Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11-003-0081
Dr. K K Patel
Vs
National Insurance Co. Ltd.

Award Dated : 3.10.2007

Partial repudiation of Mediclaim : An amount of Rs. 26250/- was disallowed while settling the Mediclaim. The Complainant had in one go purchased medicines in gross. The reimbursement for the medicines to be used within the 60 days of post-hospitalisation was reimbursed and the decision of the Respondent not to reimburse cost of medicines for the period beyond 60 days was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0067
Mr. S D Vyas
Vs
New India Assurance Co. Ltd.

Award Dated : 4.10.2007

Repudiation of Mediclaim: The Insured was admitted for Intestinal Obstructions. The treating doctor on inquiry, had mentioned in the consulting paper that the Insured does not have any record of previous surgery done before 16 years probably for benign correction. This remark of the treating doctor led the Respondent to repudiate the Claim citing the disease to have been pre-existing. There were no other documents to substantiate any pre-existing consultations. The Respondent could also not prove whether the current treatment had any connection with any previous surgery and whether it constitutes non disclosure of material facts. As such, the Respondent was directed to pay the full claim amount after deducting Ambulance Charges claimed by the Insured.

Ahmedabad Ombudsman Centre
Case No. 11-002-0118
Ms. K T Patel
Vs
New India Assurance Company Ltd.

Award Dated : 5.10.2007

Repudiation of mediclaim due to delayed submission of Claim Forms: The Complainant was hospitalised for treatment of Rt. Renal Calculus. After 8 months of discharge, the Claim papers were submitted to the Respondent. The reason attributed were delay on the part of the Agent to submit the forms. 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. 11-002-0122
Mr. Nilesh Shah
Vs
New India Assurance Company Ltd.

Award Dated: 24.10.2007

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. During the course of Hearing, the Respondent agreed to settle the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0167
Mr. P B Savalia
Vs
New India Assurance Company Ltd.

Award Dated: 25.10.2007

Repudiation of Mediclaim: The Respondent admitted the Claim and issued a cheque for Rs. 1818/-. The same had been fraudulently encashed by someone else. The Respondent had been informed about the non-receipt of the claim cheque long back, but they had not investigated the matter properly. Under these circumstances, the Respondent was directed to pay Rs. 1818/- plus and exgratia amount of Rs. 100/- towards expenses for postage, telephone ext.

Ahmedabad Ombudsman Centre
Case No. 11-005-0110
Mr. B D Daftari
Vs
Oriental Insurance Company Ltd.

Award Dated : 31.10.2007

Repudiation of Mediclaim. The Insured underwent surgical treatment of removal of Dermoid Cyst from the left ovary of the Insured. Papers on record contained Discharge Card etc. which showed that the Insured was treated for sterility. Hence on opinion of their Medical Referee, the Respondent repudiated the Claim since the policy excluded payments for treatment of infertility. However, books of gynaecology gave a contradictory opinion. The Case was hence referred for another opinion by the Forum. The expert gynaecologist opined that 'Cyst does not impair ovum formation. Dermoid cyst and pregnancy can exist together'. Hence the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 14-002-0114
Mr. A A Frank
Vs
Bajaj Allianz Life Insurance Co. Ltd.

Award Dated : 31.10.2007

Delay in settlement of Mediclaim : The Respondent pointed out that the Insured was hospitalised 26 times for which an amount of Rs. 3.56 has been released in the last 2 years. Delayed intimation of claim was waived in 18 occasions and delayed submission of claim in 21 occasions considering the fact that the Insured was suffering from Cancer. Besides, the records did not show any evidence of malafide intention on the part of the Insurer to harass the Complainant. Even this Claim had been paid by exercising discretionary power. As such it was decided that the Complainant is not entitled to receive any interest on the delayed settlement of Mediclaim as prayed for.

Ahmedabad Ombudsman Centre
Case No. 11-002-0180
Mr. V M Patel
Vs
New India Assurance Company Ltd.

Award Dated : 1.11.2007

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. During the course of Hearing, the Respondent agreed to settle the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0132
Mr. Y Pandya
Vs
New India Assurance Co. Ltd.

Award Dated : 2.11.2007

Repudiation of mediclaim: The Insured was hospitalised for Hernia. The Mediclaim Policy excludes treatment for Hernia in the first year of the policy only if it is 'congenital'. In the present case, the treatment has not taken place in the first year of the Policy. During the course of Hearing, the Respondent agreed to settle the Claim. An amicable settlement was reached and joint agreement to this effect was signed by both parties.

Ahmedabad Ombudsman Centre
Case No. 11-005-0098
Ms. G R Jani
Vs
Oriental Insurance Company Ltd.

Award Dated : 5.11.2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of Atrial Septic Defect (Congenital heart disease). Claim was repudiated on recommendations of the investigating doctor, who mentioned in his report that the disease is always present from birth, may be asymptomatic for many years. The Respondent had no evidence to prove this fact.

Congenital Diseases are excluded for payment, if the treatment is taken in the first policy year. The subject Claim is for a treatment which was taken in the 2nd policy year. As such, it does not attract provisions of exclusion under the Policy. The Respondent was hence directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 14-003-0094
Dr. N L Jagada
Vs
National Insurance Co. Ltd.

Award Dated : 5.11.2007

Repudiation of Mediclaim on the grounds that hospitalisation is not justified: The Insured person, himself a Doctor aged 72 years was operated for infectious sebaceous cyst under local anaesthesia. Except for local anaesthesia and oral medication, no other active management was done. As such, the TPA of the Respondent asked for the opinion of the Respondent whether to accept the Claim since the cyst was malignant in nature, biopsy was carried out and the age of the Insured was more the Respondent did not give any valid reason nor rejected the Claim. In view of the fact that the advanced age of the patient required post-operative care in a hospital, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0129
Mr. P Jain
Vs
Oriental Insurance Company Ltd.

Award Dated : 7.11.2007

Repudiation of Mediclaim. The following amounts were recovered while settling the Mediclaim Claim

- Rs. 1000/- Anaesthesia Charges-Receipt not submitted
- Rs. 4400/- Operation Charges-Charges on higher side as per opinion of the panel doctor of the Insurer

Since the original receipt for anaesthesia charges were not submitted, the same was not allowed by the Forum. However, in the absence of any uniform yard-stick to justify the reduction in operation charges and in a situation where the expenses have been paid for by the Complainant supported by proper bills and receipts, it was decided to allow the Operation Charges recovered from the Complainant in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-003-0046
Mr. V M Jaimalani
Vs
National Insurance Co. Ltd.

Award Dated: 16.11.2007

Repudiation of Mediclaim since the disease was pre-existing. The Insured was treated for Retinitis Pigmetosa (a disorder of the eyesight) in the third month of commencement of the policy. Claim thereof was repudiated by invoking the pre-existing

clause. The treatment papers contained certificate which stated that the Complainant was able to do his regular duties before 2 years. Gradually, he experienced deterioration of vision. The Complainant's version that he had not consulted an ophthalmologist within these 2 years and had for the first time directly taken treatment from an ayurvedic hospital that too within the first 3 months of the policy proves the pre-existence of the disease. As such the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-002-0125
Mr. H B Vaghasiya
Vs
New India Assurance Co. Ltd.

Award Dated: 16.11.2007

Repudiation of Mediclaim. The Insured was hospitalised for treatment of chest pain, giddiness, perspiration and k/c/o hypertension. She was transferred to another hospital for treatment of Interior Wall myocardial infarction, hyper-tension and hypothyroidism. The Respondent had called for certain papers from the Hospital through the Complainant. To obtain the attested copies of the Hospital records, the Complainant had paid Rs. 100/- to the hospital but the receipt got lost. In the absence of the original receipt, the Respondent could not get access to the records and hence closed the Claim file. During the course of Hearing, the Complainant agreed to once again pay Rs. 100/- to the Hospital and submit the original receipt thereof to the Respondent to enable them to re-open the Claim and pay the dues.

Ahmedabad Ombudsman Centre
Case No. 11-004-0075
Mr. P R Arora
Vs
United India Insurance Company Ltd.

Award Dated : 20.11.2007

Repudiation of Mediclaim. The Insured was admitted in a Mental patient's Hospital for episodes of gabhraman, un-easiness, restlessness, agitation, fear of death, excessive thoughts. The Claim was repudiated in the absence of any indoor case papers. However, the Hospital receipt giving breakup of charges and the Discharge Card gave details of the day to day treatment given in the Hospital. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0069
Ms. R N Soni
Vs
Oriental Insurance Company Ltd.

Award Dated : 20.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 33479/- payable, the Respondent had settled the Claim for Rs. 18679/-. During the

course of Hearing, the Respondent agreed to pay the balance amount of Rs. 15000/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0160
Mr. J M Prajapati
Vs
New India Assurance Company Ltd.

Award Dated: 20.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 10000/- payable, the Respondent had settled the Claim for Rs. 5526/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 4474/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0047
Sri M M Patel
Vs
Oriental Insurance Company Ltd.

Award Dated: 26.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 41421/- payable, the Respondent had settled the Claim for Rs. 18621/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 22800/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0096
Mr. B M Thakkar
Vs
Oriental Insurance Company Ltd.

Award Dated : 26.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 32480/- payable, the Respondent had settled the Claim for Rs. 19480/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 13000/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0100
Mr. R B Shah
Vs
Oriental Insurance Company Ltd.

Award Date: 26.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 27184/- payable, the Respondent had settled the Claim for Rs. 18334/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 8850/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0099
Ms. H R Shah
Vs
Oriental Insurance Company Ltd.

Award Date: 26.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 27293/- payable, the Respondent had settled the Claim for Rs. 18443/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 8850/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0073
Mr. B S Thakkar
Vs
Oriental Insurance Company Ltd.

Award Date: 26.11.2007

Partial settlement of Mediclaim. For a total amount of Rs. 42182/- payable, the Respondent had settled the Claim for Rs. 19101/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 23081/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0061
Sri. V M Shah
Vs
United India Insurance Company Ltd.

Award Dated : 27.11.2007

Partial settlement of Mediclaim. The Respondent settled the Claim for 50% amount due to an exclusion in the policy which stated '50% deduction for exclusion of Diabetes related claim'. An examination of the policy document showed that the policy was initially issued for a Sum Insured of Rs. 50000/-. When the Complainant requested for an increase in Sum Insured by Rs.10000/-, the policy was issued with no exclusion for the initial sum insured and an exclusion for Diabetes related disease only for the increased sum Insured of Rs. 10000/-. In view of this, the decision of the Respondent to settle the entire claim only for 50% amount is not justified. As such, the Respondent was directed to settle the full claim with interest at 8% for the delay.

Ahmedabad Ombudsman Centre
Case No. 11-002-0077
Mr. A R Patel
Vs
New India Assurance Company Ltd.

Award Date: 29.11.2007

Repudiation of Mediclaim on the grounds that treatment was for a condition due to consumption of alcohol:: The Insured was hospitalised for treatment of Cirrhosis of Liver and severe haematemesis. The indoor case papers revealed provisional diagnosis of Alcoholic Blood Disease. The Hospital clarified by a letter that the Doctor on duty was new and by mistake had written ALD as provisional diagnosis. However

the fact that the Hospital did not carry out any other tests to rule out the possibility of Cirrhosis due to Hepatitis Virus B/C, it was clear that the Doctors in the Hospital were clear that the disease was ALD and not any other type of Chronic Liver Disease. As such, the appeal of the Complainant was not found to have been maintainable and the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0163
Mr. V S Gosai
Vs
New India Assurance Company Ltd.

Award Dated : 29-11-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for treatment of Ureteris Stone. According to the Indoor Case papers of the Hospital, the Patient was a known case of renal stone and he had already undergone right sided ureteroscopy before six years. The Policy had incepted only 3 years back. The Complainant submitted that the history of 6 months had been wrongly noted by the hospital as 6 years. To support the case, he provided a letter of the Hospital which had so many inconsistencies in the syntax, spelling and language that it could not be relied upon as a document that could be placed on record. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-005-0121
Mr T G Patel
Vs
Oriental Insurance Company Ltd.

Award Dated : 29.11.2007

Repudiation of Mediclaim. The subject Mediclaim Policy incepted five years back. However, the Cheque for payment of renewal premium was dishonoured due to ‘insufficient funds’. Since, there was a break in renewal of the policy, a fresh proposal form was obtained and the policy was considered to have started afresh. The Claim arose within the first year of the fresh policy for treatment of benign prostate hyperplacia. Claim was rejected since the policy specifically excludes expenses for treatment of diseases like cataract, benign prostatic hypertrophy etc. The clause being clear and un-ambiguous, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0299
Mr. V K Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 30-11-2007

Repudiation of Mediclaim: It was observed that the Complainant had filed a dispute with the Hon’ble Consumer Dispute Redressal Forum which had registered the Complaint. In view of this, as per the Redressal of Public Grievance Rules, 1998 the Complaint cannot be processed further by the Hon’ble Insurance Ombudsman.

Ahmedabad Ombudsman Centre
Case No. 11-002-0144

Mr. C U Shah
Vs
New India Assurance Company Ltd.

Award Dated : 30-11-2007

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Insured was hospitalised for treatment of Cardiovascular stroke and hypertension. The Discharge Card of the Hospital stated that it is a known case of hypertension. There was a letter by the treating Doctor who had noted that the Insured was suffering from Hypertension since 1 year under irregular treatment. The Doctor had again issued certificates stating that Hypertension was detected for the first time on the day of hospitalisation and that the incorrect history was noted due to false statement by the relatives. Relying on the date of onset of hypertension as one year prior to the date of hospitalisation, it was observed that the same incepted after commencement of the Insurance coverage. So the disease was not pre-existing. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0144
Mr. H B Gohil
Vs
New India Assurance Co. Ltd.

Award Dated : 30.11.2007

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was admitted to a Hospital for treatment of peri-anal abscess and fistula-in-ano. The treating Doctor has in his certificate noted that the Complainant had a minor abscess in the perianal region before 15 years. Some pus had accumulated and the same was treated by a family doctor without any stitches. The Policy commenced 7 years back. Thus, pre-existence having been proved beyond doubt, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0091
Mr. D J Patel
Vs
United India Insurance Company Ltd.

Award Dated : 30-11-2007

Partial settlement of Mediclaim. An amount of Rs. 125/- had been recovered by the Respondent while settling the Mediclaim Policy. During the course of Hearing, the Cheque for Rs. 125/- was presented to the Complainant who agreed to accept the cheque only if interest of Rs. 10/- was paid to him for the delay in settlement, which was awarded.

Ahmedabad Ombudsman Centre
Case No. 11-004-0358
Mr. P D Shah
vs
United India Insurance Company Ltd.

Award Dated: 30.11.2007

Partial settlement of Mediclaim: Claim for hospitalisation was settled after 16 months by deducting an amount of Rs. 170675/- detailed under

1. Rs .63000/- towards physician, surgeon and anaesthesia charges : Later admitted by the Respondent to be payable.
2. Rs. 85782/- towards Chemotherapy 6 cycles-Medicine Bills as per prescription of the treating Oncologist from Hinduja Hospital, Mumbai. The Forum found the amount admissible in totality.
3. Rs. 19008/- towards discount. The Respondent could not justify the deduction in the Self Contained Note and in Hearing. So found admissible.
4. Rs. 1000/- pre-hospitalisation expenses paid to Doctor/Hospital.

In course of Hearing, the Respondent could not put forward any argument worth recording and accepted the factual situation. As per analysis of the whole complaint it was observed that an amount of Rs. 1885/- towards cost of registration, administration charges and charges for linen, blanket etc. were not admissible. Due to the extreme delay in settlement of claim, the balance amount was awarded with an interest at 6%.

Ahmedabad Ombudsman Centre
Case No. 11-005-0140
Mr. S Trivedi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 10.12.2007

Repudiation of Mediclaim due to late submission of Claim Forms. During the course of hearing the Respondent agreed that they had not gone into the merits of the case to determine any infirmity as to the genuineness of hospitalisation or quantum of claim amount since it was a prima facie case of inordinate late submission by about 122 days. After persuasion during Hearing, the Respondent expressed their willingness to condone the delay and process the claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0128
Mr. A K Thakkar
Vs
Oriental Insurance Company Ltd.

Award Dated: 10.12.2007

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was admitted to a Hospital for treatment of umbilical Hernia. The Claim had been repudiated stating that it was related to the incisional Hernia operated 9 years back consequent to family planning operation. The papers on record showed that the said operation had been disclosed in the Proposal Form while going in for Mediclaim. Besides the current hernia had no nexus with the one suffered 9 years back. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0101
Mr. R R Modi
Vs
United India Insurance Co. Ltd.

Award Dated: 10.12.2007

Partial settlement of Mediclaim: While settling the Claim, the Respondent had recovered Rs. 8100/- towards Room Charges and Visit Charges since hospitalisation not justified for more than 3 days. The Respondent informed that the same had been

subsequently settled. However, they recovered Rs.2278/- towards Surcharges, Rs. 100/- towards admission charge and Rs.308/- towards cost of medicines not related to the disease. Since, the same were not allowed as per policy condition, the Complainant was not allowed any further relief.

Ahmedabad Ombudsman Centre
Case No. 14-005-0141
Ms. R G Shah
Vs
Oriental Insurance Company Ltd.

Award Dated : 11.12.2007

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was admitted to a Hospital twice for treatment of

1. Cellulitis of right lower limb and
2. Hypertension, IHD, DM/Acute Left Ventricular Failure.

The Case History of the Treating Hospital noted that the Complainant had a history of hyperthyroidism since 21 years and hypertension/IHD/DM since 7 years. Both the claims were repudiated. During the course of hearing, the Respondent could not shown any relation of the pre-existing ailment with the present hospitalisation for treatment of Cellulitis. Hence, the Respondent was directed to settle the claim for the same. However, the pre-existing diseases definitely had a relation with the second bout of hospitalisation for which the decision of the Respondent to decline the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-008-0016
Mr. N T Shah
Vs
Royal Sundaram Alliance Co. Ltd.

Award Dated: 11-12-2007

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was admitted to a Hospital for Total Knee Replacement of Left Leg. The Operating Surgeon had noted that the Complainant had pain in both the knees and osteoarthritis for the last 1½ years, Hypertension for 1 year and IHD for 2½ years. Claim had been repudiated on the opinion of the in-house Doctor who had noted that such an advanced disease requiring knee replacement takes longer time to develop. Hence the same was treated as pre-existing. Meanwhile, the Operating Surgeon vehemently refuted this assumption. Hence it was decided to take a neutral opinion from another Orthopaedic Surgeon chosen by the Forum who opined that it is difficult to predict the condition as pre-existing. Considering all the probabilities in the case, he opined that the Claim is payable as per the terms of the Policy. Based on this opinion, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0093
Dr. G G Ladla
Vs
New India Assurance Co. Ltd.

Award Dated : 13.12.2007

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was admitted to a Hospital for MDR Koch's with secondary infection and Candidasis-Left Lung. The Discharge Summary noted history of Pulmonary Koch's for the last 3 years. During the course of hearing, the Complainant showed details of claims paid for the said disease in the earlier years by the same Respondent. Taking a wholesome view, it was decided to allow payment of the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0090
Mr. R J Valani
Vs
United India Insurance Company Ltd.

Award Dated: 20-12-2007

Repudiation of Mediclaim on the grounds that hospitalisation is not justified: The treating Orthopaedist after taking X-rays etc., opined that the Insured be admitted to the hospital for treatment of cellulites in left foot. Operation under regional anaesthesia was done. The Hospital receipt showed that that Bed Charges etc. were given for 4 days while the Claim was for hospitalisation for 6 days. The treating physician confirmed that indoor treatment records were not available. As per the conditions of a Mediclaim Policy, the Respondent is well within their rights to insist upon the Complainant to furnish details of indoor treatment papers for settlement of Claim. Since, the Complainant failed to comply to the requirements, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-004-0357
Mr. P D Shah
Vs
United India Insurance Company Ltd.

Award Dated: 27-12-2007

Non settlement of Mediclaim. The Respondent submitted that they are not in receipt of the Claim papers. They also submitted that the Agent had lost the papers and had unfairly used the office stamp to suggest that the documents had been submitted to the Office. During the course of Hearing, the Complainant handed over a copy of another letter similarly stamped by the Respondent for the earlier claim. Hence the Respondent's argument that the rubber stamp of the Office was being fraudulently used cannot be established. Besides the Complainant had sent several follow-up letters before approaching the Insurance Ombudsman. The Respondent had never before informed him that the Claim forms etc were not received by them. It is only now that they are raising such a plea. Decision in such a case requires detailed enquiry to be conducted, calling for witnesses, detailed evidence, cross examination for which the Forum is not empowered by law nor structurally equipped to. As such, the Complainant is advised to take up the matter with the appropriate Forum for the resolution of his grievance.

