blocks in LAD. He was advised Angioplasty which was performed on 20/5/2005. The claim for reimbursement of hospitalization expenses was partially honoured by the TPA as his present illness was linked to Hypertension which was specifically excluded under the policy and also Hypertension would be one of the major risk factors for CAD.

The above-referred exclusion will all its import and connotation would be comprehensive and exhaustive . In the context of this exclusion, it would be appropriate to note that the Company settled the claim for Rs. 1,05,000/- (Original SI of Rs. 1 lakh plus 5% CB accrued under the policy at the time of claim) as Hypertension and its consequences were excluded under the policy for enhanced Sum Insured and therefore, there is no justifiable reason for this Forum to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-480 of 2006-07
Shri Suresh U. Gupta
V/s.
The New India Assurance Co. Ltd.

Award Dated : 10.05.07

Shri Suresh Gupta was covered under a Mediclaim policy issued by The New India Assurance Company Limited, for a Sum Insured of Rs. 2 Lakhs with CB 10% and Rs. 3

lakhs with CB Nil. Shri Gupta was hospitalized at Lilavati Hospital on 8/8/2005 for Sleep Apnoea Syndrome and when Shri Gupta filed the claim for Rs.83,045/- for the said hospitalization after scrutiny settled the claim for Rs. 18,000/- after deducting Rs.65,045/- towards the CPAP machine which as per the Insurance Company was not payable. Not satisfied with the decision of the Company, Shri Gupta represented to the Company stating that CPAP machine was prescribed by his doctor to keep him well without hospitalization and without drugs. He also emphasized that this was the only remedy for his ailment through which he gets the quantum of oxygen required for his body and hence should be payable.

The complaint was registered and as per RPG Rules 1998, the Ombudsman is empowered to issue an Award without holding personal hearing if he is satisfied that the documents submitted are comprehensive in nature and that all relevant points have been addressed. The main dispute under this claim is the non-payment of an apparatus cost viz. CPAP Machine which was required by Shri Gupta to ward off his problem of Sleep Apnoea. The basic treatment received by him in the hospital was admitted by the Company under the terms of the policy and was settled which was accepted by the Insured under protest. A close scrutiny of the policy would reveal that Mediclaim policy covers hospitalisation expenses for medical/surgical treatment at any Nursing Home/Hospital in India"- as defined, as in patient, or "on domiciliary treatment" under domiciliary hospitalisation benefits under specific circumstances. There has also been reference under Condition 1.0 (d) that cost of pacemaker, artificial limbs and cost of organs would be reimbursed. However, the expenses for apparatus which are not on the body system as such but are external adjuncts, would fall outside the scope of Mediclaim Policy coverage. In respect of CPAP machines in particular, the policy conditions excluded any external machine for payment. Hence on this ground the claim for CPAP machine fell outside the scope of the policy and therefore, the repudiation of the Company to that extent is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-808 of 2006-07
Shri K. Padmanabhan
V/s.
The Oriental Insurance Co. Ltd.

Award Dated : 14.05.07

Shri K. Padmanabhan took an Individual Mediclaim Policy covering his spouse and daughter for the first time in the year 1999 for SI of Rs. 1 lakh for himself and his spouse and Rs. 50,000/- for his daughter. From the policy copies submitted to this Forum it appears that he enhanced the SI to Rs. 3 lakhs each for himself and his wife and to Rs. 1 lakh for his daughter in the year 2005-2006. Shri K. Padmanabhan was admitted to the Arya Vaidya Chikitsalayam and Research Institute, Coimbatore on 6/5/2006 and he was discharged on 28/5/2006 after the course of treatment for Kateesoolam (low back pain). When he preferred a claim the Third Party Administrator, repudiated the claim invoking clause 4.10 of the mediclaim policy. Their contention was that the Ayurvedic treatment taken by Shri Padmanabhan did not require hospitalisation and it could be done on an OPD basis. There is no record as to who advised the admission, on what basis and whether admission was required at all. The Insured was admitted based on symptoms only at the said Vaidya Sala. No investigations were carried out prior to the admission in Hospital and the medicines in connection therewith were ayurvedic in nature.

The complaint was registered and as per RPG Rules 1998, the Ombudsman is empowered to issue an Award without holding personal hearing if he is satisfied that the documents submitted are comprehensive in nature and that all relevant points have been addressed. Accordingly, the documents submitted by both the parties were examined and felt that a suitable Award can be issued based on the documents submitted by both parties without calling them for personal hearing.The diagnosis in respect of Shri Padmanabhan was Kateesoolam which talks about the back pain due to sacralisation and dengenerative disc disease. The treatment received at the hospital were oral medicines and application of oil. For such therapy the treatment can be taken as an outpatient as well. Going by the scope of the cover of Mediclaim insurance policy, the preamble clearly says that upon the advice of a duly qualified physician/ medical specialist/ medical practitioner if expenses are incurred due to hospitalisation for medical/surgical treatment at any nursing home /hospital in India as an inpatient, it would be payable. The Complainant admitted that he took the initial treatment from Dr. K.G. Raveendran in his OPD and was on medications and felt better and as per his advice got admitted to Arya Vaidya Chikitsalayam for further intensive treatment. This points to the fact that his was a case of complete diagnosis done well before the hospitalisation in Coimbatore and in fact, the line of treatment was also available in the said stream of medicine. Therefore, it was a conscious decision by Shri Padmanabhan to avail the treatment only from Arya Vaidya Chikitsalayam for better results. Unfortunately under the terms of the Mediclaim policy his claim would fall under clause 4.10 where hospitalisation is not justified due to any serious emergency health status. After thorough examination of the papers submitted by the Complainant and the Company it was found that Shri Padmanabhan was confined to hospital for about 22 days and the line of treatment given was oral medications, oil therapies with certain dietary and physical restrictions which were repititive in nature. In view of the above facts and circumstances, this Forum does not find any justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI- 617 of 2006-2007
Shri Hanuman P. Toshniwal
V/s
United India Insurance Co. Ltd.

Award Dated : 18.05.07

Shri Hanuman Toshniwal and his wife were covered under an Individual Mediclaim policy for the first time w.e.f. 12/5/2004 to 11/5/2005 for a SI of Rs. 3 lakhs each and the policy was issued without any exclusion based on the pre-insurance medical test reports. In the following year during renewal the policy was converted to Mediguard Policy and the continuity was maintained by the Company as evident from the accrued CB of 5% reflected under the Mediguard policy. During the currency of the policy Shri Toshniwal reported 3 claims in respect of his wife, Smt. Laxmidevi Toshniwal for the hospitalization period from 19/6/2005 to 20/6/2005 at Life Line Hospital for chest pain, 23/6/2005 to 25/6/2005 at Bombay Hospital for CAG and 30/6/2205 to 5/7/2005 for PTCA. The Company repudiated the claim under exclusion 4.1. of the policy.

Analysis of the case reveals that the dispute is primarily relating to pre-existence of DM and HT . Since the claim was reported in the second year of the policy, an investigation was arranged by the Company through Swastika International. On going through the investigator’s report, it is observed that the investigator mentioned that the DM/HT was pre-existing only because of the word “yrs” written in the Bombay Hospital papers and some discrepancy in the Life line hospital notings of DM/HTN since

12/6/2005 / 19/6/2005. The investigator's have not proved the pre-existence of DM/HTN by way of any other medical corroboration. The Company also repudiated the claim on the basis of the Investigator's Report and their panel doctor who have made the statement merely on assumption, which is not acceptable to this Forum.

On scrutiny of the pre-insurance medical test report of blood sugar, it appears that only blood sugar random test was carried out, which noted 116.9 mg/dl. It does not contain blood sugar fasting and PP readings and no urine sugar reports along with it. In the Discharge Summary of Dr. Waghmare's Lifeline Hospital & ICCU, it is noted that the urine sugar is shown as ++++ as also the urine sugar report dated 19/6/2005 i.e. on admission is in the file showing ++++. Blood report dated 19/6/2005 showed blood sugar random reading as 217.5 mg/dl and BP recorded was 140/90. It is known through the medical theory that Diabetes and HTN do not develop overnight and therefore the above report showing urine sugar ++++ and blood sugar random reading of 217.5 mg./dl points to the fact that the ailment was of some duration. It is to be noted the Shri Hanuman Toshniwal and his wife entered the Mediclaim Scheme at the age of 54 and 51 respectively and that the claim of Smt. Toshniwal was lodged in the 2nd year of the policy. It is also noted that the Dr. Waghmare's Lifeline hospital recorded history of DM/HT as "detected first time" while the Bombay Hospital papers is silent about the history of Diabetes mentioning "k/co/ HTN + DM __yrs" which neither proves or disproves the status. The history recorded in hospitals are inconsistent. There is also a noting in the Nurses' Daily Record papers of Bombay Hospital that the patient is on insulin. Based on the reports available to this Forum, I do not find any justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-564 of 2006-2007
Shri Hargundas A.Nihalani
V/s
United India Insurance Co. Ltd.

Award Dated : 29.06.07

Shri Hargundas A.Nihalani is a mediclaim policyholder of United India Insurance Co. Ltd. since 1998. The claim arose under policy no.121402/48/04/20/00002147 during the policy period 23.05.2005 to 22.03.2006. He was admitted in Wockhardt hospital on 23.11.2005 with a complaint of headache, inability to move right side and to speak. The diagnosis made at the hospital was 'left Middle Cerebral Artery (MCA) Large Infarct with right hemiplegia and Motor Aphasia' and was discharged on 18.12.2005. After his hospitalisation, he preferred a claim to the Company for Rs.2,10,000/-. The claim was processed by M/s Med Save Health Care and they informed the Insured by letter dated 14.02.2006 that he was a known case of Ischaemic Heart Disease which was excluded in the policy and in discharge summary it has been clearly mentioned that he was a known case of Hypertension and the present hospitalisation was direct consequence of Hypertension due to which the claim fell under Exclusion Clause 4.1 of the mediclaim policy. In the meanwhile, he approached the Insurance Ombudsman for his intervention in the matter.

The analysis of the case reveals that the Insured had an Ischaemic Heart disease in July, 2002 for which he was admitted to Wockhardt Hospital from 22.09.2002 to 30.09.2002. The past history noted by the hospital states "No HT/DM/COPD". The history recorded in November,2005 i.e. present hospitalisation in Wockhardt Hospital reads as "H/o HT, H/o IHD- CABG done". The final diagnosis was 'Left MCA Large

Infarct with Right Hemiplegia and motor Aphasia.' His BP reading was 160/100 which is very high. Under the heading "Other important Events" it was written that 'Thrombolysis was tried which lead to GI bleed and hemarthrosis.The CT scan done on 01.12.2005 gives a finding that there is a large infarct in the left middle cerebral artery and anterior Cerebral artery territory with mass effect over the left half of lateral ventricle. The diagnosis made at the Wockhardt hospital was Middle Cerebral Artery (MCA) large Infarct with right hemiplegia and motor asphasia which is related to brain but heart being the main organ to supply the blood to all parts of body, which is obstructed by a blood clot i.e. Thrombus.

It is also noticed that the insured had been continuously covered under the mediclaim policy since 1998 and the company had already settled the claim for Ischaemic Heart Disease in the year 2002. From the hospital record of 9/2002, there was no history of Hypertension/DM and hence the first rejection of claim is not sustainable. Hence the claim of the Complainant, Shri Hargundas A.Nihalani is sustainable.. Under the circumstances, the repudiation of claim by the Insurance Company is not fully justified.

Mumbai Ombudsman Centre
Case No. : GI-463 of 2006-2007
Shri Dattaram S.Taware
V/s
United India Insurance Co. Ltd.

Award Dated : 29.06.07

Shri Dattaram S.Taware took a mediclaim policy for himself and his wife from United India Insurance Co. Ltd., since 1998. As there was a break in the year 2002, the company asked the insured to get medical tests done at Sehat India, accordingly, the company issued a policy with an exclusion 'any expenses incurred due to Dsylipidemeia, overweight (Obesity) should be excluded from the scope of the policy'. He was admitted to Bombay Hospital on 20.01.2006 and was diagnosed to have Coronary Artery Disease with an advice that PTCA + stenting to LAD and RCA. He was discharged on 21.01.2006. Again on 23.01.2006 he was admitted to Asian Heart Institute under care of Dr.Ramakanta Panda to undergo Coronary Artery Bypass Graft (CABG) x 4 Grafts on 25.01.2006 and was discharged on 01.02.2006. Shri Taware preferred a claim to M/s Family Health Plan Ltd., the TPA of the Company for reimbursement of hospitalisation expenses. The Company took a Expert Medical Opinion from Consultant Cardiologist who was also of the opinion that the diabetes and dyslipidemia are pre-existing diseases which led to the cardiac blocks for which he had to undergo Angioplasty/CABG. After getting his opinion, the company upheld the decision taken by the TPA for rejection of the claim.

The analysis of the case along with the essential points of dispute would reveal that the Insured Shri Dattaram S.Taware was covered under Mediclaim Policy for the first time in the year 1998 and there was a break in the year 2002 hence the policy was renewed after some medical check-up by Sehat India in the year 2003. The Insured, Shri Taware was first admitted in Bombay Hospital for CAG and there was an advice to go for PTCA (Angioplasty) and with same disease he got admitted in Asian Heart Institute where CABG was done at the evaluation of doctor's at Asian Heart Institute.Shri Taware had produced a certificate dated 18.02.2006 from Dr. Ramakanta Panda of Asian Heart Institute to refute the contention of the company that he was obese before and at the time of operation. The family doctor, Dr. Benny Negalur had also confirmed the fact that Shri Taware was not obese but overweight and he was advised to modify his life style and did not require any medication. If we see the

pathological tests conducted on 08.03.2003 at Clinitech Computerised Laboratory shows that his Serum Cholesterol was 150 mg/dl and Blood Sugar (fasting) was 116mg/dl which is a case of borderline and Serum Triglyceride showed 211.40mg/dl and H.D.L.Cholesterol 32.80mg/dl. It shows that he is a case of borderline diabetes and Triglyceride was on higher side. As it is a known fact that the chances of having Isheamic Heart Disease is more on those people who have hypertension, diabetes and high cholesterol level. It is to be noted that the policy was issued with exclusion of Dyslipidemia and overweight (obesity) and the endorsement on the policy The exclusion mentioned in the policy is one of the risk factor for heart disease. Therefore, the contention of the Insurance Company to reject the claim is justified on this ground.

Mumbai Ombudsman Centre
Case No. : GI-365 of 2006-07
Shri Vijay W. Pohray
V/s.
The New India Assurance Co. Ltd.

Award Dated : 15.06.2007

Shri Vijay W. Pohray was covered under Individual Mediclaim Policy No. 111200/48/04/87529 for the period 21.02.2005 to 20,02.2006 with 10 % accrued CB & exclusion of Diabetes Mellitus & Bilateral Refractive error & related complications. Shri Pohray was admitted to Wockhardt Hospitals Ltd., Mumbai, on 24.08.2005 with complaints of chest pain since 3-4 days, Retrosternal, & chocking sensation. He underwent CABG X 5 GRAFTS on 29.08.2005. He was treated and discharged on 06.09.2005. When he claimed the hospitalization expenses incurred by him, from New India Assurance Co. Ltd., they rejected the claim on the ground that Coronary Artery Disease is a direct complication of Diabetes an exclusion under his policy and hence pre-existing in nature and therefore, the claim fell under Exclusion Clause No. 4.1 of the Mediclaim policy.

Analysis of the case reveals that Shri Pohray was admitted for chest pain, Retrosternal, Choking sensation. Past history recorded in the Discharge summary were H/o HT 2 years & DM 2 years. The point of dispute is quite focussed as it evidently appears that the policy issued to Shri Pohray had a clear exclusion of Diabetes Mellitus & Bilateral Refractive error & related complications in the policy issued to him. However, the policyholder stated that his diabetes was under control. A certificate was issued by Dr. Rajesh Gaikwad, Consulting Physician wherein he states that the DM of Shri Vijay W. Pohray was well within control since last 3 years. Hence, perse DM cannot be considered as an immediate cause for IHD/AM in this case. Morever he had DM when he took the mediclaim policy.

It is an admitted fact that Diabetes Mellitus / Hypertension are great risk factors for Ischaemic Heart Disease (IHD). Hypertension is caused by atherosclerosis of the arteries throughout the body. It is very likely that if a person has atherosclerosis in the general circulation, the coronary arteries will also be affected. Hypertension may cause damage to artery walls. It is medically established that the risk of IHD is increased in people with diabetes. 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. Under the circumstances the decision of the Insurer not to admit the claim is tenable.

Mumbai Ombudsman Centre
Case No. : GI-834 of 2006-2007

Shri Prakash D. Patel
V/s.
The New India Assurance Co. Ltd.

Award Dated : 12.06.2007

Shri Prakash D. Patel who was covered under the Hospitalization & Domiciliary Hospitalization Benefit Policy under Individual Mediclaim Policy issued by The New India Assurance Company Ltd. He had preferred a claim for treatment of Rt Va Aneurysm at Bombay Hospital & Medical Research Centre on 28.08.2006. The TPA of the Company, M/s Paramount Health Services Pvt. Ltd. while going through the papers noted that as per the hospital records the patient was suffering from severe headache since 4-5 years and as headache was the proximate cause of present ailment i.e. Aneurysm the claim was rejected under clause 4.1 of the mediclaim policy relating to pre-existing disease.

On analysis of the records it is seen the policy is in its 5th year. As per the Medicalim policy issued to the complainant for the period 2006-2007 and he was enjoying 20% cumulative bonus. In the notings of Dr. Anil P. Karapurkar of Bombay Hospital, on 17.08.2006 the symptoms given is "sudden onset occipital headache, gradually worsened and was severe for 5-6 days, no nausea, vomiting, diplopia, coma. Since 4-5 years has been getting episodes of headache with diplopia – diplopia would disappear when the headache would subside". There is a Certificate given by Dr.G.S. Sandeep, family doctor dated 07.03.2007 that Shri Prakash Patel had never before approached him for treatment for headache, except for on 19.08.2006 when he complained about severe headache and pain in neck region. As the pain killers prescribed were found ineffective, he was advised to get a CT Scan done. He also certified that there was no history of Aneurysm before 19.08.2006. There are no records to prove that he was suffering from Aneurysm prior to the inception of the policy. From the above notings and in the absence of any corroborative evidence it is not proper to conclude that the patient was suffering from Aneurysm prior to the inception of the policy. The conclusion made by the TPA in their repudiation letter is purely based on the history of headache noted by the Doctor and not on any conclusive evidence. The Insured has not taken any treatment earlier as per the statement of the family physician and no one would like to wait for taking the treatment for a known disease. In the prescription of Dr. Pawan Ojha , it has been mentioned that the patient had a fall from the bike 2 months ago. The present problem might have been caused or accelerated by this fall also cannot be ruled out. The policy is in the 5th year and the history of headache is between 4-5 years, so even for headache it is border line case.

Under the circumstance, the benefit of doubt goes in favour of the Insured.

Mumbai Ombudsman Centre
Case No. : GI- 514 of 2006-2007
Shri Vijay S. Ghag
V/s
United India Insurance Co. Ltd.

Award Dated : 15.06.07

Shri Vijay S. Ghag and his family were covered under Health Care Plus Policy w.e.f. 6/12/2005- 5/12/2006 for S.I. of Rs. 50,000/- each issued by United India Insurance Co. Ltd. to the account holders of Indian Overseas Bank. During the currency of the policy, Smt. Ghag was hospitalized at Guru Nanak Hospital & Research Centre on 31/7/2006 with complaints of persistent cough with intermittent haemoptysis and

breathlessness. She was diagnosed to have Pulmonary Koch's, for which thoracoscopy with decortication was done on 3/8/2006. She was discharged on 10/8/2006. The claim preferred by Shri Ghag was rejected by the TPA – Family Health Plan Limited for the reason that the present hospitalization is for the management of an ailment which is related to a pre-existing condition since 6-7 months. His contention was that there was a contradiction in the history noting in the discharge card and Inpatient history of 5-6 months and 6-7 months respectively and the Company has considered the 6-7 months recordings to repudiate the claim and not considered the first consultation papers while processing the claim. He emphasized that his wife was suffering since last 4-5 months i.e. from February 2006 onwards as evident from the first consultation paper of 14th Feb. 2006 and therefore the disease was not pre-existing. Analysis of the case reveals that the dispute has arisen primarily because of the minor inconsistency in the recording of the duration of the history of AKT in the hospital papers. Discharge Card noted "cough and breathlessness since 6 months." In-patient history under the column of chief complaints noted "k/c/o Left-sided Empyma, k/c/o Pulm – TB, k/c of breathlessness". Under column history of present Illness noted "h/o persistent cough/intermittent haemoptysis with loss of weight for 6-7 months, k/c/o TB on AKT". Under column of Past Medical History it is noted "On AKT since 5 months."

The TPA went by the recordings of the Inpatient papers where the history recorded was 6-7 months and repudiated the claim. On going through the papers it is revealed that the Smt. Ghag was suffering from persistent cough and cold problem for which she was consulting her family physician from 24/1/2005 and various tests in the form of x-ray and audiogram were advised which was carried out at Shree Vardhaman Sthanakvasi Jain Shravak Sangh , Dadar. One x-ray PNS Water's & Coldwell's view done on 26/11/2005 revealed bilateral maxillary sinusitis. An audiogram Report dated 11/2/2005 reveals that some hearing tests had been carried out. On going through all these papers there is no doubt that she has been continuously suffering from cold and cough problems for which she was taking medicines for quite some time and it was only in Feb. 2006 that she was advised AKT treatment as evident from the prescription of Dr.Deshpande. Even if we go by the hospital recordings of 6-7 months it would make it coincide with the policy period or slightly before that time and therefore, it would be a borderline case.

Except for the history recorded at the time of admission, which is also different at two places, the Insurer has not produced any other medical corroboration to prove their point. In view of this, the benefit of doubt goes in favour of the Complainant and the Insurer is directed to entertain the claim for the admissible expenses to the tune of eligible S.I. under the policy.

Mumbai Ombudsman Centre
Case No. : GI- 633 of 2006-2007
Shri Rajesh Jagtiani
V/s
The New India Assurance Co. Ltd.

Award Dated : 26.06.07

Smt. Gulshan G. Jagtiani was covered under an Individual Mediclaim Policy since 1992 and The New India Assurance Co. Ltd. issued the policy with a specific exclusion of "any correction surgery for left hip bone" based on the disclosure by the Insured that she was operated for left hip in 1967. The present disputed claim was preferred under Policy No. 110900/48/05/20/700529164649 in respect of hospitalization of Smt. Jagtiani at Breach Candy Hospital from 1/8/2006 to 10/8/2006 for Post traumatic

instability with left hip pain which was partially settled by the TPA – TTK Healthcare Services Pvt. Limited to the extent of Rs. 55,598/- as against her claim of Rs. 1,85,328/- thereby disallowing Rs. 1,29,729/- for reason – 'treatment taken is for left hip bone which is under exclusion.

TTK in their letter dated 3/1/07 addressed to this Forum has stated that in view of a previous claim settled by NIA in the year 1999 for the 'fracture of left femur bone', they have partially settled the present claim to the extent of charges pertaining to implant removal and disallowed the rest. Analysis of the complaint reveals that Smt. Jagtiani was admitted to Breach Candy Hospital with complaints of pain in left hip, shortening and instability. Her diagnosis was post traumatic Instability with left hip pain. She had a history of past surgery for left hip fracture in 1999, history of fall two years ago and she was operated on left hip in 1967 which was disclosed at the time of taking the policy in 1992 and accordingly the policy was issued with an exclusion of "any corrective surgery for left hip bone".

The point of dispute is quite focussed as it evidently appears that the policy issued to Smt. Jagtiani had a clear exclusion of any correction surgery for left hip bone and all related diseases on the basis of the disclosure made by him in the proposal form. Straightway, therefore, it becomes a knowledge on the part of the Insured that he would not be covered for surgery to left hip bone and consequences thereof" as per the exclusion clause endorsed on the policy itself. Based on the disclosure there has been clear exclusion under the policy which has been examined above in its total import and comprehensiveness to exclude consequences arising from hip bone surgery. Therefore, New India's stand-point is tenable.

Shri Rajesh Jagtiani , the complainant mentioned during the hearing that the exclusion incorporated at the time of inception of the policy was incorrect as the problem at that time was not of the hip but of the leg. However, this Forum feels that there was no point in raising an objection at this stage, as the exclusion was incorporated way back in the year 1992 and no issue was raised then.

Mumbai Ombudsman Centre
Case No. : GI- 500 of 2006-2007
Shri Bharat N. Zaveri
V/s
The New India Assurance Co. Ltd.

Award Dated : 26.06.07

Shri Bharat N. Zaveri along with his wife and son were covered under Mediclaim Policy for the period 21/6/2006 to 20/6/2007, issued by the New India Assurance Co. Ltd. for S.I. of Rs. 5 lakhs each. The policy shows an accrued CB of 10%. A claim was preferred under the Policy in respect of hospitalization of his wife, Smt. Chhaya Zaveri at Breach Candy Hospital on 13/8/2006 for Umbilical Hernia (Laparoscopic Surgery). TTK Healthcare Services (P) Limited, TPA, processed the claim and settled it for Rs. 1,50,000/- as a package charge as against Rs. 3,45,736/- claimed by the Insured. Not satisfied with the settlement, Shri Zaveri respresented to the TPA and also to the Company for review. His contention was that the TPA allowed only the doctor's fees and disallowed the hospitalization and medication charges.

Analysis of the case reveals that the dispute is primarily relating to the quantum of claim settlement. The TPA settled the claim to the extent of Rs. 1,50,000/- as a package charge after comparing the rates charged for such surgery in other top class hospitals. They alleged that the Complainant had prior to admission estimated Rs.

1,50,000/- towards the surgery of Umbilical Hernia, whereas the final claim bill submitted by the Insured amounted to Rs. 3,45,746/-. On enquiry, the complainant explained that the surgery took 5 hours due to complications and hence his wife required hospitalization for 10-12 days. TPA then sought clarifications from Breach Candy Hospital for escalation in the cost of surgery from the initial estimate of Rs. 1,50,000/- to Rs. 3,45,736/- vide their letter dated 30/11/2006. Upon receipt of clarifications from Breach Candy Hospital, the TPA referred the matter to the Company, who maintained the stand taken by the TPA and conveyed to the Complainant about the same and stated that the settlement of Rs. 1,50,000/- itself was on a higher side.

If we go by the letter of Breach Candy, it appears that the patient/relative took his own decision to opt for Laparoscopic Surgery despite caution by the doctor about the greater risk of complications involved in this procedure. The doctor had obtained a special consent from the patient before the surgery in view of greater risk and the prolonged stay was also on the request of the complainant. From the above, it is observed that the decision of the Insurer to settle the claim as a package for Rs.1,50,000/- was arrived at by taking various points into consideration. In the facts and circumstances, I do not find any justifiable reason to interfere with the decision of the Insurance Company. However, the hospital in their letter dated 22.12.2006 to the TTK Health Care Services Ltd., has mentioned that in this surgery Special Gortex Mesh was used costing Rs.45,169/-. In view of this, I direct the Insurance Company to reimburse this cost in addition to what they have already paid.

Mumbai Ombudsman Centre
Case No. : GI- 721 of 2006-2007
Shri Yogesh R. Raiyani
V/s
The New India Assurance Co. Ltd.

Award Dated : 26.06.07

Shri Yogesh R Raiyani and his wife, Smt. Bhavana Y. Raiyani, were covered under an Individual Mediclaim policy for the first time w.e.f. 18/12/1997 for a SI of Rs. 1 lakh each. The S.I. was increased by Rs. 1 lakh each in the year 2003-04. The CB reflected under the Policy of 2005-06 shows 40% for original SI of Rs. 1 lakhs and 10% for the increased Rs. 1 lakh.

Shri Raiyani was hospitalized at Lilavati Hospital and Research Centre on 7/2/2006 with complaints of loss of appetite, nausea and vomiting and altered sleep pattern since 2- 3 months. His diagnosis was “k/c/o Gout with DM with CKD V (Chronic Kidney Disease) Stage 5 - on maintenance HD (haemodialysis) thrice a week. His claim for hospitalization amounting to Rs. 88,449/- was rejected by the TPA under exclusion 4.1 stating that the patient was suffering from gout since last 15 years and long standing gout is the proximate cause of present renal impairment.

Analysis of the Complaint reveals that Shri Raiyani was hospitalized on three occasions i.e. from 7/2/2006 to 2/0/2/2006 for chronic kidney disease with Gout & DM, on 1/4/2006 to 31/5/2006 for dialysis and 20/8/2006 to 29/8/2006 for renal transplant and the TPA/Company has repudiated all the three claims. However, as per the P III form, the complaint is only for non-settlement of his first hospitalization claim.

From the documents available with this Forum it is noted that that the Company has rejected the claim on the ground of long duration of Gout as per hospital recordings of past history and non disclosure of the same (the Company has not produced a copy of

the proposal form to substantiate non-disclosure). The Complainant's brother contested the grounds of repudiation during the hearing, by mentioning that they came to know that his brother, Shri Raiyani was suffering from Gout only during the hospitalization at Lilavati Hospital. This implies that the Gout was not disclosed at the time of proposal for insurance.

In the light of the above analysis, Company's repudiation of the claim on the grounds of pre-existing gout appears to be based on the history recorded in the hospital papers. There has been further notings in the subsequent hospitalization papers that he was a "k/c/o Type II DM & HTN since 4 years on OHA and anti-hypertensive medicines. Also he is a k/c/o Pulmonary Koch's since Feb. 2006 on AKT since then."

It is clear that the Insured had history of Gout and was on medicine. The history of Gout has been disputed by the complainant. The Company has relied on the history recorded in the hospital and has not produced any other evidence. The complainant has also not produced any proof for the onset of the disease but has only produced clarification from the treating doctors. In the absence of any evidence, I give benefit of doubt to the complainant for not treating present problem as pre-existing for original sum insured of Rs. 1 lakh with CB, however, for the increased SI, the other history of DM & HTN are also vital. Therefore, for enhanced SI of Rs. 1 lakh taken in the year 2003-04, the decision of the Insurer for non-admission is tenable.

Mumbai Ombudsman Centre
Case No. : GI- 560 of 2006-2007
Smt. Manju Sudhir Lal
V/s
National Insurance Co. Ltd.

Award Dated : 28.06.06

Shri Sudhir Mohan Lal was covered under an Individual Mediclaim Policy along with his wife, Smt. Manju Sudhir Lal and daughter w.e.f. 29/3/2004 for a sum insured of Rs. 2.5 lakhs for himself and his wife and Rs. 50,000/- for his daughter. In the following year, his wife was hospitalized at Bharatiya Arogya Nidhi Hospital for unstable Angina. She was treated and discharged on 11/5/2005. She then underwent CAG at Nanavati Hospital on 11/5/2005 which revealed disease in LAD and LCX. She was admitted to Asian Heart Hospital for further evaluation and management and it was reported by the complainant that since there was no cashless facility available in the said hospital, Smt. Lal took a discharge and underwent PTCA at Nanavati Hospital on 14/5/2005. A claim was preferred for all the hospitalisations amounting to Rs. 2,63,037/- which was rejected by the TPA – Medicare TPA Services (I) Pvt. Limited as per exclusion 4.1. Analysis of the case reveals that Shri Sudhir Lal and his wife entered the Mediclaim scheme in the year 2004-2005 at the age of 49 years and the claim has arisen in the beginning of the second year of the policy. Smt. Lal was taken to Sanghvi Hospital with complaints of pain in right mammary region radiating to neck. BP recorded was 160/90 ECG revealed ST changes she was advised admission to ICCU. The complainant stated that his wife was referred to Bharatiya Arogya Nidhi and the presenting symptoms of the first hospitalization at Bharatiya Arogya Nidhi noted h/o chest pain on left side with breathlessness, k/c/o/ HTN on oral medication. Her BP reading was 170/80 mmHg. Discharge Summary of 2nd Hospitalisation at Dr. Balabhai Nanavati Hospital noted k/c/o HTN on treatment, BP reading noted 140/100 mmHg. Third Hospitalisation at Asian Heart Institute noted past history k/c/o HTN on treatment and

operated for Uterine Retro version. 4th hospitalization at Dr. Bhalabhai Nanavati Hospital noted diagnosis as HTN + Critical double vessel disease. Admitted for PTCA.

The Complainant's contention was that his wife did not have any BP problem prior to taking the policy and he emphasized that the policy was issued on the basis of pre-insurance medical test reports which were all normal. Since the exact duration of the HTN was the main dispute, the Complainant was advised during the hearing to submit previous prescriptions for medicines taken to substantiate his stand that HTN was from 3 months as stated by his doctor. However, no such papers were submitted to this Forum by the Complainant. Since Smt. Lal was already on medicine before the first hospitalization at Arogya Nidhi, the progress of the disease would bear substantial evidence that the HTN was there for quite sometime and it is a major risk factor for heart disease, for which PTCA was done. However, the Company has submitted that while taking the Mediclaim policy, medical tests like ECG, BP and blood sugar were done which were found normal and no restriction/exclusion clause was imposed while issuing the policy Taking all the above facts into consideration and in the absence of proof for the onset of BP I am inclined to strike a balance by allowing the claim upto the extent of 70% of the admissible expenses in this case.

Mumbai Ombudsman Centre
Case No. : GI- 785of 2006-2007
Smt. Savitri M. Narang
V/s
The Oriental Insurance Co. Ltd.

Award Dated : 29.06.07

It is reported by Smt. Savitri M. Narang that she was insured with The Oriental Insurance Co. Ltd. since last 18 years. She had undergone Bypass Surgery in the year 1980 in London before she took the Mediclaim Policy and the said fact was disclosed by her at the time of proposing for insurance, for which there was an exclusion of Heart Disease in the policy issued by Oriental. DO 7.Smt. Narang was covered under Mediclaim policy for Sum Insured of Rs. 5 lakhs and a fresh proposal form was filled up by the Insured (Copy of proposal in the file) wherein there is a remark of the Company's official – 'continuation of policy expiring on 13/8/2004 with DO 7'. It is noted that the past surgery was not disclosed in the said proposal form.

A claim was lodged in the following year under in respect of hospitalization at Breach Candy hospital for Carotid Artery Stenosis/Diabetic Neuropathy/IHD/DM/Hypertension. Raksha TPA rejected the claim under cashless arrangement in view of the past history of HT/DM and Cardiac ailment since 15yrs, 15yrs and 17 yrs. respectively. Thereafter the reimbursement was also rejected by them under exclusion 4.1. stating as per hospital records, patient was suffering from DM since 20 years and had undergone CABG in 1980.

Analysis of the case reveals that the Company and the TPA have rejected the claim on two grounds on the basis of the recordings in the discharge card of Breach Candy Hospital. Firstly that the Insured had a history of CABG in the year 1980 and secondly she was a k/c/o DM since last 20 years. It is clear from the Complainant's letters that she has not contested the first ground of repudiation as she has emphatically mentioned in her various letters to the Company as also to this Forum that the Company issued the policy to her with exclusion of heart disease on the basis of the disclosure made by her while proposing for insurance. The main contention of the

Insured was to establish that the DM was not since 20 years which was wrongly recorded in the hospital papers which should be since 15 years.

Going by the history of past illnesses of CABG undergone, Diabetes, Hypertension, and Ischaemic heart disease being longstanding i.e., DM & HT being of 20 years and 15 years respectively, evidently the diseases were pre-existing at the time of insurance and therefore, would be automatically excluded. As the nature of the disease is apparent from the surgical intervention made at the Breach Candy Hospital, it would be reasonable to conclude that longstanding diabetes as pre-existing illness has caused substantial impact to result into bilateral SFA and carotid stenosis. Accordingly the decision of the Company to reject the claim on the ground of pre-existing illness (clause 4.1) is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-867 of 2006-2007
Shri Jai Kumar Jain
V/s.
Reliance General Insurance Co. Ltd.

Award Dated : 29.06.07

Shri Jai Kumar Jain alongwith his wife was covered under the mediclaim policy issued by Reliance General Insurance Co. Ltd. He was initially insured with New India Assurance Company Limited from 1991 with CBof 25%. Shri Jain then increased the S.I twice one in the year 1998-99 and another in the year 1999-2000 and renewed till he shifted his policy to to Reliance Insurance Co. Ltd. in 2002. When the policy came for renewal in the year 2003, it was enhanced to Rs. 5.00 lacs which were renewed thereafter regularly.

Smt. Ramitidevi Jain, wife of the complainant, had chest pain with sweating on 14.06.2006. E.C.G. was done by Dr. Pandey and was referred to Dr. Pehlajani. She was admitted to Breach Candy Hospital and PTCA was done under L.A. through R.F.A When a claim was preferred the same was rejected stating that since 12 years as pre-existing. After perusal of the records, parties to the dispute were called for hearing on 30.05.2007. The patient was admitted to Breach Candy Hospital and the history noted was HTN for 2 years and DM for 12 years was not correct. He was asked to prove by way of medical evidences / prescriptions or pathological reports the history of on-set of HTN and/or DM. He was advised to submit the proof of continuity of medical policy since inception. Reliance General Insurance Company Ltd. stated that longstanding HTN and DM were more prone to CAD. Pursuant to the hearing, Shri Jai Kumar Jain submitted the policy copies from the year 1996-97 to 2005-06 alongwith Stress Test Report dated 27.04.2004, ECG Report dated 15.06.2005, and Blood Sugar Reports dated 17.08.2005 and 12.01.2006. Insurance Company was also asked to submit the proposal form and other medical reports taken at the time of granting the policy which they failed to submit.

Patient had undergone Stress Test on 27.04.2004 i.e. after taking the policy for S.I. for Rs. 5.00 lacs. The report shows “Negative Stress Response. It is true that DM is indeed one of the major risk factor for Coronary artery disease but not the only cause for it. The history of onset of DM has not been proved either by the Insured or by the Insurance Company. In the facts and circumstances, to arrive at a balance in this case to resolve the dispute, reimbursement of claim. upto Rs. 3.00 lacs with New India Assurance Co. Ltd. was advised. The Insurer could have very well checked the DM and HT before granting the Insurance. The history may go beyond 1999 but the Insurer has

not produced by way of any cogent evidence to prove their point and therefore, the benefit of doubt goes in favour of the Insured.

Mumbai Ombudsman Centre
Case No. : GI-815 of 2006-2007
Shri Nari Dickey Chothia
V/s
United India Insurance Co. Ltd.

Award Dated : 31.07.07

Shri Nari Dickey Chothia was covered under mediclaim policy of the United India Insurance Co. Ltd. since 1991. He renewed the policy continuously without any break and was enjoying 50% Cumulative Bonus. The present claim for his hospitalisation arose when he was admitted for Angiography and Angioplasty at Breach Candy hospital for a period from 15.12.2005 to 19.12.2005. He preferred a claim of Rs.5,11,122/- to the TPA-M/s Medicare Services, after hospitalisation. After processing the claim, the TPA settled the claim for Rs.4,14,750/-. Not satisfied with the decision of the TPA, Shri Nari Chothia represented to the company stating that the deduction of surgeon's fees from Rs.2,00,000/- to Rs.1,05,000/- was not correct and he had to undergo the operation on emergency basis hence the doctor was summoned immediately for the said operation. Shri Nari Dickey Chothia approached this Forum vide his letter dated 22.02.2007. After perusing the records, both the parties were called for hearing on 25.06.2007. Shri Suresh Warik on behalf of Shri Nari Dickey Chothia deposed before the Ombudsman that Shri Chothia was admitted in Breach Candy Hospital on emergency basis and Angiography and Angioplasty was done. He stated that when Shri Chothia preferred a claim for Rs.5,11,122/-, the TPA-M/s Medicare Services settled it for Rs.4,14,750/-, disallowing an amount of Rs.96,372/-. Shri Warik said that as Shri Chothia was having a Sum Insured of Rs. 4,50,000/- ,the deduction made by the company for Rs.35,250/- as against the amount settled for Rs.4,14,750/- is not correct and he is entitled for full claim amount.

Shri B.Misra represented United India Insurance Co. Ltd. and deposed before the Ombudsman that the Insured Shri Nari Dickey Chothia made a claim for Rs.5,11,122/- after his hospitalisation at Breach Candy hospital. He stated that the TPA –M/s Medicare disallowed an amount of Rs.96,372/-. He said that the surgeons fees of Rs.2,00,000/- has been reduced to Rs.1,05,000/- on the basis of the fees charged by the same surgeon for similar operation in other cases. He also stated that the TPA had taken into consideration the charges levied by eminent cardiologist in Mumbai. The TPA was asked to produce the charges levied by Dr. Pahlajani in similar operations in other cases to this Forum. In the meanwhile, the TPA M/s Medicare T.P.A Services Pvt.Ltd. vide their letter dated 26.07.2007 informed this forum that they have settled the balance amount of Rs.35,250/-, the amount under dispute, to Shri Nari Chothia vide cheque no. 004799 dated 21.07.2007. Under the circumstances, the complaint of Shri Nari Dickey Chothia for balance amount of Rs.35,250/- is closed in this Forum.

Mumbai Ombudsman Centre
Case No. : GI-225 of 2006-2007
Shri Champaklal D Goradia
V/s
The United India Insurance Co. Ltd.

Award Dated : 31.07.07

Shri Champaklal D Goradia, was insured under mediclaim policy of the United India Insurance Company Ltd. He was admitted at Shah Surgical Hospital and Maternity Home Pvt. Ltd., for Viral Hepatitis with Liver Abscess. He preferred a claim to the Company for reimbursement of expenses incurred on hospitalisation from 6.9.05 to 27.9.05, The Company's TPA, settled the claim for Rs.72,261/- after deducting an amount of Rs. 31,800/- contending that Rs.11000/- towards Room Charges, Rs.16,400/- towards doctor's visit charges and Rs.4400/- towards nursing charges were 'more than required'. Shri Champaklal Goradia approached the Insurance Ombudsman praying that his claim should be settled fully.

The parties to the dispute were called for a hearing on 16.7.2007 . Shri Champaklal D Goradia appeared and deposed before the Ombudsman. He requested the Ombudsman that his total claim should be settled by the Company ,and not partly, as he had paid the total bill to the Hospital.

On going through the Hospital Records, it was felt that the patient remained for 22 days in Hospital for Viral Hepatitis, which seems to be a prolonged period as his position was stable after a few days and the line of treatment was, more or less, the same. In view of this, there was no justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-791 of 2006-2007
Shri Ajay Kumar Kaushal
V/s
Oriental Insurance Company Limited

Award Dated : 16.07.07

Shri Ajay Kumar Kaushal is covered under mediclaim Policy No. for S. I. of Rs. 5,00,000/- with Oriental Insurance Company Limited, CDO No.2. He approached the Office of the Insurance Ombudsman with a complaint against Dispute in Quantum of settlement of his claim.

Shri Kaushal was advised to undergo surgery of removal of cataract from both the eyes and was asked to implant multi-focal lens in place of the old lens. Accordingly he got his left eye operated on 24.10.2005 by Dr. Keiki Mehta at Dr. Bacha's Memorial Bell-Vue Nursing Home. The total expenditure incurred was Rs. 58,431/- which was settled for Rs. 55,856/-. In this Hospital, he was discharged on the same day and incurred expenditure amounting to Rs. 52,262.73 which was settled for Rs. 39,763/- after deducting Rs. 12,500/-. He persuaded for reimbursement of Rs. 12,500/- with Insurance Company. They asked Shri Kaushal to give bifurcation of Rs. 40,000/- charged as Doctor's Fees. After receipt of bifurcation he was informed that since the Surgeon fees have already been reimbursed in the main hospital bill, separate lens implantation charges will not be reimbursed.

The records were perused and parties to the dispute were called for hearing on 25.06.2007. Shri Ajay Kumar Kaushal submitted that instead of making the payment of balance amount they wrote to him to refund Rs. 12,500/- which was paid in earlier claim in excess. Oriental Insurance Co. Ltd., submitted that based on the payments made earlier in the same hospital for the similar surgery, in support of reasonability clause, they deducted the amount.

We have gone through the expenses incurred in the same hospital for similar surgeries which is in the range of Rs. 30,000/- to 35,000/-. Therefore, the expense allowed by the Insurer in this case seems to be

reasonable. Under the circumstances, there is no justifiable reason to interfere with the decision of Oriental Insurance Company Limited.

Mumbai Ombudsman Centre
Case No. : GI-740 of 2006-2007
Shri Kirit J. Shah
V/s.
The New India Assurance Co. Ltd.

Award Dated : 26.07.07

Shri Kirit J. Shah alongwith his wife was covered under the mediclaim policy issued by The New India Assurance Co. Ltd., for a Sum Insured of Rs. 1.00 lac with Cumulative Bonus of 50% each and another S.I. to Rs. 1.00 lac with Cumulative Bonus of Rs. 25% for himself and 20% for his wife.

Complainant's wife Smt. Anjana K. Shah, aged 55 years was hospitalized at Breach Candy Hospital and was operated for Vaginal Hysterectomy plus Bilateral Salpingo Oopherectomy. When a claim was preferred by Shri Shah for Rs. 1,13,715/- for the said hospitalization, the Company settled the claim for Rs. 70,397/-. Not satisfied with the decision Shri Shah approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his balance claim amount of Rs.43,318/-.

As per policy conditions the Registration and Excess charges are not payable. The contention of the Company was that the amount charged towards Physician, Surgeon and Anesthetist were on higher side and hence under reasonability clause the above amounts were deducted. It to be noted that Surgeon and Anesthetist's Fee has been raised in the Hospital bill and not paid directly to the Doctors by a separate receipt. In view of this and in the absence of any limit imposed on surgeon's Fee in the policy conditions, any cut in these charges raised by Breach Candy Hospitals are not justified. The Complainant has chosen the Surgeon in view that he was the consultants for the patient for earlier period and there is no specific direction for not choosing a Hospital or Surgeon by the Insured. The Complainant has paid the amount billed by the Hospital and got discharged. As regards other deductions are concerned, the company has already quoted the reasons which are justified. In view of this the Company was directed to pay the balance amount deducted form the Surgeon's Fees and Anesthetist's Charges and reimburse Rs. 580/- towards Histopathology small/large done on production of the report from the Hospital.

Mumbai Ombudsman Centre
Case No. : GI-439 of 2006-2007
Smt. Ratan Lulla
V/s.
National Insurance Co.Ltd.

Award Dated : 31.07.2007

Smt. Ratan Lulla alongwith her son Shri Yogesh Ratan Lulla was covered under Hospitalization and Domiciliary Hospitalization Benefit Policy issued by The National Insurance Company Limited, under policy No.270100/48/05/8500001352 for the period from 13.07.2005 to 12.07.2006 for a Sum Insured of Rs.1,00,000 each and Domiciliary Hospitalization limit of 20,000 each The policy showed an exclusion of By Pass Surgery in the case of Smt.Ratan Lulla, whereas for her son Shri Yogesh Ratan Lulla there was no exclusion.

Smt. Ratan Lulla was hospitalized at Jehangir Hospital & Medical Research Centre, Pune, from 26.02.2006 to 03.03.2006. She was treated and operated for Epigastric Hernia. Her claim was repudiated by the TPA M/s Paramount Health Services Pvt. Ltd. on the grounds of pre-existing illness i.e clause 4.1. of the mediclaim policy. Their contention was that the illness i.e. Epigastric Hernia suffered by Smt.Ratan Lulla in epigastric region was a complication of the previous surgeries i.e. Bypass surgery done earlier.

Smt. Ratan Lulla had a Bypass surgery in the year 1992. On 27.02.2006 she underwent operation for Epigastric Hernia. The expression 'pre-existing' which means that the disease or the symptoms were existing before hand of which she was aware and did not deliberately disclose. Even if there was an argument that it developed through the scar – the diagnosis and operation was done on 27.02.2006. Any surgery would leave a scar and over a period of time this scar settles down alongwith the tissues and gets back original strength. There are two certificates dated 27.2.2006 from Dr. R.D. Edibam, Consultant Surgeon from Jehangir Hospital which states "Mrs. Ratan Lulla has undergone surgery for Epigastric Hernia which is NOT related to the previous cardiac surgery". The second certificate dated 27.4.2007 from Dr. Edibam certifying " Mr. Ratan Lulla has had epigastric hernia for last four months and it was not an incisional hernia from previous bypass surgery. It was below level of the previous scar. The said Doctor has also furnished the information with a specific diagram in the letter to the TPA dated 02.03.2006 as to where the operation was performed on the said complainant and that the operation was actually performed below the scar.