Ahmedabad Ombudsman Centre
Case No. 11-005-0126
Dr. M K Bhansali

Vs

Oriental Insurance Company Ltd.

Award Dated : 01.01.2008

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured aged 71 underwent Total Knee Replacement of the Right Knee. Reimbursement was restricted to Rs. 45000/- the Sum Insured prior to increase in coverage. Papers on record showed that the left knee was operated in 1999 when the Sum Insured was Rs. 45000/-. In 2001, after undergoing various medical/pathological tests, the Sum Insured was increased to Rs.110000/- without any exclusion. While rejecting the claim for the full sum insured, the Respondent has written that the ailment Osteoarthritis is a chronic ailment which develops in the old age. The degenerative process had already started in 1999 resulting to TKR of left knee. Hence the current claim cannot be paid for a sum exceeding the SI prior to such onset. However, it was observed that the current TKR has taken place after 7 yrs of the previous one. History given in the Hospital too noted Rt. Knee pain-arthritis for 5 years. The two knees of a human body are two independent limbs. It is not necessarily so that when one knee is operated, the other should necessarily get operated. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre

Case No. 11-003-0120

Mr. M S Gohel

Vs

National Insurance Co. Ltd.

Award Dated: 01.01.2008

Repudiation of Mediclaim. The Complainant had submitted claim for Rs.33880/- for surgical treatment of prostate enlargement. The Respondent found that an amount of Rs. 6600/- was to be disallowed since the same did not contain the required information. Both the parties signed a joint agreement to this effect during the course of Hearing.

Ahmedabad Ombudsman Centre

Case No. 11-005-0257

Mr. M P Shah

Vs

Oriental Insurance Company Ltd.

Award Dated : 07.01.2008

Partial settlement of Mediclaim. For a total amount of Rs. 92241/- payable, the Respondent had settled the Claim for Rs. 61066/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 3012/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre

Case No. 11-005-0258

Mr. C P Sanghavi

Vs

Oriental Insurance Company Ltd.

Award Date: 09.01.2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified: The Insured was hospitalised for treatment of Crohn's disease by Remicade Therapy. The Claim was repudiated since there was no need for hospitalisation. The Complainant submitted that his previous insurer had settled the Claim for the same therapy. He also submitted a certificate of a renowned Gastro-enterologist justifying the hospitalisation. During the course of Hearing, the Respondent confirmed that they had not taken opinion of an expert before repudiating the claim. After mediation, they agreed to process the claim afresh within 30 days.

Ahmedabad Ombudsman Centre
Case No. 11-005-0142
Mr. K C Bhavsar
Vs
Oriental Insurance Company Ltd.

Award Dated: 24.01.2008

Repudiation of Mediclaim: The Insured was admitted for treatment by Kshar Sutra application Private Ayurvedic Hospital. Claim was repudiated on the ground that the Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. Since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0029
Mr. R B Agrawal
Vs
New India Assurance Co. Ltd.

Award Dated: 24.01.2008

Partial settlement of Mediclaim. The Insured was hospitalised for severe high density P Falciparum with Renal Azotemia. While settling the Claim, an amount of Rs. 24890/- was disallowed since it pertained to treatment of Bronchial Asthma for which a history of 20 years was recorded by the Hospital. During the course of Hearing, the Complainant explained in detail the necessity of the treatment. He also submitted a copy of the X-Ray Report. The Respondent took a fresh opinion from their expert Doctor and that expert clarified that the Insured had asthma-allergic bronchitis for 2 years. The same is also confirmed from several other papers available. In the result, the Respondent was directed to pay the balance of Rs. 24890/- to the Complainant in full and final settlement.

Ahmedabad Ombudsman Centre
Case No. 11-005-0119
Mr. N B Soni
Vs
Oriental Insurance Company Ltd.

Award Dated : 24.01.2008

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. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0278
Mr. D D Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 24.01.2008

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Fistula in Ano by Haemorrhoid Ligation. 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. As a result of medication, the Respondent agreed to settle the claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0159
Mr. J G Thakkar
Vs
Oriental Insurance Company Ltd.

Award Dated : 24.01.2008

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. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-008-0147
Sri. D A Patel
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 28.01.2008

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured had chest pain, perspiration when the Consulting Doctor advised immediate hospitalisation. This was followed by Angiography which disclosed Myocardial Infarction, CAD(Single Vessel Disease). The Echo-cardiogram showed positive Left Ventricular Hypertrophy which is an effect of long standing hypertension and could not have developed over 1 year 4 months. The Policy excluded expenses incurred in connection to the existence of any pre-existing conditions whether or not the Insured

person had knowledge of the same or not. As such, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-003-0168
Smt. C D Thakkar
Vs
National Insurance Co. Ltd.

Award Dated : 29.01.2008

Repudiation of Claim due to late submission of Claim documents: The Insured was diagnosed of Cancer buccal mucosa. Even though surgery, chemotherapy etc. were done, the Insured died. Two Claims were approved but two more were rejected due to delay in submission of the Claim documents even though the treatment was continuous. These claims pertained to a critical and serious phase of his treatment where the family gave more priority to save the life rather than to enter into Mediclaim paper formalities. The delay was not intentionally done. After going through the Complainant's submission, the Respondent spontaneously agreed to condone the delay and process the claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0089
Mr. R P Patel
Vs
New India Assurance Company Ltd.

Award Dated : 29.01.2008

Repudiation of Mediclaim due to late submission of Claim documents: The Insured was hospitalised for leg injury which took time for healing of the bone fracture. It was only after this that he could move out. The Complainant could also provide evidence that he could not attend his work with his employer. During the course of hearing the Respondent agreed to condone the delay and process the claim

Ahmedabad Ombudsman Centre
Case No. 11-005-0205
Mr. B H Gohel
Vs
Oriental Insurance Company Ltd.

Award Dated : 30.01.2008

Repudiation of Mediclaim on the ground that the disease was pre-existing. The Insured was under treatment for Chronic Gastritis and anxiety neurosis off and on due to which he was advised to be admitted in the Hospital where upper GI Scopy with video-endoscopy was done under local sedation. The tests diagnosed that the complainant was suffering from Hiatus Hernia with moderate oesohagitis and oesophagal ulceration, pangastritis with gastric erosion. Claim was repudiated by mentioning that the Insured had Chronic Gastritis prior to the inception of the policy. The papers showed that the complainant was hospitalised basically for the treatment of Dyspepsia, Dysphagia, Oesophagitis and Hiaturs Hernia Gastritis and the Respondent's plea to repudiate the Claim by mentioning that chronic gastritis is not tenable. As such, they were directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0204
Mr. B C Patel
Vs
United India Insurance Company Ltd.

Award Dated : 30.01.2008

Repudiation of Mediclaim on the grounds that Hospitalisation is not justified: The Insured experienced left side chest pain which prompted him to consult a specialist. When the treadmill test proved negative, the Insured was recommended to be admitted to the hospital. Claim was repudiated stating that hospitalisation was done only to carry out investigations. However, the Respondent could not produce any proof thereof. Moreover the Insured had chest pain which prompted him to consult a qualified doctor on whose advice he was admitted to a Hospital and then the processes in the Hospital is a matter on which the Insured cannot have any control. To deny reimbursement of expenses in such circumstances is not legitimate. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0254
Dr. J C Shah
Vs
New India Assurance Company Ltd.

Award Dated : 31.01.2008

Partial settlement of Mediclaim. For a total amount of Rs. 64500/- payable since the Sum Insured of Rs. 43000/- + 50% Bonus of Rs. 21500/-, the Respondent had settled the Claim for Rs. 43000/-. During the course of Hearing, the Respondent agreed to pay the balance amount of Rs. 21500/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0253
Mr. V G Trivedi
Vs
United India Insurance Company Ltd.

Award Dated : 31-1-2008

Partial settlement of Mediclaim. For a total amount of Rs. 5617/- claimed for, the Respondent had settled the Claim for Rs. 3677/-. The Respondent did not submit a written submission. During the course of Hearing, it was observed that Ambulance Charges of Rs. 600/- was not admissible but the Respondent was directed to pay the balance of Rs. 1340/- with interest for the delayed period in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-003-0249
Mr. L T Makwana
Vs
National Insurance Co. Ltd.

Award Dated : 06.02.2008

Repudiation of Mediclaim. The Respondent had agreed to admit the Claim only after the Complainant registered a case with the Insurance Ombudsman. During the course of Hearing, the Respondent could not explain any justification for repudiation of the Claim. They could only submit that the persons dealing with the claim did not have the technical knowledge to deal with such a claim. As such, the Respondent was directed to pay the Claim with interest for the delay.

Ahmedabad Ombudsman Centre
Case No. 11-004-0203
Mr. M M Upadhyay
Vs
United India Insurance Company Ltd.

Award Dated : 06.02.2008

Repudiation of Mediclaim on the grounds that Hospitalisation is not justified. The Insured aged 77 years was hospitalised in a Medical College Hospital for treatment of fracture of lateral malleolus following an accidental injury. This is the first claim in the policy history of 6 years. Claim was repudiated stating that hospitalisation was not justified. However, taking a holistic view, the Respondent was directed to pay Rs. 1192/- towards the Claim on an exgratia basis.

Ahmedabad Ombudsman Centre
Case No. 11-005-0224
Sri M D Baid
Vs
Oriental Insurance Company Ltd.

Award Dated : 07.02.2008

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. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0223
Mr. D C Parikh
Vs
Oriental Insurance Co. Ltd.

Award Dated : 08.02.2008

Repudiation of Mediclaim on the grounds that Hospitalisation is not justified. The Insured aged 12 years was hospitalised for foreign body (ear ring) removal with I & D on the advice of a Doctor. The screw of the ear ring was embedded in the ear lobe. Claim was repudiated stating that the treatment was in relation to a Cosmetic/Aesthetic Treatment or plastic surgery not necessitated due to an accident/disease. During the course of Hearing, the Complainant argued that in India, a girl wears an ear ring due to customs and not for aesthetic purposes. The surgery was done to stop the infection

rather than for cosmetic purposes. Besides Hospitalisation was done under Medical advice. Taking a holistic view, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0158
Sri. A B Patel
Vs
Oriental Insurance Company Ltd.

Award Dated : 14.02.2008

Repudiation of Mediclaim on the grounds that Hospitalisation is not justified: The Insured had cluster headache radiating to both eyes and pain in abdomen due to which he was admitted to a hospital where several investigations like X-Ray of Chest, C T Scan, USG of Abdomen, 2D Echo and TR X-Ray was done. All these investigations could have been done on an OPD basis. At the Hospital too, oral medication was given. As such, it gets established that the Insured got himself admitted to the hospital for various investigations. As such, the Respondent's decision to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-003-0217
Mr. V R Raval
Vs
National Insurance Co. Ltd.

Award Dated : 14.02.2008

Repudiation of Mediclaim: The Insured was hospitalised for Idiopathic Thrombo-cytopenic. As against an amount of Rs. 59121/- claimed, the Respondent settled for Rs. 25000/- as approved on a cashless basis. The Respondent submitted that the Sum Insured of the Mediclaim policy had been increased from Rs. 25000/- when a claim for the similar disease had been settled. As such, this disease would be treating as pre-existing for the increased amount. The Complainant informed that had this clarification been made earlier, he would not have raised the grievance at all.

Ahmedabad Ombudsman Centre
Case No. 11-002-0215
Dr. M R Patel
Vs
New India Assurance Company Ltd.

Award Dated : 14.02.2008

Repudiation of Mediclaim: The Insured had been operated for Cataract of the Left eye. The Policy commenced from 1997 with exclusion for Diabetes treatment. From 2003-04, the exclusion was modified to include exclusion for expenses for Cataract and Hysterectomy. Due to this exclusion, the current Claim had been repudiated. The Complainant challenged the imposition of further exclusions in a policy being renewed without break. The Respondent submitted that they had done so in response to their Regional Office Circular dated March 2002 which instructed their operating offices to exclude Cataract for fresh insurances granted to persons over 50 years of age not only in the first policy years but also in all subsequent renewals. The cited policy commenced in 1997. So the additional exclusion had not been applied correctly by the

Respondent. As such, the Respondent was directed to rectify the error in the policy and pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0340
Mr. P C Parekh
Vs
New India Assurance Co. Ltd.

Award Dated : 14.02.2008

Repudiation of Mediclaim: The Insured had incurred a total expenses of Rs.37599/- for hospitalisation for which Rs.30500/- was paid by him in cash as per the Hospital Bill towards Consultancy/Operation/Operation Theatre/ Deluxe Room Charge at Rs. 3000/- per day, the balance being costs towards diagnostic tests. The Respondent pleaded that the Room Charges of Rs.3000/- per day was much on the higher side and repudiated the claim on the ground of misleading the Insurance Company. The Respondent produced another handwritten statement by the same Doctor that the rate of Deluxe Room Charges as Rs. 1500/- per day. The Doctor was not questioned for the vast difference in rates. No investigation was done to find which of the two, viz. the amount paid by the Insured or the handwritten statement is valid. The discrepancy in room rates is attributable to the Hospital Authorities and not to the Insured. As such, the Respondent was directed to pay the full claim

Ahmedabad Ombudsman Centre
Case No. 14-002-0088
Mr. K T Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 15.02.2008

Repudiation of Mediclaim on the ground that Hospitalisation is not justified. The Insured was hospitalised for 'Urinary Tract Infection, Gastritis and Chikunguniya'. Claim was repudiated on recommendations of their Medical Referee who opined that since the pus cells in urine had increased to 20 at the time of discharge from 8 at the time of admission, hospitalisation was not justified. The hospitalisation had been done on the advise of the treating physician since the epidemic of Chikunguniya was in full swing and urgent diagnosis of the ailment could only help the patient to recover. Taking a holistic view, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-003-0312
Mr. S K Dutta
Vs
National Insurance Co. Ltd.

Award Dated : 15.02.2008

Partial settlement of Mediclaim. The Insured was covered for Sum Insured of Rs. 300000/- + No Claim Bonus Rs. 105000/-. As against a total claim of Rs.436000/-, the Respondent had settled the claim for Rs. 277000/- on a cashless basis. The reimbursement was done on the basis of the sub-limits of Room Charges @ 25% of SI, Surgeons Charges @ 25% of SI, Medicines at 50% of SI as per the new Mediclaim Policy from 1-4-2007. The Complainant submitted that his Policy commenced on 3-4-2007 and he was not informed of the new Policy conditions. The Respondent clarified

that the revised norms were informed with the revised premium rates at the time of renewal of the policy. However, it was observed from the Claim file that the Respondent had disallowed Rs.12300/- towards Surgeon's Charges which was ordered to be paid with an interest at 8% for the delayed period.

Ahmedabad Ombudsman Centre
Case No. 11-002-0279
Mr R K Sengar
Vs
New India Assurance Company Ltd.

Award Dated : 15.02.2008

Repudiation of Mediclaim on the ground that the disease is pre-existing: The Insured received neck sprain while lifting a heavy box. He consulted a Neuro-Surgeon who on the basis of MRI Report found that C4-C5 disc showed right centrolateral herniation compressing the Spinal Cord and C5 nerve roots more on the right side. He was admitted to a Hospital and operated for acute prolapsed disc with root compression. Claim was repudiated citing that occupational strain and the lesions in the cervical disc proved pre-existence of the disease. The Insured person is not a labourer whose job is to lift weights. The ailment and damage to the cervical disc occurred from a one time help he rendered while unloading a heavy box due to shortage of workers in his factory. There is absolutely no evidence to prove repeated and chronic strain or the pre-existence of the disease. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0225
Ms. P B Parikh
Vs
Oriental Insurance Co. Ltd.

Award Dated : 19.02.2008

Partial settlement of Mediclaim. The Insured was hospitalised for treatment of Obesity +++, Back Pain, Knee Pain-Severe Discomfort and was operated for Abdominoplasty and Debulking Surgery. Claim was repudiated on the ground that the policy excluded reimbursement for treatment in respect of obesity including morbid obesity. During the course of Hearing, the Complainant focussed on the fact that the Surgery had not been done for cosmetic purposes, so claim should not be denied. The Forum obtained an independent expert opinion. The Doctor opined that the surgery for debulking and abdominoplasty was done for reducing obesity. The Policy conditions being quite clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0300
Mr. R J Chokshi
Vs
New India Assurance Co. Ltd.

Award Dated : 21.02.2008

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Coronary Artery Disease. Claim was repudiated since the Policy had been issued with a clause excluding payments for treatment of ailments following from Diabetes Mellitus and High Blood Pressure. The Insured submitted that the Blood Pressure was kept under control by medicines and hence the Coronary Artery Disease was not due to High Blood Pressure excluded from the scope of the policy. However since Coronary Artery

Disease has a direct nexus with High BP especially at increasing age, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-005-0306
Mr. H M Dalwadi
Vs
Oriental Insurance Company Ltd.

Award Dated : 25.02.2008

Repudiation of Mediclaim: The Insured was admitted for treatment by Kshar Sutra application Private Ayurvedic Hospital. Claim was repudiated on the ground that the Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. Since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-005-0250
Sri R G Shah
Vs
Oriental Insurance Company Ltd.

Award Dated : 25.02.2008

Repudiation of Mediclaim: The Insured was admitted for treatment by Kshar Sutra application Private Ayurvedic Hospital. Claim was repudiated on the ground that the Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. Since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-005-0243
Mr. R S Dixit
Vs
Oriental Insurance Company Ltd.

Award Dated : 25.02.2008

Repudiation of Mediclaim: The Insured was admitted for treatment by Kshar Sutra application Private Ayurvedic Hospital. Claim was repudiated on the ground that the Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. Since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0053
Mr. R J Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 26.02.2008

Partial settlement of Mediclaim: The Respondent disallowed the following amounts while settling the Claim

- Rs. 275/- towards Pharmacy Bill-During the course of Hearing, the Complainant was convinced that the same was not payable

- Rs. 400/- towards AC Dormitory Bed Charges and Rs. 275/- towards Registration Charges not payable as per policy conditions.
- Rs. 4545/- towards Nursing Care-Subsequently found payable by the Forum. The same was awarded with interest at 8% for the delay

Ahmedabad Ombudsman Centre
Case No. 11-002-0104
Mr. M M Chundawat
Vs
New India Assurance Company Ltd.

Award Dated : 26.02.2008

Partial settlement of Mediclaim: The Respondent disallowed Rs. 1806/- while settling the Claim since there was an overwriting in the Date of Discharge in the Hospital Bill which was corrected by means of a certificate by the treating Doctor. Hence it is not correct to make judgement on the basis of inferences/ doubts. As such, the Respondent was directed to pay the balance of Rs. 1806/- in full and final settlement of the Claim

Ahmedabad Ombudsman Centre
Case No. 11-002-0134
Mr. J K Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 26.02.2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified. The Insured was admitted for treatment of PID-Sudden onset of radicular pain while travelling in a motor bike. MRI of Spine was done. Thereafter, the Complainant consulted several other orthopaedic doctors. Claim was repudiated since no active medical line of treatment was taken. Moreover the Claim was submitted late by 7 months. From the papers on record, it could be established that the treatment given in the hospital could have been given even without hospitalisation. The Mediclaim Policy specifically excludes reimbursement for hospitalisation done for diagnostic purposes. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0137
Mr. K M Gandhi
Vs
New India Assurance Co. Ltd.

Award Dated : 26.02.2008

Repudiation of Mediclaim on the grounds that the disease is pre-existing: The Insured was admitted to a hospital for Coronary Angiography and then for Coronary Artery Bypass Surgery in 2007. The Hospital noted the previous history of Diabetes for 6 years, Hypertension for 1 year. The history of diabetes was prior to taking the policy in 2001 and the same had not been declared in the Proposal Form. Hence the Claim was repudiated as pre-existing diseases are not covered under Mediclaim. During the course of Hearing, the Complainant submitted that he was a member of a Group Mediclaim Policy for Credit Card holders of Canara Bank since 1993. The same were serviced by Bangalore Divisional Office of the same Insurer. Since he was finding it difficult to send payments every year, he preferred to go in for an individual Mediclaim policy. However, the rules for both the types of policy are different. So, the contention

of the Insured that he was enjoying continuous coverage is not correct. Besides, non disclosure of diabetes while filling in the proposal form for the individual Mediclaim policy tantamounts to non-disclosure treated as breach of Utmost Good Faith thus vitiating the contract itself. As such, the decision of the Respondent to repudiate the Claim is upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0124
Mr. P J Patel
Vs
New India Assurance Company Ltd.