In the present case the claim has been rejected on the ground that the Bypass surgery which was performed in the year 1992 about 14 years ago was the causative factor for Epigastric Hernia. The clause 4.1 excludes only pre-existing diseases/injuries. What was existing was only a scar of incision for Bypass Surgery It would not, therefore, be in order for the company to invoke clause 4.1 to reject the claim for Epigastric Hernia surgery unless it is proved to have been proximately caused by Bypass Surgery done 14 years ago.

In the discharge summary the diagnosis given is Post Incisional Hernia (ventral Hernia). The chief complaint given : - K/C/o HTN admitted, Incisional Hernia Repair. The repudiation of the claim on the ground of pre-existing illness - Hypertension not tenable as HTN is no way connected with the present illness and consequent operation.

Mumbai Ombudsman Centre
Case No. : GI-226 of 2006-2007
Shri Dipak Mukherjee
V/s.
The New India Assurance Co.Ltd.

Award Dated : 26.07.2007

Shri Dipak Mukherjee is covered under Bhavishya Arogya Provident Mediclaim Insurance Policy No.151603/91/0000/000199 issued by The New India Assurance Co. Ltd. The premium paying period was from 27.03.1991 to 27.03.1997. The policy became effective from 27.03.1998. Shri Dipak Mukherjee preferred a claim for various investigations on domicilliary basis on 20.06.2005. The New India Assurance Co. Ltd. repudiated the claim as per clause No.2.2 and 6.5. of the policy terms & conditions.

As per Doctor's report this is an OPD case and no hospitalization was required. The insured was not hospitalized for the treatment and has claimed for the reimbursement of investigation expenses under domiciliary hospitalization benefit. As there was no

hospitalization claim was repudiated as per policy clause 2.2 & 6.5 . As per the policy conditions under Bhavishya Arogya Provident Mediclaim Insurance clause 2.2. – Domicillary Hospitalisation Benefit reads : Means medical treatment for a period exceeding three days for such illness/disease/injury which in the normal course should require care and treatment at a Hospital/Nursing Home but actually taken whilst confirmed at home in India under any of the folliwing circumstances viz.

2.2.1 the condition of the patient is such that he/she cannot be removed to the hospital/nursing home or

2.2.2 The patient cannot be removed to hospital/nursing home for lack of accomodation therein or

2.2.3 The patient prefers to be confined at home for the treatment with the approval of the attending Medical Pratitioner.

A certificate dated 20.07.2005 issued by S.M.S. Mody, F.R.C.P., Of N.M. Wadia Institute of Cardiology states " Mr. D. Mukherjee is an operated case of Ca Lung (1971) and CABG 1994. He presented with a history of chest uneasiness, loss of appetite and weight loss for which he is advised Stress Thallium, USG abdomen, chest X -ray, T.T, ESR, thyroid functions and LFT which can be done on OPD basis. A case paper dated 21.07.2005 issued by Dr. D.B. Gaware, MD, N.M. Wadia Institute of Cardiology states CT Angiography on OPD basis & rest at home. Admission not necessary There is no diagnosis and treatment advised in this case.

Result : The Complaint is not allowed

Mumbai Ombudsman Centre
Case No. : GI-328 of 2006-2007
Smt. Uma Kejriwal
V/s.
The National Insurance Co.Ltd.

Award Dated : 19.07.2007

Smt. Uma Kejriwal had a mediclaim Policy No.260301/48/04/8500001744 from National Insurance Co. Ltd. Her dispute with the Company was the quantum of claim settlement. She was admitted to Breach Candy Hospital on 09.10.2005 and operated for Laparotomy with Hysterectomy and discharged on 25.10.2005. Smt. Kejriwal had submitted a claim for Rs.3,06,866 to the Company. While in hospital Rs.1,75,000 was paid to the hospital by Medicare as part as cashless, thereby having balance of Rs.1,31,866/- Subsequently, a cheque for Rs.77,337 dated 23.05.2006 was sent to her. She approached the Company for the balance payment Getting no response from the Company, she approached this forum with her grievance. Upon receipt of her representation a hearing was fixed and the parties to the dispute were called for a hearing on 18.07.2007 at 11.00 A.M.

A joint hearing was to be held with the representatives of The National Insurance Co. Ltd. and the Complainant. Mrs. Uma Kejriwal vide her letter dated 15.07.2007 addressed to the Office of the Insurance Ombudsman, requested for her son Mr. Ashish Kejriwal to represent her case. There was no representative from National Insurance Co. Ltd. However, there was a representative from TPA. Shri Narayan Nerurkar, Manager – Operation, Medicare TPA services Pvt. Ltd. was present.

It was informed by Shri Ashish Kejriwal that the dispute for the balance amount of Rs.53,500/- has been agreed by the Insurance company. Since the full amount has been settled, there is no dispute with the Company. As regards the complaint for the year 2003, it was not lodged in time, so it is not entertainable.

Subsequent to hearing the Insurance Company has sent a fax dated 17.07.2007 giving the details of payment of the claim as under:

Cheque No. : 115657, drawn on State Bank of India

Date : 16.07.2007

Amount : Rs. 53,500/-

In view of the settlement of the claim by the Respondent the complaint is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-369 of 2006-2007
Shri Mahesh S. Gupta
V/s.
The National Insurance Co.Ltd.

Award Dated : 27.07.2007

Shri Mahesh S. Gupta alongwith his two daughters were covered under Hospital & Domiciliary Hospitalization Benefit Policy for Rs. 5 lakhs each w.e.f. 20.03.2005 to 19.03.2006 by The National Insurance Co. Ltd.

Ms. Ritika M. Gupta, daughter of Shri Mahesh S. Gupta was admitted to Breach Candy Hospital Trust on 13.01.2006 for removal of lesion epidermal cyst in right groin. When a claim was preferred under Policy No.260501/48/04/8501042, the Third Party Administrator, M/s. Paramount Health Services Pvt. Ltd. repudiated the claim stating that the excision of cyst was done under local anesthesia for which the same could be done on OPD basis and hence hospitalization was not justified and hence the claim is not admissible as per terms & condition of the policy.

On going through the papers related to this case, it is observed from the Reservation form of Breach Candy Hospital Trust, that Ms. Ritika Gupta was admitted at 10.00 A.M on 13.01.2006 and under the column – Room type preferred – it was marked for “Day Care”. There is no inpatient record and surgical notes on file. In the “Surgical

Discharge Folio” of the hospital it is mentioned that she was discharged at 11.00 A.M. the next day i.e. on 14.01.2007 and the excision of the Cyst was done under local anesthesia. There is a receipt from Dr. K.P. Balsara dated 05.01.2006 for professional attendance. The consultation fee and operation charges paid to Dr. K.P. Balsara was through a separate receipt in addition to Rs.1000/- charged by the hospital in their bill.

From the above it is clear that the excision of cyst could have been done without 24 hour hospitalization.

Result : The complaint is not allowed.

Mumbai Ombudsman Centre
Case No. : GI-894 of 2006-2007
Shri Srichand A. Bijlani
V/s
United India Insurance Co. Ltd.

Award Dated : 23.07.2007

Shri Srichand A. Bijlani alongwith his wife Smt. Gauri S. Bijlani was insured with United India Insurance Co. Ltd. for a sum insured of Rs.1,00,000 each and enjoying 25% CB. The claim arose under the policy No.121300/48/05/04150 during the policy period 16.03.2006 to 15.03.2007. Smt. Gauri Bijlani was admitted in Vedicure Wellness Hospital on 03.05.2006 and diagnosis was Osteoporosis, Cx spondylosis. M/s.

Medsave Healthcare – the TPA of the company, informed her that as there was no active line of treatment given at the time of hospitalisation and she was given only oral tablets and the same can be taken on OPD basis, the claim is not admissible.

The clinical findings in the discharge card from Vedicure Wellness Hospital, states the diagnosis as Osteoporosis, Cx spondylosis and the patient was prescribed to continue with tablets with massage & steam Bastillhama. The history recorded in the hospital record about the present illness is as under:

"She was quite assymptomatic about a year ago. She gradually developed pain in both knees, neck and lower back. She also had tingling sensation in whole body and sense of tension in skin, with these complaints she was admitted in the hospital".

The complainant had submitted some medical prescriptions prior to hospitalization from Dr. Alka Chadha, MD , dated 15.04.2006, Dr. Ashok Handa, M.S., M.C., Brain & Spine Surgeon, & the problem mentioned was severe backache radiating to both LLS R.L, severe osteoporosis, Tenderness all over. This Doctor referred to Dr. Manoj Chadda for Osteoporosis on 08.04.2006 Dr. Subhas Dhiware, M.S. Orthopedic Surgeon was consulted and treatment was taken and for diagnosis some pathological test were also conducted. From the above it is clear that the patient was taking treatment on OPD basis prior to hospitalization. It appears when the treatment did not respond positively, perhaps the admission become inevitable. The diagnosis evaluated on discharge – Osteoporosis, Cx Spondylosis.

Result: Awarded Ex-gratia payment of 60% of expenses incurred by the Complainant.

Mumbai Ombudsman Centre
Case No. : GI-399 of 2006-2007
Shri Amratlal Chunnilal Kothari
V/s.
The New India Assurance Co.Ltd.

Award Dated : 24.07.2007

Shri Amratlal C. Kothari alongwith his wife Smt. Mehtabai A. Kothari have been insured with New Indian Assurance Co. Ltd., D.O. 111700 under Hospitalisation & Domiciliary Hospitalisation Benefit Policy for Rs. 1 lakh each from 27.01.2000.

Smt. Mehtabai Kothari was admitted to Bombay Hospital from 07.06.2006 to 10.06.2006 for Post Herpetic Neuralgia. M/s. Raksha, repudiated the claim under exclusion clause 4.10 of the policy and that she could be treated on OPD basis and hospitalization was not justified.

On analysis on the case and on going through the documents submitted Mrs. Kothari was admitted to Bombay Hospital and Medical Research Centre. She was admitted on 07.06.2006 and discharged on 10.06.2006. The diagnosis given is Post Herpetic Neuralgia The Indoor papers of Bombay Hospital shows that Mrs. Kothari was given medicines - Tab. Tigritol, Tab. Pantocid, Tab. Gabaptin, Tab. Ostage, Tab. Vaws A.P., Inj. Methylcobal. During her treatment in hospital she had undergone various tests viz. UL Trasonography of the Abdomen, Blood Count, Blood Sugar & Urine, Pap Smears. The above tests and medicines could have been taken on OPD basis. The New India Assurance Company Ltd. repudiated the claim under clause 4.10.

In the discharge summary of Bombay Hospital the history recorded was K/C/O Hyper Zoster-6 months back, No H/O - fever cough-Pt. admitted with Burning sensation over Rt. half of abd. & back –over dorso. Lumber region since 6 months back. The final diagnosis was Post Herpetic Neuralgia. From the above it is clear that the diagnosis

was known before admission, no emergency was reported and the treatment given could have been taken on OPD basis.

Result : The Complaint is not allowed.

Mumbai Ombudsman Centre
Case No. : GI 599 of 2006-2007
Shri Paresh M Jariwala
V/s
The Oriental Insurance Co. Ltd.

Award Dated : 06.07.07

Shri Paresh M. Jariwala along with his family and his parents were covered under an Individual Mediclaim Policy for SI of Rs. 2 lakhs each and Rs. 1,00,000/- for his son. w.e.f. 13/7/2005. From the policy copies submitted to this Forum it appears that the present policy was in continuation of earlier Group Mediclaim Policy taken by his employer, M/s.Chemtex Global Engineers valid from 15/9/2004-05.

Shri Jariwalla's mother, Smt. Niranjana M. Jariwalla was admitted to Ashwini Ayurvedic Hospital, Borivli (W) on 27/3//2006 with complaints of severe back pain and took the course of ayurvedic treatment for Katigraham (back pain). When a claim was preferred the same was rejected under 4.10. The analysis of the claim reveals that Smt. Jariwala was admitted to Ashwini Ayurvedic Centre for Katigraham (Back Pain) on 27/3/2006 and got discharged on 17/4/2006 i.e. after 21 days and she received the following treatments – 7 days Pizhichil, 7 days Elabizhi, 7 days Njavrabizhi, 7 days Kativasti and 1day Virechan. M/s Raksha TPA repudiated the claim invoking clause 4.10 of the Mediclaim policy.

The whole matter is centering around this issue and we have to examine and resolve the issue in relation to the final diagnosis of the case revealed through subsequent hospitalization papers and the treatment received.

If we analyse the documents made available to this Forum, it would appear that the correct diagnosis of the illness was done much later and Smt. Jariwala diagnosis at the Ayurvedic center and even prior to hospitalization was only 'Back Pain' as per the x-ray of Spine It looks as if this was the onset of the actual problem (which was diagnosed as multiple metastasis of the spine subsequently and the Insured having succumbed to it later) Looking to the line of treatment which was repetitive in nature, it was absolutely in order that hospitalization of 21 days was not justified. But the subsequent hospitalization papers of Holy Spirit Hospital and the MRI of Spine would point to the fact that she did have a serious problem. The complainant had mentioned during the hearing that his mother had consulted Orthopaedic Surgeon and was on allopathic treatment and since there was no improvement in her condition, he resorted to Ayurvedic treatment.

In view of the foregoing analysis, this Forum takes a lenient view in this case and allow the claim for 50 % of the admissible expenses on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI- 614 of 2006-2007
Shri Joy Palathingal
Vs
The New India Assurance Co. Ltd.

Award Dated : 10.07.07

Shri Joy Palathingal and his family were covered under Individual Mediclaim Policy since 5/1/2000 for SI of Rs. 50,000/- each for himself and his wife and Rs. 25,000/- each for his two sons and a daughter. In the following year, he increased the SI to Rs. 1 lakh each for himself and his wife. Smt. Jessy Joy was admitted to Holy Spirit Hospital on 11/5/2006 for Fibroid Uterus with Adenomyosis and the claim was rejected under exclusion 4.1. stating as per hospital consultation dated 21/3/2006, patient had done ultrasound in 1996, which had revealed evidence of adenomyosis with small fibroid and patient had complaints of dysmenorrhoea since 9 years

Analysis of the case reveals that Smt. Jessy Joy was admitted to Holy Spirit Hospital on 11/5/2006 for Fibroid in the Uterus with Adenomyosis . She underwent total abdominal hysterectomy with bilateral salphingo-oophorectomy on 12/5/2006 and got discharged on 17/5/2006. The TPA and the Company repudiated the claim on the basis of notings in the hospital's consultation paper dated 21/3/2006 that patient had done ultrasound in 1996, which had revealed Adenomyosis with small fibroid, which was well before the policy inception in January, 2000 and patient had complaints of dysmenorrhoea since 9 years.

Sonography revealed fibroid uterus with adenomyosis with thickened endometriosis. Also the Cytology Report dated 15/9/2005 and Pelvic Sonography report dated 17/9/2005 confirmed the presence of Fibroids and Adenomyosis changes. Thus it is clear from the report as well as from the doctor's certificate that even though there was presence of suspected Adenomyosis there were no fibroids present in 1996 and it was detected later.

A sharper analysis through the documents made available to this Forum would make one point clear that Smt. Jessy Joy did have gynaecological problems before the policy inception i.e. since 1996 for which she was referred for Pelvic sonography by Dr. N. Phadke and this fact cannot be overlooked. Whether this information was disclosed at the time of policy inception is difficult to ascertain in the absence of the proposal form. It is also noted that she had complaints of severe dysmennorhoea since 9 years which is a painful menstruation. In view of the foregoing analysis, this Forum is not convinced with the total repudiation of the claim by the Insurer for the fact that fibroids were detected somewhere in the year 2002 i.e. after the policy inception but since the present ailment for which Smt. Joy was hospitalized has causative relationship with severe Dysmennorhoea, as examined above, it is decided that the reimbursement of the claim may be made to the extent of 90%

Mumbai Ombudsman Centre
Case No. : GI- 860 of 2006-2007
Shri Suresh Mehta
V/s
United India Insurance Co. Ltd.

Award Dated : 12.07.07

Shri Suresh Mehta was holding a Mediclaim Policy since 27/3/1998 for a S.I. of Rs. 50,000/- and it is reported by him that a claim was settled by the Company in the year 1998-99. Shri Mehta was hospitalized at Asian Heart Hospital on 21/2/2006 for IHD and he underwent CABG. The claim lodged by Shri Mehta was rejected by the TPA – Family Health Plan on two grounds 1) discrepancy in information provided by the Hospital and 2) exclusion clause 4.1.

Analysis of the case reveals that Shri Suresh Madanlal Mehta was admitted to Asian Heart Institute on 21/2/2006 with chief complaints of breathlessness on exertion since

3 months and severe chest pain since 1 week. Past history noted in the discharge summary was k/c/o HTN since 2004, h/o appendectomy 15 years back. He had one episode of haematuria in 2004. He was diagnosed as IHD/HT/Multivessel CAD. Coronary Angiography revealed multi vessel coronary artery disease and he was advised CABG and discharged on 22/2/2006. Thereafter he was admitted again on 16/3/2006 and CABG was performed on 17/3/2006 and after treatment he was discharged on 24/3/2006.

Shri Mehta contested the decision of the TPA and stated that the present claim was pertaining to hypertension and therefore it was stated in the hospital record that similar complaint was present in 1998 and one claim in respect of said hypertension disease was settled by the Company in 1998. Upon representation from the Insured, the Company also reviewed the claim by referring the file to their panel doctor, Dr. M.S. Kamath who opined that " It is clear from the discharge card of the Hospital submitted that Mr. Suresh Mehta was suffering from IHD and Hypertension and was admitted for the same. In the discharge card of the Hospital, it is mentioned that the Insured was having chest pain prior to admission. It is further mentioned that the Insured is a known case of similar chest pain in 1998. A look at the discharge card of the patient at his previous admission at Bhaktivedanta Hosital in 1998 reveals that the patient had IHD and was admitted for the same in July 1998. At that time it is stated that the patient is a known case of Hypertension. ……. In my opinion the claim is not payable by United India Insurance Co. Ltd."

Taking into account the notings as per the Bhakti Vedanta Hospital in the Discharge Card, it can be concluded that Shri Mehta was suffering from HTN before the hospitalization in 1998 for which he was even taking medicine Cap. Deprin 5 mg and the policy was taken on 27/3/1998. Therefore, the contention of the Complainant during the hearing that he was not taking medicines for HTN and that he was hospitalized for Gastritis problem in 1998 is not acceptable as it is clearly noted in the discharge card as "k/c/o HTN on Cap. Deprin 5 mg OD and the diagnosis was " IHD with Gastritis".

It would be relevant to point out here that the present hospitalization for CAG and CABG came after a long gap of about 7 years and there was no claim reported for heart problem till the present one. It is also pertinent to note that the Company had settled the previous hospitalization claim of 1998 despite of notings of "k/c/o of HTN".

The Company has now alleged that HTN was not disclosed by the Insured while proposing for Insurance, but the Company has not submitted the proposal form to substantiate their stand. However, the TPA/Company have not raised any objection to non-disclosure in their repudiation letter but they have alleged that there was discrepancy in the information provided by the Hospital. They have not precisely mentioned which information but it is perhaps the duration of the HTN which is mentioned since 2004 in the Asian Heart Hospital Papers which is contradictory to the notings of Bhaktivedanta Hospital. Though the history of the HTN was not correctly recorded in the discharge summary of Asian Heart Institute, the duration of HTN has also not been mentioned in the Hospital records of 1998, but since the Insured was already on medication for HTN, the possibility of HTN prior to policy inception cannot be ruled out.

Based on the above analysis, the Company having settled the earlier claim in 1998, the total repudiation of the claim by the Insurer is not justified. HTN is one of the major risk factors for IHD, but IHD has not been established as pre-existing in this case.

Considering all the above facts and circumstances, I am of the opinion to settle the claim to the extent of the Sum Insured plus accrued CB if any, under the policy with a

first 10% to be borne by the Insured, and remaining to be reimbursed to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI- 458 of 2006-2007
Shri Vimal S. Banka
V/s
The Oriental Insurance Co. Ltd.

Award Dated : 18.07.07

Shri Vimal S. Banka along with his wife and three daughters were covered under an Individual Mediclaim Policy No.122200/48/06/6686 (18/2/2006-07) for S.I. of Rs. 2 lakhs each. Shri Banka approached the Forum of Insurance Ombudsman through his letter dated 5th October, 2006 with a complaint against Oriental Insurance Company Ltd for rejection of a claim lodged by him for reimbursement of hospitalization expenses in connection with his hospitalization at Lilavati Hospital on 23/4/2006 to 25/4/2006 for Anxiety Disorder The claim was repudiated by the TPA/Company on the ground that admission was not necessary as he was given only oral medications and only investigations were carried out during confinement. The complainant represented to the Insurer's Grievance Cell for reconsideration of the claim on the ground that he had severe suffocation and breathlessness which were identical to signs of angina and in his case the initial diagnosis was acute coronary syndrome for which NTG injection was given and the investigation related to Myocardial Infarction were done.

If we examine the Discharge Summary, we find that the presenting complaints were choking sensation in the chest accompanied by breathlessness and ECG was taken and injection NTG (Nitroglycerine) 50 mg. was started. Nitroglycerine (Glyceryl Trinitrate) is a drug that dilates blood vessels and is used to prevent and treat Angina. (quoted from Oxford Medical Dictionary) After studying the ECG and other reports, the doctor advised to withhold NTG and inj. Paritodac and tab. Restyl were started. His condition was comfortable and fair the following day and subsequent investigations were carried out to rule out ACS (acute coronary syndrome) which were all normal. Thus it is clear that the symptoms proved to be not related to any cardiac problem. It also emerged that after investigations, he was diagnosed to be suffering from severe anxiety disorder, for which he was referred to a Psychiatrist. The only treatment that was given to him was by way of medication which was Inj. Paritodac and Tab. Restyl. Even though the final diagnosis was Anxiety Disorder, but the presenting symptoms which the patient had was indicating towards some heart problem and even the hospital treated him on those lines. It was only after other tests were done , the NTG treatment was stopped. However, it is observed from the hospital's letter that the Insured was directly admitted in ICU/twin sharing on 23rd April, 2006 and when he was fit for transfer from the ICU, he requested for a Super Deluxe Class (Higher than Twin Sharing) and therefore, as per hospital policy, all the charges were upgraded to the higher class from the date of admission. In view of the above, I am inclined to grant 60% of the admissible expenses to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI- 520 of 2006-2007
Shri Manoj K. Tiwari
V/s
The New India Assurance Co. Ltd.

Award Dated : 20.07.07

Shri Manoj Tiwari along with his wife and daughter were covered under an Individual Mediclaim Policy w.e.f. 24/3/2003 for a sum insured of Rs. 50,000/- each. The policy was issued without any exclusions for Shri Tiwari and his wife but there a specific exclusion of "Fever, Pneumonia, Asthama, Bronchitis, Diarrhoea etc. also accident related claims" in respect of his daughter, Baby Urvi M. Tiwari.

Shri Tiwari's daughter, aged 4 yrs was hospitalized at Karuna Hospital with complaints of pain in abdomen alleged h/o trauma blunt abdomen for which she was operated. When a claim for Rs. 64,416/- was preferred under the policy No. 140501/48/04/76018 (24/3/2005-2006) , the TPA - Paramount Health Services (P) Limited rejected the claim as per the specific exclusion on the policy.

Analysis of the case reveals that Baby Urvi Tiwari was admitted to Karuna Hospital on 21/3/2006 at 3.10 a.m. for alleged h/o trauma over the abdomen while playing. (Child was hit in the abdomen by a boy's leg while playing at 9.45 p.m.) She had complaints of pain in the abdomen and not passed urine since the trauma. The child was immediately taken to local medical practitioner's home and given some analgesic and was advised x-ray and sonography. Sonography revealed Hemoperitoreum with Spleen Rupture. She was therefore, admitted to Karuna Hospital and Exploratory Laparotomy with Splenorrhaphy was done on 21/3/2006. She was treated and discharged on 27/3/2006.

If we look into the exclusions imposed on the Mediclaim policy, then there remains hardly any diseases to be covered for children. The Company imposed exclusions based on their past high claim ratio in respect of children, but in this case, the Insured has not lodged any claim earlier under the policy and has earned 10% of cumulative bonus. It is also important to note that the present hospitalisation of the child was not for any pre-existing disease or for other common diseases to which children are susceptible to at that age, but for a serious injury due to alleged history of trauma over the abdomen while playing through left leg requiring hospitalization..

It is noted that Shri Manoj Tiwari decided to take insurance cover for himself and his wife from a very young age of 24 yrs and 23 yrs respectively along with their daughter which deserves notice.

In view of the foregoing analysis and looking to the seriousness of the injury sustained by the child, it will be appropriate to pay the admissible expenses to the extent of Sum Insured with CB accrued under the policy with a 10% deduction, to resolve the grievance under the case.

Mumbai Ombudsman Centre
Case No. : GI- 465 of 2006-2007
Shri Chunilal H. Bhatt
Vs
The New India Assurance Co. Ltd.

Award Dated : 23.07.07

Smt. Ramaben C. Bhatt was hospitalized at Sterling Hospital for acute gastroenteritis and she was diagnosed to have acute infective diarrhoea. The complaint is in respect of quantum of settlement of claim for Diarrhoea. The Company settled the claim partially for Rs. 48,906/- as against the claimed amount of Rs. 53,613/- disallowing Rs. 4625/- towards Nursing Charges and Diapers. Insured represented to the TPA- TTK Health Care as well as to the Company for settlement of the balance amount on the basis of a certificate issued by the treating doctor.

On perusal of the claim papers, it is noted that the claim was processed by M/s. TTK and after proper scrutiny of the expenses, they settled the claim for Rs. 48,906/-. The main dispute was only in respect of deduction of expenses to the tune of Rs. 4,625/- which mainly comprised of the nursing charges and cost of diapers. As regards, the cost of diapers, the Complainant was explained during the hearing that such charges are not admissible as per condition 1.2 of the Mediclaim Policy. Therefore, the issue before this Forum is only about non-settlement of cost of engaging private nurse during hospitalization.

The TPA/Company's contention was that in a Hospital nursing care is provided 24x7 days and therefore, requirement of a private attendant is not justified and hence cost incurred towards it is not payable. The Complainant has stated in his letter and also mentioned during the hearing that that his wife's condition was very serious and therefore the hospital arranged for a nurse as per the treating doctor's advice. He also mentioned that there was no family members with her at the hospital.

On examination of the certificate issued by the treating doctor, Dr. Sudhendu Patel, MD, it appears that the special nursing staff was basically appointed as there was no near relative to attend to her and in view of the nature of illness, they decided to appoint special nursing staff during her hospital stay. It is observed from the hospital bill that the charges under dispute are not towards nursing but charged separately under Private attendant. As mentioned earlier, there was no near relative with the patient, it appears in the absence of family attendant they engaged a private attendant.

Thus it can be inferred that even though the hospital arranged for private attendant, it was mainly because there were no family members around to look after her, which was also confirmed by the Complainant.

Based on the above analysis and notings in the hospital bill, the decision of the Company to disallow private attendant's charges and cost of diapers is sustainable.

Mumbai Ombudsman Centre
Case No. : GI- 610 of 2006-2007
Shri Ajit C. Raje
Vs
Cholamandalam Gen. Insce. Co. Ltd.

Award Dated : 25.07.07

Shri Ajit Chandrakant Raje was covered under an Individual Health Policy w.e.f. 18th November, 2005 for sum insured of Rs. 1 lakh. The policy was issued based on pre-insurance medical reports which had recommendations to exclude HTN.

During the currency of the policy, the Insured was admitted for Angiography on 11.9.2006 and CABG on 24/9/2006 at Grant Medical Foundation(Ruby Hall Clinic) and Jehangir Hospital respectively. He raised a requisition for cashless facility which was refused looking to the medical details and therefore a claim for reimbursement was lodged for Rs.1.20 lakhs.

On scrutiny of the claim documents by the panel doctors of TPA, the claim was found to be non-admissible after verification of all the relevant medical records as per general exclusion clause C-1. Accordingly, the Insurer conveyed the repudiation of the claim to the Insured vide their letter dated 4/11/2006.

Analysis of the case reveals that Shri Raje was admitted for CAG and CABG. Past history recorded in the hospital papers were "H/o HTN on treatment" however, the

duration of the HTN mentioned were different at the two hospitals, but since the dispute is not about the discrepancy in the duration of history, this Forum would not dwell into it. It was also noted in the hospital papers that he had risk factors of smoking, chronic tobacco chewer and family history.

The point of dispute is quite focussed as it evidently appears that the policy issued to Shri Raje had a clear exclusion of Hypertension and all related diseases on the basis of the disclosure made by him regarding his personal history during the pre-insurance Medical check up. It is noted from the pre-insurance Medical Examination Report in respect of Q No. 5 – the answer was in the affirmative for high blood pressure and stated to suffering from 5- 6 years BP Reading taken on that day showed 150/90 and in the column details of medication i.e. Q. No. 6 the name of the medicine taken by him was also mentioned as Tab. _____(spelling not clear) 0.5 mg. OD. Therefore the contention of the Insured during the hearing that he was never suffering from HTN is not tenable.

It was therefore, clear that hypertension was pre-existing before the policy inception and the policy specifically excluded HTN and consequences thereof" as per the exclusion clause endorsed on the policy.

Based on the recommendation in the pre-insurance medical reports there has been clear exclusion under the policy which has been examined above in its total import and comprehensiveness to exclude consequences arising from Hypertension and HTN being one of the major risk factors for Coronary Artery Disease, the Insurer's stand-point is justified.

Mumbai Ombudsman Centre
Case No. : GI- 698 of 2006-2007
Smt. Nalini R. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 27.07.07

Shri Ratilal M. Shah and his wife, Smt. Nalini R. Shah were covered under an Individual Mediclaim . Smt. Nalini Shah was hospitalized at Vedicure Wellness Hospital, Navi Mumbai, for Sciatica from 26/7/2006 to 25/8/2006 i.e. for one month. Smt. Shah's claim was initially settled for Rs. 29,490/- but later they paid yet another amount of Rs.6,300/- towards food charges thus totaling to Rs. 35,790/- as against her claim for Rs. 44,340/-. Complainant, Shri Ratilal Shah approached this Forum with a grievance for full settlement of the claim with 12% interest and Rs. 1000/- towards expenses incurred by him for travelling, typing and zerox. Parties to the dispute were called for personal hearing on 20th July , 2007.

The claim which was lodged in September, 2006 was initially settled for Rs. 29,490/- vide cheque no. 974387 dated 15/11/2006 and another cheque for Rs. 6,300/- towards food charges was paid vide cheque dated 19/2/2007. The complainant approached this Forum in respect of non-settlement of Rs. 8550/- bifurcated as Rs. 6000/- for Physiotherapy (Rs. 200 X 30 sittings) and Rs. 2550/- for Accupuncture, Sujoke, Reiki (Rs. 85 x 30 sittings), which were disallowed by the TPA as per circular in respect of Supreme Court Judgement for non-payment of cross disciplinary practice/treatment. But during the hearing the Company submitted a revised settlement details in respect of Smt. Shah in which it was noted that they have considered an amount of Rs. 6000/- out of the disallowed amount towards physiotheraphy charges despite the above

mentioned circular and therefore the final disallowed amount thus stands at Rs. 2,550/- in respect of acupressure, sujoke, reiki, which the TPA stated that it was inadmissible because they pertain to naturopathy treatment and is excluded from the scope of the policy under clause 4.13.

This Forum has examined the entire course of treatment taken by Smt. Shah at Vedicure Wellness Hospital and felt that the confinement of 30 days for Sciatica with Hypertension was for a prolonged duration and the treatment comprised of only oral medications, diet and exercise, which were repetitive in nature and there was no criticality or emergency for this type of illness. However, since the Company has already settled the claim, this Forum would not like to go into the issue of admissibility of the claim or otherwise. It is to be noted that Smt. Shah's husband, Shri Ratilal Shah was also admitted to the same hospital during the same period for a similar disease and the same line of treatment was given

As regards non-settlement of Rs. 2,550/- towards acupressure/acupuncture, reiki sujoke etc. the contention of the Insurance Company for non-settlement is justified.

Mumbai Ombudsman Centre
Case No. : GI- 733 of 2006-2007
Smt. Maherah Hashmi
Vs
The New India Assurance Co. Ltd.

Award Dated : 30.07.07

Smt. Maherah Hashmi suffered from vague abdominal pain for which she was advised Endoscopy. She therefore, got admitted to Lilavati Hospital under Dr. D.R. Kulkarni on 17th July 2006. She was treated and discharged on 18th July, 2006. The claim lodged by the Insured was rejected by the TPA under exclusion clause 4.10. She therefore, approached this Forum for the intervention of the Ombudsman in the matter.

On examination of the hospital papers submitted to this Forum, it is noted that Smt. Hashmi, 61 years was admitted to Lilavati Hospital with complaints of pain in upper abdomen, no vomiting /nausea, pain increased after food, no h/o Malena, H/o Liver disease. Upper GI endoscopy was done which showed antral gastritis and she was put on conservative management.

The Company felt that the procedure for which she was hospitalized was an investigative procedure which could have been done on OPD basis and the treatment that followed did not require hospitalization. Smt. Hashmi contested this decision of the TPA Company and argued that in her case the Endoscopy was done under general anaesthesia and therefore hospitalization was justified.

Records submitted to this Forum have been perused and it is observed that there is no mention in the hospital papers that the said procedure has been done under G.A. In fact the hospital bill also does not reflect anaesthetist's charges at all. The certificate of Dr. D.R. Kulkarni of Lilavati Hospital subsequently submitted by the Insured as per Company's requirement only mentions that Smt. Hashmi suffered from vague abdominal pain for which she was advised to get an endoscopy done. It does not mention that endoscopy was done under GA. However, looking to the notings in the discharge card – "Advised anti liver management and OGD scopy" and the papers relating to the treatment taken prior to hospitalization on OPD basis and the complexity of the stomach problem the patient was passing through , the hospitalization is justified.

Mumbai Ombudsman Centre
Case No. : GI- 346 of 2006-2007
Shri Shrikant V. Godbole
Vs
The New India Assurance Co. Ltd.

Award Dated : 30.07.07

Shri Ajey S. Godbole took an Individual Mediclaim Policy for the first time from 15/12/2005 for a S.I. of Rs. 1 lakh.. During the currency of the policy, Shri Godbole was hospitalized at Sanjeevan Hospital on 7/3/2006 for complaints of jaundice, pain in abdomen, Nausea and Vomitting. He developed portal hypertension and he expired in the ICU on 12/3/2006 due to later development of ARDS, Cellulitis, Liver Cirrhosis, Septicemia and Shock. The hospitalization claim lodged by his father, Shri Shrikant V. Godbole was repudiated by the TPA under exclusion 4.8 as Indoor case papers noted history of alcohol intake.

Analysis of the case reveals that Shri Ajey Godbole, aged 35yrs, resident of Mumbai, was admitted with history of Anorexia, weakness, yellowish discolouration of sclera with associated complaints of distension of abdomen, rash and itching all over body and Malena. It is mentioned that he took some ayurvedic treatment in Mumbai but since he did not get relief he was admitted to Sanjeevan Hospital, Pune on 7/3/2006 for further management. On 11/3/2006, he had sudden onset of dyspnoea, sweating dryness of mouth, hypotension and hence shifted to ICU. However, he did not respond to the treatment in the ICU and died on 12/3/2006.

One of the common cause for cirrhosis of liver is Alcohol consumption. In fact the various complications which the patient had during hospitalization for eg. Anorexia, Malena, Jaundice, rash and itching over the body may be due to liver problems. Other reasons for Cirrhosis of liver can be due to causes like: Cryptogenic (unknown), Viral hepatitis, chronic obstruction of bile duct, Alcohol, Malnutrition, Food contaminant, Immunological Causes, Cardiac Cirrhosis, Wilsons disease, Metabolic and inherited disorders etc. Since nowhere in the medical reports it was categorically mentioned that Shri Godbole had alcoholic cirrhosis of liver, it would be unfair to reject the claim on the grounds of alcoholism. His cirrhosis of liver could have been due to unknown cause or any other cause as mentioned above. The noting in the hospital records reads as under :

“ A 35 yrs M / ? Alcoholic/ not a known case of any major illness in past admitted with (Resident of Mumbai) h/o - Anorexia – weakness – Yellowish discolouration of sclera since one month”.

From the records submitted there is no conclusive evidence that cirrhosis of liver in this case was due to alcohol. The Insurer has not brought on record any material to establish that the Insured was alcoholic. The Insured is therefore, entitled to benefit of doubt and therefore the decision of the Insurance Company to repudiate the claim is not sustainable.

Mumbai Ombudsman Centre
Case No. : GI- 164 of 2006-2007
Shri M.G. Subramanian
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.07.07

Shri M.G. Subramaniam took a Mediclaim Policy w.e.f. 28/3/2005 for a S.I. of Rs. 3 lakhs for himself, Rs. 1 lakh for his wife and Rs. 50,000/- each for his two daughters. The policy was issued with exclusion of Cataract for Shri Subramanian on the basis of pre-insurance medical reports.

Shri Subramaniam was hospitalized at Divine Brain-Spine Hospital & Trauma Centre on 1/2/2006 with complaints of giddiness and headache since 2 days. The claim lodged by Shri Subramaniam for Rs. 6,800/- was rejected by the TPA under exclusion 4.10.

On scrutiny of the papers submitted to this Forum, it is noted that Shri Subramaniam consulted Dr. Dinesh Shetty, MD,MS, Mch,Consultant Neuro Surgeon at Divine Brain-Spine Hospital & Trauma Centre on 1/2/2006 with complaints of heaviness since 10-15 days. Notings in the prescription sheet were " No vomiting/convulsion, G.C. Fair Vitals Normal, Fully conscious, No focal neuro deficit. To rule out chronic SDH (subdural haematoma) advised MRI Brain. Admit in General Ward and he was prescribed two Tablets - Voveran and Alprox Plus for 7 days.

He was hospitalized at the said hospital from 1/2/2006 to 2/2/2006 and the diagnosis as per discharge card was TIA (Transient Ischaemic Attack) with varicose veins of both lower limbs. During hospitalization he was prescribed two tablets - Tab. Ecospirin and Tab. Neurobion Forte and MRI Scan was done which was normal. The Company repudiated the claim under exclusion 4.10, but Shri Subramaniam did not appreciate this decision of the TPA and he argued that without admission to the hospital and investigations, the exact diagnosis cannot be made by the doctor and therefore admission was necessary.

It has to be noted that the Mediclaim Insurance Policy is guided by the basic preamble which clearly says that upon the advice of a duly qualified physician/ medical specialist/ medical practitioner if expenses are incurred due to hospitalisation for medical/surgical treatment at any nursing home /hospital in India as an inpatient, it would be payable. In the present case there was a recommendation for admission by his treating doctor, Dr. Shetty . However, the notings in the discharge card is clear that he was admitted for investigating the cause of his presenting complaints and rule out SDH. Moreover, if we look at the hospitalization bill, it is noted that the major expense is pertaining to MRI of Rs. 5000/- and hospitalization expenses and consultation charges are only Rs. 700/- and Rs. 300/- respectively.

In view of the foregoing, the Insurer's contention that hospitalization was only for investigation purpose cannot be faulted.

Mumbai Ombudsman Centre
Case No. : GI- 823 of 2006-2007
Shri Bhavesh S. Ajmera
Vs
United India Insurance Co. Ltd.

Award Dated : 31.07.07

Shri Bhavesh Ajmera was covered under the Mediclaim Policy since 2001 for a S.I. of Rs. 2 lakhs. In the year 2003 he increased his S.I. to Rs. 4 lakhs. His present Policy No.020700/48/05/00224 (Prd. 19/4/2005-06) under which a claim arose showed S.I. as under (i.e. Rs. 2 lakhs with 20% CB and Rs. 2 lakh with 10% CB.) Shri Bhavesh Ajmera underwent CAG and CABG at Lilavati Hospital on 24/2/2006 – 26/2/2006 under a package scheme as follows - CAG Package Amount Rs.20,000/- and CABG Package amount Rs. 1,06,000/-. He submitted a hospital bill to the tune of Rs. 2,96,585/-, out of which the TPA settled an amount of Rs. 2,57,176/- thereby disallowing Rs. 39,409/-.

The main dispute is in respect of disallowance of Rs. 11,793/- and Rs. 27,616/- The Insured mentioned that Rs. 11,793/- was in respect of medicines which was administered to him as a special case and not inclusive in the package amount. Necessary clarification to this effect was obtained by him from the hospital which was submitted to the TPA. Yet they did not agree to reconsider it. It is noted from the Pharmacy details that bifurcation of this amount was as under :

- 3 Nos. Aggribloc Infusion costing Rs. 3850/- per unit

- cost of syringe and accessories Rs. 243/-.

In the clarification by the hospital it was stated that this infusion was not required in every patient and hence was not the part of the package charges and have been charged separately. Since there is a proper substantiation for this amount, it is felt that it should be made admissible.

The other expense of Rs. 27,616/- which was disallowed by the Company was in respect of OT material aggregating to Rs. 1,83,574. On scrutiny of the above bill for Rs. 1,83,574/- it is observed that the Company has allowed the Iomeron expenses and Balloon Catheter expenses but allowed the stent expenses partially. The Complainant mentioned that the TPA considered the cost of regular/non-medicated stent of Rs. 67,000/- (package costing was between Rs. 30,000/- to Rs. 67,000/-) instead of the medicated stent. Since this Forum was not provided with the surgical notes of the hospital to confirm that medicated stents were used during the surgery, the TPA may reimburse the expenses allowed under this head after confirmation of the same from the CABG operative notes of the hospital.

As regards payment of Rs. 1,400/-, the complainant may submit the relevant documents to the TPA directly to enable them to process and reimburse the same.

Mumbai Ombudsman Centre
Case No. : GI-718 of 2006-2007
Smt. Bharti K. Madhu
V/s
The New India Assurance Co. Ltd.

Award Dated : 31.07.07

Smt. Bharti K. Madhu, was covered under the Mediclaim policy issued by The New India Assurance Co. Ltd., for a Sum Insured of Rs. 1.00 lac with Cumulative Bonus of 35% with no exclusions. She was covered under the Mediclaim policy since 28.1.1998. Smt. Bharti K. Madhu, was hospitalized at Datt Maternity & Surgical Nursing Home. During Hospitalisation, she underwent D&C, RT, Diagnosticscopy followed by Expl. Lap. Myomectomy & Rt. Cystectomy with adhesiolysis under GA as per the discharge card of the hospital and the diagnosis was Secondary Infertility. When a claim was preferred by Smt. Madhu for Rs.58,611/- for the said hospitalization, the TPA of the Company, M/s TTK Healthcare Services rejected the claim vide their letter dated 27.3.2006 under Exclusion Clause 4.8 of the Mediclaim Policy. Not satisfied with the decision of the Company, she represented to the Grievance Cell of the Company and the TPA on 24.4.2006, enclosing a certificate issued by Dr. B.M. Inamdar, Datt Maternity Hospital certifying that though she initially approached for Secondary Infertility, in view of her pain and mass in the pelvis no treatment was given for Secondary Infertility and, she was operated for diagnosis of Fibrod (multiple) with Endometiosis Gr.IV. New India Assurance Co. repudiated the claim under Exclusion Clause 4.12 of the policy and the TPA also regretted to pay the claim stating that there were no signs and symptoms like pain dysmenorrhoea/menorrhagia and reiterated their earlier stand in rejecting the claim.

Aggrieved by the decision of the Company, Smt. Madhu,, approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman.

An analysis of the case reveals that as per the discharge card, although the diagnosis was Secondary Infertility, in the operative notes it is mentioned Fibroid + Endometriosis Gr.IV for which D&C was done. She had also undergone Ultrasound of Pelvis prior to hospitalization on 9.12,2005, which showed presence of fibroids, and the treating doctor, Dr. B.M. Inamdar, has clarified in his certificate, that though she initially approached for Secondary Infertility, in view of her pain and mass in the pelvis no treatment was given for Secondary Infertility and she was operated for diagnosis of Fibroid (multiple) with Endometiosis Gr.IV. Further, he has stated that Secondary Infertility was abandoned in favour of treatment of Fibroid & Endometiosis Gr.IV which was a much more serious diagnosis.It is also noted that during hospitalization, the specimen of Multiple Fibroids were sent for Histopathology test on 25.1.2006 and as per the Histopathology report "There were three fibroids measuring 1.5 to 3 cm in diam. C/s shows watered silk appearance. Three is an ovarian cyst measuring 3 cm. in diam. C/s shows blood clot". Though the diagnosis was mentioned as 'Secondary Infertility' in the post-operative record of the hospital, the various reports on record and the operative notes reveal that she underwent D&C, RT, Diagnostic Scopy followed by Expl. Lap. Myomectomy & Rt. Cystectomy with Adhesiolysis under GA. The treating doctor has also clarified the treatment given in his certificate. Based on the facts and circumstances, the repudiation of the claim is not tenable .The New India Assurance Co. Ltd., is directed to settle the admissible expenses as per the bill raised by Datt Maternity Hospital, in respect of hospitalization of Smt. Bharati Madhu.

Mumbai Ombudsman Centre
Case No. : GI-677 of 2006-2007
Shri C.R. Naik
V/s
The Oriental Insurance Company Limited

Award Dated : 04.07.07

Smt. Rekha Naik, an employee of Oriental Insurance Company Ltd., alongwith her husband Shri C.R. Naik were covered under the Staff Mediclaim Policy. Shri C.R. Naik, reported in his complaint to this Forum that he slipped and fell at home on 22nd May, 2006 which led to tissue rupture in his left leg for which he underwent surgery at Punit Orthopaedic Surgical Hospital and was hospitalised from 1.6.2006 to 3.6.2006. He lodged a claim under Staff Medicalim Policy and under the Personal Accident Policy of the company. The hospitalization expenses were paid in full under the Mediclaim Policy. However, the claim under the Personal Accident Policy, T.T.D (Temporary Total Disability) claim was referred to Panel Doctor as it was beyond Rs.10,000/-.

Based on the above opinion the company repudiated the claim vide letter dated 21st September, 2006. Smt. Naik, represented to the company vide letter dated 26.9.2006 enclosing a certificate by Dr. Ramesh Patel (Orthopaedic Surgeon), stating that the injury was due to slip while walking on slippery road. It had no direct relation with previous injection taken. However, the company maintained their stand of repudiation, stating that the claim does not meet the terms and conditions of the Personal Accident Policy. The company had referred the matter to Dr. L.N. Vora, Orthopaedic Specialist and he had stated that the Insured had seen Dr. Parelkar on 26.5.2005 and Dr. Patel on 30.5.2006. There is no mention of fall by Dr. Parelkar. Last local injection taken on 13.4.2006. Local injection is known to predispose to tendon rupture. There is no treatment for four days after injury. There is no injury and injury cannot be

proximate cause. The Insured in his complaint to this Forum and in the representation reported that the tissue rupture was on account of accident while walking at his residence. The complainant produced a certificate from Dr. R.K. Patel, Punit Orthopaedic Surgical Hospital dated 26.9.2006 which states that rupture of Calcaneal Tendon was due to slip while walking on slippery road. Tear of tandon is directly due to injury occurred due to slip. It has no direct relation with previous injection taken elsewhere. However, this certificate was issued after rejection of the claim. The first prescription dated 26.5.2006 of Mandapeshwar Hospital does not mention the history of fall. The Insured had polio in the right leg leading to greater stress and instability on the affected leg. As per opinion of Dr. Kamath, Panel Doctor and Dr. L.N. Vora, Orthopaedic Specialist the injections in the heel have contributed to weakening of the ligament and its subsequent rupture and the cause of disability did not solely and directly arise out of the incident of slipping. In view of the circumstances and based on the opinion of both the doctors, Dr. M.S. Kamath, Panel Doctor and Dr. L.N. Vora, Orthopaedic Surgeon the underlying reasons indicate more towards weakening of the ligament and greater stress on the affected leg and the disability did not arise solely and directly out of the incident of slipping. Under the circumstances, I do not find justifiable reasons to interfere with the decision of the Insurance Company.