Award Dated : 27-2-2008

Repudiation of Mediclaim on the grounds that the hospitalisation was due to Use of intoxicating drugs/alcohol:: The Insured was hospitalised for treatment of 'Chronic Liver disease-cirrhosis + Ascites+Acute Renal Infiltration". The tests conducted by the Hospital rules out all the known causes of Cirrhosis. Besides, it was observed that Steroid Treatment was administered to control Alcoholic Hepatitis. Thus it was confirmed that the treatment was for liver damage caused by use of Alcohol thus attracting the exclusion condition of the Mediclaim Policy. As such, the decision of the Respondent to repudiate the claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14-002-0314
Mr. A N Patel
Vs
New India Assurance Company Ltd.

Award Dated : 29-2-2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified. The Insured experiences severe back pain radiating to both lower limbs. She could not stand, sit or do any of her daily routine activities. On the advice of her orthopaedist, she was admitted for treatment of Prolapsed Intra-vertible Disc-Severe back pain. During this period conservative treatment like Lumbar Traction, Electro-therapy and Physiotherapy was done. She was given pain killers and sedatives. The Patient's posture and its duration was slowly gradually rehabilitated over the entire period of hospitalisation. Thus active treatment having been administered during her stay in the Hospital, the repudiation is not sustainable.

Ahmedabad Ombudsman Centre
Case No. 11-005-0200
Ms. I B Shah
Vs
Oriental Insurance Company Ltd.

Award Dated : 29.02.2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing:: The Insured was covered for a Sum Insured of Rs. 1 lac from 2001 to 2007, for Rs. 5 lacs in 2005-06 and for Rs. 4 lacs thereafter. He was admitted for Right Side Total Knee Replacement surgery in 2006. When in 2005, the Insured had gone in for increase in coverage, he had submitted amongst several medical requirements, an arthritic report which stated that 'X-Ray shows Knee AP and Lateral O bilateral osteoarthritis changes' Even though, the Respondent was provided with the necessary data, he did not apply

the same to exclude Osteoarthritis from the scope of the Policy. Now, when the claim arose, the Respondent sought to use the same report to repudiate the Claim stating that the disease is pre-existing. At the same time, the Insured too is not without fault. Even though he was experiencing painful knee movement, that too vetted by an Orthopaedist, he did not disclose the same in the Proposal Form. In view of this, an amount of Rs. 1 lac was granted in full and final settlement on an ex-gratia basis.

Ahmedabad Ombudsman Centre
Case No. 11-004-0326
Mr. G H Mistry
Vs
United India Insurance Co. Ltd.

Award Dated : 29.02.2008

Repudiation of Mediclaim on the ground of late submission of Claim papers. The Insured was discharge from the Hospital after treatment of Chest Pain on 13-7-2007. He had intimated the Respondent of his hospitalisation well in time. He was declared fit only on 14-8-2007 and was undergoing treatment till 19-9-2007. He submitted the Claim forms only on 24-9-2007. The TPA had refused to accept the claim papers since as per the Mediclaim Policy Conditions, the claim papers should be submitted within 7 days of discharge from the Hospital. However, it was observed that there is a provision to call for clarification from the Insured for the delay and if found in order, waive this condition. This was not done in the case. Besides, the Respondent had refused to accept the Claim papers. Since, they have taken the decision without even accepting the papers, the Respondent was directed to reopen the case and examine it afresh and decide in the matter.

Ahmedabad Ombudsman Centre
Case No. 14-005-0288
Mr. R V Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 29.02.2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for Coronary Angiography with PTCA and Stenting. The Insurer through cashless settlement paid Rs. 69000/- to the Hospital. On his discharge, the Insured claimed two amounts as under

H Rs. 4471/- Claim papers submitted late by 2½ months- papers rightly returned back to the Insured since they were not submitted in time

H Rs. 116516/- not paid by the Insurer treating the disease to have been pre-existing. During the course of Hearing, the Complainant gave copies of Policy documents right from 1992 and gave photocopies of the cheque settled by the same Insurance Company for By-Pass Surgery in 1996. So to treat Heart diseases as pre-existing is not fair. As such, the Respondent was directed to pay Rs. 116516/- in full and final settlement of the claim.

Ahmedabad Ombudsman Centre
Case No. 14-004-0184
Mr. S P Patel
Vs
United India Insurance Co. Ltd.

Award Dated : 29.02.2008

Repudiation of Mediclaim: The Insured underwent an operation for Kidney Stone removal-Lithotripsy. Claim was not settled since the original Hospital bills and Medical Bills had been lost by the Insured. The Insured however submitted photocopies of the Bills with a request to the Insurer. The Assistant Divisional Manager of the Insurer endorsed on the request letter and instructed the TPA to settle the Claim on the available copy papers after taking proper declarations etc. However, the Claim was not settled on directions of the controlling Regional Office. There being no other infirmity as to the genuineness of hospitalisation or quantum of claim amount, the Respondent was directed to condone the lack of original claim documents and process the claim as per the rules in this regard.

Ahmedabad Ombudsman Centre
Case No. 11-002-0190
Mr. S K Gidwani
Vs
New India Assurance Co. Ltd.

Award Dated : 29.02.2008

Repudiation of Mediclaim. The Insured was 19 weeks pregnant when she experienced abdominal pain for which she was admitted to a hospital. During her stay there an Ultrasound Gravid Uterus Test was done which revealed that there is a fibroid at the fundal region on the right side of the uterus. The Hospital Discharge Note mentioned that Cervical OS Tightening was done. The Claim papers were referred to a senior Gynaecologist who opined that the OS tightening was done to prevent abortion and to save the baby. It is not treatment of fibroid. All the drugs given and the operation done was to prevent abortion. On the basis of the expert opinion, the Claim was repudiated since the Mediclaim Policy excludes payment for treatment directly traceable to pregnancy. From the various reports, hospital certificate and expert opinion, it is clear that the decision of the Respondent to repudiate the claim is justified. As such, no further relief was awarded to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11-002-0187
Ms. L T Parmar
Vs
New India Assurance Co. Ltd.

Award Dated : 29.02.2008

Partial settlement of Mediclaim:

H The Insured was hospitalised for cystoscopy done under local anaesthesia for which he claimed Rs. 4247/-. The same was allowed

H He had lumbar pain for which he consulted an Orthopaedist who prescribed some medicines but not hospitalisation. Claim for Rs.2473/- was not allowed by the Respondent since the treatment did not require hospitalisation and since the two diseases had no correlation to one another.

Taking a holistic view, no further relief was offered to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11-002-0189
Mr R N Bhavsar

Vs

New India Assurance Co. Ltd.

Award Dated : 10.03.2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified. The Insured was hospitalised for treatment of Acute Abdominal Pain for 15 days. During this period, no active treatment was given. Only diagnostic tests like CT Scan of Abdomen was done. He was given oral medicines only. In fact 85% of the Claim amount was towards the diagnostic tests done. Mediclaim policy excludes reimbursement of expenses done in a hospital solely for diagnostic purposes. As such, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre

Case No. 14-004-0353

Mr. B J Shah

Vs

United India Insurance Co. Ltd.

Award Dated : 10.03.2008

Repudiation of Mediclaim on the ground of late submission of Claim papers. The Insured was discharge from the Hospital after treatment of Malaria and Bronchitis on 11-8-2007. He had intimated the Respondent of his hospitalisation well in time. He submitted the Claim forms only after he was declared fit on 26-10-2007. The TPA had refused to accept the claim papers since as per the Mediclaim Policy Conditions, the claim papers should be submitted within 7 days of discharge from the Hospital. However, it was observed that there is a provision to call for clarification from the Insured for the delay and if found in order, waive this condition. This was not done in the case. Besides, the Respondent had refused to accept the Claim papers. Since, they have taken the decision without even accepting the papers, the Respondent was directed to reopen the case and settle the claim along with interest for the delay.

Ahmedabad Ombudsman Centre

Case No. 11-005-0360

Sri M T Bhojwani

Vs

Oriental Insurance Co. Ltd.

Award Dated : 10.03.2008

Repudiation of Mediclaim. The Insured was hospitalised for operation of a soft tender swelling in the Pilonoidal sinus with an abscess causing painful swelling in the Gluteal Cleft. Claim was rejected since fistula and its related disorders are not payable in the first year of the policy. However, materials on record could convincingly prove that the Complainant was operated for Pilonidal Sinus and not fistula in ano. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre

Case No. 11-002-0259

Mr. C T Sanghavi

Vs

New India Assurance Co. Ltd.

Award Dated : 11.03.2008

Partial Repudiation of Mediclaim. The Insured was admitted for a fractured right ankle. Claim papers were lodged after 57 days of discharge from the Hospital. The Complainant approached the Respondent and agreed to accept 75% of the admissible claim amount in full and final settlement. Thus the claim having been settled on the basis of a mutual consent, no further relief was granted to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 14-002-0177
Mr. J S Parikh
Vs
New India Assurance Co. Ltd.

Award Dated : 12.03.2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for a day for treatment of Diabetes Mellitus and Coronary Artery Disease for which Angiography was done. In the Discharge Summary, the Hospital has noted that the Insured was a known case of Hypertension and Diabetes for 25 years. Surprisingly after some time, the Respondent received another set of Discharge Summary which had a revised history of HTN/DM for 7 years only. Hence the Claim was repudiated due to non disclosure of material facts at the time of taking the policy and on the ground of pre-existing disease. The Respondent has very casually dealt with the claim. The Complainant could prove that he had a history of HTN/DM for 7 years only and not 25 years and that the same Respondent had made payment of claim for the same disease earlier. As such, the Respondent was directed to settle the claim with interest for the delay.

Ahmedabad Ombudsman Centre
Case No. 11-002-0235
Mr. N K Ramani
Vs
New India Assurance Co. Ltd.

Award Dated : 12.03.2008

Repudiation of Mediclaim. The Insured was hospitalised for treatment of Fistulecomy. 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. During the course of Hearing, the Respondent agreed to settle the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0211
Ms. S A Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 12.03.2008

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified: The Insured aged 40 years sustained injury when the scooter slipped. He was hospitalised

on the advise of an Orthopaedist, where thorough investigation through X-Ray and MRI was done. He was diagnosed for Haemarthrosis Knee with internal injury. Aspiration for haemarthrosis was carried out under local anaesthesia. Claim was repudiated on the plea that the treatment could have been done on an OPD basis. However, the treating Doctor had marked the case as SOS and the procedures were such that they could not have taken place without hospitalisation. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-003-0221
Mr. N U Pandya
Vs
National Insurance Co. Ltd.

Award Dated : 13.03.2008

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

Ahmedabad Ombudsman Centre
Case No. 11-002-0274
Mr. N P Sheth
Vs
New India Assurance Co. Ltd.

Award Dated : 13.03.2008

Partial settlement of Mediclaim: Claim for hospitalisation for malaria accelerated hypertension was settled by deducting an amount of Rs. 3022/- detailed under

1. Rs. 2000/- towards 2D Echo-Cardiogram found payable due to his treatment of hypertension
2. Rs. 877/- towards Service Charges for nursing found payable
3. Rs. 75/- towards Registration Charges and Rs. 70/- towards cost of Thermometer are not payable as per policy conditions.

As such, the Respondent was directed to pay Rs. 2877/- to the complainant.

Ahmedabad Ombudsman Centre
Case No. 11-004-0351
Mr. I R Rajaji
Vs
United India Insurance Co. Ltd.

Award Dated: 13.03.2008

Repudiation of Mediclaim on the ground of late submission of Claim papers. The Insured was discharge from the Hospital after treatment of Piles on 12-9-2007. He had intimated the Respondent of his hospitalisation well in time. He submitted the Claim forms only after he was declared fit on 20-10-2007. The TPA had refused to accept the claim papers since as per the Mediclaim Policy Conditions, the claim papers should be

submitted within 7 days of discharge from the Hospital. However, it was observed that there is a provision to call for clarification from the Insured for the delay and if found in order, waive this condition. This was not done in the case. Besides, the Respondent had refused to accept the Claim papers. Since, they have taken the decision without even accepting the papers, the Respondent was directed to reopen the case and settle the claim by condoning the delay.

Ahmedabad Ombudsman Centre
Case No. 11-005-0201
Smt. R A Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 14.03.2008

Repudiation of Mediclaim: The Insured had severe abdominal pain for which the Doctor advised USG. Since nothing abnormal was detected, the Doctor advised hospitalised for diagnostic laparoscopy for acute and chronic pain and small sub serous fibroin on the posterior wall of the uterus was removed with bipolar coagulation. Fibroid formation in uterus takes place in chronic condition and not in acute condition. The Claim had arisen in the 2nd year of the policy. Hence the disease was treated as pre-existing and claim repudiated. However, the Doctor in all the forms had informed that the Patient had acute pain. The Respondent could not prove the fact of chronic pain. The Insured, a Municipal Corporation employee had not been on leave for sick grounds in the last 2 years still confirming the fact that the pain was not chronic. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0320
Ms. J H Khatri
Vs
Oriental Insurance Co. Ltd.

Award Dated : 14.03.2008

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified: The Insured aged 52 years had a complaint of back pain sustained due to an accident. Digital X-ray of the spine showed a compression fracture and wedging of vertebral body. He was referred to another Orthopaedist who advised hospitalisation. The Discharge summary noted MRI-SOS. Claim was repudiated on the plea that hospitalisation was not justified. However, the treating Doctor had marked the case as SOS and he was the best judge to decide whether or not hospitalisation was necessary. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 14-005-0323
Mr. A V Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 14.03.2008

Partial settlement of Mediclaim: Claim for hospitalisation due to complaints of pain in leg due to which arthroscopic surgery was done was settled by deducting an amount of Rs. 3500/- towards MRI Charges since the same was done more than 30 days before

the date of admission. The Complainant pleaded that the MRI report formed the basis of the operation of the knee joint. In all fairness, the Respondent was directed to pay the amount deducted.

Ahmedabad Ombudsman Centre
Case No. 11-004-0105
Ms. T A Mehta
Vs
United India Insurance Co. Ltd.

Award Dated : 17-3-2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured was hospitalised for recurrent tonsillitis in the second year of the Policy. Claim was repudiated on the opinion of the Medical Referee of the Insurer who stated that Recurrent Tonsillitis progressing to enlarged Tonsils requiring Tonsillectomy cannot develop within 2 years time. As per Black's Medical Dictionary, Tonsillitis usually occurs due to bacterial infection. The onset is sudden with pain in swallowing, fever and malaise. Occasionally abscess develops. Due to collection of pus, surgical treatment is necessary. The Treating Doctor had clearly mentioned the duration of illness as 2-3 months. The Respondent could not bring forth any evidence to trace pre-existence of the disease. As such, they were directed to settle the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0219
Mr. M P Dhandharia
Vs
United India Insurance Co. Ltd.

Award Dated : 17.03.2008

Repudiation of Mediclaim on the ground that the treatment was for Congenital External Disease: The Insured, s 4 year old child was operated for "tight phimosis for which circumcision was done". The Respondent Insurer repudiated the claim stating that Inguinal Hernia in a 4 year old child is a Congenital Disorder. But it could not prove Externality. As a result, the decision of the Respondent to repudiate the Claim was set aside and the Complainant was awarded the full claim amount.

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

Award Dated : 18-3-2008

Repudiation of Mediclaim on the grounds that Hospitalisation was not justified: The Insured aged 66 years had a complaint of restlessness, weakness in limbs with tingling sensation and numbness. Looking to his high blood pressure, hospitalisation was advised by a neuro-physician. Colour Doppler Test, USG of Abdomen, CT Angiography of neck, X-Ray of chest, ECG, other pathological tests were all normal. He was treated with anti-hypertensive, anti-platelet and other supporting treatment. The Discharge summary noted that the patient had Trasient Ischemic attack, atherosclerosis and

hypertension. Claim was repudiated on the plea that hospitalisation was not justified. However, the treating Doctor was the best judge to decide whether or not hospitalisation was necessary. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0229
Mr R H Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 18.03.2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing: The Insured had taken treatment for fracture of Patella in 1992. The present bout of hospitalisation is to remove the Wires THR Stab incision for the same operation. The Respondent had repudiated the claim citing the disease to have been pre-existing. However, since the Insured had declared the fracture of 1992 while proposing for Mediclaim in 1998, the Claim was found to have been admissible.

Ahmedabad Ombudsman Centre
Case No. 11-002-0164
Mr. N B Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 18.03.2008

Repudiation of Mediclaim: The Insured was admitted to a Hospital which was not registered under the local authorities nor which complied to the other conditions of 15 beds etc. The Hospital authorities did not co-operate to give the relevant information. Since this is a clear violation of the Policy conditions, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0328
Ms. M P Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 19.03.2008

Partial settlement of Mediclaim: An amount of Rs. 2331/- was deducted while making the payment for treatment of accidental injuries towards cost of medicines claimed to have been purchased on credit within the prescribed 60 days of post-hospitalisation but cash payment for which was done after this 60 days period. Under these circumstances, the Respondent was directed to open the claim only if proper proof to this effect can be submitted by the Insured that the medicines were actually purchased within the prescribed 60 days.

Ahmedabad Ombudsman Centre
Case No. 11-002-0260
Mr. R M Patel
Vs

New India Assurance Co. Ltd.

Award Dated : 21.03.2008

Repudiation of Mediclaim due to late submission of Claim papers. It was observed, that due to late submission of Claim Papers, the Claim was repudiated. The Complainant replied that he was out of town for 3 months for treatment of his aged father. He also pleaded that his economic condition is very weak. The Respondent was directed to pay to the complainant 75% claim on an ex-gratia basis

Ahmedabad Ombudsman Centre
Case No. 11-004-0301
Mr. B S Shah
Vs
United India Insurance Co. Ltd.

Award Dated : 21.03.2008

Partial settlement of Mediclaim: The Insured had undergone treatment for Cancer. Claim was settled for the Sum Insured and the Bonus for the financial year. Having verified the same, no further amount becomes payable. As such, the Complaint was taken to be disposed with no further relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 11-002-0330
Mr. M P Joshi
Vs
New India Assurance Co. Ltd.

Award Dated : 24.03.2008

Repudiation of Mediclaim on the ground of the disease being pre-existing. The Insured was hospitalised for treatment of Chest Pain. He was subjected to Enhanced External Counter Pulsation. Claim was repudiated since EECP can be taken on an OPD basis and does not require hospitalisation. Moreover the treating Doctor has in his certificate mentioned that the Insured was a known case of Ischaemic Heart Disease since one year. A closer look at the papers on record showed that the cash receipt for EECP treatment mentioned that the same had been given on an OPD basis. In view of this, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-003-0337
Mr K J Hingorani
Vs
National Insurance Co. Ltd.

Award Dated : 24.03.2008

Repudiation of Mediclaim on the grounds that the disease is pre-existing: The Insured was hospitalised in 2007 for coronary angiography. He had undergone Coronary Angiography and CABG in 1992. Claim was repudiated citing pre-existing disease. The Insured submitted that he had disclosed these operations while taking the policy in 1993. The first policy and all the subsequent policies had been issued without any exclusion. It only goes to suggest that the Insurer had waived or condoned the past history of CABG and had issued a policy without any exclusion. In view of the same, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0341
Mr. J G Dalal
Vs
New India Assurance Co. Ltd.

Award Dated : 24-03-2008

Repudiation of Mediclaim. The Insured was admitted under a gynaecologist due to labour pains and underwent Obstetric sub tool hysterectomy performed for Atonics PPH. The Uterus had not contracted after delivery and continued to bleed profusely necessitating removal of uterus. Hysterectomy was performed. Claim lodged for treatment was repudiated since the policy conditions excludes treatment arising or traceable to pregnancy. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0233
Sri. N K Vaghela
Vs
New India Assurance Co. Ltd.

Award Dated : 24.03.2008

Repudiation of Mediclaim on the grounds that the disease is pre-existing: The Insured had complaints of blurred vision. He was diagnosed for retinal detachment due to weak area in the retina called Lattice degeneration with holes. Claim was repudiated citing pre-existing disease. The treating doctor had noted that the complaint of blurred vision was since 1½ years which when taken back goes prior to the date of proposal for Mediclaim. As such, the decision to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0214
Mr. N K Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 25.03.2008

Repudiation of Mediclaim: The Insured was admitted in a reputed Hospital for Rt. Shoulder Dislocation and seizure and was also given treatment for convulsions. Claim was repudiated since the original money receipts were not submitted to the Respondent. The receipts had been lost. The Insured submitted duplicate receipt from the same Hospital. There being no other infirmity in the case, the Respondent was directed to settle the claim on the basis of the duplicate receipt.

Ahmedabad Ombudsman Centre
Case No. 11-005-0327
Mr. M K Sheth
Vs
Oriental Insurance Co. Ltd.

Award Dated : 26.03.2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified: The Insured met with an accident and sustained knee injuries. On the advice of the treating Orthopaedist she was admitted to the hospital for treatment. She was X-Rayed and diagnosed as having left knee haemarthrosis with left knee collateral ligament injury. Knee Aspiration and AKBK Plaster cast was done. Claim was repudiated on the opinion of the Medical Referee. However the treating doctor is the best judge and his opinion

should find higher credence. In view of the same, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0212
Ms. S C Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated : 26-03-2008

Repudiation of Mediclaim: The Insured was hospitalised for 13 hours for fracture proximal humerous displaced. The TPA rejected the claim since the hospitalisation was not for more than 24 hours. The Insured resented the rejection and on his representation, the Insurer took an opinion of their panel orthopaedist. On the basis of the opinion, it directed the TPA to pay the claim. The TPA still did not comply. In view of the same, the Forum directed the Respondent to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0197
Mr. M N Patel
Vs
United India Insurance Co. Ltd.

Award Dated : 27.03.2008

Partial settlement of Mediclaim: Claim for hospitalisation was settled by deducting an amount of Rs. 7334/- detailed under

1. Rs .500/- towards Doctor charges : Directed to be paid since reasons for disallowing the amount is not convincing
2. Rs. 420/- towards medicines invoiced-Allowed to be paid
3. Rs. 2400/- towards cost of Medicines charged by the Doctor and Rs.4014/- towards cost of Medicines not related to the disease were not allowed since the Respondent is justified as there are valid grounds for deduction.

Ahmedabad Ombudsman Centre
Case No. 11-002-0270
Mr. R H Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 27-03-2008

Repudiation of Mediclaim on the grounds that the disease is pre-existing. The Insured was hospitalised for Post PTCA insignificant coronary lesion and Angiography was done. The treating Doctor noted that the patient was suffering from hypertension for the last 12 year Post PTCA for 4 years. The subject Mediclaim Policy commenced 11 years back. As such, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0256
Mr. P M Jain
Vs
New India Assurance Co. Ltd.

Award Dated : 27.03.2008

Repudiation of Mediclaim on the grounds of pre-existing disease: The Insured was operated for exploratory laparotomy for carcinoma colon in 1987. This fact was not disclosed when he went in for the Mediclaim Policy in 1991. Later in 2006 he was again hospitalised for abdominal pain and recurrence of carcinoma colon. The current hospitalisation has a direct nexus with the disease not disclosed. As such the decision of the Respondent to repudiate was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0297
Ms. S J Vora
Vs
New India Assurance Co. Ltd.

Award Dated : 27.03.2008

Repudiation of Mediclaim on the grounds on delayed submission of Claim documents: The Insured was hospitalised. Claim was repudiated on the ground that the documents had been submitted late by 97 days. The Complainant pleaded that she was declared fit on 21-1-2007 and had submitted the forms 10 days later in time and not late. During the course of hearing the Complainant informed that she had agreed to accept 75% of the claim amount but had not received the same so far. Taking a holistic view of the matter, the Respondent was directed to pay the agreed Claim amount with interest at 8% for the delayed period.

Ahmedabad Ombudsman Centre
Case No. 14-002-0228
Mr. V George
Vs
New India Assurance Co. Ltd.

Award Dated : 28-03-2008

Repudiation of Mediclaim: The Insured was admitted to a hospital for treatment of irregular bowel habits. Claim was not processed since the Claim forms had not reached the Respondent. The Insured could not produce any acknowledgement. However, during the course of Hearing, the Respondent agreed to settle the Claim on receipt of photocopies of the Documents.

Ahmedabad Ombudsman Centre
Case No. 11-002-0355
Sri V N Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 28-03-2008

Partial settlement of Mediclaim: The Insured was admitted for surgery of ‘Hernioplasty and Herniotomy’. An amount of Rs. 5000/- was not paid towards Assistant Surgeon’s Charges. The Insured submitted that the Assistant Surgeon had been called by the Hospital and not by himself. There being no contributory default on the part of the Complainant, the Respondent was directed to pay the balance of Rs. 5000/-

Ahmedabad Ombudsman Centre
Case No. 11-002-0363
Ms. A R Darbar
Vs

New India Assurance Co. Ltd.

Award Dated : 28.03.2008

Repudiation of Mediclaim on the grounds on delayed submission of Claim documents: The Insured was hospitalised. Claim was repudiated on the ground that the documents had been submitted late by 262 days. During the course of Hearing, the Complainant pleaded that she had studied only upto 3rd Std. and that she is staying alone and struggling for her livelihood. She had borrowed money for treatment. There was no infirmity of the claim. Taking a holistic view of the matter, the Respondent was directed to pay the full Claim amount on an ex-gratia basis.

Ahmedabad Ombudsman Centre
Case No. 11-005-0193
Mr. S K Dabhi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 28.03.2008

Repudiation of Mediclaim on the grounds that the disease is pre-existing. The Insured child while playing cricket had an accidental fall and had to be hospitalised for Athroscopy of right knee for Osteochondrial loose bodies. The Respondent that the accidental fall had occurred prior to the date of inception of the Policy. could not prove that the disease was pre-existing. As such, the Respondent was directed to pay the full Claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0362
Mr. J S Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated : 28-3-2008

Repudiation of Mediclaim. The Claim was repudiated since the Policy condition excludes payment for treatment related to pregnancy. The Insured was operated for LSCS 6 years back. The treating Doctor too had certified that the surgery was not pregnancy related. Through a process of mediation, the Respondent agreed to pay the Claim and a joint agreement was signed in the course of the Hearing.

Ahmedabad Ombudsman Centre
Case No. 11-005-0165
Mr. J M Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Insured was admitted for Coronary Angiography which showed that he has Triple Vessel Disease affecting major arteries and wide spread coronary artery disease. The Claim was repudiated on the advice of the Medical Referee of the Respondent who opined that the disease must have commenced well prior to the inception of the policy. The Policy had incepted 5 years back. The Respondent could not produce any documentary evidence other than the opinion of the Medical Referee based on his knowledge. As such, the Respondent was directed to settle the full claim.

Ahmedabad Ombudsman Centre

Case No. 11-005-0186
Mr. P R Patel
Vs
Oriental Insurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim: The Insured was hospitalised for treatment in the first year of the Policy of Compressed Nasal Airways Syndrome for which she was treated with Tonsillectomy and Adenoidectomy. Claim was repudiated since Mediclaim Policy excludes payment for sinusitis and allied disease treatment in the first policy year. The treating physician had certified that the Insured was not having any swelling/disease of her Nasal Mucosa or her sinuses. Hence it is not correct to relate the treatment with sinusitis and allied treatments. In view of this, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre
Case No. 11-005-0236
Mr. V K Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 31-3-2008

Repudiation of Mediclaim on the grounds of pre-existing disease. The Insured was hospitalised for acute onset septicaemia with convulsions. EEG and MRI Scanning revealed peri-ventricular demyelination. The EEG report suggested generalised epileptiform activity. The Policy had commenced only 1½ months back. As such pre-existence being proved, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0281
Mr. A N Trivedi
Vs
New India Assurance Co. Ltd.

Award Dated : 31-3-2008

Repudiation of Mediclaim on the grounds that the disease was pre-existing. The Insured was covered under Mediclaim policy for 7 years. The Treating Doctor's report mentioned that the Insured had a history of Trans-urethral Resection of Prostate since 20 years. The present hospitalisation is for Prostate Hypertrophy Benign. The Complainant did not dispute the Clinical History but stated that he did not have any complaints for the last 20 years. The nexus between the current hospitalisation and the disease prior to the policy having been proved, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0354
Mr N N Raval
Vs
New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Partial settlement of Mediclaim: The Insured was operated for Left RGPT, Left ureterscopy stone removal and Left DJ Stenting. As against an estimate of Rs.39100/- the TPA offered cashless reimbursement to the Hospital for Rs.15400/-. On his discharge, the Respondent claimed the balance of Rs.12322/- paid by him directly to the Hospital which was rejected. The reasons given for the rejection were not convincing. As such, the Respondent was directed to pay the balance of Rs. 12322/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0308
Case No. 11-002-0309
Case No. 11-002-0310
Case No. 11-002-0311
Dr. PN Zaveri
vs
New India Assurance Co. Ltd.

Award Dated : 31-3-2008

Repudiation of Mediclaim: The Insured a Doctor himself admitted himself, his wife and children to his own hospital. Since the Hospital was not registered, it should have complied to the other rules like 15 in-patient beds, operation theatre, qualified Doctor/Nursing Staff round the clock etc. The Insured submitted that his hospital has 9 beds and he has made an informal agreement with another Doctor who has a hospital with 7 beds to share the in-patient beds to comply with the requirement of Mediclaim. The Respondent's investigator found that the two hospitals had separate boards but no medical officer on duty and only one nurse. Since the Hospital does not fulfil the criteria as set in the Mediclaim Policy, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-002-0241
Mr. A K Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim. The Insured admitted the fact that he had ingested a poisonous drug due to fear of threats of some antisocial elements under duress. Later she was hospitalised. Claim was repudiated since the Mediclaim Policy excludes reimbursement of treatment due to intentional self injury. The fact of suicidal poisoning having been also contained in the Police FIR, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 11-004-0277
Mr A S Modi
Vs
United India Insurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim on the grounds that disease was pre-existing. The Insured was hospitalised for treatment of Incisional Hernia. The Claim was repudiated by stating that this was a complication of previous LSCS surgery done 7 years back even before the commencement of the policy. The action of the Respondent was not justified since even though Incisional Hernia follows a surgery but it cannot be said to be pre-existing since the operation had been done 7 years back. As such, the Respondent was directed to reopen the claim.

Ahmedabad Ombudsman Centre
Case No. 11-002-0345
Mr. D M Patel
Vs
New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim. In order to settle the Claim, the Respondent asked the Hospital authorities to submit the Indoor Patient Records. The Hospital records are fully paperless. As such, the Hospital provided with a handwritten transcript copied from the Computer Records. Claim was repudiated stating that the said Indoor Record having been written in one stretch shows that the documents are fabricated. During the course of Hearing, the Respondent was unable to prove the allegations of manipulation of papers. As such, they were directed to pay the full claim

Ahmedabad Ombudsman Centre
Case No. 14-005-0322
Mr. P R Shah
Vs
Oriental Insurance Company Limited

Award Dated: 31-3-2008

Repudiation of Mediclaim: The Insured was hospitalised for treatment of Bladder Stone with Cystitis. Claim was repudiated since the disease is not covered in the first 2 years of the Policy. A study of the Policy history showed that the policy had run for over 5 years. As a result, the decision of the Respondent to repudiate the Claim was set aside and the Complainant was awarded the full claim amount.

Ahmedabad Ombudsman Centre
Case No. 11-002-0348
Sri. T K Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 31.03.2008

Partial settlement of Mediclaim: The Insured was operated for Urethral Stricture. The TPA offered cashless reimbursement to the Hospital. On his discharge, the Respondent claimed the balance of Rs.2100/- paid by him directly to the Hospital which was rejected. The reasons given for the rejection were not convincing. As such, the Respondent was directed to pay the balance of Rs. 2100/- in full and final settlement of the Claim.

Ahmedabad Ombudsman Centre
Case No. 11-004-0352
Mr. P N Pandey

Vs

United India Insurance Co. Ltd.

Award Dated : 31-3-2008

Repudiation of Mediclaim: The Insured was hospitalisation for treatment of acute pancreatitis. Claim file was closed since the Insured could not provide the evidence in the form of Ultra Sonography report of the Abdomen to prove that he was suffering from pancreatitis. The Respondent had directly closed the file without waiting for a reasonable time for compliance. Hence, it was directed to re-open the claim, allow the Insured reasonable time to comply and then only close the file.

Ahmedabad Ombudsman Centre

Case No. 11-004-0237

Mr. R M Varaiya

Vs

United India Insurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim on the grounds that hospitalisation is not justified: The Insured was admitted to a hospital for treatment of Idiopathic Mega Colon with Encopresis. The Insured was suffering from chronic constipation for the last 6 months. Claim was rejected since the treatment could have been taken on an OPD basis. However, a closer look at the papers on record showed that the Insured was suffering from Megacolon, the cause of which is not known. The findings in the hospital is suggestive of Hirschprung's Disease, a rare congenital disorder. As such, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre

Case No. 11-002-0248

Mr. K J Baxi

Vs

New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim: The Insured had a tumour treated in the left breast in 1996. She declared the same while proposing for Mediclaim in 2001. The Mediclaim policy excluded reimbursement for treatment of Breast Cancer. Now, in 2007 she was operated for Right Breast Cancer. Breast Cancer having been excluded, the Claim was repudiated. As such, the Respondent's decision was upheld.

Ahmedabad Ombudsman Centre

Case No. 14-002-0358

Sri. A R Rajput

Vs

New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Repudiation of Mediclaim. The Claim for oral treatment taken at home in lieu of Chemotherapy was repudiated. However, the claim being one for terminal cancer, the Respondent was directed to pay the full claim.

Ahmedabad Ombudsman Centre

Case No. 11-005-0162

Mr. P C Shah
Vs
Oriental Insurance Co. Ltd.

Award Dated : 31.03.2008

Partial settlement of Mediclaim: The Insured was operated for Bilateral Inguinal Hernia under Laparascopic procedure. As against an estimate of Rs.50000/-, the TPA offered cashless reimbursement of Rs. 27000/-to the Hospital. On his discharge, the Respondent claimed the balance of Rs.20845/- paid by him directly to the Hospital which was rejected. The amounts included

1. Rs. 2050/- towards difference of room charges due to opting for Deluxe Room afterwards. Not found admissible
2. Rs. 795/- towards service charges-Not allowed due to policy conditions
3. Rs.18000/-towards consultation charges-Found admissible and the Respondent was directed to pay the same.

Ahmedabad Ombudsman Centre
Case No. 11-005-0294
Mr. M C Shah
Vs
Oriental Insurance Co. Ltd

Award Dated : 31.03.2008

Partial repudiation of Mediclaim. The Claim for hospitalisation was settled by deducting an amount of Rs. 5000/- towards excess in each and every claim. An examination of the policy history showed that the excess was imposed as under:

- 1998-2002 : NIL Excess
- 2002-2003 Excess Rs. 3000/-
- 2003-2004 Excess Rs. 4000/-
- 2005-2008 Excess Rs. 5000/-
- 2008-2009 NIL Excess

The Respondent could not give any cogent reasons for the imposition of the excess in 2002 when the policy was renewed in chain. As such, the Respondent was directed to pay the amount of Rs. 5000/- wrongly deducted with an interest at 8% for the delayed period.

Bhubneshwar Ombudsman Centre
Case No. 11-008-0182
Mr. Pappu Vanamalli
Vs
Roayl Sundaram Alliance Insurance Co. Ltd.

Award Dated : 22.10.2007

Insured Complainant obtained a mediclaim policyfor one year commencing from 25-01-2005 from Royal Sundram Alliance Insurance co. Ltd for sum insured of Rs 100,000/. During currency of policy insured was admitted to Kar Clinic on 27-5-2005 for chest pain and subsequently referred to Kalinga Hospital for treatment of angina and final diagnosis was Cad- Recent IWMI significant OM2 and RCA disease. Insured was denied the cash less treatment by authorised TPA during his stay at Kalinga Hospital.

Insured was admitted to Care Hospital, Hyderabad for angioplasty and stenting of OM and RCA. Insured claimed for the reimbursement of Rs 25492.60 the amount he spent in Kar Clinic and Kalinga Hospital. Insurer repudiated the claim as the disease was pre existing. Insured being dissatisfied with the decision of insurer preferred this complaint.

During Hearing insurer stated that as per opinion of medical practitioner it is not possible that double vessel disease in a dyslipidemic individual developed within two months of inception of policy. The ailment was pre existing.

Insured stated that as per policy issued by insurer it has been specifically mentioned in the pre existing disease column as nil and under key benefit terms it is specifically mentioned that no medical examination is required for people up to 60 years.So, the repudiation is arbitrary

Hon'ble Ombudsman directed the insurer to pay the claim as there is no evidence in the discharge summery report that disease was pre existing.

The opinion of medical practitioner is not convincing regarding the pre existing of disease.

Bhubneshwar Ombudsman Centre
Case No.11– 003-0227
Smt. Subhra Bhattacharjee
Vs
National Insurance Co. Ltd.

Award Dated : 2.11.2007

Insured Complainant insured herself along with her son under mediclaim Policy of National Insurance Co. Ltd. On 6-8-2003 complainant's son admitted to KEM Hospital ,Mumbai for removal of unicameral bone cyst and grafting of bones. Her son was discharged on 4-9-2003. Complainant intimated to the insurer about the treatment on 7-10-2003 and submitted a bill of Rs 26,439/ towards re imbursement of medical expenses.

Insurer repudiated the claim as complainant did not intimate them within seven days from the date of operation nor lodged the claim within 30 days of from the date of discharge as per condition 5.3 and 5.4 of the policy.

Being aggrieved the complainant approached this forum.

Insurer has not filed Self Contained Note regarding this complaint

During hearing Insurer did not appear . Complainant stated that she was worried about treatment of her son and she was under depression and ignorant about the terms and condition of the policy.

Honourable Ombudsman directed insurer to pay Rs 26439/ as the delay was not deliberate and intentional on the part of insured complainant. The ground taken by insurer is not justified.

Bhubneshwar Ombudsman Centre
Case No.14– 005-0334
Mr. Manik Chand Agarwal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 23.11.2007

Insured Complainant along with his spouse obtained a mediclaim policy from Oriental Insurance Co. Ltd for a period of one year commencing from 13-4-2002 for S.I. of Rs 100,000/ . On 8-8-2003 complainant's wife admitted to Mohan Eye Institute for treatment of cataract in her left eye. Insured complainant consulted Dr. S. Acharya and Dr. S. Verma for treatment of OA Rt. Knee and for RCT C+ along with oral pharyngitis respectively.

Insured submitted bills and cash memos along with the required papers for re imbursement of medical expenses he had incurred. Despite of several reminders insurer sat on the matter.

Being aggrieved the complainant approached this forum.

Insurer did not file Self Contained Note.

During hearing Insurer representative stated that they have taken up the matter with TPA but TPA is not responding.

Complainant stated that despite of submission of all the documents his claim has not been settled by insurer.

Honourable Ombudsman directed the insurer to pay Rs 19689/ to the complainant towards re imbursement of medical expenses of Smt,. J.Devi but insured is not entitled to get any re imbursement as he was not hospitalised in any hospital rather treated as an out patient in a clinic.

Bhubneshwar Ombudsman Centre
Case No.11– 005-0298
Sri Raj Kumar Bansal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 14.01.2008

Insured Complainant obtained a mediclaim policy Oriental Insurance Co. Ltd for a period of one year commencing from 9-3-2004 for sum insured of Rs 300,000/ . On 01-04-2004 insured person under went kidney transplantation in Institute of Kidney diseases and Research Centre ,Ahmedabad . Insured submitted a bill of Rs 331,898/ towards re imbursement of medical expenses . Insurer obtained a certificate from attending physician where it has been stated the cause of renal failure must have been 4-6 months prior to his presentation . Insurer declared only he had high blood pressure in the proposal form. Insurer repudiated the claim on the ground of suppression of material facts as regards to his health because the cause of disease has direct nexus with the pre existing disease.

Complainant being aggrieved approached this forum.

Insurer filed Self Contained Note stating that complainant suppressed the material facts and disease was pre existing.