Mumbai Ombudsman Centre
Case No. : GI-19 of 2004-2005
Shri Bomi Hormusji Irani
V/s
The New India Assurance Co.Ltd.

Award Dated : 31.08.07

Shri Bomi H.Irani along with his wife was covered under a Mediclaim Policy of The New India Assurance Co.Ltd. Smt. Irani was admitted in Bombay Hospital the diagnosis was Lumbar Canal Stenosis L3-4, L4-5. Shri Bomi H.Irani preferred a claim of Rs.3,83,067/- to M/s TTK Healthcare Services Pvt. Ltd.,. After scrutiny of the documents, M/s TTK settled the claim for Rs.1,26,780/-, disallowing Rs.2,56,287/-. Not satisfied with the partial settlement , Shri Irani represented to the TPA as well as to the company stating that Rs. 2,50,000/- paid by him to Dr.Turel should be reimbursed by the company, he also submitted a letter from the treating doctor, Dr. Keki E. Turel. The Company referred the matter to Expert Medicolegal Consultant who was of the opinion that the doctors charge was already included in the bill produced from the hospital hence the additional surgeon's fees paid by the insured should not be borne by the company. Aggrieved by the reply from the Company, Shri Bomi Irani represented to the Insurance Ombudsman.

Shri Bomi Irani preferred a claim for his wife's hospitalisation at Bombay Hospital for Microsurgical Internal Decompression for Spinal Stenosis L4-5, L5 SI. The dispute is regarding non-settlement of Rs.2,50,000/- surgeon's fees charged by Dr.Keki E.Turel. The contention of the company was that as the hospital bill had already charged Rs.35,000/- under the head surgeon's fees, the additional fees of Rs.2,50,000/- paid by the insured to the doctor should be borne by the insured himself. The insurance company is not liable for such payment. As against company's contention, the Insured, Shri Bomi Irani stated that for a simple surgery like Appendicitis costs around Rs.20,000 to Rs.30,000/- , his wife had undergone a major operation which requires expert skill of the doctor hence a mere amount of Rs.35,000/- settled by the company under surgeon's fees was not acceptable to him. Shri Irani submitted a receipt of Rs.2,50,000/- from Dr.Keki E.Turel to the company as advised by them. Hence the contention of the company that the bill submitted by the claimant was not authentic and

without any revenue stamp does not hold water. Despite clarification given by Dr.Turel, the Company informed him that surgeon's fee charged by the hospital was reimbursed by them and it would not be possible to pay again for the same purpose and treatment. It emerges from the above, that while the hospital has billed Rs.35,000/- towards surgeon's fees, Dr. Turel has issued a separate receipt for Rs.2,50,000/- towards his professional fee. The surgeons fees has been raised by the hospital and the party also submitted an extra receipt from the treating surgeon. In fact the fee should have been raised through the hospital bill as per the policy. In such cases, when the Complainant start negotiating with surgeons' it will be very difficult to assess the reasonable fee. In view of this, the contention of the Insurance Company seems to be logical. However, looking to the spinal surgery conducted in this case, I am inclined to take a lenient view in this case and direct the company to reimburse the surgeon's fee after deducting Rs.35,000/- charged by the hospital to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI-896 of 2006-2007
Shri Mukesh R.Soni
V/s.
United India Insurance Co. Ltd.

Award Dated : 31.08.07

The brief facts of the case as per complaint to the Insurance Ombudsman are as under:

Shri Mukesh R.Soni alongwith his family members were insured under a Mediclaim policy issued by United India Insurance Co. Ltd., The policy was issued without any exclusions. He renewed the policy continuously without any break. Smt.Bharati Soni, wife of Shri Mukesh R.Soni, hospitalised at Vinayak Maternity & General Hospital, for the treatment of Dysfunctional Uterine bleeding (DUB), TCRE + Endometrial ablation using Thermachoice Balloon Therapy. The TPA –M/s Family Health Plan Ltd. sanctioned an amount of Rs.27,435/- towards cashless facility. Shri Soni preferred a claim for Rs.36,685/- in respect of his wife's hospitalisation and the TPA reimbursed Rs.4185/- towards cost of medicines, disallowing an amount of Rs.32,500/- towards cost of Thermachoice Uterine Balloon. They disallowed the same by stating that Thermachoice Uterine Balloon is not a disposable material, it can be reused for other patients. Not agreeing with the decision of the TPA, Shri Soni represented to the company with his grievance. Shri Soni approached the Insurance Ombudsman with a pray that the company should settle the cost of the Thermachoice Uterine Balloon.

The complaint for which the insured, Shri Mukesh R.Soni, approached this Forum was for reimbursement of the cost of Thermachoice Uterine Balloon which according to him was purchased as per the advice of the treating doctor. The contention of the Company/TPA was that Thermachoice Uterine Balloon can be reused for other patients hence its cost is not payable. The insured, Shri Soni has produced a text 'Gynecare Worldwide Edition' in which under 'instruction for use' it has mentioned that 'Thermal Balloon Ablation Silicone Catheter and Syringe (Single-use)' and under 'Warnings' it has stated that 'The Gynecare Thermachoice III UBT Balloon Catheter is for single use only'. It is a known fact that the catheter or syringe once used cannot be reused to other patients, hence the stand taken by the TPA to reject the cost of TUB is not correct and insured Shri Soni is liable to get the cost of Thermachoice Uterine Balloon.

Mumbai Ombudsman Centre
Case No. : GI-826 of 2006-2007
Smt. Lilawati Dubey

V/s

The New India Assurance Co.Ltd.

Award Dated : 16.08.07

Smt Lilawati Dubey along with her grandson Mast. Gautam were insured under a mediclaim policy of the New India Assurance Co. Ltd., Divisional Office 141700. Smt. Lilawati Dubey preferred a claim for her hospitalisation at Dr.Bhute Nursing Home from 14.08.2006 to 24.08.2006 and from 16.12.2006 to 23.12.2006 for Falciparam Malaria c enteric fever c platelets shut down c Hemolysis. When she preferred a claim for her hospitalisation, the TPA appointed an investigator to investigate the genuineness of the claim. M/s Decent Investigators, the investigating agency submitted their report dated 04.03.2007 and after getting the same the TPA M/s.Paramount Health Services Pvt.Ltd. informed the insured on 24.03.2007 that as per investigation report the claim made for hospitalisation

falls under Exclusion Clause 5.7 of the mediclaim policy. She approached the Insurance Ombudsman with her grievance.

On 14.08.2006, she was admitted for first time to Dr.Bhute Nursing Home and at the time of admission she deposited Rs.10,000/- to the hospital and in turn the hospital issued a receipt under receipt no.441 to her. After taking treatment, she was discharged on 24.08.2006 and the hospital issued a total bill of Rs.38,110/- showing deposit as Rs.1000/- under receipt no.329. Smt. Dubey was again admitted to the same hospital on 16.12.2006 and at the time of admission, she deposited Rs.5,000/- which was confirmed by the hospital by issuing a receipt no.319. On 23.12.2006, the date of discharge, the hospital issued a total bill of Rs.22,165/- under receipt no. 398 showing the deposit as nil. Smt. Dubey has produced the bills to the company for the total amount paid by her during her hospitalisation. The contention of the investigator that the amount of Rs.22,165/- claimed twice by Smt Dubey by submitting two different bills does not hold water because even though she had submitted the bills of different dates and receipt nos. the amount claimed by her was same. The stand taken by the company that Dr.Bhute Nursing Home was under scanner for some fraudulent cases hence the bills produced by Smt. Dubey was also of fraudulent nature is not correct as they have not produced any cogent evidence to prove that the insured had fraudulently submitted the bills. The allegation of fraud is subject to strict proof of suppression of material information affecting the very basis of claim by which the insurer would have been made to suffer. On scrutinizing the bills, it can be seen that the bills submitted by Smt.Dubey was of the expenses incurred by her during her hospitalisation, even though there is difference in the receipt no. the amount claimed by her was same. From this it is clear that the insured does not have any intention of suppressing the material fact and causing any harm to the insurer i.e. company, she had claimed the amount paid by her to the hospital. It is to be noted that Smt. Dubey was hospitalized and treatment was taken as per treating doctor's advice.In the facts and circumstances, the claim of Smt. Lilawati Dubey for reimbursement of expenses incurred by her for her hospitalisation at Dr.Bhute Nursing Home is sustainable.

Mumbai Ombudsman Centre

Case No. : GI-573 of 2006-2007

Shri Harish N Thakkar

V/s.

The New India Assurance Company Limited

Award Dated : 08.08.07

Shri Harish N Thakkar, was covered under Mediclaim Policy for the period 25.02.2005 to 24.02.2006. Shri Thakkar was hospitalized on 26.11.2005 at the Lilavati Hospital in

Mumbai for Left Frontal Lobe Fraction with Bilateral Narrowing with accelerated HTN with Hypermatrimia and was discharged on 11.12.2005. When Shri Thakkar preferred a claim for the said hospitalisation with The New India Assurance Company Limited, the Insurer rejected the claim by invoking clause 4.1 of the mediclaim policy. Their contention was that Hypertension was since 20 years which was the proximate cause for the present ailment. Aggrieved, he approached this Forum seeking intervention of the Insurance Ombudsman for settlement of his claim.

The issue before this Forum would be to examine how far the claim, of the Insured that he was hypertensive since 20 months to 2 years and not 20 years, would be tenable. It is commonly observed that while mentioning the duration of illness, generally, it is mentioned in number of months (if the duration is of a lesser period) or in number of years , if the duration is more than a year. The rejection of the claim, by the Insurer, is based on the duration of the illness given in the discharge card and preauthorization request, which was subsequently corrected by the doctor through another letter. The Insurer has not produced any cogent evidence to prove the history of Hypertension. Taking all the above facts and circumstances into consideration, the total rejection of the claim by the New India Assurance Company is not justified and 90% of the claim was allowed to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI-895 of 2006-2007
Shri Jagdish Narayan Salian
V/s
The United India Insurance Company Limited

Award Dated : 10.08.07

Shri Jagdish Salian was covered under Mediclaim Policy. Shri Salian was hospitalized on 28.9.2006 for treatment of L4 – L5 Disc and was discharged on 9.10.2006. When Shri Salian preferred a claim for the said hospitalisation with The United India Insurance Company Limited, they repudiated the claim by invoking clause 4.1 of the mediclaim policy. Their contention was that as per the Indoor Case Papers submitted, Shri Salian had backache since 3–4 years and the present hospitalization is for the management of an ailment which is pre existing. Hence, being aggrieved, Shri Salian approached this Forum, vide letter dated 14.3.2007, seeking intervention of the Insurance Ombudsman for settlement of his claim.

Records have been perused and the parties to the dispute were called for hearing on 30 July, 2007, which was attended only by the complainant. Shri Jagdish Narayan Salian appeared and submitted that a few months before the surgery, while he was playing Volleyball, he fell down accidentally, when the doctor checked and said there was no problem with his disc. However, after 15 days, he could not get up or move his leg due to severe back pain An MRI was taken at the Hospital and the doctor advised for immediate surgery, which he underwent. He requested for payment of his claim. Subsequent to the hearing, Shri Salian submitted treatment papers which confirmed his fall while playing volleyball. The issue before this Forum was to examine how far the claim, of the Insured that he was suffering from backache from 3 – 4 days and not 3 - 4 years, would be tenable. The MRI of Shri Salian supported the same fact. A study of the MRI dated 29.9.2006 did not reveal any chronicity or acuteness of backache. . The burden of proof was on the Company to establish beyond doubt that the disease was pre-existing , which they had not done.

The repudiation of the claim was therefore, set aside.

Mumbai Ombudsman Centre
Case No. : GI-621 of 2006-2007
Shri Deepak Ratilal Panchal
V/s
The New India Asurance Company Limited

Award Dated : 13.08.07

Shri Deepak Ratilal Panchal and his family were covered under Mediclaim Policy No. 111200/40/04/85553 for the period 9.1.2005 to 8.1.2006. Smt. Panchal was hospitalized for treatment of Pemphigus Vulgaris, a skin ailment, When Shri Panchal preferred a claim for the same with the Insurer, they repudiated the claim by invoking clause 4.1 of the mediclaim policy. Their contention was that as per the Indoor Case Papers submitted, Smt.Panchal was a known case of Pemphigus Vulgaris since two years and hence it was pre-existing. Aggrieved, Shri Panchal approached this Forum, seeking intervention of the Insurance Ombudsman for settlement of his claim.

Parties to the dispute were called for hearing on 6th August, 2007. Shri Deepak R Panchal, along with his wife, appeared and deposed before the Ombudsman. He stated that his wife suffered from the said disease for 4 – 5 months only. Shri Panchal said that his wife was confused due to sudden entry of the doctor when she was not mentally prepared for such examination and she blurted out that she was suffering from the said disease since two years. Shri K N Vaja represented the Insurer. He submitted that the Company had rejected Shri Panchal's claim under the exclusion clause 4.1 . According to hospital Indoor Case Papers, Smt.Panchal was mentioned as a known case of Pemphigus Vulgaris since 2 years.

Shri Panchal's contention during the hearing that his wife was confused and hence she could not report the correct history of the disease, is not convincing. Also, this Forum is unable to find any justifiable reason for such a long period of hospitalization However, the New India Assurance Company have solely relied on the Indoor Case Papers for determining the duration of illness and no other conclusive evidence has been provided to establish the duration of the illness. The repudiation of the claim, in total, is, therefore, not sustainable. Hence, 50% of the admissible expenses was granted.

Mumbai Ombudsman Centre
Case No. : GI-629 of 2006-2007
Smt. Rukmani K. Thakker
V/s
The New India Assurance Company Ltd.

Award Dated : 08.08.07

Shri K. P. Thakker alongwith his wife Smt. Rukmani K. Thakker was covered under Mediclaim Policy issued by The New India Assurance Company Limited, D.O. 130800 under the Senior Citizens' Unit Plan 11419 Membership Certificate No. 93100100255 by Unit Trust of India for their Members (UTI – SCUP).

Shri K.P. Thakker was suffering from Weakness of right side of the body and his wife Smt. Rukmani Thakker was suffering from Pain in both knee and wrist with occasional swelling, Constipation and Obesity. They took oral medicine treatment of Arya Vidhya Sala, Matunga, Mumbai and as per Doctor's both of them were admitted to Vaidyaratnam P.S.Varier's Kottakkal Arya Vaidya Sala, Kerala for 1 month. Claim was

rejected stating “the treatment taken by the Insured is similar to Naturopathy and same is under exclusion and not payable under the UTI - SUCP Policy”.

They approached the Insurance Ombudsman for justice.

Complainant submits that the hospital at Kerala is full fledged hospital and even foreigners are taking treatment. Scrutiny of the file reveals Shri Thakker was suffering from Paralysis and Smt. Thakker was suffering from Arthritis and Obesity. Thus in both cases the disease was already diagnosed. Hospitalisation is required depending upon the condition of the patient and the seriousness of the problem. The Insured was hospitalized for 32 days in Arya Vaidya Sala, Kottakal, Kerala with many faceted curriculum including yoga, morning walk, ultrasonic treatment, body massage, etc. which took such a long time.

Under the circumstances, the decision of the company to repudiate the claim stating that the treatment taken is a rejuvenation treatment similar to naturopathy is tenable.

Mumbai Ombudsman Centre
Case No. : GI – 568 of 2006-2007
Smt. Vaishali S. Shinde
VS.
The New India Assurance Co.Ltd.

Award Dated : 21.08.2007

Smt. Vaishali S. Shinde was covered under the Mediclaim Policy No.111900/48/05/77741 alongwith her husband for a period 16.07.2005 to 15.07.2006 for sum insured Rs.1,00,000/- with C.B. 20% each. The inception of the policy was from the year 2001. She was admitted to Bombay Hospital Institute of Medical Sciences from 21.12.2005 to 06.01.2006 and underwent an operation for Fibrous Dysplasia of Frontal Bone. The TPA, M/s TTK Healthcare Services Pvt. Ltd. repudiated the claim under exclusion clause 4.8 and 4.1.

Shri Shankar Shinde stated that his wife, Smt. Vaishali started getting a swelling on her forehead during the period November 2005, near her left eye. They thought it was an eye infection so they consulted Dr. R.C. Patel an Eye Specialist. They were advised by Dr. Patel to consult an Orthopedic Specialist for which Dr. Pradhan was consulted. She was then admitted to Bombay Hospital for further investigations and tests. It was diagnosed for Fibrous Dysplasia of Frontal Bone and operated. As the swelling was serious and painful leading to closure of eyelid and would have caused damage to eye, they decided to go for an operation with Doctor’s advise. He stated that even when he was asked to submit his wife’s earlier photograph, he submitted the same. There was no deformity. He requested for the settlement of the claim

M/s TTK Healthcare Services Pvt. Ltd. Dr.Gajanan Kagalkar stated that this swelling was pre-existing. From the discharge summary of Bombay Hospital - the History & examination/findings are noted as “swelling over upper lid - 2 years and in the next sentence it was mentioned that swelling during pregnancy. Her pregnancy was during the year 2003 and this indicates that she had this swelling over 3 years. The TTK in their letter dated 25.08.2006 to the party has observed that the photograph of October, 2000 given shows gross swelling over left upper eye lid with asymmetrical face, which is pre-existing to policy. In view of this TPA treated the ailment as preexisting and repudiated the claim under clause 4.8. and 4.1.

Let us examine whether the exclusion clauses 4.8 & 4.1 applies to the claim submitted by the Complainant “Congenital external disease or defects”. Other than the photograph of 2000, no other evidence was produced by the Company to prove Fibrous Dysplasia of Frontal bone as congenital problem. In the Discharge Summary of Bombay Hospital - History & Examination/Findings it is mentioned as “Swelling over upper lid – 2 years & swelling during pregnancy. The photograph does indicate some swelling over the left upper eye lid. The contention of the Complainant that the Insurer should have investigated and then insured a person is not tenable, as it is a contract of utmost good faith and there should be full disclosure of the facts in the proposal form. However, since the swelling in the eye lid can be due to many reasons, the Insured was perhaps not aware of the problem of the Frontal Bone. In view of this, I am inclined to give the benefit of doubt to the Insured and to strike a balance it will be appropriate to allow 80% of the admissible expenses in this case to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI-334 of 2006-2007
Shri Anil Bhagwandas Soni
V/s.
The New India Assurance Co.Ltd.

Award Dated : 06.08.2007

Shri Anil Bhagwandas Soni had a mediclaim Policy No.111400/48/05/70062431. for sum insured Rs.3,00,000/- with C.B. 25%. His dispute with the Company was the quantum of claim settlement. He was admitted to Netrajyoti Eye Care Centre, Mumbai on 20.06.2006 and had a cataract surgery for the left eye. He was discharged on the same day. The amount billed by the Hospital was for Rs.37,000/-. A sum of Rs.21,500/- was settled by the Company as Cashless directly to the hospital. The company refused to pay the balance amount of Rs.15,500/- which he has paid to the hospital.

Shri Anil Bhagwandas Soni appeared and deposed before the Ombudsman. He submitted that he had a policy with The New India Assurance Co. Ltd. He underwent an operation for Cataract for which a sum of Rs.37,000/- was billed. A sum of Rs.21,500/- was paid by the Company directly to the hospital. The balance amount of Rs.15,500/- was paid by him. He has demanded that the Company reimburse him the amount of Rs.15,500/-.

Shri A.B. Soni underwent cataract surgery for left eye on 20.05.2006 for which an amount of Rs.37,000/- was billed by Netrajyoti Eyecare Centre vide their bill No.256. An amount of Rs.21,500/- as cashless was settled directly by the TPA to the hospital. A further amount of Rs.3,423/- was also settled to the insured. The balance amount of Rs.15,500/- was paid directly by the Insured to the hospital. The dispute is regarding the balance amount of Rs.15,500/-. The New India Assurance Co. Ltd. repudiated the claim vide their letter dated 19.12.2006 for the balance amount of Rs.15,500/- . As per the Authorization letter dated 20.05.2006 from the TPA - M/s. TTK Healthcare Services Pvt. Ltd., addressed to Netrajyoti Eye Care Centre, a sum of Rs.21,500 was the authorized limit for the cataract operation with remarks as “Authorized as per available package. No further enhancement”. This authorization letter has been signed by Shri Anil Bhagwandas Soni before discharge from the hospital. Shri Soni is aware of the limit to be paid as cashless by the company directly to the hospital.

The Company is justified in repudiating the claim

Mumbai Ombudsman Centre
Case No. : GI-713 of 2006-2007
Shri Pratap Rijhsinghani
V/s.
Oriental Insurance Company Ltd.

Award Dated : 07.08.2007

Shri Pratap Rijhsinghani had a mediclaim Policy No.121200/48/06/4807 for sum insured of Rs.65,000/- with C.B. Rs.9750/-. He was admitted to Lilavati Hospital & Research Centre and was operated for Lumber Canal Stenosis He submitted a claim to the Company for payment. The TPA, M/s Raksha repudiated his claim for the reason that PID and its related disorders are exclusion in the policy. Hence the claim is repudiated under clause 4.1. of the policy terms and conditions.

Shri Pratap Rijhsinghani submitted that he underwent an operation for Lumber Canal Stenosis and was admitted to Lilavati Hospital & Research Centre and was operated. He submitted a claim to the Insurer and it was refused stating PID & related disorder was excluded from the policy. He stated that he underwent an operation for PID in the year 1960 i.e. more than 45 years back. Even the Insurance Companies recently have changed the exclusion clause for any preexisting diseases to 4 years. He stated that since he had the previous operation 45 years back, the Insurer should pay the claim.

On analysis of the case Shri Pratp Rijhsinghani had first taken out a mediclaim policy with the Insurer on 23.12.1997 for sum insured Rs.65,000/-, wherein he had declared that he was operated for PID in 1960 (37 years back). In his policy document, PID and its related disorders were the exclusions. Two claims were settled for period 9.9.2000 for an amount of Rs.8,217/- for prostate gland and in 2000-20001, Rs.5,450 for fracture. He was admitted to Lilavati Hospital & Research Centre from 26.02.2006 to 01.03.2006 and was operated for Lumber Canal Stenosis on 27.02.2006. He submitted his claim to the Company which was repudiated by Raksha TPA vide their letter dated 24.07.2006 under Exclusion clause No.4.1 which states “all diseases/injuries, which are pre-existing when the cover incepts for the first time, is not payable”.

Looking to the medical history of the insured, Shri Rijhsinghani had an operation of the spine in the year 1960 i.e. more than 45 years before the second operation was performed. He first took out the policy in the year 1997 i.e. 37 years after his first operation and in all good faith declared about his first operation. Looking to the gap of 45 years between the two operations, it is clear that the insured was not suffering from the same condition/disease in the intermediate period. Consequently, though the policy condition excludes PID and its related disorders, I am inclined to take a lenient view and allow 100% claim as exgratia.

Mumbai Ombudsman Centre
Case No. : GI-638 of 2006-2007
Shri Suresh Kumar Gupta
V/s
National Insurance Co.Ltd.

Award Dated : 01.08.2007

Shri Suresh Kumar Gupta had purchased mediclaim policy No.260300/48/05/8500001895 for himself and his wife Smt. Anju Suresh Gupta and renewed the policy for next year. The Sum Insured is Rs.2,50,000/- each with C.B. Rs.12,500 for each. Smt. Anju Suresh Gupta was operated for piles on 13.02.2006 i.e.

within 15 months of inception of policy. Shri Suresh Kumar Gupta lodged a claim which was repudiated by Medicare TPA services (I) Pvt. Ltd on grounds of preexisting disease.

Smt. Anju Gupta was admitted to Agrawal Clinic on 13.02.2006 for operation of piles and discharged on 14.02.2006. The diagnosis given is – Sphinterectomy with excision of piles. The clinical note states - pain in peri anal region – sometime coming out – bleeding of rectum. A certificate issued by Dr. J.B. Agrawal, Consultant, states:

"This is to state that Mrs. Anju Gupta, female, aged 45 years was admitted in this hospital on 13.02.2006 at 9.00 A.M. and discharged on 14.02.2006 at 10.00 P.M. She came with the complaint of pain in peri anal region and something coming out and bleeding from rectum since about 3 to 4 months duration. She has undergone surgery of Sphinterectomy with excision of piles on 13.02.2006."

Sphincterectomy means the surgical removal of any sphincter muscle – the complete division of a sphincter. Spincter is a specialized ring of muscle that surrounds an orifice. Contractions of the sphincter partly or completely close the orifice. Sphincters are found, for example around the anus. Haemorrhoids (Piles) is usually a consequence of prolonged constipation or, occasionally, diarrhea. The main symptoms are bleeding – The first degree haemorrhoids, which never appear at the anus, bleeding at the end of defecation is the only symptom. Second degree haemorrhoids protrude beyond the anus as an uncomfortable swelling and return spontaneously. The third degree haemorrhoids remain outside the anus and need to be returned by pressure. The first and second degree haemorrhoids can be treated with high fibre diet. However the third degree haemorrhoids remain outside the anus and need to be returned by pressure. The third degree haemorrhoids often require surgery as they become painful and enlarged.In this case Smt. Anju Gupta underwent a surgery which proves that she was suffering from piles and reached the third stage which takes a long time.

In view of the above analysis, the decision of the Insurer to treat the ailment as pre-existing is tenable.

Mumbai Ombudsman Centre
Case No. : GI-646 of 2006-2007
Shri Mahesh M. Shah
V/s.
United India Insurance Co. Ltd.

Award Dated : 22.08.2007

Shri Mahesh M. Shah was covered under the Mediclaim Policy No.120100/48/03/11494 for a period 23.01.2004 to 22.01.2005, and Sum Insured for Rs.1,00,000 with C.B. Rs.10,000.. He was admitted to Navneet Memorial Hospital from 21.12.2004 to 29.12.2004 for heart problem. He submitted a claim to the Company and a claim of Rs.1,10,000 was settled. He renewed his medicalim policy No.120100/48/0412716 with the same Company from 23.01.2005 to 22.01.2006 He was admitted to The Asian Heart Institute during the period 02.02.2005 to 12.02.2005 and underwent a Bypass Surgery. He preferred a claim for treatment of Bypass Surgery with the Company for the period 02.02.2005 to 12.02.2005. The Third Party Administrator of the Company, M/s MedSave Health Care, Mumbai, repudiated the claim stating that since the second hospitalization has occurred within 45 days of the first admission the claim is to be registered under the previous policy. Since the sum insured is exhausted of the previous policy the claim is repudiated.

A clarification was sought from the Head Office of the United India Insurance Company Ltd., Chennai, vide letters dated 31.07.2007 and 17.08.2007. A reply dated 21.08.2007 was received from The General Manager, United India Insurance Co. Ltd., Head Office, Chennai, giving clarification to this particular clause 3.0 of the mediclaim policy terms and conditions

Shri Mahesh Shah first suffered a heart problem from 21.04.2004 to 29.12.2004. Thereafter, again within 35 days i.e. from 02.02.2005 to 12.02.2005 he was admitted to Asian Heart Institute and underwent Bypass surgery on 06.02.2005. The Company has treated the claim for the second hospitalization under the previous policy and since the sum insured was exhausted, the claim was repudiated. Based on the above clarification, the case is again referred back to the Insurer, as repudiation under clause 3 is not tenable.

Mumbai Ombudsman Centre
Case No. : GI- 613 of 2006-2007
Shri Hasnain Nanavati
V/s
Cholamandalam MS Gen. Insce. Co. Ltd.

Award Dated : 11.08.07

Shri Hasnain Nanavati and his family were covered under a Group Health Insurance Policy taken by his Employer from Cholamandalam MS General Insurance Co. Limited, bearing No. HWT 00000374-000-01 valid from 16/12/2005 and 15/12/2006 for SI of Rs. 1 lakh each. During the currency of the policy the Insured lodged a claim for reimbursement of expenses incurred by him for the treatment of his daughter for 'development Dysplasia of Hip'(DDH) at Johari Nursing Home from 3/5/2006 to 6/5/2006.. The Company rejected the claim as per opinion of their panel doctor stating that the ailment was congenital in nature and hence inadmissible as per the General exclusion C No. 24.

Analysis of the case reveals that Baby Mazina Nanavati, aged 3 yrs 10 months, daughter of Shri Hasnain Nanavati was admitted to Johari Nursing Home on 3/5/2006 for developmental dysplasia of left Hip and underwent surgery for the same. Shri Nanavati approached this Forum through his Employer – Prebon Yamane vide letter dated 12th December, 2006 with a complaint against Cholamandalam M.S. General Insurance Co. Ltd. for rejection of a claim lodged by him in respect of the above hospitalization . His claim for reimbursement expenses for treatment received at the above hospitals was rejected by the Company under Clause C-24 (Congenital Disease) of their Policy,

Following the repudiation of the claim, Shri Nanavati represented his case for reconsideration, supported by opinion from the treating surgeon. However, the Company reiterated their earlier stand. Let us examine what is a Developmental Dysplasia of the HIP ? " It is a congenital (present at birth) condition of the hip joint. It occurs once in every 1,000 live births. The hip joint is created as a ball and socket joint. In DDH , the hip socket may be shallow, letting the "ball" of the long leg bone also known as Femoral head, slip and out of the socket. The "ball" may move partially or completely out of the hip socket.

The medical reference on DDH convincingly proves that it is a congenital disorder which is excluded from the scope of the policy under clause C-24and therefore the rejection by the Company on this ground cannot be faulted.

Case No. : GI-939 of 2006-2007
Shri Vimal N. Shah
V/s.
The New India Assurance Co.Ltd.

Award Dated : 22.08.2007

Shri Vimal N. Shah alongwith his wife Smt. Nita V. Shah and their two children were covered under the mediclaim policy issued by The New India Assurance Company Limited, under Policy No.2131000/48/05/20/70057951 for sum Insured Rs.1,50,000/- each and for their children Rs.50,000/- each with C.B. 15%. Smt. Nita V. Shah was hospitalized at Breach Candy Hospital from 19.04.2006 to 25.04.2006 and underwent an operation on 20.04.2006 at Breach Candy Hospital Trust for Total Abdominal Hysterectomy with Bilateral Salpingoophorectomy plus Kelly's repair. TPA M/s. Raksha repudiated the claim on the ground of pre-existing disease by invoking clause 4.1 of the mediclaim policy.

From the Gynaec Discharge Folio the chief complaints mentioned is Heavy Menses – 6 months & Dribbling of urine on straining. The operation performed was for Total abdominal Hysterectomy with Bilateral Salpingoophorectomy plus Kelly's repair. From the discharge card of Dr. Shirish S. Sheth the Diagnosis given is Uterine Fibroids.

The above noting indicates that Smt. Nita V. Shah had fibroids before the incept of the mediclaim policy. Whether fibroids require any treatment or not is based on the patient's condition and the line of treatment by the doctor, but when the patient is hospitalized for such problem which was prevailing prior to incept of policy the company can invoke preexisting clause. It was also noted that operation for Kelly's repair (Stress Urinary Incontinence) and Endometrial polypii (inner lining of uterus with mucus growth) consisting of 2 cms. and 1.3 cms. was also performed during the same hospitalization. The complainant has simply stated that these were not pre-existing but he has not produced any documentary proof to substantiate his stand..

In the facts and circumstances the repudiation of mediclaim by the company is not adversarial to the policy conditions. There is no valid ground for interference.

Mumbai Ombudsman Centre
Case No. : GI- 539 of 2006-2007
Shri Ravindra J. Maniar
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 2.08.07

Shri Ravindra J. Maniar and his wife were covered under the Mediclaim Policy since 15/10/1996-97 for a S.I. of Rs. 2 lakhs each and there was exclusion of cataract of both eyes in respect of Shri Maniar. The S.I. under the policy was increased in the subsequent year by Rs. 1 lakh for both and then again increased by Rs. 2 lakh in the year 2004-05 for both. The Medical Report detected that Shri Maniar was diabetic and therefore an endorsement for exclusion of diabetes was passed w.e.f. 16/10/2004 reading as under : :

"As per Medical Reports it is hereby declared and agree that the following exclusion should be read under withinmentioned policy w.e.f. inception i.e. 16/10/2004 Ravindra J. Maniar - Exclude Diabetes Mellitus , Cataract "

Shri Maniar did not renew the policy with United but shifted his insurance to Oriental Insurance Company w.e.f. 13/10/2005. Oriental Insurance issued the policy for Rs. 5 lakhs and imposed an exclusion "all ailments related to DM S.I. restricted to Rs. 2

lakhs" as per United India's policy. The Company also obtained a fresh proposal form filled by the Insured in which it was noted that though Shri Maniar disclosed about the cataract surgery, there was no disclosure of diabetes. Shri Maniar was hospitalized for DM with IHD at Bhatia Hospital from 13/5/2006 to 17/5/2006 and the diagnosis was DM with IHD. It is noted in the discharge card that he was a k/c/o DM since 15 years and on Insulin Therapy. On 11/5/2006 he was admitted to a Peripheral hospital near Bhavnagar . ECG showed signs of Anterio Septal MI . He was managed conservatively and shifted to SAL Hospital & Medical Institute at Ahmedabad and was advised Angiography. Since Shri Maniar wanted to get himself treated in Mumbai he got discharged on request and admitted to Bhatia Hospital for further treatment He was admitted to Breach Candy and he underwent PTCA to LAD on 29/5/2006 and was treated and discharged on 31/5/2006.

When he lodged a claim For Rs. 4,58,964/- with the Company, their TPA - Raksha TPA Pvt. Limited, repudiated the claim under exclusion clause 4.1.On scrutiny of the papers submitted to this Forum, it is observed that the policy issued by Oriental Insurance Company was for a S.I. of Rs. 5 lakhs and there was a exclusion for Diabetes related ailment with restriction of S.I. upto Rs. 2 lakhs. If we go by the exclusions imposed on the policy, the Insured is eligible for the claim upto Rs. 2 lakhs. In the present case, since there was a specific condition of restriction of S.I. upto Rs. 2 lakhs for diabetes related ailments, on the policy schedule, the Insured was led to nourish the belief that he would be eligible for S.I. of Rs. 2 lakhs in respect of diabetes related ailments.

Under the circumstances, once the contract has been agreed with the knowledge of DM for which a restriction has been imposed, the Insurer cannot go back simply on the basis of history noted in the hospital records. At the same time, the fact cannot be ignored that the Insured failed to disclose ' about diabetes ' in the proposal form by not replying the relevant question. Though the history of DM goes back before the inception of the policy, yet the benefit goes in favour of the Insured as the Company has not questioned the Insured at the appropriate time but simultaneously the Insured also has not come with honest disclosure and therefore to strike a balance, it will be appropriate to entertain the claim to the extent of 80% of the restricted S.I of Rs. 2 lakhs.

Mumbai Ombudsman Centre
Case No. : GI- 511of 2006-2007
Shri Harendra P. Desai
Vs
United India Insurance Co. Ltd.

Award Dated : 07.08.07

Shri Harendra Desai along with his wife, Smt. Mrudula Desai and daughter were covered under Mediclaim Policy from 31/10/2000 for Rs. 1 lakh each. The S.I. was subsequently increased to Rs. 3.50 lakhs for Shri Desai and to Rs. 2 lakhs for Smt. Desai, as evident from the policy copy of 31/10/2005-06. The policy was issued with exclusion of diabetes and heart diseases in case of Smt. Mrudula Desai in view of the disclosure that she had DM and had undergone CABG. Present claim was in respect of Smt. Desai who was hospitalized at Parekh Hospital on 21/3/2006 and the diagnosis was Proteinuria and Renal disease. She was treated and discharged on 25/3/2006.

Whilst processing of the claim the TPA, asked the Insured to obtain the etiology for Proteinuria and Renal Disease from the treating doctor. The treating doctor opined that " the probable etiology for proteinuria and renal disease appears to be DM and

clinically diabetes nephropathy". Accordingly, the TPA repudiated the claim stating that the present hospitalization was for an ailment related to DM which is a specific exclusion under the Policy. Complainant did not appreciate this decision of the TPA and felt that his claim should be settled.

Analysis of the case reveals that Smt. Desai was admitted to Parekh Hospital on 22/3/2006 with complaints of giddiness, breathlessness, h/o weight gain . It is noted in the hospital paper that she was a k/c/o/ DM/HT/IHD/Post CABG/Hypothyrodism. Diagnosis noted in the discharge card was Proteinuria.

The point of dispute is quite focussed as it evidently appears that the policy issued to Smt. Desai had a clear exclusion of diabetes & Heart Related diseases as per the disclosure in the proposal form. Therefore, it becomes a knowledge on the part of the Insured that she would not be covered for "diabetes & Heart Related diseases and consequences thereof" as per the exclusion clause endorsed on the policy itself 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 & Heart Diseases) for consequences attributable thereto or accelerated thereby or arising therefrom."

Based on the disclosure of diabetes & Heart Diseases there has been clear exclusion under the policy which has been examined above in its total import and comprehensiveness to exclude consequences arising from them and as noted above, the present ailment for which Smt. Desai was hospitalized was related to the exclusions imposed on the policy, the Insurer's stand-point is tenable.

Mumbai Ombudsman Centre
Case No. : GI- 386 of 2006-2007
Shri Bhupendra P. Mehta
Vs
The Oriental Insurance Co. Ltd..

Award Dated : 07.08.07

Shri Bhupenda Mehta and his wife Smt.Neeta Mehta were covered under Mediclaim Policy effective from 16/2/1999 for S.I. of Rs. 50,000/-. The Sum Insured under the policy was increased to Rs. 1 lakh each in the year 2006-2007 and the cumulative bonus on this date was Rs. 20,000/- for Smt. Mehta. In the policy for the year 2007-08 it was for Rs. 1,25,000/- each with no cumulative bonus shown.

A Claim for Rs. 1,22,500/- lodged by Shri Mehta in respect of his wife's hospitalization at Shalby Hospital for Left Total Knee Replacement (Lt. TKR) was rejected by the TPA under 4.1 stating that as per indoor case papers she had a history of intra articular injection given to left knee 15 years back and according to them this injection is normally given for Osteoarthritis Rheumatic arthritis, Reactive arthritis Gouty arthritis and other related Sero negative arthritis. The analysis of the complaint reveals that Shri Bhupenra P. Mehta, along with his wife Smt. Neeta Mehta (Residential Address as per policy is of Andhra Pradesh) were covered under a Mediclaim Policy issued by Oriental Insurance, Mumbai Divisional Office since 16/2/1999 and it was continuously renewed without any break. The hospitalisation claim lodged in respect of Smt. Neeta Mehta for Total Knee Replacement at Shalby Hospital, Ahmedabad from 20/3/2006 to 28/3/2006 was processed by the TPA – Raksha TPA and they called for certain information regarding OPD consultation papers, duration of complaint from treating

surgeon and clarification regarding the intra-articular injection taken on the left knee 15 years back.

It is noted that Smt. Mehta consulted the doctor at Shalby Hospital on 17/2/2006 and she was advised X-ray of both Knees which revealed “Osteoarthritic changes seen in both knee joints”. There was an advice for Bilateral TKR and a few tablets were prescribed. The Discharge card gives the diagnosis as Left Knee Osteoarthritis for which she underwent left TKR. In the clinical visit form, in the column of history of treatment taken for Arthritis there are options of different treatments and in the option Intrarticular Injection it is mentioned as Yes, Side - Left - 15 years back. In the column of history of medical illness , it is mentioned HTN and DM– controlled. In another sheet the duration for the same was mentioned as 10 yrs and 6 yrs respectively. In the pre-operative sheet the name of the medicines taken for the same was also mentioned. In the present case surgery was resorted at the beginning of the treatment itself, which becomes a little difficult to believe that the duration of the ailment could have been only for 1 – 2 yrs as mentioned by the Complainant. However, from the records submitted since there is no conclusive evidence that the ailment was pre-existing and the Insurer having not brought on record any other material to establish that the ailment was pre-existing except the fact of intra-articular injection taken 15 years back which may be too long a duration to treat the ailment as pre-existing, looking to the fact that Smt.Mehta did not have any problem till the present one, the benefit of doubt goes in favour of the Insured and therefore the decision of the Insurance Company for total repudiation of the claim is not sustainable. The Company is directed to settle the claim for the initial sum insured of Rs. 50,000/- with cumulative bonus to settle the dispute.

Mumbai Ombudsman Centre
Case No. : GI- 516 of 2006-2007
Shri Pravinbhai Sanghvi
Vs
National Insurance Co. Ltd.

Award Dated : 13.08.07

The National Insurance Co. Ltd. issued a Mediclaim Policy No. 250501/46/04/8500970 for the period 5/1/2005 to 4/1/2006 to Winner Insurance Benefits Limited covering their members. One such Member, Smt. Rita Sanghvi covered herself and her husband, Shri Pravinbhai Sanghvi and their son for a S.I. of Rs. 50,000/- each. The complainant stated that there was a gap in renewal of the Policy of about 15 days and the renewed policy was made effective from 20/1/2006 instead of 5/1/2006.

The claim lodged by the Insured was initially processed by the TPA and they sought a certificate from the Insured’s treating doctor stating the past history of HTN/DM/IHD vide their letter dated 17/4/2006 which was submitted by the Insured. The certificate mentioned there was no history of the above diseases. But subsequently, the claim was repudiated by the TPA stating that the policy was a fresh policy from 20/1/2006 and Unstable Angina cannot develop within 2 months of policy inception. They also stated that looking to the investigation reports which were all normal, the hospitalization was not necessary.

It is reported by the Complainant that on 2/1/2006, the agent, Mrs.Harsha Kothari, collected the cheque for renewal of the Policy, and delivered a new policy to him which was made effective from 20/1/2006 to 19/1/2007. However, he has stated that his account was debited on 6/1/2006 because of which he felt that his policy would have been renewed in time but he was surprised to see the effective date of policy from

20/1/2006 instead of 5/1/2006. It is noted from the papers submitted to this Forum that the Company has nowhere disputed/denied the fact that the Insured's account was debited on 6/1/2006. Therefore, a question arises why the policy was made effective from 20/1/2006 when the premium amount was already debited to his account on 6/1/2006. The Company is directed to look into this aspect and regularize the policy through an endorsement.

As regards repudiation of the claim it is to be noted from the discharge summary that Shri Sanghvi was admitted with complaints of headache, heaviness and giddiness and had vomited 4- 5 times for which Dr. Jain was called at home and looking to his condition, he was advised hospitalisation. Hence, the contention of the Company, that hospitalization was not required is not tenable. The other ground on which the Company has repudiated is that the claim has arisen in the first year of the policy within two months. The Company can take this plea only if the disease has been proved to be pre-existing. Since there has not been any conclusive proof for pre-existence of the ailments, the decision of the Insurer to repudiate the claim is not sustainable.

Mumbai Ombudsman Centre
Case No. : GI- 762 of 2006-2007
Shri Rajbahadur R. Vishwakarma
Vs
United India Insurance Co. Ltd.

Award Dated : 14.08.07

Shri R.R. Vishwakarma and his wife were covered under Mediclaim Policy since 31/12/2001 for S.I. of Rs.35,000/- and Rs. 25,000/- respectively. Shri Vishwakarma was hospitalized at Nidhi Nursing Home on 14/8/2005 with complaints of feverish feeling, mild bodyache, general motion 4- 5 times. The claim lodged by was repudiated under exclusion clause 4.10. He represented his case to the Company for review, but the Company maintained their earlier stand. He then decided to lodge a complaint against the Company with this Forum. His contention was that he did not get hospitalized on his own but on the advice of his doctor and therefore the Company should get clarification from the hospital for the reason of his hospitalization. The Complaint was registered and parties to the dispute were called for personal deposition on 13th August, 2007.

Analysis of the claim reveals that Shri Rajbahadur Vishwakarma was hospitalized at Nidhi Nursing Home & ICU on 14/8/2005 with complaints of feverish feeling since 4-5 days, mild bodyache, mild headache and passing of motion 4-5 times. He was diagnosed as " k/c/o SVT (Supraventricular Tachycardia) with PUO (Pyrexia of Unknown origin)." He was treated and discharged on 16/8/2005.

On examination of the hospital papers, it is observed that the medications prescribed during hospitalization were oral medications and some pathological tests were carried out which were all normal. In the medical papers it was noted "patient was admitted with feverish feeling since 4-5 days. He is known case of SVT and patient was on regular medicine "Caloptin". The temperatures noted in the daily sheet were ranging from 100 degree F to 98.6 degree F. Bodyache/Headache were noted to be mild in nature. The temperature recorded also does not show any criticality in the health status of the Insured. His BP recordings were also more or less consistent and vitals were all normal. For his SVT he was prescribed the same medicine which he was regularly taking.

Going by the nature of illness and the treatment received during his stay at the hospital, it would reveal that there was no criticality in the health status of Shri Vishwakarma warranting hospitalization. Moreover, there was no advice from the doctor for hospitalization either. Based on the facts and analysis made, this Forum does not find any grounds to interfere with the decision of the Company to repudiate the claim.

Mumbai Ombudsman Centre
Case No. : GI- 196 of 2007-2008
Shri Ram M. Hinge
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 22.08.07

Shri Ram Hinge and his wife were covered under Individual. Mediclaim Policy since 5/12/2005. Immediately in the following year, i.e. on 15/12/2006 he was hospitalized for Lt. Ureteric Renal Calculi.

Analysis of the case reveals that Shri Ram Hinge was hospitalized for Lt. Lower Ureteric and Right Renal Calculi on 15/12/2006 and he was treated and discharged on 19/12/2006. He had incurred an expense of 84,862/- for which he had lodged a claim which was rejected by the TPA and therefore he represented to the Company/TPA and not getting any favourable reply by their TPA and Oriental Insurance as well, he approached the Insurance Ombudsman for his intervention in the matter. The Complainant's contention was that, as per terms and conditions of the policy which was initially issued to him, the exclusion clause 4.3 did not have calculus disease excluded in it. Further he stated that the concerned development officer neither informed him about the change of Mediclaim Policy/exclusion clauses, nor immediately handed over the renewed policy to him to enable him to go through the revised terms and conditions before undergoing the medical treatment.

The claim has been repudiated by the Insurer as per their policy provisions and terms of the contract.Therefore, it is clear that the subject claim falls outside the scope of cover for the first two years of the policy operation, while the Complainant felt since he had a policy since 2005-2006, the revised terms and conditions should not be made applicable to him and his claim should be processed and settled as per the original terms and conditions.

The present Mediclaim policy is an annual contract and it is renewable on mutual consent. The renewed policy is a fresh contract and the Company can offer fresh terms and other conditions. The Insured also has a right to cancel the policy if the terms and conditions are not acceptable to him by serving a notice on the Company.

Mumbai Ombudsman Centre
Case No. : GI- 412 of 2006-2007
Miss. Dipinti Modi
Vs
United India Insurance Co. Ltd.

Award Dated : 23.08.07

Miss Dipinti Modi aged 16 years was covered under an Individual Mediclaim Policy No. 121200/48/05/07806 issued by United India Insurance Co. Ltd. for a SI of Rs. 25,000/- since 1/4/2006. During the currency of the policy, she was hospitalized at Sanjeevani Hospital on 29/3/2006 for complaints of high grade fever, abdominal pain, loose motions, generalized weakness, bodyache etc. When a claim was preferred by her

father, Shri Jagdish Modi, the Company's TPA, M/s.Medsave, repudiated the claim by stating that hospitalization was for less than 24 hours and hence the claim was not payable as per Clause 2.3 of the Mediclaim Policy. Not satisfied with the decision, Shri Modi represented to the Company which was also not considered.

An analysis of the entire records submitted to this Forum would reveal that Miss Dipinti Modi consulted Dr. R.B. Pasi prior to hospitalization and the diagnosis was Pulmonary TB, Epilepsy, Typhoid Fever with CAPD. The Discharge Summary revealed that Miss Modi was admitted to the hospital on 29/3/2006 at 10.30 a.m. and there was a remark on the same date that "patient is taken by her parents for expert opinion at his own risk". Based on these notings, the TPA rejected the claim under Condition 2.3. Shri Modi represented his case along with a certificate from Dr. Rajesh M. Binyala dated 7/7/2006 which is reproduced below.

"Miss Dipinti J. Modi, F/17years , minor in age, was admitted from 29/3/2006 at 10.30 a.m. to 30/3/2006 1.30 a.m. under my care. During her hospital stay she was not willing for hospital stay and at 1.30 a.m. she became roudy. Hence the relatives/parents took discharge against medical. She required hospitalization. Kindly consider this."