During hearing Insurer re iterated their stand taken in SCN.

Insured complainant stated that he had disclosed the blood pressure in proposal form but insurer instead of doing medical examination accepted the proposal now repudiating the claim.

Honourable Ombudsman uphold the repudiation as it has been clearly established the disease was pre existing since 12-12-2003 by Dr. Chittaranjan but policy was commenced only on 9-3-2004.

Bhubneshwar Ombudsman Centre
Case No.14-005-0259
Sri Bijay Keshari Panda
Vs
Oriental Insurance Co. Ltd.

Award Dated : 7.02.2008

Insured Complainant along with his spouse was covered under the LIC staff group Mediclaim policy of Oriental Insurance Co. Ltd for a period of one year commencing from 1-4-2003 . Complainant's wife Mrs .Samita Panda was admitted in to Gupta Nursing Home on 24-3-2004 for child birth . Mrs Panda gave birth a child and discharged on 2-4-2004. Insured complainant submitted a bill of Rs 14,958/ for re imbursement through his employer LIC Sambalpur D.O.. As per the arrangement LIC sent all the papers to TPA for re imbursement. The said TPA returned the papers to LIC as they have been discharged of that function since 30-06-2004.LIc ,Sambalpur D.O. sent all the papers to Oriental Insurance Co. Ltd,Mumbai D.O.-XI on 7-8-2004. Despite of several correspondence insurer sat on the matter .

Insured complainant being aggrieved of the decision of insurer approached this forum.

Insurer did not file Self Contained Note.

During hearing Insurer's representative stated that their Mumbai Office is not co-operating .

Insured complainant stated that he has written several letters but insurer has not settled his claim .

Honourable Ombudsman directed the insurer to pay Rs 13591.40 as insurer has failed in every respects for settlement of claim.

Chandigarh Ombudsman Centre
Case No. : GIC/310/OIC/11/08
Dr. Sant Parkash
Vs
Oriental Insurance Co. Ltd.

Award Dated : 13.11.07

FACTS : Dr. Sant Parkash and his wife were covered under Mediclaim Policy issued by BO Jalalabad for the period 27.5.06 to 26.5.07 for sum insured of Rs. 3 lakhs each. He fell down in his bathroom on 12.2.07, whereafter he was hospitalized from 18.2.07 to 24.2.07. The claim lodged with the insurer was repudiated on the ground of pre-existing disease. He contended that ailment could not be pre-existing as he was hospitalized because of accident. He further stated that he had continuous Mediclaim Policy since 2000, first with National Insurance Co. and then with the insurer after 2005.

FINDINGS : The insurer informed that a surgery was performed on the femur of the complainant in 2001. In the instant case of treatment given during hospitalization from 18.2.07 to 24.2.07, the discharge summary stated that the screws implanted in the femur in 2001 were broken and had to be replanted. Since there was a gap in insurance from 2002 to 2003 as per their records, the planting of screws was taken as part of pre-existing disease and hence the whole treatment was considered owing to pre-existing disease for which surgery was done in 2001. He also stated that had there been no break in insurance it would have been treated as continuation of policy and would not have been treated as pre-existing disease. On a query whether the

immediate cause of hospitalization was due to a fall or not, the insurer replied that it was because of the fall.

DECISION : Held that the immediate cause of the treatment being due to a fall the case should be treated as one of the accident without any reference to any pre-existing disease. Since the hospitalization was due to an accident, the claim was payable and the repudiation of the claim by the insurer 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/341/NIC/14/08
Kulbhushan Rampal
Vs
National Insurance Co. Ltd.

Award Dated : 15.11.07

FACTS : Shri Kulbhushan Rampal and his wife were covered under Mediclaim Policy for the period 9.2.06 to 8.2.07. The policy was initially taken in 2000. There was a break of one day from 8.2.04 to 9.2.04. His wife had a heart problem in 2004, for which claim had been paid. She was hospitalized again from 7.12.06 to 17.12.06. The claim lodged with the TPA had not been paid as they required condonation of break for one day in order not to treat the disease as pre-existing disease.

FINDINGS : The insurer informed that as per their understanding, it was not a case of break but of continuous policy. On a query as to why condonation was not being done they replied that it was to be done by their Faridabad office where the break occurred.

DECISION : As per the circular of the insurer dated 13.6.03 regarding renewal of the policy "If there is a break, a fresh policy may be issued after obtaining a fresh proposal form and this policy will be subject to exclusion of the disease contracted during the expiring policy period and during the break period and such disease must be specifically mentioned in the schedule of the policy."

In the instant case the insurer neither got a fresh form filled up nor asked for a fresh medical check up to be done. Hence the insurer erred at the time of renewing the policy and there was an underwriting lapse on their part. Therefore, for all practical purposes, the policy should be treated as a continuation of existing policy and not as a fresh policy. The claim was payable. Hence ordered that the admissible amount of claim should be paid by the insurer/TPA.

Chandigarh Ombudsman Centre
Case No. : TATA AIG/326/Mumbai/Ludhiana/21/08
Usha Sharma
Vs
TATA AIG Life Insurance Co. Ltd.

Award Dated : 22.11.07

FACTS : Smt. Usha Sharma had purchased a Health Protector Plan dated 10.07.2006. Since, she was diagnosed for failure of both kidneys, she lodged a claim under Critical Illness and submitted all the requisite original documents on 20.04.2007. On 09.05.2007, she received a reply informing her that the illness suffered by her is not covered under the said plan. Hence, sought intervention of this forum in getting the claim at the earliest.

FINDINGS : The insurer informed that the complainant was diagnosed to have Chronic Renal Failure on 27th January, 2007. The treating doctor mentioned that she was on

conservative treatment-domiciliary basis and issued certificates stating that she was diagnosed with Chronic Renal Failure-Stage IV (permanent and irreversible failure of both the kidneys) and shall progress with time and the patient will need maintenance haemodialysis and renal transplantation in near future. As per the terms and condition of the contract, the illness is not a qualifying condition under the supplementary Critical Illness Rider. The claim was accordingly declined. During the course of hearing, the insurer clarified the position by stating that the patient required dialysis but as per their understanding the stage of dialysis had not reached so far. As per para 5 of the terms and conditions of the policy the claim is permissible in case of permanent irreversible renal failure of both kidneys requiring dialysis or kidney transplant. There was no document to prove that the patient was on dialysis and any step had been taken to get the kidney transplant. The treating doctor, Dr. Rajan Isaacs of Deep Hospital, Ludhiana was consulted on telephone to enquire whether the complainant was undergoing dialysis or renal transplantation. He stated that the stage for dialysis or transplantation had not been reached so far.

DECISION : Held that the claim is payable as the disease requires dialysis/renal transplantation. However, the claim should be paid only after the treatment viz. dialysis/renal transplantation starts. Ordered that admissible amount of claim under Critical Rider clause of the policy should be paid by the insurer to the complainant as soon as written proof is produced by the complainant that the dialysis/renal transplantation has started.

Chandigarh Ombudsman Centre
Case No. : GIC/357/OIC/12/08
K. N. Gupta
Vs
Oriental Insurance Co. Ltd.

Award Dated : 26.11.07

FACTS : Shri K.N. Gupta and his wife were holding a Health Insurance Policy with the insurer for the last 20 years and were also enjoying cumulative bonus for good claim experience. He had lodged claims with the insurer for the last 3-4 years and because of this the insurer had asked him to pay a heavy amount for sum insured of Rs. 4 lakhs each for himself and his wife. Since it was a heavy amount he was forced to reduce the insurance coverage to Rs. 50,000/-. He also showed a letter written by IRDA to CMD of the insurer, in which it had been stated that senior citizens should not be charged undue heavy premium for renewal of policies.

FINDINGS : The insurer informed that they had calculated the premium as per the circular of Head Office dated August'06. They were not aware of the IRDA Guidelines for senior citizens.

DECISION : After perusing the letter no. IRDA/2007-08/OIC/Mediclaim/04 addressed to CMD of the insurer by ED of IRDA, held that since there is an IRDA letter dated April'07, the case of the complainant should be considered in the light of these guidelines and the premium charged from the insured should be premium at the time of expiry of previous policy plus 50% loading in premium. Since there was no excess clause in the expiring policy, the same should not be charged. The policy should be issued for the amount as required by the complainant accordingly.

Chandigarh Ombudsman Centre
Case No. : GIC/324/UII/11/08
S.K. Sehgal

Vs

United India Insurance Co. Ltd.

Award Dated : 27.11.07

FACTS : Shri S.K. Sehgal was covered under Mediclaim Policy with the insurer for more than 10 years without any break. On the night of 14.8.06, he developed pain in the leg and since the leg could not take the body weight, he fell down. He was admitted in Escorts Hospital, Amritsar where emergency operation was performed on his right leg on 15.8.06 for removal of a clot. The claim lodged with the insurer and the TPA M/s Paramount Health Services had not been settled so far, although he was told verbally that the claim had been repudiated by the TPA.

FINDINGS : The insurer informed that the patient was a known case of hypertension for the last 20 years and CABG was performed in 1992. On a query whether the surgery of CABG has any nexus with the surgery on the leg, no satisfactory reply was given by the insurer.

DECISION : Held that repudiation of claim purely on the basis of person having hypertension as pre-existing disease was not in order. The surgery performed in 1992 does not have any nexus with the surgery performed on the right leg. Hence, ordered that the admissible amount of claim for the surgery should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

Case No. : LIC/356/Jalandhar/Jalandhar/22/08

Brij Mohan Gupta

Vs

Life Insurance Corporation of India

Award Dated : 05.12.07

FACTS : The complainant, Sh. Brij Mohan Gupta had purchased a Mediclaim policy with sum assured of Rs.1.20 lakhs. A renewal notice was received for the payment of renewal premium for the year 2007-08 and option to increase cover was also offered. He got cover for Rs. 3 lakhs, Rs.10,227/- was deposited on 28.03.2007 and risk started from 01.04.2007. Further, he received a letter dated 18.04.2007 demanding amount of Rs.4,469/- for sum assured of Rs. 3 lakhs. As he was not able to pay such a heavy amount he requested the insurer to retain the existing level of basic sum assured of Rs.1.20 lakhs. However, his request for reduction of sum assured under mediclaim cover for 2007-08 was denied. Hence, he requested for refund of provisional premium of Rs.10,227/- as he was neither covered for Rs.1.20 lakhs nor 3 lakhs. In view of the refund having not been received, the complainant sought intervention of this forum either in getting cover for a sum assured of Rs.1.20 lakhs alongwith refund of excess amount paid by him, or in getting refund of the entire amount.

FINDINGS : During the course of hearing, the complainant explained the case by stating that he had taken a “Group Mediclaim policy for LIC employees” for himself and his wife, for the period 1.4.2007 to 31.3.2008. The earlier sum insured in the previous year was Rs.1.20 lakhs and the same was enhanced to Rs. 3.00 lakhs for which he had to pay an amount of Rs. 10,227/-. However, he was later on asked by the insurer to pay an additional amount of Rs.4,469/- being the difference, in the revised premium fixed by the New India Assurance Company, and the old premium. He was not aware of this increase and hence wanted the insurance cover to be reduced back to Rs.1.20 lakhs or the premium of Rs. 10,227/- refunded to him. The insurer clarified the position by stating that the premium

was fixed by New India Assurance Company with whom the insurer had a tie up for Group Mediclaim Scheme. The difference in the premium was further to be remitted to New India Assurance Co. The Competent Authority had not agreed for refund of premium or lowering of the sum insured within the current year as per guidelines of the insurer.

DECISION : The guidelines of the insurer regarding deduction of sum insured in respect of serving / retired employees clearly stated that once a higher sum insured has been opted by the insured, the same cannot be reduced except in exceptional circumstances and that too at the time of renewal of policy. Hence, the policy should be continued for Rs. 3 lakhs during the current year of the policy upto 31.3.2008. As an exceptional case, the policy should be issued for Rs.1.20 lakhs insurance cover w.e.f. 1.4.2008. For this the complainant is required to pay Rs. 4,469/-. In case, he fails to pay this amount, the provisional amount already paid would stand forfeited. However, the policy for Rs.1.20 lakhs should be issued from 1.4.2008 onwards either in the form of renewal or a fresh policy if the policy during the current year lapses. It is left to the option of the complainant whether to keep the policy alive during the current year or to start a fresh policy w.ef. 1.4.2008 and forego the benefit of continuous renewal policy.

Chandigarh Ombudsman Centre
Case No. : GIC/412/UII/14/08
Suraksha
Vs
United India Insurance Co. Ltd.

Award Dated : 08.01.08

FACTS : This complaint has been filed by Suraksha Society for Protecting Human Life, Ballabhgarh on 15.11.07. The facts are that one of their members, Shri Rasa Nand was covered under Mediclaim Policy for the period 8.6.06 to 7.6.07 for sum insured of Rs. 35,000/- taken by the Suraksha Society from the insurer. A claim in respect of treatment of Shri Rasa Nand was lodged with the insurer. All the requisite documents along with bills were submitted with the insurer but the TPA M/s Medsave Health Care, New Delhi repudiated the claim on the ground of inadequate hospital facilities under clause 2.1 of the terms and conditions of the policy. The complainant enclosed a copy of letter addressed to Akash Hospital in connection with some other case in which they had approved cashless treatment from the same hospital. Parties were called for hearing on 8.1.08.

FINDINGS : The complainant stated that one of their members Shri Rasa Nand was covered under Mediclaim Policy for the period 8.6.06 to 7.6.07 for sum insured of Rs. 35,000/- taken by the Suraksha Society from the insurer. Shri Rasa Nand was admitted in Aakash Hospital from 29.4.07 to 2.5.07. The claim lodged with the insurer had been repudiated by the TPA on the ground that it was not a 15 bedded hospital. He stated that the hospital is 30 bedded and the same TPA M/s MedSave Health Care Pvt Ltd, New Delhi have approved the same for cashless facility in another case.

DECISION : Held that the TPA have written a letter to Aakash Hospital on 30.5.07 giving sanction for cashless facility in respect of one Smt. Kamlesh Devi. While they had approved cashless facility for one patient of Aakash Hospital, the same has been denied for another patient even for reimbursement contradiction in terms and hence not in order. The claim is payable.

Chandigarh Ombudsman Centre
Case No. : GIC/421/NIA/14/08

Amar Pal Singh
Vs
New India Assurance Co. Ltd.

Award Dated : 11.01.08

FACTS : Shri Amar Pal Singh was insured under Mediclaim Policy for the period 28.3.06 to 27.3.07 for sum insured of Rs. one lakh plus 10% bonus. He alleged that he had been having Mediclaim Policy since 6-7 years without any break. He underwent PDR of both eyes on 11.8.06 and 22.8.06 from Chugh Eye Surgery Centre, Ludhiana. All the claim papers were submitted but the claim had not been settled till date. Parties were called for hearing on 11.1.08.

FINDINGS : During the course of hearing the insurer stated that the case regarding Mediclaim was referred to the TPA. The TPA had repudiated the claim on the ground that the treating doctor had stated that the patient was suffering from DM (diabetic) for the last 18 years. The case was taken up by the complainant with the treating doctor Dr Chugh who clarified that the complainant was suffering from DM (diabetic) for the last 5 years and not 18 years, which had earlier been written through an over sight. The complainant had also stated that he had been paid the similar claim earlier in 2004. At that time the treating doctor had mentioned that the patient was suffering from DM (diabetic) for the last 3 years. After receiving these clarifications the TPA was asked to reopen the case but the same had not been done so far.

DECISION : Held that the case has been dealt with in a very lackadaisical manner by the insurer/TPA. The insurer has not been able to reopen the case even after the clarification given by the treating doctor. In my view, taking 5 years as the period when the patient was suffering from DM (diabetic), onset of the disease was within the policy period which is 6-7 years old without any break. The claim is payable.

Chandigarh Ombudsman Centre
Case No. : GIC/383/UII/14/08
Daljit Singh
Vs
United India Insurance Co. Ltd.

Award Dated : 16.01.08

FACTS : Shri Daljit Singh, his wife, his mother and father were insured under Mediclaim Policy. He suffered from heart trouble and got himself examined at Fortis Hospital on 19.01.07. He was admitted as an indoor patient and after conducting Angiography, it was found that he was suffering from CAD. The doctor gave him post PTCA and put stent to LCX and LAD. Intimation was given to the insurer who referred the case for processing to the TPA. The policy allowed cashless facility but the company denied and he himself had to pay Rs. 5,27,576/-. The TPA vide letter dated 23.1.07 asked for previous consultation papers as they felt there was discrepancy in the age of the patient. All the papers were submitted. He was also asked to provide previous years policies which were duly supplied but despite that the claim was not settled. Parties were called for hearing on 11.12.07 and 16.01.08.

FINDINGS : During the course of hearing the insurer stated that the claim had been repudiated by the TPA in 30th August, 2007 on the ground of pre-existing disease as per clause 4.1 of the terms and conditions of the policy. On a query as to how the claim could become a pre-existing disease when the policy was in force from 2001 onwards, the insurer stated that previous policy expired on 15.8.06 and renewal form 30.8.06 to 29.8.07. Thus there was a gap of 15 days and it was being treated as a fresh policy. Accordingly, the disease was contracted in July'07 was a pre-existing disease. On a

query whether a fresh proposal form was got filled from the complainant, the insurer replied in the negative. On a query whether a fresh medical was done before issuing the policy on 30.8.06, the insurer replied in the negative.

DECISION : Held that due to underwriting lapse on the part of the insurer, the policy should be treated as a continuous policy and the claim is, therefore, payable. However, since the complainant has not got the policy renewed in time and also not followed the procedure to get the delay condoned from the Competent Authority, in the interest of the justice and fair play the claim should be restricted to 75% of the admissible amount.

Chandigarh Ombudsman Centre
Case No. : GIC/440/OIC/12/08
R.D Gupta
Vs
Oriental Insurance Co. Ltd.

Award Dated : 18.01.08

FACTS : Shri R.D. Gupta and his wife were reportedly holders of Mediclaim Policy with the insurer since the last 20 years, who had earlier also lodged a complaint in respect of harassment meted out in renewal of the Mediclaim Policy for self and his wife. The complaint was disposed off vide order dated 22.10.07 with directions to renew the policy for the year 2007-08 with appropriate loading in premium. It was further ordered that the excess clause included on renewal should be removed and cumulative bonus that was withdrawn be included. The complainant has now submitted a letter dated 30.4.07 issued by ED, IRDA instructing the insurer to restrict the increases in premium on renewal of Mediclaim policies of senior citizens. Parties were called for hearing on 18.1.08.

FINDINGS : During the course of hearing the insurer stated that the clarification, issued by IRDA was not available with them at the time of last hearing and hence the policy had been renewed keeping in view the revised premium. He also stated that cumulative bonus of 50% had been given and excess clause had been removed.

DECISION : Held that the contention of the complainant that he should be charged premium at existing rates is in order as borne out by the letter of ED, IRDA. However since there is a claim of Rs. 1,86,000/- immediately in the preceding year some loading should be there to cover the risk. In my opinion 50% loading at the old unrevised rates should suffice and meet the concerns of the insurer for the risk involved. It is hereby ordered that the premium in the expiring policy should be calculated afresh keeping in view old unrevised rates and charging 50% loading on the same. As far as cumulative bonus is concerned, this should be given as per terms and conditions of the earlier policy. The excess clause should also be removed. The proper endorsement should be made on the policy document and the policy should be sent to the complainant along with refund of premium due to him.

Chandigarh Ombudsman Centre
Case No. : GIC/462/NIC/14/08
S.S. Garg
Vs
National Insurance Co. Ltd.

Award Dated : 24.01.08

FACTS : Dr S.S.Garg was covered under Mediclaim Policy for the period 16.3.06 to 15.3.07. He incurred an expenditure of Rs. 10,644/- on hospitalization for the period

02.10.06 to 9.10.06. He lodged a claim alongwith all the bills with the insurer. He was informed after more than 2 months that his file was misplaced. While he was trying to get the duplicate papers, he was informed that his file was found. However, his claim was repudiated by the insurer as per exclusion clause 4.8 of the policy that excluded all psychiatric and psychosmatic disorders and diseases. He also represented to the insurer's TPA on 18.6.07 but there was no response. Parties were called for hearing on 24.1.08.