From the above certificate it was very much clear that Miss Modi's hospitalization was for less than 24 hours. Therefore, the basic requirement of fulfillment of condition 2.3 of Mediclaim Policy which is "expenses on hospitalisation for minimum period of 24 hours are admissible" is not fulfilled in this case and therefore the claim disqualifies for reimbursement of hospitalization expenses. Since the Policy specifies minimum period of hospitalization of 24 hours, there is no merit in the complaint. As such the Insurer is justified in repudiating the claim.

Mumbai Ombudsman Centre
Case No. : GI- 188 of 2006-2007
Shri L.D. Vora
Vs
The New India Assurance Co. Ltd.

Award Dated : 24.08.07

Shri Laxmidas Vora and Smt. Uma Vora were insured with The New India Assurance Co. Ltd under their Policy No. 111200/48/05/20/70064808 for the period 2/3/2006 to 1/3/2007. Shri Vora approached the Office of the Insurance Ombudsman with the grievance against the Company for partial settlement/repudiation of the following two claims. Records were perused and parties to the dispute were called for personal hearing on 6th August, 2007.

- Policy No. 111200/48/04/88133 – Quantum Dispute. This claim was processed by TPA- TTK Health Care Services and they had settled an amount of Rs. 34,320/- as against Rs. 57401/- for hospitalization at Criticare Hospital from 8/8/2005 to 13/8/2005 for Pulmonary Oedema. Hence complaint for balance amount.
- Policy No. 111200/48/05/20/70064808 - Claim was processed by Raksha TPA which was repudiated by them. The claim was for Rs. 25,897/- in respect of hospitalization at Criticare Multi speciality hospital for acute airway obstruction disease from 22/3/2006 - 25/3/2006

Analysis of the case reveals that the policy issued to Smt. Vora had specific exclusions of diabetes and thyroid in view of the disclosure by the Insured at the time of taking the policy that she was diabetic and had undergone thyroid surgery. Smt. Vora was admitted to Criticare Multi- speciality hospital from 22/3/2006 - 25/3/2006 with complaints of sudden onset of breathlessness, cough ++. It is noted in the discharge

card that she was a k/c/o DM,IHD,HT and Hypothyroidsm on regular treatment. Diagnosis noted was Acute airway obstruction disease.

The point of dispute is quite focussed as it evidently appears that the policy issued to Smt. Desai had a clear exclusion of Diabetes & Thyroid as per the disclosure in the proposal form. Therefore, it becomes a knowledge on the part of the Insured that she would not be covered for “diabetes & thyroid diseases and consequences thereof” as per the exclusion clause endorsed on the policy itself 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 & Thyroid) for consequences attributable thereto or accelerated thereby or arising therefrom.”

As diabetes was taken to be a contributory factor and the scope of exclusion was very exhaustive and comprehensive to cover all consequences attributable thereto or accelerated thereby or arising therefrom from diabetes, the admissibility of the claim would be in question following an exclusion of diabetes since policy inception.

Mumbai Ombudsman Centre
Case No. : GI- 799 of 2006-2007
Shri Rajul C. Tambawala
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 31.08.07

Shri Rajul C. Tambawala was covered under Mediclaim Policy since 9/1/1995 for S.I. of Rs. 83,000/-. The S.I. was enhanced to Rs. 2 lakh in the year 1997-98 and the present Policy No. 122201/48/06/2348 (19/1/2006-07) under which a claim has arisen the S.I. was Rs. 5 lakhs.

Shri Tambawala was hospitalized for Haemorrhagic Infarct and the claim lodged by him was settled by the Company for Rs. 83,000/- i.e. to the extent of original S.I. as against the claimed amount of Rs. 1,07,307.06 for the reason that hospital records mentioned history of HT and DM since last 10 years and on regular treatment.

From the documents produced before this Forum, it is noted that Shri Tambawala was first admitted to Aum Hospital, Surat on 20/7/2006 to 23/7/2006 for Right Cerebellar Haemorrhagic Infarct and the discharge card recorded history DM & HT since 10 years – on regular treatment. It also recorded the names of the medicines taken by Shri Tambawala for the said ailments. He was shifted to Bharatiya Arogya Nidhi, Mumbai, for further management from 23/7/2006 to 2/8/2006 and the diagnosis in the discharge card was Cerebral Infarct (Rt), HT, DM.

The Insured contested the history of DM & HT noted in the hospital papers and mentioned that it was wrongly noted as he was detected to be diabetic since 1997-98 and HT was detected during 2003-2004. However, he has not submitted any medical evidence to substantiate his stand except an affidavit . HT & DM as circulatory disorders would be pre-disposing factors and the hospital recordings of 10 years would make it around the year 1997. It is also observed from the policy document of 1997-98 that his sum insured under the policy was enhanced to Rs. 2 lakhs and there was no accrued cumulative bonus for Shri Tambawala whereas there was 10% CB reflected in case of his wife which meant that there could have been some claim lodged earlier by him. This Forum had called for the past claim details from the Company subsequent to the hearing but they showed their helplessness in retrieving the past claim records. The complainant invariably mentioned in his letters as also at the hearing that diabetes was detected in the year 1997-98 and not earlier and the Company had settled a claim

in the past for treatment taken for diabetes. Therefore, it would be reasonable to consider the onset of DM after the enhancement of SI to Rs. 2 lakh and settle the claim to the extent of Rs. 2 lakhs by giving benefit of doubt to the Insured, as it is a borderline case.

Mumbai Ombudsman Centre
Case No. : GI- 783 of 2006-2007
Smt. Mehrunissa H. Bloch
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 12.09.07

Smt. Mehrunissa H. Bloch along with her husband had been enrolled in the Health Shield Premium Plan of Royal Sundaram for Health Insurane Cover of Rs. 2 lakhs each effective from 4th Jan. 2006. She was admitted to Bombay Hospital on 3/8/2006 for Amyloidosis causing Chronic Kidney Disease and got discharged on 28/8/2006 after treatment. She was again hospitalized on 21/9/2006 and got treated and discharged on 29/9/2006 for the same ailment. The claim lodged was repudiated by the Company for the reason that the disease was pre-existing.

Analysis of the case reveals that Smt. Mehrunissa H. bloch was covered under a Health Shield Premiere Insurance Policy issued Royal Sundaram General Insurance Company for the period commencing from 4/1/2006 to 3/1/2007 and another policy - Hospital Cash Insurance Policy effective from 22/5/2006 to 21/5/2007. She lodged the claims under both the policies for Rs. 1,65,845/- and Rs. 35,000/- respectively for reimbursement of expenses incurred by her at the hospital. Smt. Bloch reportedly fell ill and experienced extraordinary weight loss (about 15 Kgs. in 3 months) in the last week of March, 2006, for which she consulted her family doctor who advised to have a complete body profile check up. She was taken to Bombay Hospital in the month of July, 2006 when she was advised to consult an Oncologist. She was under observation and treatment of the Oncologist and got admitted to Bombay Hospital on 3/8/2006 for Amyloidosis causing Chronic Kidney Disease and got discharged on 28/8/2006 after treatment. She was again hospitalized on 21/9/2006 for the further management of the disease and got treated and discharged on 29/9/2006.The claims were repudiated under exclusion D (reproduced below) based on their panel doctor's opinion that Amyloidosis was pre-existing and was itself a chronic disease and Chronic Kidney Disease is a complication of Amyloidosis. The Company also alleged that the Insured has not disclosed the factum of Diabetes and also there was tampering in the history of HTN recorded in the hospital papers and further invoked Clause 6 of the Policy to repudiate the claim.

On a deeper scrutiny of the records submitted to this Forum, it is observed that Smt. Bloch had undergone certain tests on 24/4/2006 such as clinical examination of Spine, and general physical examination at P.H. Medical Centre, prior to hospitalization which revealed that she had a history of hypertension and in one of the reports the BP reading was 160/90 mm Hg. The diet plan recommended was specifically a diabetic diet. Hence the complainant's statement that his wife was healthy is not tenable. It is also observed that the hospital papers recorded history of HTN since few years and also noted that she was on Tablet Loran. The history of HTN was later tampered with by scoring off the words "since few years". Both HTN and DM have nexus with Kidney Disease.

Since the diagnosis made at the hospital was Amyloidosis with Chronic kidney disease, for which she is undergoing dialysis at present, it would appear that the disease were existing for quite some time and definitely would have developed over a considerable period of time and not within a period of seven months as contended by the Complainant as it is medically a well known fact that such ailment take their time to reach such a stage. Therefore, the decision of the Company to repudiate the claim on grounds of pre-existing illness and misdescription both being proved is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-792 of 2006-2007
Shri Mohit Kothari
V/s
New India Assurance Co. Ltd.

Award Dated : 24.09.07

Shri Mohit Kothari along with his family members were insured under Mediclaim Policy issued by the New India Assurance Co. Ltd. Smt. Manisha M.Kothari, was admitted in Breach Candy Hospital on 24.08.2006 for Cholelithiasis and Laparoscopic Cholecystectomy surgery was done. When the claim for Rs.1,07,817/- was submitted by Shri Mohit Kothari to M/s Raksha TPA, who processed the claim, informed him vide their letter dated 22.11.2006 that Rs.77,381/- was allowed as against the amount claimed and an amount of Rs.30,000/- was disallowed towards surgeons fees. According to them, the surgeon's fees of Rs. 60,000/- was on higher side hence only Rs.30,000/- was admissible. Not satisfied with the settlement, Shri Kothari represented to the TPA and also to the Company. Not getting any favourable reply from them, he approached the Insurance Ombudsman

The main complaint for which the Complainant approached this Forum was for deduction of surgeon's fees from the total amount claimed by him. The TPA, M/s Raksha TPA Pvt.Ltd. in their letter to the Insured dated 22.11.2006 stated that the amount claimed for Surgeons' fees Rs.60,000/- was on higher side and allowed an amount of Rs.30,000/- as per reasonability clause. Shri Kothari in his letter dated 19.12.2006 stated that he opted for a normal room instead of a Deluxe Room and the surgery was inevitable hence he selected one of the best surgeon in the city. He also stated that he never claimed for Health Check-up Expenses as his family was having good health.

It is relevant to observe that reasonableness of surgeon's fees varies from case to case depending upon the hospital, operative procedure, surgeon's standing, the accommodation (A/c, non A/c, deluxe, Super deluxe etc.) post operative care and the like, even in respect of similar operations. There are no specific guidelines in the policy contract for cap on the surgeon's fee and Breach Candy Hospital is one of such hospitals, which fall in line for comparison of fee structure by the TPA. The TPA has reduced the surgeon's fee but their decision seems to be subjective and not objective as they have failed to prove by data that it was not reasonable. Whereas from the Complainant side, they opted for a normal room instead of delux, which they could have availed as Sum Insured is 4lakhs. In view of the above, there is no justification in reducing the surgeon's fee. The Insurer's decision is interfered by the following order.

Mumbai Ombudsman Centre
Case No. : GI-660 of 2006-2007
Babulal O. Jain
V/s

The Oriental Insurance Company Limited

Award Dated : 18.09.07

Shri Babulal O.Jain along with his wife took a mediclaim policy with the Oriental Insurance Company Ltd. since 1993. The policy was renewed continuously and the Sum Insured was increased to Rs.1,50,000/-. Smt. Ladiben Jain, the wife of Shri Babulal Jain was admitted in Bombay Hospital on 19.01.2005 to 21.01.2005 for Systemic Hypertension. When a claim was preferred to M/s Raksha TPA they rejected the same by stating that in the indoor case papers and discharge card of Bombay Hospital it has clearly stated that the patient was suffering from Hypertension since last 15 years which fell under pre-existing disease hence claim was not payable under Exclusion Clause 4.1. Not agreeing with the decision of the TPA, Shri Jain represented to the company. The Company upheld the decision of the TPA. The company was asked to submit hospital records of cataract operation of Smt. Jain to this forum and also explain the relevant policy condition which does not allow complaint over one year. As per the hearing, the company has submitted the hospital records of cataract operation of Smt.Jain done on 12.01.2002 at Bombay Hospital to this Forum. After scrutinising the same, it was found that under 'History & Examination Findings' it has mentioned as 'HT | Rx. 12yrs'. In the indoor case papers of 2005 i.e present hospitalisation at Bombay hospital, the duration of hypertension was mentioned as 15yrs. It is clear from all these records that she was suffering from hypertension before the inception of the policy and in 2002 the duration of hypertension mentioned as 12yrs and in 2005 it has mentioned as 15yrs i.e. exactly 3yrs after the first admission hence the contention of the insured that his wife was suffering from hypertension since last 2yrs is not acceptable as the hospital records are clear and transparent. In the facts and circumstances, I have no valid grounds to interfere with the decision of the Oriental Insurance Company Ltd. to repudiate the claim preferred by Shri Jain.

Mumbai Ombudsman Centre
Case No. : GI-156 of 2006-2007
Shri Farokh N.Hillo
V/s
The New India Assurance Co.Ltd.

Award Dated : 17.09.07

Shri Farokh N. Hilloo along with his wife Smt. Daisy F.Hilloo was covered under the mediclaim policy of the New India Assurance Co.Ltd. which was being renewed continuously. Smt. Daisy F.Hilloo was hospitalised on 27.08.2001 at Holy Spirit Hospital for primary infertility c post artificial insemination Pelvic inflammatory c Left Sided T-O and was discharged on 01.09.2001. Shri Farokh preferred a claim to the Company for reimbursement of the expenses incurred for his wife's hospitalisation. The Company referred the matter to its panel doctor and after getting opinion from him, the company rejected the claim by stating that the insured was hospitalised for the complication of treatment of sterility/infertility hence it fell under Exclusion Clause 4.8. The company informed the rejection of the claim under Exclusion Clause 4.8.Not satisfied with the reply from the Company, Shri Hilloo approached Ombudsman

As per RPG Rules 13 (3)(b) the Complaint is to be made not later than one year after the insurer had rejected representation or Complainant has not received any reply within a period of one month after the Insurer received his representation or Complainant is not satisfied with the reply. In this case the Complainant, Shri Hilloo should have approached this Forum within one year from the first rejection of the complaint by the office of the Insurance Company instead he went on representing to

the insurer for which company also responded. Since the complaint has already been registered, the complaints will be resolved on its merit. As per the noting on the discharge card of Holy Spirit hospital it was mentioned under final diagnosis that Smt. Daisy F.Hillo was admitted for primary infertility c post artificial insemination Pelvic inflammatory c Left sided T-O. The Insurance Company has rejected the claim for infertility treatment as it fell under Exclusion Clause 4.8. Thus it is evident from the final diagnosis arrived at the hospital that the insured was admitted primarily for the treatment of infertility. On rejection of claim a certificate from Dr.M.P.Shah, Medical Superintendent of Holy Spirit Hospital was submitted to the insurer stating that the patient was admitted for "infected ovarian cyst, infected tube and loop of bowel" and was treated under the care of Dr.(Mrs) Atit. There is another letter from Dr.S.M.Atit of Holy Spirit Hospital dated 19.11.2003 stating that the patient was admitted on 27.08.2001 with severe abdominal pain and other details of treatment and finally stating that she was not treated for infertility in their hospital. From the above, it is clear that subsequent clarification by the treating doctor and hospital superintendent is subsequent to rejection. The patient was discharged on 01.09.2001 and the treating doctor gave the clarification on 19.11.2003. Since such clarification is subsequent to rejection, what has been stated in the Discharge Card and the inpatient record is to be taken as the first truth. In view of this, the decision of the Insurer to reject the claim under Clause 4.8 of Mediclaim Policy is tenable.

Mumbai Ombudsman Centre
Case No. : GI-656 of 2006-2007
Shri Maneklal Shah
V/s
The New India Assurance Co. Ltd.

Award Dated : 14.09.07

Shri Maneklal M.Shah and his wife Smt. Damyanti M.Shah were covered under a Mediclaim Policy of the New India Assurance Co.Ltd. and enjoying Cumulative Bonus. Shri Maneklal Shah was admitted in Dwarkesh Nursing Home for a period from 12.03.2006 to 21.03.2006 and the diagnosis was Hypertension c Dorsolumbar Spondylosis. Shri Maneklal Shah preferred a claim to M/s Paramount Health Services Pvt.Ltd., who after scrutiny of the documents informed Shri Shah that his claim was not entertainable as there was no active line of treatment given during hospitalisation. Shri Shah represented against the rejection and the TPA after review of the matter informed the insured that he was admitted in the hospital with complaints of backpain radiating to lower limbs with hypertension. During hospitalisation he was only investigated and no active line of treatment was given justifying the need for hospitalisation for 10 days. Shri Maneklal Shah represented to the company who also upheld the decision of the TPA. Shri Shah approached Insurance Ombudsman

The scrutiny of the file reveals that Shri Maneklal Shah was referred to Dr.S.C.Gupta, Consutant Cardiologist by his son Dr. Nitin M.Shah. After admission in the hospital various tests were carried out, MRI of Lumbo-Sacral Spine and E.M.G. & N.C.Study were carried out to diagnose the disease properly and final diagnosis made was Hypertension c Dorsolumbar spondylosis. During hospitalisation, Shri Shah was referred to Dr. Manoj Rajani, Neurologist for lower limbs problems. At the time of admission the BP recorded as 160/100mmHg which is on higher side. The contention of the company was that the insured was admitted in the hospital for hypertension with Dorsolumbar Spondylosis and during hospitalisation there was no active line of treatment hence hospitalisation was not justifiable. The Company felt that since active

treatment was not given for Dorsolumbar Spondylosis, it was evidentially only for evaluation. As against the stand of company , Shri Shah produced two letters from Dr. Manoj Rajani and Dr.S.C.Gupta. Dr.Manoj Rajani stated in his letter dated 01.07.2006 that the patient was suffering from acute severe backache, radiculopathy and he was having fluctuating BP due which domiciliary treatment was not feasible. Considering his age and fluctuating BP, the doctor possibly decided to admit him in the hospital for better evaluation. From the inpatient record, it is observed that on 13.03.2006 MRI was advised and thereafter from 15.03.2006 to 21.03.2006 except BP readings there was no major observation on the record. Under the circumstances, the Insurer is justified in rejecting the claim under Exclusion Clause 4.10.

Mumbai Ombudsman Centre
Case No. : GI-871 of 2006-2007
Shri Nanji Gangji Gada
V/s
The New India Assurance Co.Ltd.

Award Dated : 17.09.07

Shri Nanji Gangji Gada, took an individual mediclaim policy as a member of the Shree Kutchi Visha Oswal Seva Samaj (KVOSS), a charitable organization registered under Society's Act. Shri Gada was hospitalized at Asha Polyclinic and Sheetal Nursing Home, Mumbai, , for Benign Prostatic Hypertrophy (BPH) and underwent treatment for the same. When Shri Gada preferred a claim for Rs.43,945/- incurred by him towards the above hospitalization, the TPA settled the same for Rs. 14,000/- , stating that as per the Policy terms and conditions, for a sum insured of Rs.1,00,000/- and for treatment pertaining to BPH, the claim amount is restricted to Rs. 14,000/- only. Not satisfied with the decision, Shri Gada approached the Office of the Insurance Ombudsman, Mumbai.

After perusing the records both the parties were given an opportunity to present their case at the personal hearing on 14.9.2007. The son of the complainant appeared and deposed before the Ombudsman. He submitted that although his father had lodged a claim for Rs.43,945/-, the same was settled for only Rs.14,000/-. He stated that he could not understand how the terms and conditions under a Policy could be different for the KVO Seva Samaj when the same individual premium was collected as in other policies. The Insurer stated that the claim was settled as per the terms and conditions of the Policy which were decided as per the MoU reached with the KVO Seva Samaj.

On an analysis of the case, it was observed that an MOU was executed between the New India Assurance Co.Ltd. and the KVO Seva Samaj and as a loss control measure, the Samaj had voluntarily agreed for certain caps and restrictions on claims.From the above, it is quite clear that owing to their earlier experience of adverse claim ratio, it has been mutually agreed that certain 'caps' would be imposed on the settlement of claims preferred by the members of the Accordingly, the Insurer has paid Rs.14,000/- to Shri Gada which is the amount allowable for a Sum Insured of Rs.100000/- for Prostrate disease. Hence the Insurer's decision was held sustainable.

Mumbai Ombudsman Centre
Case No. : GI-816 of 2006-2007
Ms.Madhavi Goradia
V/s.
The Royal Sundaram Alliance Insurance Company Limited

Award Dated : 25.09.07

Ms.Madhavi P Goradia , along with her mother, Smt. Indiraben P Goradia, was covered under Health Shield Insurance Policy of Royal Sundaram Alliance Insurance Company Limited. Smt. Indiraben, mother of the complainant, was hospitalized for Intracerebral Haemorrhage, for the period from 23.10.06 to 31.10.2006. Smt.Goradia expired on 31.10.2006. A claim was preferred by Ms.Madhavi Goradia for Rs.2,55,992/-. The Insurer repudiated the claim on the ground that as the antecedent cause of death, i.e., Hypertension was pre-existing and material facts were not disclosed at the time of inception of the policy, it fell under the exclusion conditions of the Policy. Not satisfied with the decision, Ms.Goradia approached this Forum for justice.

The parties to the dispute were called for hearing on 7th September, 2007. Ms.Madhavi Goradia appeared and deposed before the Ombudsman. She submitted that her mother died after an accidental fall in the bathroom and that her mother had heart problem few years back and some medicines were given for HTN but later on, when she was alright, they were stopped. Royal Sundaram General Insurance Company submitted that mother of the complainant, was a known case of HTN/DM, on regular treatment and so the Company has repudiated the claim based on pre-existing diseases.

The analysis of the case reveals the hospitalization was due to a fall in the bathroom. Even the Report of Health India Medical Services Pvt.Ltd., states that the recordings of the Nanavati Hospital gives them the 'impression' that HTN has lead to the fall of the deceased. After studying the various reports, one can conclude that the Insured had some health problem and that HTN/DM were present in the case of Late Smt.Goradia. However, it cannot be presumed that HTN was the reason for her fall in the bathroom. In view of the facts and circumstances of the case, the total repudiation of claim by Royal Sundaram was set aside and they were directed to pay 50% of the admissible expenses to Ms.Goradia.

Mumbai Ombudsman Centre
Case No. : GI – 879 of 2006-2007
Shri Vilas Bhupendra Shah
VS.
The Oriental Insurance Company Limited

Award Dated : 28.09.2007

Smt. Vilasben Bhupendra was covered under the Mediclaim Policy No.124300/48/05/03848, for a period 04.12.2004 to 03.12.2005 for sum insured Rs.1,00,000/- with C.B. 20% each. The inception of the policy was from the year 2003. She had a fall in her residence and sustained a fracture to Pubic Rami Lt. Side. She was admitted to hospital from 08.10.2005 to 11.11.2005. The claim was repudiated by the TPA, M/s Paramount Health Services Pvt. Ltd. stating that the claim is not admissible for Chronic Renal Failure & Diabetes Mellitus as Chronic Renal Failure is complication of Diabetes Mellitus and Diabetes Mellitus is excluded from scope of policy.

The entire records pertaining to the case have been scrutinized at this Forum. The ailments like Cataract, IHD and Diabetes Mellitus were excluded in the policy. The insured had a fall and had a fracture of Pubic Rami Lt. Side. She was admitted on 08.10.2005 to Karuna Hospital. She was discharged on 11.11.2005. In the discharge card the case summary states k/c/o DM/HTN/CRF on Dialysis 3 times a week. She was undergoing physiotherapy for the fracture sustained to Pubic Rami Lt. Side alongwith the treatment for CRF/HT/DM. When the insured submitted her claim, the claim was repudiated by M/s. Paramount Health Services Pvt. Ltd., vide their letter dated 12.01.2006 stating the reason as she was suffering from Chronic Renal Failure which is a complication of DM and since DM is an exclusion the claim is not payable. The

insured has vide their letter dated 16.02.2006 represented that the claim was for fracture treatment and not for CRF & DM. The claim was reconsidered by Paramount Health Services Pvt. Ltd. and they conveyed their decision of No Claim vide their letter dated 05.05.2006, since the hospitalization was not justified for the said ailment of fracture. The insured had again vide their letter dated 22.12.2006 enclosed letters from Karuna Hospital to which Paramount had vide their letter dated 08.01.2007 reiterated their stand of repudiation.