FINDINGS : During the course of hearing the insurer clarified the position by stating that the complainant was suffering from depression and was hospitalized for treatment. Since this is a psychiatric disorder, the claim was not payable under clause 4.8 of terms and conditions of the policy. On a query whether the terms and conditions of the policy were sent to the complainant, the insurer could not give a satisfactory reply. The complainant stated that he had not received the terms and conditions of the policy.

DECISION : Held that the contention of the insurer that psychiatric diseases are not covered under the policy is in order. However, since the terms and conditions of the policy have not been received by the complainant, the benefit of doubt goes to him. In my opinion therefore, payment of 75% of admissible amount on ex-gratia basis would meet the ends of justice. It is hereby ordered that insurer should make payment of 75% of admissible amount to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/490/OIC/11/08
Lovely Sood
Vs
Oriental Insurance Co. Ltd.

Award Dated : 06.02.08

FACTS : Shri Lovely Sood was covered under Mediclaim Policy for the period 5.2.07 to 04.2.08 for sum insured of Rs. 1 lakh. He underwent major heart surgery at Fortis Hospital, Mohali where he was admitted from 4.4.07 to 13.4.07. He submitted all the requisite documents to M/s Paramount Health Services, TPA. However despite a lapse of considerable time there was no response from the TPA. Parties were called for hearing on 6.02.08.

FINDINGS : The insurer clarified that as per the medical opinion obtained by the TPA from their panel doctor, the disease could not develop overnight. It is a slow process and since the policy had run for only two months prior to the surgery, the disease was considered as a pre-existing disease and the claim was not admissible under exclusion clause 4.1 of terms and conditions of the policy. On a query whether the terms and conditions of the policy were sent to the complainant along with the policy bond, the insurer could not give a satisfactory reply. On a query whether the policy bond had been received by him, the complainant replied in the negative.

DECISION : Held that after hearing both the parties and gone through the discharge summary given by the Fortis Hospital carefully, the history portion in the discharge summary does not show any symptoms of the pre-existing disease prior to 15 days before the admission in the hospital. Moreover, since the complainant stated that he had not received the terms and conditions of the policy in the absence of any proof to the contrary given by the insurer, the benefit of doubt goes to the complainant. In view of the above two reasons, I am of the opinion that the repudiation of the claim on the basis of exclusion clause 4.1 is not in order as the complainant was not aware of this clause. The claim in my view is, therefore, payable.

Chandigarh Ombudsman Centre
Case No. : GIC/482/NIA/11/08
T. C. Gupta
Vs
New India Assurance Co. Ltd.

Award Dated : 08.02.08

FACTS : Shri T.C. Gupta and his wife were covered under Mediclaim Policy for the period 29.06.06 to 28.06.07 for sum insured of Rs. 2 lakhs plus 5% cumulative bonus. They were covered under Mediclaim Policy since 24.06.02. While taking the first insurance policy in 2002 he had clearly declared in the proposal form that he had undergone a heart bypass surgery in the year 1993 and it was clearly mentioned in the relevant column of exclusion of pre-existing disease in the policy document. When he approached for subsequent renewal, he requested the insurer to cover the heart disease also, the then Branch Manager confirmed him that his disease would be covered and the exclusion was not mentioned in the policy issued for the year 2003-04 and subsequent years 2004-05, 2005-06 and 2006-07. In January'07 he suffered from some heart problem and took medical treatment and incurred an expenditure of Rs. 4,64,636/-. He was reimbursed Rs. 3,87,360/- by Punjab State Electricity Board from where he had retired. The balance claim amount of Rs. 77,276/- was referred to Raksha TPA but his claim was rejected on the ground that since the disease was in existence from 1993, the claim was not payable as per exclusion clause 4.1 of terms and conditions of the policy. Parties were called for hearing on 8.2.08.

FINDINGS : The insurer clarified that due to a clerical mistake the exclusion clause was deleted from the policy bond in 2003 when the policy was renewed from 2003-04 and subsequent renewals. However the terms and conditions of the policy were known to the complainant who signed the terms and conditions while taking the policy for the first time.

DECISION : Held that since the complainant was aware of the exclusion clause 4.1 of the policy, he was bound by this clause. Any clerical or other omission or commission while making endorsement on the policy bond by the insurer while renewing the policy cannot be taken as authentic for the purpose of making payment of the claim. In my view, therefore, the repudiation of the claim by the insurer/TPA is in order.

Chandigarh Ombudsman Centre
Case No. : GIC/510/NIA/11/08
Ashok Kumar
Vs
New India Assurance Co. Ltd.

Award Dated : 08.02.08

FACTS : Shri Ashok Kumar was covered under Mediclaim Policy issued by BO Ambala Cantt for the period 12.12.05 to 11.12.06 for sum insured of Rs. 1,40,000/- plus 15% cumulative bonus. He had been having Mediclaim Policy since 11.12.01. He had pain in the abdomen and was admitted in PGI, Chandigarh from 7.9.06 to 26.9.06. He submitted a claim for Rs. 1,07,302.19 with the insurer. However the claim was settled for Rs. 40,000/- only. The balance amount of Rs. 67,302/- was deducted due to the fact that the disease of pancreatitis was diagnosed in 2004 and the sum insured at that time was Rs. 40,000/-. Hence Rs. 40,000/- was paid. Parties were called for hearing on 8.2.08.

FINDINGS : The insurer clarified the position by stating that the earlier policy was for Rs. 40,000/- for which claim was taken in 2003-04. At the time of enhancement in

2004-05 from sum insured to Rs. 1,30,000/- and subsequently to Rs. 1,40,000/- the disease of pancreatitis was considered as pre-existing disease. Hence all treatment relating to this was pegged at Rs. 40,000/- as per exclusion clause 4.1 of terms and conditions of the policy. Therefore the claim was settled for Rs. 40,000/-. On a query whether any cumulative bonus was payable, the insurer replied that this was the second year after the claim was lodged earlier and hence 5% bonus on sum insured of Rs. 40,000/- was payable.

DECISION : Held that the settlement of the claim for Rs. 40,000/- by treating the pancreatitis as pre-existing disease by the insurer is in order. However, since the cumulative bonus of 5% has not been paid. It is hereby ordered that Rs. 2000 being 5% cumulative bonus on Rs. 40,000/- should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/508/NIC/14/08
J.N. Malhotra
Vs
National Insurance Co. Ltd.

Award Dated : 14.02.08

FACTS : Shri J.N. Malhotra and his wife Saroj Malhotra were covered under Mediclaim Policy. He lodged a claim with the insurer in respect of surgery and treatment undergone by his wife at Manipal Hospital Bangalore where she was admitted from 19.4.07 to 22.4.07. Despite repeated follow up his claim remained unsettled. He was informed that his claim had been referred to Head Office for approval. He approached Head Office vide letter dated 8.12.07, but received no response thereto. Parties were called for hearing on 14.02.08.

FINDINGS : The insurer clarified that as per the earlier guidelines issued by the Head Office the endorsement was made on the insurance policy. However, at the time of processing the claim, a circular dated 23.12.04 came to notice in which it had been mentioned that the policy should not be extended automatically but the policy should be renewed by the insured at a discounted premium for the period of OMP. The insurer through an oversight had not informed the complainant to get the policy renewed before its expiry on 11.2.07. Since there was a discrepancy in the extension of the Mediclaim Policy as per endorsement on the cover, a clarification had been sought from the Head Office which was awaited.

DECISION : Held that since the complainant was not asked to renew the policy as per new guidelines he cannot be faulted for non-renewal before 11.2.07. Moreover there is a clear endorsement on the insurance policy document that the insurance cover was valid upto 6.11.07. Hence the claim should be settled based on the endorsement on the insurance policy document terms and conditions of which will hold good on the date of hospitalization. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chennai Ombudsman Centre
Case No. : 11.08.1201/2007-08
Mr. R. Sriram
Vs
The Royal Sundaram All. Ins. Co. Ltd.

Award Dated : 18.10.2007

The Complainant, Mr. R. Sriram has taken a Health Shield Policy for his father Mr. R. Raju, 67 years old for the period 21.06.2006 to 20.06.2007 with M/s. Royal Sundaram Alliance Insurance Co. Ltd. He has been hospitalized from 05.04.2007 to 11.04.2007 for and diagnosed as Acute CVA. A claim has been lodged for Rs. 53,000/-. His claim was repudiated on the ground that the disease was pre-existing and not admissible under the policy.

The Insurer contended that the insured was admitted on 5.4.2007 with history of seizures during sleep. He was unconscious for sometime before he was admitted. In the discharge summary it was stated that he had a past history of similar episode for the past 15 years but not on treatment & diagnosed as Acute CVA. Present MRI brain findings point to multiple lacunar infarcts in both cerebellar hemisphere and lenticular nucliei & multiple small vessel ischemic changes in periventricular and deep white matter in both fronto parieto occipital lobes. Overall, these seizures must have started well before 9 months, under the clause of pre-existing diseases, they have repudiated the claim.

The Forum perused the documents and observed that there is no recorded evidence to prove that the patient is suffering from Acute CVA problem prior to 21.06.2006. The Doctor who had given the opinion to the Insurer differed with the diagnosis of treating Doctor and has also not confirmed when was the on set of the ischemic lesions in the brain of Mr. Raju and whether the insured was suffering from the same at the time of proposing for insurance. However, at present he has been diagnosed with Acute CVA Therefore, investigation report submitted by the insurer is ambiguous and inconclusive. Hence, the direction was given to the Insurer to settle the claim as per policy terms & conditions.
Complaint was allowed.

Chennai Ombudsman Centre
Case No. : 11.08.1192/2007-08
Mr. V. Surendra Nath
Vs
M/s. Royal Sundaram All. Ins. Co. Ltd.

Award Dated : 18.10.2007

The complainant, Mr. Surendra Nath has taken a Health Shield Policy covering his mother. She has been hospitalized for the complaint of right knee weakness, inability to walk without support etc. The complainant has submitted the claim papers to the Insurer. However, his claim was rejected on the ground of pre-existing disease. He also submitted a copy of the certificate issued by the attending doctor. He contended that the present hospitalization was not for any pre-existing disease.
The representative of the Insurer stated that Health Shield Policy is a double protection policy where the insured was covered for 2 years. This was the first year policy. It was revealed from the discharge summary and indoor case sheets that the patient was a known hypertensive & on T.Aten 25 mg. They have obtained a medical opinion from a Neuro Surgeon, which states that the patient was suffering from the carotid artery with calcified plaques that must have taken longer time to develop and also hypertension. Both of which have contributed to the acute ischemic stroke in the left side of the brain. After perusing the documents, it is evident that the patient was suffering from hypertension and was under medication prior to the hospitalization or commencement of the policy. The complainant has failed to furnish that hypertension and other diseases are not pre-existing diseases or the present hospitalization was no way connected with any pre-existing disease. Therefore, the Insurer is justified in rejecting the claim.

The Forum has dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.05.1204/2007-08
Mr. V.S. Chakrapani
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 30.10.2007

The complainant Mr. V.S Chakrapani and his family were covered under individual mediclaim policy since 1990. He renewed the policy for the period 31-03-2006 to 31-03-2007 also. His spouse was covered for the sum insured Rs.1,60,000/- with a cumulative bonus of Rs.68,700/-. She has been hospitalized for the complaint of pain in both the knees etc and diagnosed as “Biloateral Osteo Arthritis”. Insurer had settled the claim only for Rs.1,00,025/- (Rs.83,000 + CB Rs.17,025/-). The balance bill amount of Rs.42,361/- was not sanctioned even though the sum insured was Rs.1,60,000-/ & CB was Rs.68,700-/ during 2006-07.

The representative of the insurer had contended that as per pre-authorisation request, under the column “past history of any chronic illness” it was mentioned that there was hypertension since 6 months & Osteo Arthritis since 1996. The patient’s sum insured was Rs.83,000/- during 1993-97, Rs.90,000/- during 1997-2000, Rs.1,15,000/- 2000-2002 and during 2003-04, sum insured was Rs.1,60,000/- to till 2006-07. Partial amount of claim has been repudiated due to the exclusion 4.1, 4.2 & 4.3 and the sum insured has enhanced only in 2003-04 & not in 1996.

The Forum has perused all the documents and it is evident that the Insurer stipulated a policy condition which was given in the schedule of the policy and they were right in interpreting the clause. The Forum also pointed out that Insurer should have cross-checked the indoor case sheets with the discharge summary as a proof of evidence that she was suffering from Osteo Arthritis since 1996 as the discharge summary does not contain the past history. The Insurer has also accepted the proposal for increase in sum insured without any condition. It emerges that both the insurer and the insured failed to defend their respective case strongly. However, if at all any benefit of doubt has to be given, it can be given only in favour of the insured. Hence, the Forum has allowed the claim on Ex-gratia of Rs.25,000/-.

Chennai Ombudsman Centre
Case No. : IO(CHN)11.08.1233/2007 – 08
Mr. N. Gopalarathnam
Vs
The Royal Sundaram Alliance Insurance Co. Ltd

Award Dated :

The complainant Mr. N. Gopalarathnam had obtained a meidclaim policy with M/s The Royal Sundaram Alliance Insurance Co. Ltd for the period 10.11.2006 to 9.11.2007. He had lodged two claims namely Papilloma left vocal cord and Coronary Artery Disease on different dates with the insurer. Both the claims were rejected by the insurer on grounds of pre existing condition. The insured represented against the same and were turned down by the insurer resulting in approaching the forum.

The insured was continuously holding the policy since 1999 with Oriental Insurance and switched over to Royal Sundaram during 2006-07 without any break. The insurer through their doctor have argued that the disease vocalcord papilloma could not have

developed over 3 months and was pre existing and also not considering previous policy from Oriental without break as a continuous cover. As per insurer's policy conditions heart diseases were specifically excluded during the first two years of the policy with them.

As per available records, it is not established that the Insured was having knowledge about Papilloma Left Vocal Cord prior to November 2006 even if the disease had been growing in the insured earlier. The coronary artery diseases were specific exclusions as per the policy conditions of the insurer.

In view of the above, the complaint is partly allowed directing the insurer to settle the claim for left vocal cord as per the terms and conditions of the policy. The other claim relating to coronary artery disease is not allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1235/2007 – 08
Mrs Umamaheswary. Swaminathan
Vs
The New India Assurance Co. Ltd

Award Dated : 30.10.07

The Complainant Mrs Umamaheswary had been covered under mediclaim policy with the New India Assurance Co. Ltd. She was continuously covered for the past 3 years and had not made any claim under the policy. She underwent Hernia operation between 11.04.2007 to 14.04.2007 and submitted the claim to the TPA. Her claim was rejected on the grounds of pre existing condition relating to caesarian surgery prior to taking the policy. The insured inform that they had not mentioned the details of caesarian operation since it is not a disease Her representation to the insurer for consideration of the claim has not resulted in any positive response, hence the present complaint.

The insurer stated that incision hernia would occur as a result of incompletely healed surgical wound occurred due to caesarian section done prior to obtaining this policy and they are treating the same as pre existing condition.

The hernia in this case occurred in a place other than on the scar and it was due to weak scar is not tenable. There is also no mention in any records that the present ailment is the complication arising out of earlier operation prior to inception of the policy. TPA also confirmed that all patients who have undergone LSCS do not get incisional hernia.

Based on the above, the insurer was not been able to establish that the hernia was existing prior to inception of the policy and the repudiation of the claim by them is not justified. Hence the complaint is allowed and the insurer is directed to process and pay the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1229/2007 – 08
Mr. K. Kulandaiappan
Vs
The National Insurance Co. Ltd

Award Dated : 30.10.07

The Complainant Mr.K. Kulandaiappan was covered under mediclaim policy issued by The National Insurance Co. Ltd for the period 15.11.2006 to 14.11.2007. The insured

had chest pain and had treatment with two different hospitals on 27/29.11.2006. The insured lodged a claim with the TPA and the same was rejected on the ground that the claim falls under waiting period of first 30 days. The representation of the insured was rejected and he approached the forum with the complaint.

The insurer's representative stated that the insured had policy with them in 2005 – 06. The policy for 2006 – 07 was renewed after a break of 36 days by submitting a fresh proposal form. Since this is a fresh policy, as per policy condition 4.2, claims happening within the first 30 days of obtaining the policy were excluded. It is found that the during an earlier occasion, the insured got an award from this forum and did not disclose the same. Therefore, the complainant was insurance conscious and well aware of the various provisions.

There was no recorded evidence to establish that there was a genuine omission to renew the policy in time and the insured also opted not to apply for condonation of the delay. Therefore, the present policy shall be treated as fresh policy and the hospitalization claimed falls under policy exclusion 4.2 and hence the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1227/2007 – 08
Mr. C. Krishna Prasad
Vs
United India Insurance Co. Ltd

Award Dated : 30.10.07

The Complainant Mr. C. Krishna Prasad was covered along with his family under mediclaim policy with United India Insurance Co. Ltd. His wife Mrs. Lakshmi Prasad had been hospitalized for Ectopic pregnancy and her claim for reimbursement of hospitalization including expenses towards food, transport and interest was rejected by the insurer on the ground that expenses incurred towards treatment arising from or traceable to pregnancy are excluded under the policy.

The insurer's representative quoted policy condition 4.12 dealing with exclusion relating to pregnancy and child birth. The TPA was also of the same opinion relying on exclusion of condition 4.12.

After scrutiny of various medical science books and opinion of doctors, it is found that ectopic pregnancy is a pathological, abnormal condition which can never result in childbirth. It is an abnormal condition and illness is life threatening if left untreated. The policy condition does not exclude abnormal situations like the one mentioned above and life threatening situations can not be equated under the broad category of pregnancy and child birth.

The situation in the present case is not that of a normal pregnancy and has to be considered as the one necessitating immediate attention and not to be viewed as being outside the scope of the policy. The insurer is directed to settle the claim for hospitalization as per the terms and conditions of the policy excluding expenses towards food, transport and interest. The complaint is partially allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1157/2007 – 08
Mr. S. Naganathan
Vs
The Oriental Insurance Co. Ltd

Award Dated : 31.10.07

The complainant Mr. S. Naganathan was covered under mediclaim policy with Oriental Insurance Co. Ltd since 2001 and the current renewal was from 19.03.2005 to 18.03.2006. He was hospitalized between 25.10.06 to 29.01.06 for non healing ulcer left 2nd toe. He lodged a claim with the TPA and the same was rejected on the ground of pre existing disease of diabetes which was specifically excluded under the policy. The insured represented for consideration of the claim. The claim was not settled and hence the present complaint.

The insurer informed that the policy issued to Mr. Naganathan specifically exclude all expenses relating to Diabetic since inception. The opinion of Dr. Manohar states that the non-healing ulcer was due to diabetic related complications and a case of diabetic foot. The TPA doctor also mentioned that diabetic was the root cause for the infection and the consequent surgery. The attending doctor of the complainant also could not categorically state that the treatment is not connected with/not due to diabeties.

The complainant could not prove that proximate cause for the present hospitalization was not due to diabetes. It is the duty of the insured to prove that the expenses for which he claims falls under the policy coverage and did not fall under policy exclusions. The insurer through their panel doctor have established that the present hospitalization was in respect of pre existing disease viz. diabetes, which is specifically excluded under the policy. Hence the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.08.1248/2007 – 08
Mrs. Padma Raghunathan
Vs
Royal Sundaram Alliance Insurance Co. Ltd

Award Dated : 06.11.07

The Complainant Ms. R. Sanjana was covered under the Health Shield Insurance for the period 21.12.2006 to 21.12.2007 along with her mother. On 22.05.2007 she underwent ‘Endoscopic Excision’ and vocal nodule excised from both vocal cord. The claim of Rs.20,867/- submitted by the insured was rejected by the insurer on the ground that minimum period of hospitalization of 24 hours as an in patient not complied with. The insured submitted certificate from the treating surgeon to the effect that this procedure does not require 24 hours stay in the hospital due to technological advance. But the insurer stuck to their stand and the insured approached the forum.

The representative of the insurer stated that as per their policy clause, hospitalization of less than 24 hours were not allowed except as provided. They contended that this procedure does not fit into the definition of similar diseases where hospitalization of less than 24 hours was allowed.

The insurer has no objection to the claim but for hospitalization of less than 24 hours. The policy clause of the insurer clearly states that the limit 24 hours hospitalization is not applicable for treatments like dialysis, chemotherapy and such other surgical operation that necessitate hospitalization less than 24 hours due to medical/technological advancement/infrastructure facilities. The treating doctor also confirmed that due to technological advances, there is no need for the patient to stay for 24 hours. The policy condition has to be interpreted in its entirety and the withinmentioned procedure for which the insured has claimed falls under treatment not requiring 24 hours hospitalization due to technological advancement/infrastructure facilities and hence the complaint is allowed . The insurer was directed to process and settle the claim as per other terms and conditions of the policy.

Chennai Ombudsman Centre

Case No. : IO(CHN) 11.02.1228/2007 – 08
Mr. K. Shankaranarayanan
Vs
United India Insurance Co. Ltd

Award Dated : 22.11.07

The Complainant Mr. K. Sankaranarayanan was covered under mediclaim policy with M/s United India Insurance Co. Ltd. He was hospitalized for heart attack and incurred hospitalisation expenses of Rs.1,50,000/-. The insured's daughter had a group mediclaim policy from her employer covering her father. A claim of Rs. 50,000/- was settled under the group policy. The insured's claim under the individual policy was declined by the insurer on the grounds of pre existing condition. After representation from the insured also the claim was not settled. Hence, the present complaint.

The representative of the insurer stated that as per the first discharge summary, the patient was a known case of hypertension and diabetes mellitus for 15 years. The insured's claim was declined. After this, the insured submitted treating doctor's certificate mentioning that the patient was suffering from diabetes for 5 years and hypertension for 3 years. The insured had not stated in the proposal the pre existing diseases which amounted to suppression of material facts. Even, as per the second discharge summary, the insured had pre existing diseases prior to inception of the policy.

The history of diabetic and hypertension before the inception of the policy in this case is clearly established. As per the insurer's policy condition all disease/injuries which are pre-existing when the cover incepts for the first time are excluded. Since the claim has been made in the second year of the policy and as per the records available, the insured was suffering from hypertension for 3 years and diabetic for 5years, the claim clearly falls under exclusion 4.1 of the policy clause of the insurer. Hence the repudiation of the claim by the insurer is in order and the complainant is dismissed.

Chennai Ombudsman Centre
Complaint No.IO(CHN) 11.03.1225/2007-08
Mr. T.K. Elangovan
Vs
The National insurance Co. Ltd.

Award Dated : 30.11.2007

The complainant Mr.T.K. Elangovan and his family were covered under Mediclaim policy of M/s National Insurance Co. Ltd. His wife Smt E Mala was hospitalized at M/s. Vikram Hospital, Coimbatore from 21.11.2006 to 23.11.2006 for ear problems. He preferred the claim with the Insurer for reimbursement of hospitalization expenses. Insurer has allowed the claim for part amount only contending that amount allowed being reasonable medical expenses as per the terms of the policy.

The representative of the Insurer stated that their TPA TTK Healthcare services pvt. Ltd, has reduced the quantum under two items viz. the surgeon's fees and Asst. surgeon's fees. Amount claimed was Rs.52,000/- and Rs.22,000/- and the amounts allowed were Rs.5000/- and Rs.2000/- respectively. The insurer concur with the settlement made by TPA as being reasonable.

Various documents submitted by the insured and also papers relating to similar surgery at Vikram Hospital were analysed. After taking into account medical advancement and type of surgery performed, it is felt that the charges at Vikram Hospital,Coimbatore is

far in excess of the fees charged for similar surgery by reputed hospitals in major cities. Since the insured was not put on alert about the high charges by the said hospital either by the insurer or by TPA, considering the financial outgo suffered by the insured, additional amount of Rs.10,000/- towards Surgeon's fees and Rs.3,000/- towards Asst. Surgeon's fees is allowed on Exgratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1259/2007 – 08
Mr. L.R. Natarajan
Vs
The United India Insurance Co. Ltd.

Award Dated :

The Complainant Mr.L. R. Natarajan has been taking the mediclaim policy from United India insurance Company for the past 13 years. In December 2005, he was hospitalized for "Syncopal Attack". The claim of the insured was declined by the TPA on the ground of pre existing condition. The insured approached the forum contending that the same was not pre existing.

The representative of the insurer stated that the insured had taken the policy in 1994 and has been renewing it. The insured underwent an operation during 1988. He had claimed for some hospitalization expenses in 2001. The insured's claim was rejected by TPA who confirms that the treatment taken in 2005 pertains to 1988 operation and as such no other illness and the hospitalization was done only for the purpose of scan and medicines. The insurer is justified in not allowing any expenses relating to pituitary adenoma.

From the hospital records it is found that the insured had been treated for ailments other than pituitary adenoma also which were not pre existing neither as per the insurer or the TPA. Taking into account the advanced age and considering the complete medical status on admission and treatment being taken for ailments other than pre existing disease also, the complaint is partly allowed with on award amount of Rs.15,000/- only on Ex Gratia Basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1274/2007 – 08
Mr. Kothamani Santhi
Vs
The National Insurance Co. Ltd

Award Dated : 24.12.2007

The Complainant Mrs. Kothamani Shanthi and her husband Mr. S. Santhi were covered under mediclaim policy issued by National insurance Co. Ltd. Mr. S. Santhi suffered an avulsion fracture of the right elbow with secondary osteoporosis. TPA Medicare repudiated the claim stating that the treatment was related to old CVA which was excluded from the scope of the policy. Representation to the insurer had not yielded any results. Aggrieved by this the insured approached the forum .

The representative of the insurer stated that CVA was excluded from the scope of the policy and since the treatment is related to the same, claim was not admissible. They further added that as per the insured severe muscular contractions in the right upper arm had led to a fracture at the elbow. As per the insured, the statement pertaining Avulsion fracture of right olecranon was obtained by TPA from her.

The TPA secured the statement from the insured regarding CVA rather than go by the opinion of the treating doctor or their own panel of experts. The insured was led to believe that claims are payable only if the treatment is related to the existing illness. The terminology used by the insured to describe the illness is not the ones used by general public and seems to be drafted either by Insurer or TPA. The insured also cannot disown a statement already submitted under their signature.

In the case of the insured, even if the muscle contraction is a symptom of the old CVA, there seems to have been no problem for a long time. As confirmed by the treating doctor, the fracture is secondary to osteoporosis and the insured suffered the fracture while trying to get off the bed. It can not be concluded that old CVA only contributed to the present fracture leaving aside other age related factors which only increases the probability.

Insurer was directed to settle the claim.

Complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.05.1308 /2007-08
Shri C.K. Sukumaran
Vs
The Oriental Insurance Co. Ltd

Award Dated : 24.01.2008

Shri C.K. Sukumaran, the complainant had taken a Mediclaim policy from the Oriental Insurance Co. Ltd. covering himself and his wife for the past few years. On renewal of his policy the vested cumulative bonus was disallowed and the quantum of sum insured was thereby reduced by the insurer. He contended that on renewing the policy and paying the enhanced premium he should be entitled to continuation of the no claim bonus.

The insured stated that a new mediclaim policy came into effect from 15.09.2006. Provision of cumulative bonus had been withdrawn and as a one time exercise the insurer's expiring policies would be renewed with enhanced sum insured (to include earned cumulative bonus). The new sum insured would be fixed in the appropriate revised sum insured slab. The corresponding difference in premium would be waived.

On comparison of the previous and current years policy it was seen that the policy with Rs 2 lacs SI and bonus of Rs 44,580 and Rs 61,400 respectively had been renewed only for Rs 2,00,000/- .On perusal of the renewed policy in the light of the administrative instructions, it was seen that on renewal of the policy, the complainant is entitled for a sum insured of Rs 2,00,000/- plus Rs 44,580/- ie Rs 2,44,580/- and his wife would be entitled for Rs 2,00,000/- plus Rs 61,400/- ie Rs 2,61,400/- respectively. In the new scheme, the applicable Sum Insured for the complainant would be Rs 2,50,000/- and the applicable the revised Sum Insured for his wife would be Rs 3,00,000/-. The corresponding premium payable would be Rs 18,886/- (i.e. Rs 12,222/- plus Rs 6,664/-). But for the year 2006-07, as a one time benefit, the hike in premium due to the merging of the Cumulative bonus with the sum Insured, would Have been waived.

However, the complainant and his wife have both be given the old sum insured of Rs 2,00,000/- each, although the complainant had paid the premium as per the revised rates.

The insurer was directed to rectify the policy so that the Complainant's Sum Insured for 2006-07 is fixed at Rs 2,50,000/- and that of his wife at Rs 3,00,000/-. The renewal for

2007-08 was to be done as if the policy rectification was done prior to the date of renewal. Since the modified product was cleared by IRDA, the insurer was well within their right to modify the terms and conditions of the policy prospectively.

The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1230/2007-08
Shri Brij Mohan Gupta
Vs
The New India Assurance Co. Ltd

Award Dated : 31.01.2008

Shri Brij Mohan Gupta had taken a mediclaim policy with New India Assurance Co. Ltd. He had claimed reimbursement for his hospitalization on 3 occasions for various complaints at Apollo Speciality Hospital, Madurai, The Arya Vaidya Chikitsalayam & Research Institute, Coimbatore and Apollo Speciality Hospitals, Madurai. His claims were repudiated on the ground of pre-existing diseases under Clause 4.1.. He represented the illness was of idiopathic origin and not due to Lumbar Spondylosis.

The insurer stated that it was clear that the initial diagnosis has been taken as the basis for medical management and the pre-existing disease/illness i.e. Lumbar Spondylosis and Osteo Arthritis of both knees which was degenerative and existing for a prolonged period (15-20 years) which resulted into the present ailment. Therefore the claims were rejected

Documents which included Discharge summary of the various hospitals, certificate of treating doctor and the indoor case sheet of Apollo hospitals were scrutinized. It had been recorded therein that patient had back pain for the last 30 years, Oesteo Arthiritis in both knees for the last 15 years and Spondylosis for the last 15 years. The same was confirmed in the Physician's remarks in the indoor case sheets as 20 years. The treating doctor had also confirmed that Mr Brij Mohan had severe Oesteo Arthritis in both knees and severe degenerative changes as a result of Lumbar Spondylosis. The discharge summary of Arya Vaidya Chikitsalayam & Research Institute, referred to weakness of both lower limbs and feeling of chillness of both feet and the diagnosis as per the alternate system on medicine i.e . Ayurveda is stated to be "Vatha complaints". Discharge summary of Apollo Specialty hospital stated that the diagnosis was Chronic Inflammatory Demyelinating Polyneuropathy(CIDP) and the primary consultant was DR S Meenakshisundaram, (Neuro) and other consultant was Dr Vivek Bose (Cardiologist). He has been admitted with complaints of difficulty in walking since 3 months. It was also mentioned that treated for Guillian Barre Syndrome in February 2006. The final diagnosis was Chronic Inflammatory Demyelinating Polyneuropathy (CIDP). In the indoor case sheet it was also mentioned he was known case of IHD on treatment.

In the circumstances, the decision of the insurer to repudiate the claim did not warrant any interference at the hands of the Insurance Ombudsman.

The Complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.08.1264/2007-08
Shri. Amit Kumar Chakraborty
Vs
Royal Sundaram Alliance Ins. Co. Ltd.,

Award Dated : 31.01.2008

The Complainant Shri Amit Kumar Chakraborthy has been covered under Health Shield Insurance Policy from Feb2006. Due to blood discharge in the gum area since May 2006, he has been admitted in the hospital and was diagnosed to suffer from bone loss –mandible and maxilla. On 19th August 2006 he was advised to undergo the surgery for periodontal disease. He has undergone flap surgery with bone grafting. When he applied for cashless facility it was denied by the TPA and he was advised to claim for reimbursement after the surgery. He has submitted the claim for Rs.55,621.95. But the Insurer repudiated his claim on the ground of pre-existing disease. He admitted that he was suffering from diabetes from 1999 onwards but his doctor has clarified that diabetes could not be cause of the surgery.

The representative of the insurer said that the complainant himself had admitted that he was a smoker and diabetic. He said that it is a progressive disease. The complainant was treated surgically and bone grafting had been done. He also mentioned that chronic periodontis is a condition resulting in inflammation within the supporting tissues of the teeth and is characterized by pocket formation or recession of the gingiva. He was suffering from diabetes from 1999 but has not disclosed the same while taking the policy. Had he disclosed, they would have excluded the risks associated with diabetes. Since he has not disclosed they have issued the policy without any exclusion. They have sent a letter to Mr.Chakraborty asking for date of commencement of diabetes

The documents like Discharge Summary, OPG REPORT,Certificate from treating doctor and dental surgeon and diabetologist were produced and scrutinized . The expert advice obtained by the forum stated that the condition of poor oral health was pre-existing and there can be generalized bone loss of maxilla and mandible even for controlled diabetic patients. On scrutiny of all the relevant papers it has been found that the coverage has started only before 19 months. The OPG report dated 18.03.06 shows generalized bone loss of mandible and maxilla. There is also mention of loss of teeth. Although the symptoms were noticed only after the policy was taken, poor dental health has definitely been pre-existing.

The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1265/2007-08
Shri. C. Balakrishnan
Vs
The New India Assurance Co. Ltd.,

Award Dated : 31.01.2008

Mr. C. Balakrishnan, had taken a mediclaim policy since 2000. He has submitted a claim during 2007 for the treatment of Right MID Calyceal Diverticulum with Calculi. His claim has been repudiated stating that these expenses incurred for an already existing ailment and are not payable as per the exclusion clause 4.1 of the policy. The complainant has taken treatment for right renal calculus in 1997 and was completely cured. The right renal calculus occurred in 2005 and got operated in 2007. But, according to the Insurer the claimant has already under gone ESWL for right renal calculus in the year 1997 and the expenses incurred now comes under pre-existing ailment as per clause 4.1 of the policy, hence they have repudiated claim. He applied for cashless facility and the same was rejected by the insurer. After discharge from the hospital, he submitted the bills but his claim was repudiated stating the exclusion clause 4.1. He said that it is not a disease but occurs due to lifestyle changes..

The representative of the insurer said that Mr.Balakrishnan has been insured with them from 1997. In his first policy there was no exclusion of pre-existing disease for right renal calculus and hence he might not have disclosed in the proposal form about the disease.

Documents like The Discharge Summary, treating doctor certificate, Outpatient test entry, Scan report were perused. The attending surgeon had categorically stated that after 1997 treatment, there was complete clearance of all residual radio opaque fragments from the right kidney as seen by him in the follow up investigation done in 2001. The proposal form and indoor were not produced by the insurer. In the absence of Indoor case papers, there was no strong clinching evidence to establish that the disease had reappeared when the insurance was proposed. Therefore benefit of doubt was given to the insured and an ex-gratia award of Rs 43,000/- was ordered.

Complaint was partly allowed on Exgratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1306/2007-08
Shri A V Ramakrishnan
Vs
United India Insurance Co. Ltd,

Award Dated : 31.01.2008

Shri A.V.Ramakrishnan, complainant had taken a Health Care Plus Policy through Indian Overseas Bank. Mrs Saraswathy, wife of the complainant was hospitalized at Venkateswara Hospitals, Chennai. He had claimed reimbursement of hospital expenditure of Rs.1.27 lakhs .The claim was repudiated under Exclusion 4.1

The Insurer stated that Smt.R.Saraswathy has stated in the proposal form that her health condition was quite normal and was not suffering from any pre-existing disease. On investigation, they found from the indoor case sheets that the patient's activities were restricted for last 2 years, vegetarian diet, sedentary life style, severe anaemia with cardiac failure CAD (ASMI) (silent infarct). They contended that she was suffering from CAD much prior to the commencement of policy period viz.11.03.2006. The representative of the TPA said that the insured was hospitalized within 9 months from the inception of the policy with a history of pedal edema and abdominal distension since 2 months. As per the hospital notings, the patient is an old case of ASMI. This means that the person has suffered a heart attack in the past. This is confirmed as per the Echo report. Loss in weight from 42 Kgs at admission to 33 Kgs. at discharge shows that there was severe edema. Moreover when the patient was admitted in the hospital, she was directly taken to the ICU which showed the severity of the symptom. Based on these facts, they had asked for further details/reports, which the insured had not provided.

The documents like Discharge Summary, Treating doctor's certificates. Indoor case sheets, he indoor case sheets were examined. Passport and other travel documents of the insured established that although the hospital stated the "patient's activities were restricted for the past 2 years", she has been traveling and she was not totally immobile for the past two years.

It was also noticed that at the very first sign of discomfort, the patient is seen by a cardiologist and admitted in a ICU of a renowned hospital and no mention of any medicines taken earlier were recorded in either discharge summary or indoor case sheets. It was hard to believe that her haemoglobin levels might have fallen to such a low level of 3.0% all of a sudden without any symptoms. However, the insurer could not

prove beyond doubt with supporting documents that the insured was suffering from the disease prior to inception of the policy. The insurer was directed to pay Rs.50,000 on ex-gratia basis.

The Complaint was partly allowed on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1270/2007-08
Shri. G. Kalimuthu
Vs
The New India Assurance Co. Ltd.,

Award Dated : 12.02.2008

Mr. G. Kalimuthu, the Complainant has taken Mediclaim policy for the period 17.06.2006 to 16.06.2007 for Rs.50,000/-. He has been hospitalized at CMC, Vellore for abdominal pain and treatment was taken. The Insurer has repudiated his claim of Rs 12,894/- stating that he was suffering from abdominal pain for the past 4 years and also an alcoholic, this disease is a pre-existing one. The complainant stated that earlier he has taken two claims for the same disease in Apollo Hospital & Meenakshi Mission Hospital & Research Centre from Medi Assist. He has never consumed alcohol in his life. In CMC's discharge summary, they have wrongly mentioned that the abdominal pain was from 5 years but actually pancreatitis pain was started only on 09.04.2005. He contended that there was a mistake in the hospital records with respect to his age i.e. in Apollo Hospital it was mentioned as '35' and in Meenakshi Mission, it was mentioned as '40' and therefore the statement that he is an alcoholic should have also been the result of clerical mistake.

The Insurer stated that the disease was pre existing before taking the first year policy i.e 17.06.2004 and their TPA who had reviewed all the medical reports have repudiated the claim as per Clause-4.1 (pre-existing) & 4.8 (run down). As per the discharge summary, the claimant is suffering from abdominal pain for the past 4 years and previous claim details show that claimant is an alcoholic. Going by the duration and the alcoholic history of the patient claims stands denied under clause 4.1 and 4.8 of the mediclaim policy.

After examining the Discharge summary of the various hospitals , self contained note etc it was held that It is clear from the Discharge Summary of CMC Hospital, Vellore that the complainant had been suffering from the instant disease for more than 5 years. The reference to 'alcoholic' in one of the earlier discharge summaries cannot be ignored since decision was being taken considering all the available records in toto. Held .the repudiation was in order.

The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1309/2007-08
Smt.K.Krishnakumari
Vs
The New India Assurance Co. Ltd

Award Dated : 12.02.2008

Smt. K. Krishnakumari had taken a Hospitalisation and Domiciliary Hospitalisation Benefit policy from the New India Assurance Co. Ltd. during 2006-07 for Rs.1,00,000/- sum insured. On 06.02.2007 she developed chest pain and was advised bypass surgery. She was denied cashless facility. Her claim for Rs One lakh was repudiated stating Exclusion Clause 4.1 (pre-existing) and 5.7 (misrepresentation). She contended

that the insurer was wrong in rejecting her claim. She had signed the proposal form when she took the mediclaim policy, and had declared that she was diabetic. She did not have hypertension at any point of time.

The insurer stated that from the papers given, medications taken and from the severity of the disease/illness, they were of the opinion that the patient/insured must have been suffering from the disease/illness even before the insurance coverage and based on the policy exclusion clause 4.1 and 5.7, the claim was not admissible and hence the claim was rejected.

Documents such as discharge summary, policy copy, proposal form were scrutinized. It was established that under the Insured Person Details form complainant has declared that she had sound health and no medical complaints. For the specific question “Have you ever suffered from diabetes, hypertension, chest pain or coronary insufficiency or myocardial infarction?” she has written “No”. As per remarks in Discharge summary complainant is a” known Diabetic on insulin. A know HTN.” The same were reported on the Indoor case sheets as well.

It was held that adequate evidence had been submitted by the insurer to establish that the insured was suffering from Diabetes and under medication before inception of the policy. She has also been a LVH patient .The insured herself has accepted that she was a diabetic. But she has failed to disclose the same in the proposal. Hence it is evident that the insured was aware of her pre-existing disease and failed to disclose the same to the insurer at the time of proposing in 2005..