It is evident from the papers submitted to this Forum that the insured suffered from various complications and had to take dialysis 3 times a week It is evident that due to fracture and immobility of the patient, she would not have been able to take dialysis and take treatment for her other complications and had to be hospitalized. Though the fracture sustained did not require hospitalization but required only bed rest and physiotherapy, however she was hospitalized for multispeciality management for her other various ailments which fall within the exclusions of the policy.

In the facts and circumstances, The Oriental Insurance Company Ltd. has justified the repudiation of claim of Shri Vilas Bhupendra Shah. However, the fact remains that the patient was admitted in the hospital for the treatment of fracture to Pubic Rami Left side. There is also no doubt, had she been alright and with no complications of her other illness, she would not have required hospitalization for fracture. Taking all the facts & circumstances into consideration, I am inclined to award an ex-gratia payment of Rs.20,000/- for treatment of fracture to strike a balance in this case. This will not be taken as precedent for other cases.

Mumbai Ombudsman Centre
Case No. : GI- 27 of 2007-08
Shri Champaklal Harilal Mehta
V/s.
The New India Assurance Co. Ltd.

Award Dated : 26.09.2007

Shri Champaklal Harilal Mehta along with his family were covered under Hospitalization and Domiciliary Hospitalization Benefit Policies. The sum insured for himself was Rs.2 lakhs. Prior to the year 2001, the sum insured was Rs1 lakh. He increased the sum insured for himself to Rs.2 lakhs from the year 2001. Shri Champaklal Mehta submitted a claim for his hospitalization to Grant Medical Foundation, Pune. He again was admitted to Lilavati Hospital from 18.02.02 to 20.02.02 and again admittted at Sushilaben Mehta Hospital from 03.03.02 to 13.03.02. He submitted a claim for hospitalization to the Company. New India Assurance Co. Ltd. repudiated his claim under clause No.4.1 of the policy for non disclosure that he was suffering from diabetes. The second repudiation letter was sent to him referring him to clauses 5.3, 5.5. and 5.11.

Analysis of the case reveals that Shri Champaklal Mehta was admitted Grant Medical Foundation for chest pain, with profuse sweating and vomited twice on the day of admission to the hospital on 26.01.02. The indoor case papers show that the insured was a known case of DM for 3-4 years and was on tablets Glyciphage & Inj. Mixtard The final diagnosis was Anterior Wall MI. He was again admitted to Lilavati Hospital and Research Centre and diagnosis given was Ischaemic Heart disease and Diabetes Mellitus. He was again admitted to Smt. Sushilaben R. Mehta Hospital where CABG x 2 grafts were done. The history and clinical notes states that he was a k/c/o DM – 3-4 years and was on oral hypoglycemic agents and Insulin (mixtard). The point of dispute is the history of Diabetes Mellitus and non-disclosure of DM while enhancing the sum

Insured from Rs.1 lakh to Rs. 2 lakhs. At the time of increasing the sum insured the Insured had given a declaration that he is enjoying good health and does not suffer any sickness/illness etc. According to the Shri Champaklal Mehta, he states that he has given no such declaration and the signature in the declaration is not his. Since the Insured has denied his signature on the disclosure, the issue of non-disclosure is set aside and this forum will deal with rejection for pre-existing disease. According to the complainant he developed diabetes only in Nov'1999 and produced a certificate to the Company from Dr. Pradip C. Shanghvi wherein he states that the Insured was detected suffering from DM only from Nov'1999. According to Company, the case paper of Dr. Jagdish Parikh submitted by the Insured states that Insured was having DM since 20 years. However, the Insured submitted a certificate issued by Dr. Jagdish Parikh which states that the patient is not his regular patient and that his noting of DM since 20 years on the consultation paper need not be treated as correct as he has seen Mr. Mehta for the first time on 4th February.

He stated that he had no Diabetes when he first took the mediclaim policy in the year 1997. Though the claimant has submitted blood sugar report dated 14.05.97 which was advised by Dr. P.B. Trivedi from whom he was taking OPD treatment, but he has not submitted the medical papers indicating the reasons for taking treatment and thus the onset of DM could not be established. However, DM is one of the major risk factors but not the only factor and looking to the mediclaim policy taken in the year 1997, I am inclined to give some relief to the claimant on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI- 604 of 2006-2007
Shri Pawan Prabhat
Vs
ICICI Lombard Gen. Insurance Co. Ltd.

Award Dated : 10.09.07

Shri Pawan Prabhat took a Individual Health Insurance w.e.f. 25/9/2006 from ICICI Lombard General Insurance Company. He suffered from acute Pancreatic and Renal Insufficiency for which he was hospitalized at Suchak Hospital from 12th Oct. 2006 to 20th Oct. 2006. When a claim for Rs. 60,000/- was preferred by Shri Prabhat Company repudiated the claim vide their letter dated 13/11/2006 invoking clause 3.2 of the Health Policy stating that the treatment was taken within 30 days of policy inception.

Analysis of the case reveals that Shri Pawan Prabhat took a fresh Individual Health Insurance Policy as per the advice of ICICI Lombard and the claim in respect of his hosptialisation was repudiated by the Company as it attracted Clause 3.2 of the Policy. Shri Prabhat in his complaint letter as also at the hearing mentioned that he was earlier covered under a Group Policy taken by his former Employer which ceased on 7/9/2006 consequent upon his change of job. The Complainant also mentioned that he did try to renew the previous insurance contract with ICICI Lombard immediately after he took up the new job on 8/9/2006, but he was asked to purchase a new policy as the earlier policy was a Group Mediclaim Policy. The New Individual Mediclaim Policy under which the claim has arisen commenced from 25/9/2006 and thus there was a break in continuity. Had there been no break in the continuity of Insurance, it would not have attracted the exclusion clause as noted below.

Since the policy taken by Shri Prabhat was a fresh Individual Health Policy, taken subsequently, the claim attracted clause 3.2 of the Policy which reads as under :

"The Company shall not be liable to make any payment for any claim directly or indirectly caused by , based on, arising out of or howsoever attributable to any of the following :

3.2. Medical charges incurred within 30 days of inception date of the policy except those that are incurred as a result of bodily injury caused by an accident."

In view of the above, this Forum does not find any valid reason to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI- 635 of 2006-2007
Shri Meghji K. Vira
Vs
The New India Assurance Co. Ltd.

Award Dated : 10.09.07

Shri Meghji K. Vira along with his wife and Son were covered under an Individual Mediclaim Policy for the period 2004-05 for a S.I. of Rs. 4 lakhs for himself, 3 lakhs for his wife and Rs. 25,000/- for his son. Shri Meghji K. Vira was hospitalized at Breach Candy Hospital on 26/1/2005 to 4/2/2005 for IHD and he underwent CABG. When he preferred a claim the TPA, initially approved the claim but later rejected it under exclusion clause 4.1. Analysis of the case reveals that Shri Meghji K. Vira was insured under Mediclaim Policy along his Wife, Son and 2 Daughters prior to 1995 Initially he and his wife were covered for a S.I. of Rs. 1 lakh each and 3 children were covered for Rs. 65,000/- . He gradually increased the sum insured for himself and his wife and the policy of 2004-05 under which the present claim has arisen reflects a S.I. of Rs. 4 lakhs for himself and Rs. 3 lakhs for his wife and his son covered for Rs. 25,000/- . Shri Meghji K. Vira was hospitalized at Breach Candy Hospital on 26/1/2005 to 4/2/2005 for IHD for which CABG was done.

The Insured mentioned that the alterations in the notings were not done by them and since it reflected in the original indoor papers also, it was clear that it was a correction made by the Breach Candy doctor himself. This statement of the Insured seems rather unusual and cannot be easily accepted as the doctors record the history as per actual narration by the patient or his relatives, and since Dr. Bhattacharya his treating Surgeon at Breach Candy was not his family physician, he would not confirm or deny the history on his own. Even if the history was written inadvertently as "since 8 years", then the corrections are always attested by a signature of the doctor who has corrected it. In the present case there is no such authentication by a signature. It is also observed from the papers submitted to this Forum, that the Insured had undergone CAG at Jaslok Hospital on 25/9/2004 and even though it was written as No h/o chest pain, there was a noting "CAG done in 2001 – suggestive of two vessel disease with LV dysfunction." It also notes k/c/o DM on OHA. At the hearing the Complainant was asked to submit hospital papers pertaining to CAG, Stress test done in 2001with details of findings and papers/prescriptions relating to his breathlessness problem prior to hospitalization. In this connection, Shri Vira has expressed his inability to submit the documents as called for, vide his letter dated 29th August, 2007, for the reason that those previous papers were not preserved by him. The Complainant is not transparent in his dealings and could not produce the necessary documents essential in this case which are generally preserved in such ailments for further management of the disease. The history reported in CAG done in 2001 has not been made available to us to decide about pre-existence of the disease. However, I am inclined to give benefit of doubt in favour of Complainant looking to the Policy cover available in this case. Since as per

the notings in the hospital record , CAG & Stress test was done in 2001 and even if we take the history of chest pain since 8 years, it goes back to 1997-98. The policy copy of 2001-02 record SI of Rs. 1.50 lakhs with CB 35%, taking it prior to the year of 1997-98. Taking the above facts and circumstances into consideration, I am inclined to consider the claim for the above treatment for S.I. Rs. 1.50 lakhs along with CB to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI- 757 of 2006-2007
Shri Vashdev Dayalani
Vs
The New India Assurance Co. Ltd.

Award Dated : 28.08.07

Shri Vashdev Dayalani was admitted to S.L. Raheja Hospital under the care of Dr. P. Jagannath on 15/1/2006 for Rectal Cancer and he was operated upon on 16/1/2006. and after treatment, got discharged from the hospital on 25/1/2006. The Insured admitted that all the bills pertaining to the surgery including pre- and post hospitalization were settled by the Company but subsequent expenses which were incurred for oral chemotherapy were not paid by them. Shri Dayalani mentioned that in continuation of the surgery, his treating surgeon, Dr. Jagannath, in consultation with the chemotherapist, recommended Intravenous Chemotherapy and Radiotherapy, but looking to his age (74 years) and health, post operation, the doctor prescribed Oral Chemotherapy (6 cycles) in the form of “Capecitabine-Xeloda Tablets” to be taken at home and was advised follow up every two weeks. The first cycle of CT which commenced within 60 days after the operation, was settled by the TPA – Health India, in full amounting to Rs. 16,115/-. The claim for 2nd cycle of CT of Rs. 11,392/- which was submitted to the TPA - M.D. India (Change of TPA) under the next policy was initially not considered but on the strength of a letter from Dr. Jagannath, the same was settled in full. However Shri Dayalani has informed this Forum that the expenses incurred by him for 3rd,4th, 5th Cycle amounting to Rs. 40,095/- and the last claim for 6th cycle amounting to Rs. 16,902/- have not been settled by the TPA/Company.

The analysis of the case reveals that the dispute is essentially relating to coverage of expenses for continuous oral chemotherapy which was prescribed as an additional treatment, post surgery. Admittedly, the oral chemotherapy would be continuous and long drawn in nature with periodic check ups by the specialist. Mediclaim Insurance Policy covers reimbursement of the cost of hospitalization expenses reasonably and necessarily incurred with a certain restriction on the period of hospitalization viz. one month pre-hospitalisation period, the actual hospitalization period and a post hospitalization period of two months. Since the date of discharge from the hospital after the basic hospitalization for surgery in the present case was on 25/1/2006, the post hospitalization expenses would be admissible upto the period 25/3/2006. The first cycle was scheduled from 4/3/2006 to 17/3/2006 and the claim lodged in this respect was settled by the TPA as it fell well within the post hospitalization period. The second cycle of CT commenced from 25/3/2006 to 7/4/2006 and the claim lodged for Rs. 11,392/- was also settled by the Company and they have been fair enough to accommodate the entire expenses for the 2nd cycle of oral CT even though the period of treatment fell a little beyond the post hospitalization time limit. The subsequent claims have been rejected by the company on the ground that they were governed by 60 days post hospitalisation limit of the policy which would justify their approach. Since the nature of oral CT was a continuous one, to be taken at home, the Insured cannot assume that all those expenses would be covered under the policy as the Mediclaim

Policy is governed by condition 3.1 and 3.2. It is admitted that the treatment of Cancer and similar other critical ailments require continued medical treatment , but to allow reimbursement of the entire cost would contravene the provisions of Mediclaim Policy. However, to resolve the dispute, I decide, to allow the reimbursement of the expenses for one more cycle of CT along with investigation and check up costs, as a special case, over and above the settlement done by the Company, to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI-831 of 2006-07
Sameer Sablok
V/s.
The New India Assurance Co. Ltd.

Award Dated : 27.09.07

Shri Sameer Sablok is covered under Mediclaim Policy No. issued by The New India Assurance Co. Ltd., Divisional Office 140100 alongwith his wife and son. His son aged 2 years had injury to his Right Foot and was bleeding. He was taken to Dr. Manoj Kumar J. Manjawani who advised him to admit the patient at CritiCare Multi Specialty Hospital for the treatment of Avulsion Right Foot. He was admitted in the Hospital and was discharged on the same day. The claim was rejected under exclusion clause 2.3 of the Policy Terms and Conditions, “Expenses on Hospitalization for minimum period of 24 hours are admissible”. He then represented his case to the Grievance Cell of the Insurance Company, received the same reply. Aggrieved by the decision of the Company, he lodged the complaint with this Forum for redressal of his grievance.

Parties to the dispute were heard. Insured’s wife submitted that her 2 years old son’s foot was stuck in the sink and when servant tried to pull his leg, he was injured and flesh came out and child was bleeding he was hospitalized and was operated under General Anesthesia and had 36 stitches. She also submitted at that time she was 6 months pregnant and ailing father-in-law was alone in the house. They could not stay in the hospital and had to come home the same day. Proof of Birth Certificate of 2nd Child and Death Certificate of Father-in-law was produced

In the present case, the basic criteria for admissibility of the claim, “hospitalization for minimum period of 24 hours” was not been fulfilled and hence the repudiation of the claim is tenable.

However, 36 stitches were given to a 2 years young child under general Anesthesia and mother was 6 months pregnant and other family circumstances forcing them to take the child at home, Ombudsman gave some relief to the Complainant on an ex-gratia basis and settled the claim for 50%.

Mumbai Ombudsman Centre
Case No. : GI-682 of 2006-2007
Shri Saurabh Agarwal
V/s.
ICICI Lombard General Insurance Company Limited

Award Dated : 28.09.07

Shri Saurabh Agarwal was insured under the Health Care Family Policy alongwith his family. Complainant’s son Master Saumil, aged 2½ years old was admitted in Bhatia Hospital for loss of speech and was diagnosed to be suffering from Landau Kleffner Syndrom. Complainant lodged a claim for Rs. 53,014/- which was repudiated under Exclusion Clause No. C-1 “Claims arising on account of or in connection with any pre-existing illness shall be excluded from the scope of cover”.

Insured appeared and deposed before the Ombudsman. He submitted Mast. Saumil aged 2½ years suffered from Epilepsy three to four times when he was 7 months old. After that he was absolutely normal. But all of a sudden he lost his speech and was admitted in Bhatia Hospital, was treated, it was a real miracle that he gained his speech by the treatment of Dr. Desai. His claim was repudiated by ICICI Lombard on the ground that disease was pre-existing. Insurance Co. submitted that there is history of Epilepsy mentioned in the Indoor Case Papers not only for Mast. Saumil but for his father and sister also suffered from the same syndrome. In the proposal form they had not mentioned anything about this fact. They had taken opinion of the Doctor and based on the same repudiated the claim that the present ailment has arisen due to Epilepsy suffered earlier. The analysis of the file with all the records of Hospital Indoor Case Papers and other relevant documents submitted by ICICI Lombard revealed that Master Saumil was admitted in the Hospital for Recurrent Attacks of Seizures and he has history of seizures 3-4 attacks in past, 1st attack when Saumil was 7 months old. As such the boy was suffering from the said disease prior to policy inception, which was not disclosed in the proposal form. Complainant's daughter- Vanshika was also admitted in Bhatia Hospital on 28.05.2006 for treatment of Landau Kleffner Syndrome and she too was suffering from attacks of Seizures when she was 2½ years old, prior to policy inception and this material fact was not disclosed while taking the policy. There is a history of epilepsy in the family i.e. father and sister suffering from this disease. Landau Kleffner Syndrome is a disorder with seizures starting in childhood in which the patient losses skills, such as speech, and develops behavior characteristics of autism. A major feature of the Landau Kleffner Syndrome is the gradual or sudden loss of the ability to understand and use spoken language.

In view of the above, there is no valid ground to interfere in the decision of the Insurer and claim was not settled.

Mumbai Ombudsman Centre
Case No. : GI-664 2006-2007
Shri Umesh Ramanlal Varma
V/s.
The United India Insurance Co. Ltd.

Award Dated : 18.09.07

Shri Umesh Ramanlal Varma alongwith his family is covered under an Individual Mediclaim Insurance Policy issued by United India Insurance Co. Ltd., He has been holding this Insurance cover since 2000. Shri Umesh Varma met with vehicular accident on 17.01.2002. Primarily he was admitted in the Casualty of Nair Hospital and then shifted to Dr. Kamdar's Nursing Home same day. As per the Discharge Card he had head injury with concussion of Brain with CLW upper hip with active bleeding with neck of radius (R) with Haemarthrosis and contusion Ankle with injury to ATF Ligament of Ankle with multiple friction burns over (R). He lodged the claim and the same was settled by the Insurance Company. Subsequently he was again admitted twice in Dr. Kamdar's Nursing Home for Pain, Swelling and painful movements (R) Elbow, excision of head and neck of radius (R) was done for acute pain (R) Hip and fever and calcified nodule. He was treated for exploration and excision of calcified nodule. Both the claims were settled by the Insurance Company.

He lodged claim of Rs. 1,12,397/- for all the above three hospitalization. Insurance Company repudiated the claim and asked him to give explanation why the treatment was not done on OPD basis. Doctor certified that Patient had acute PID L34, L35 with Radioculopathy, weakness and required hospitalization after the Epidural Injection for

observation. Based on the word “Observation”, Insurance Company repudiated all the claims. The Epidural Injections were given in OT under anesthesia, and at the time of hospitalization on 25.03.2005, MRI, X-Ray was done on urgent basis and traction was given. Company also obtained opinion of their panel doctor, Dr. H.A. Chiniwala who vide letter dated 03.08.2006 opined that “under usual circumstances, such patients can be managed on Out Patient Basis.” An analysis of the entire records produced to this Forum would reveal that prior to suffering from vehicular accident Insured was admitted in Jaslok Hospital from and was diagnosed as IHD and PTCA to KSD was done. Now the complaint is lodged for the ailment which Insured is suffering after the vehicular accident viz off and on Acute backache, PID L34, L35 with Radioculopaty, Weakness of EHL and EDL, Pain in (L) Lower Limb. X-Ray of Lumbo Sacral Spine AP/LAT was taken on 08.03.2005 which showed decrease disc space L23, L34, L45 I L5 S1 and Loss of Lumbar lordosis suggests paraspinal muscle spasm. Patient was treated by Dr. Kamdar. He was advised complete bed rest, Pelvic Traction was given and Epidural Injection for Lumbar spine was given in OT under anesthesia. On a scrutiny of the records it is observed that the Insured was basically admitted only for having Epidural injection. which could have been taken during Day Care also and hence not tenable.

However, the decision for repudiation of the claim for hospitalization from 25.03.2005 to 02.04.2005 needs some consideration in view of the Investigations including MRI and X-Ray for finding the cause of backache and pain in Lower Limb and the treatment of Traction, Physiotherapy along with Epidural Injection, Medicines and further management to treat the ailment. In view of this I am inclined to give 75% of the admissible expenses for hospitalization.

Mumbai Ombudsman Centre
Case No. : GI-438 of 2006-2007
Shri Madhu D. Parikh
V/s
The New India Assurance Company Ltd.

Award Dated : 28.09.07

Shri Madhu D. Parikh alongwith his wife was insured with The New India Assurance Co. Ltd., under a Mediclaim. Shri Parikh was admitted in Cumballa Hill Hospital and was diagnosed as “An Infective Exacerbation of Bronchitis”. Complainant had a history of PTCA for Ischemic Heart Disease; hence there was exclusion in the policy for Heart Ailment. His claim was rejected by TPA giving reasons that as per the history patient was not an asthmatic and as per policy, hypertension and heart related ailments were excluded. Based on the indoor case papers it was a case of cardiac asthma (cardiac failure) and treatment also given on these lines hence repudiated as per exclusion. Shri Parikh obtained a neutral opinion of Dr. J. C. Kothari, Consulting Physician and Chest Specialist, dated September 17, 2004 and submitted the same to TPA. The certificate issued by Dr. Kothari clearly stated that “the patient did not have cardiac asthma but acute exacerbation of asthma due to infection”. Based on Doctor Kothari’s opinion the hospitalization claim of complainant was settled.

The Complainant then made Pre and Post Hospitalisation claim of Rs. 51,935/-. As per TPA Discharge Voucher dated 29.12.2004 first they settled the claim for Rs. 24,277/- . The Complainant accepted the same and made representation to TPA as well as company for settlement of balance amount for which he received rejection letter giving reasons thereof. He approached Ombudsman in the matter for settlement of his claim.As scrutiny reveals that out of this amount Rs. 15,000/- alone pertains to family physician’s visit . It is noted that the complainant has raised a bill for his family

physician's visit during the hospitalization also. It is observed that in the present case, his family physician, who has specialized in Ayurvedic line of treatment, has made about 23 visits and charged for it @ Rs. 600/- per visit. As regards, the dispute in respect of non-allowance of certain medicine bills amounting to Rs. 14,648/- the Company has stated that they don't fall under post-hospitalisation period. The Company was directed to explain the reason against each item, as to why it does not fall within 60 days period and reimburse those which are payable and satisfy the Complainant under advice to this Forum.

This is a very unusual approach of the Company, nonetheless, since the Company has neither represented the hearing nor submitted a written submission denying the statement, the Company was directed to pay 50% of the expenses under this head.

Mumbai Ombudsman Centre
Case No. : GI-875 of 2006-2007
Shri Jotinder Singh Babber
V/s.
The Oriental Insurance Company Limited

Award Dated : 17.09.07

Shri Jotinder Singh Babber, aged 68years, along with his wife covered under Mediclaim Policy since June 1987 with The Oriental Insurance Co. Ltd. He also took another policy in the year 1999 where he covered his wife and son.. Second policy has exclusion of "Heart Disease". He continuously renewed both the policies without any interruption.

He was admitted in Cumballa Hill Hospital on 01.02.2006 and was discharged on 04.02.2006. He undergone CABG. His claim was rejected under Exclusion clause No. 4.1 – Pre-existing as Discharge Card mentioned k/c/o HTN since last 20 years.

He submitted that history of DM was recorded incorrectly and was not before first policy. He submitted that when earlier 5 claims from 1989 to 2000 were settled, how the company now denying this claim. The Oriental Insurance Co. Ltd., D.O. submitted that the claim was repudiated based on the history of HTN since last 20 years as mentioned in Indoor Case papers and Discharge Card. Insurance Company did not had any previous record of claims settled, the Insured was advised to submit the documents of earlier hospitalization if any with him and also record of CABG at the Cleaveland Clinic (U.A.S.).

It is observed from the medical papers submitted that he had history of HTN but the duration has not been mentioned in the Cleveland Clinic Foundation Discharge Summary. From the Reeport of Bombay Hospital Diabetic Clinic dated 30.10.2001 where it is mentioned that "HTN since last 10 years". This takes the suffering from HTN around 1991.

The Policy is actually from 1987 for which the complainant has given Policy Copy. Policy is in force for the last 19 years and HTN as per Bombay Hospital Report is for 15 years as on date

The Insurer had paid all the earlier claims pertaining to heart problem and the present claim is denied on the history of HT recorded in the hospital papers without producing any evidence. In the discharge card of Breach Candy Hospital no history has been mentioned but the BP reading recorded was 130/100. The Complainant has also not produced evidence to prove the onset of HTN. Since his earlier claims were settled and the first mediclaim Policy was taken long back, the benefit of doubt was given in favour of the Complainant