The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1266/2007-08
Shri. M. M. Devanarayanan
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 19.02.2008

The Complainant, a 37 year old man, and his family were covered under the mediclaim policy of Oriental Insurance Co. Ltd. Madurai from 2002 onwards. In July 2005 he underwent eye surgery at Aravind Eye Hospital, Madurai for immature cataract and he had a claim for Rs.25,014/-. But the claim was turned down vide letter dated 21.12.2006 quoting Clause 2.1.3, - first year exclusion clause.

The insurer contended that there was a break of 40 days at the time of renewal in 2005 and therefore the policy for 2005-06 is to be treated as a fresh policy and claim has arisen in the first year. Their Panel Doctor has opined that as per the Discharge summary the surgical treatment has been done for immature cataract in both eyes. Surgery for cataract is excluded in the first year of policy under Sec 2.1.3 of the Good Health Policy. Since there was a break in payment of premium in 2005, the subsequent renewal was treated as fresh policy. Therefore they denied the claim.

The main point of contest was whether immature cataract is as good or as bad as a matured cataract for the purpose of exclusion under policy condition2.1.3. As per the expert opinion Immature Cataract is one of the stages to be proceeded before it becomes a matured cataract which is the opacification of the lens. It is also opined that the progression of cataract is slow and takes a number of years. In view of this, in the instant case the treating doctor would have felt that patient could be operated even for an immature cataract. Decision of insurer to repudiate was upheld.

The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1215/2007-08
Shri V.S.Raghavan
Vs
The United India Insurance Co. Ltd.

Award Dated : 28.02.2008

Shri V.S.Raghavan, complainant who was covered under the Mediclaim had undergone treatment from 31.12.2005 to 13.01.2006 for Post-infective raw area in the left leg and the insurer had settled the claim. He enhanced the sum insured from Rs.2 Lakhs to Rs.3.5 Lakhs during the renewal in 2006. He again had discomfort in the right leg and was hospitalized from 26.03.2007 to 26.04.2007. He had sought cashless facility but same had been approved only for the original sum insured. His claim for the balance amount of Rs.183252/- which fell under the enhanced sum insured was denied stating that the treatment was given for pre-existing disease Cellulites in the left leg, for which the claim was settled previously. He disputed the contention of the insurer since his treating doctor had stated that he was now treated for right leg only and Cellulitis in his left leg had been cured. The present surgery in the right leg was not for pre-existing disease or for extension of existing ailment.

The insurer stated that the complainant had undergone surgery for the problem of Post Infective Raw Area in the left leg from 31.12.2005 to 30.01.2006. He renewed his policy for a further period of one year from for an enhanced sum insured of Rs.3,50,000/- anticipating the claim. During the current year he developed the same problem in the right leg. Cashless facility had been approved up to a sum of Rs.2,00,000/- but they declined to consider the expenses for the increased sum insured of Rs.1,50,000/- since the disease had the same pathology which would make it a pre-existing one.

On scrutiny of the discharge summary, indoor case sheets and expert opinion obtained by the Forum, it was evident that the complainant had been suffering peripheral vascular disease and venous ulcer of both legs and as per “past history” Special skin Grafting (SSG) had been done for venous ulcers right and left legs – 2004 and 2005 respectively. It is very clear from the hospital records itself that though the complainant was suffering from ulcers in different legs, the pathology of the disease was one and the same. Moreover SSG for ulcer in the right leg had been done in 2004 itself. Under Exclusion clause 4.1 the pre-existing diseases are excluded under the policy. Even though surgeries were performed on two different legs, the pathology is one and the same it becomes pre-existing disease. Hence the claim was not payable for the enhanced sum insured.

Complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/ 11.03.1322/2007-08
Shri. V.N. Surya Narayanan
Vs
The National Insurance Co. Ltd.

Award Dated : 29.02.2008

The complainant, V.N. Surya Narayanan, who had a Mediclaim policy since 2003 was hospitalized due to breathing problem. He had suffered from symptoms like nose block and deep breaths for about 5 months . He had also started feeling some

irritation/itching in his ears. His doctor conducted some tests, including scan and advised him to undergo surgery for Deviated Nasal Septum. He underwent surgery and made a claim for Rs 44,476/-. The insurer repudiated the claim as per policy condition 4.8. He denied that it was congenital anomaly and he was not suffering from his childhood. He has also submitted a letter from the ENT surgeon who treated him that it was not congenital anomaly. He has not taken any treatment for his nasal problem earlier.

The Insurer had denied the claim based on opinion of their panel doctor who had opined that DNS was a disease acquired developmentally (during teenage) and it is a pre-existing problem. The 3 causes for Deviated Nasal Septum are Trauma, large Polyp and congenital anomaly. In this case since there was no mention of trauma or large polyp, they concluded that it was due to congenital anomaly. Probably the patient would not have been aware that he suffered from Deviated Nasal Septum. All other problems were the complications of DNS and hence claim was not admissible.

Documents such as Discharge Summary, medical opinion, treating doctors report and policy wordings were scrutinized. It was observed that Exclusion 4.8 of the policy relates to congenital external disease or defects or anomalies. It was held that the insurer had failed to take into the account the treating Doctor's certificate which confirmed that the illness was not a congenital deformity. The insurer did not establish by way of documentary evidence that the present hospitalization was for congenital external disease. The panel doctor who had given an opinion to the insurer has not categorically certified that the present hospitalization was for treating a congenital external disease or defect, but opined that it is a developmental disease and considered pre-existing. He has also stated that the disease could be either acquired congenitally or developmentally.

In this case, the insurer has failed to establish that the problem is due to congenital external disease/defect/anomalies. Further the policy condition 4.8 specifically excludes only congenital external disease or defect or anomalies and not any complication arising out of external congenital disease.

The complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/ 11.03.1394/2007-08
Shri. P. Sundararajan
Vs
The National Insurance Co. Ltd

Award Dated : 05.03.2008

The Complainant, Shri P.Sundararajan a 72 year old man had problems in walking steadily. He also had pain in the back and neck. He was diagnosed to suffer from Vertebro Basilar Insufficiency. He was hospitalized for a day and incurred a hospital expenditure of Rs.14,327.50. After discharge, when he preferred the claim, the same was repudiated under exclusion clause 4.10 on the ground that he got admitted for mere investigation and the treatment could have been done as an out-patient..

The insurer stated that they rejected the claim as they felt that the patient was admitted in the hospital for investigation purpose and that could have been done as an out-patient. During the hearing the insurer said that as per the Discharge Summary course of treatment was only MRI & Dexa scan and some medicines were prescribed. As per their investigation, the insured was not in the hospital on 23rd June 2007 night (as per indoor case sheets) and has not gone on 24th as well. He has settled the bills on 25th only. When the insurer had requested the hospital authorities for the copies of

indoor case sheets, they had refused to part with it. The hospital staff informed the insurer that the insured had come to the hospital at around 11.00 a.m. as that was the time when the treating doctor would come to visit his patients. This being so, it was only an investigation and as such no treatment was given and hence the claim was repudiated under exclusion clause 4.10.

Although the forum asked the insured to obtain and submit the copies of the indoor case papers he expressed their inability to do so.

On perusal of documents like discharge summary, treating doctor's certificates etc it was established that the treatment and investigation did not warrant hospitalization and could have been taken as an out-patient. The nurse's notes of the hospital also confirm that insured did not return to the hospital after he went for investigation. It was therefore held that the repudiation of the claim by the insurer was in order. .The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1320/2007-08
Shri B.Rajappa
Vs
The National Insurance Co. Ltd

Award Dated : 12.03.2008

Shri B.Rajappa, was admitted at Vijaya Hospital on 30.06.2007 and discharged on 03.07.2007. He submitted the claim papers for Rs.14160.15 to the TPA and they had rejected his claim stating "Admission for Investigation under Clause 4.10". The complainant Mr Rajappa, said he and his family have been having mediclaim policy for over 22 years. He suffered from high fever for over 10 to 15 days and he had high temperature of 104^0 and105^0. In spite of taking medicines, the fever did not subside and his family doctor advised him to get admitted for in-patient treatment. During the hospitalsiation, many tests were conducted including x-ray ECG etc. and finally it was diagnosed as viral fever.

The insurer stated that they had obtained opinion from their panel doctor who confirmed that the admission was only for evaluation purposes and hence, they did not pay the claim. Their TPA had repudiated the claim stating that he was admitted to hospital for investigation purposes. They had obtained the indoor case sheets from the Hospital and produced the copies before this Forum. The discharge summary and indoor case sheets contained different information. There was a lot of suppression of facts in the discharge summary. The TPA stated that the insured might have been suffering from chronic problems of diabetes and hypertension. But they could not pay the hospital expenditure for the in-patient treatment and that too for evaluation purposes.

On scrutiny of records like discharge summary, hospital bills, treating doctor's certificate and indoor case sheets it was observed that insured was suffering from prolonged fever and was treated for the same in the hospital. However, the letter of the doctor recommending admission was not produced by the insured. Therefore, proof that hospitalization was necessary was not established. However, the insured had been treated at hospital for illnesses including low-grade fever.

The insurer was directed to pay a sum of Rs.5000/- on Ex-gratia basis.

The Complaint was partly allowed on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1357/2007-08
Shri K.Giribalan
Vs
The New India Assurance Company Ltd.

Award Dated : 19.03.2008

Shri Kannappan Giribalan had taken a mediclaim policy with New India Assurance Co. Ltd. His son underwent a dental surgery and he claimed reimbursement of Rs.42,206.24. His son had consulted an Oral & Maxillofacial Surgeon and had the OPG X-ray taken. It was observed that the lower 3rd molar was impacted and besides the impacted tooth on the right side of the lower jaw, there were also three more impacted wisdom teeth. Since the surgeon felt that all the wisdom teeth were impacted, only surgical removal of the teeth could be done and that too as it could not be done on multiple sittings/sutures, the removal of teeth could be done in one sitting for the best advantage of the patient. The impacted tooth was removed under general anaesthesia along with the other 3 molars as per treating doctor's advice. The insurer repudiated the claim under exclusion clause 4.7 that the affected 3 molars could have been extracted in OP clinic itself and hospitalization was not necessary.

The insurer said that the claim was rejected for the reason that the impacted teeth was neither due to an injury nor a disease and under exclusion 4.7.claim was rejected. As per exclusion clause 4.7 any dental treatment or surgery unless arising from disease or injury was not payable and even in such cases only medical expenses as are reasonably and necessarily incurred were reimbursable. In this case, the insured had gone to the doctor with the pain and swelling in the right lower jaw due to the right lower impacted 3rd molar. When an OPG was done, the other impacted wisdom teeth were observed and therefore the main reason for which the insured went to the doctor was only one impacted tooth and the findings of the OPG was only a coincidence and therefore the main complaint (right lower 3rd molar) tooth could well be extracted as an out-patient and hospitalisation was not necessary as confirmed by their panel doctor.

The documents such as policy wordings, repudiation letter, specialist doctor's opinion, Discharge summary and treating doctor's certificate were perused. It was held that the insurer's contention that it is not a disease or injury is not tenable. The pain and swelling might have made the insured to undergo the surgery and the complainant has submitted the treating doctor's certificate to prove that the surgery was necessary and the patient has acted as per the advice of the doctor. The insurer was directed to pay a sum of Rs 25,000/- on Exgratia basis.

The Complaint was partly allowed on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1412/ 2007-08
Smt R Alamelu
Vs
The National Insurance Co. Ltd

Award Dated : 20.03.2008

The complainant, had taken a Mediclaim from National Insurance Company from 2004 onwards. During 2006-07, her husband Mr Kesavan had undergone bypass surgery and submitted her claim for Rs 1,25,000/-.The claim was repudiated on the ground that

there was a discrepancy in the duration of Diabetes Mellitus in various documents /certificates. He clarified that he did not have any Blood pressure, diabetes prior to inception of the policy. In January 2006 he suffered from stress and stain due to his official duties that resulted in some discomfort. After consulting a doctor he started taking medicines for control of initial stage of diabetes. On 22.05.2006 he was having heaviness in the chest. He was admitted in hospital and had undergone various tests including Echo and was advised to undergo Angiogram. He was diagnosed to suffer from blocks and hence advised bypass surgery. The surgery was performed on 24.05.2006. His request for cashless facility was rejected probably because his son had by mistake informed that he was having diabetes for 3 or 4 years. He had submitted the necessary clarifications sought by the TPA including the certificate from his diabetologist as well as cardiologist that he was suffering from diabetes for one year.

The insurer stated that in the pre-authorisation form, the duration of diabetes was mentioned as “3 - 4 years”. Hence cashless facility was denied as the policy was taken only from 2004. In the discharge summary the duration of Diabetes was mentioned as 2 years. Subsequently, another certificate was issued by the treating doctor that he was treating the patient for DM from Jan 2006. Because of the discrepancies in the statements regarding the duration of DM, claim was rejected as the treatment was for a pre-existing disease since CAD was directly related to DM.

After perusal of documents like Mediclaim, Repudiation letter, Pre-authorisation ,Discharge summary of hospital , treating diabetologist and cardiologists opinion it was held that since diabetes mellitus diabetes is not sole risk factor for coronary artery disease and it is not proved that it was pre- existing in Mr Kesavan. The insurer failed to establish beyond doubt that CABG was a pre-existing disease. The insurer was directed to settle the claim .

The complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.05.1318/2007-08
Shri R.Santhanam
Vs
The Oriental Insurance Co. Ltd

Award Dated : 26.03.2008

Shri R.Santhanam, complainant was covered under the Individual Nagrik Suraksha policy for a sum insured of Rs.2,00,000 (Rs.160000 – PA and Rs.40,000 – Hospitalisation. He met with a road accident on 10.04.2006 at 09.00 p.m. when he was travelling in a two wheeler as a pillion rider. He fell down as the vehicle he traveled collided with another vehicle and sustained severe injuries. He was initially treated at Chidambram Annamalai University Rajah Muthiah Medical College Hospital and later at Vijaya Health Centre, Chennai. He preferred the claim on 28.07.2006. His claim was denied by the insurer on the grounds of delayed intimation and for not producing satisfactory proof of accident. Hence he approached this forum.

The insurer stated that there was delayed intimation of claim and only medical bills were submitted without sufficient proof for accident. Hence they rejected the claim.

During the hearing, the complainant stated that he had lost his consciousness and his leg had been fractured with swelling and heavy pain. Immediately he was taken to a nearby hospital for preliminary treatment. Later he was shifted to another hospital where he had undergone a bone surgery and was in the hospital for 15 days. Since he

was not satisfied with the treatment at the hospital, he was discharged against medical advice and got admitted in a major hospital in Chennai for further treatment including plastic surgery. He admitted the delayed submission of records was due to the fact that he was unconscious immediately after the accident and at that time he did not remember any of the insurance cover. The clerk of the hospital had confirmed that his name had been in the Accident register maintained by the hospital.

Although the Forum directed the insurer to obtain extract of the accident register maintained by hospital they were unable to do so. However, the insured was able to obtain and submit copy of the relevant page of the Accident Register Police intimation confirming the accident.

On scrutiny of the documents including the Treatment Certificate, Discharge summary, clarifications from the hospitals and copy of the relevant page of the accident claim register , the happening of the accident was confirmed and insurer was directed to settle the claim.

The Complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.02.1368/2007-08
Shri R.Rajendra
Vs
The New India Assurance Co. Ltd

Award Dated : 26.03.2008

Shri R.Rajendra, was covered under the Mediclaim of New India Assurance Co. Ltd. He lodged a claim hospitalisation for Acute Lumbar Disc Disease but his claims was rejected.

The insurer stated that the claim was repudiated since as per discharge summary there is no active treatment during the hospitalization period except the investigations done and oral medicines given which does not warrant hospitalization. The MRI scan could have been taken as out- patient. In the case of another claim made by Mr Rajendra for a subsequent hospitalization, they had extended cashless facility and approved the expenditure because the line of treatment involved pelvic traction, short-wave diathermy etc.

On perusal of the documents like Discharge Summary, Claim form, indoor case sheets and opinion of a specialist it was established that there was no indication of any active treatment given which required the infrastructure of a hospital and only diagnostic tests had been conducted.

It was held that repudiation of claim by the insurer was in order.

The Complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1420/ 2007-08
Shri R. Krishnamurthy
Vs
New India Assurance Co. Ltd

Award Dated : 26.03.2008

The complainants wife Mrs Nagambal had undergone cataract surgery. Treating doctor had certified that the insured was a cardiac patient and required proper facility in the

theatre in case the need arises during the surgery. However, they had disallowed a part of the claim without considering the cardiac status of the patient. She requested that her surgery should be considered in conjunction with her cardiac ailment and the ceiling of 20% should not be applied and her full claim to be settled.

The insurer stated that the insured was covered under the revised Good Health Policy which came into effect from October 2004 .As per Clause 1.1.(f) of the policy, the limit of 20% of the Sum Insured is applicable for a cataract surgery. Besides, as per discharge summary there was no mention of any cardiac problem during the surgery.

Documents like Good Health Policy certificate, Pre-operation authorization from the TPA for Cashless facility, Terms and Conditions of the Good Health Policy and discharge summary of the hospital were scrutinized. It was found that the contention of the insurer that no cardiac treatment had been given during the current hospitalization and the policy conditions that had been modified to include a cap of 20% of Sum Insured for cataract surgery were factual and therefore the restriction on the amount claimed had been in order.

Complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.05.1385/2007-08
Shri M Rajeev
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 27.03.2008

The complainant Shri M. Rajeev had taken a Mediclaim policy with M/s. Oriental Insurance Co. Ltd for a sum insured of Rs 75,000/- for the period 25.01.2007 to 24.01.2008. He had submitted a hospitalization claim for Rs 75,000/- along with all necessary receipts, bills, vouchers and discharge summary. He stated that he was aware that no reimbursement is allowed for cosmetic surgery. But his case was totally different and he had undergone surgery not for any cosmetic purpose but as a measure to save his life.

During the hearing, representative of the complainant stated that the complainant has been having neurological problems coupled with frequent occurrence of fits. Treatment under various specialists in Coimbatore and Chennai did not give the desired result. During this period of treatment, his weight has been increasing alarmingly which was perhaps side effect of medicine. His mobility was restricted due to obesity. In addition, he suffered from hypertension, hernia and pituitary tumour which necessitated treatment. Mr Rajeev underwent laparoscopic gastric bypass for morbid obesity (super obesity). His body mass index was 63.04 and he was suffering from breathlessness with difficulty in walking.

The representative of the insurer stated that the policy was taken for the first time on 25.01.2005 and he has not revealed about his past illness in the proposal form and has said that he was in good health. Claim had been repudiated under clause 4.19 which specifically excludes “Treatment of obesity or condition arising there from including morbid obesity.

On scrutiny of documents it was established that Para 4 of the mediclaim policy relates to specific exclusions and Condition 4.19 specifically excludes “Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc. The policy does not restrict the exclusion to cosmetic purposes. The treating doctor has confirmed that the insured underwent

laparoscopic gastric bypass for morbid obesity (super obesity). In the circumstances, the decision of the insurer to repudiate the claim as per the specific policy condition is in order.

The Complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1427/2007-08
Smt.S. Premavathy
Vs
New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Smt.S.Premavathy, complainant has been having mediclaim policy with the New India Assurance Co. Ltd., Coonoor for about 10 years. She had severe pain and swelling in the left knee joint and it became worse in May 2007. She was hospitalized at Vijaya Hospital, Coimbatore for 17 days for treatment. Her claim for Rs.42,813/- was rejected by the TPA and the Insurer stating that hospitalization was not warranted and she could have taken the treatment as an out-patient. The insurer held that conservative treatment and physiotherapy could have been taken as an out-patient and the treatment does not warrant hospitalization.

During the hearing, the complainant Suddenly her leg started swelling and experienced pain in the joints and three to four months she had been suffering from the same. The pain was so severe that she needed a stick to walk. She had consulted consulted Dr.Daniel in Coimbatore who had advised her to be under complete bed rest, wax bath, physiotherapy etc. Since she was staying at Conoor, she could not commute everyday from Conoor to Coimbatore.So she had to get admitted in the hospital and have her treatment done. Everyday she was given current treatment in joints, wax bath, physiotherapy and some injection in the muscles.

The representative of the insurer stated that this treatment could had been taken as an outpatient but the insured got admitted in the hospital only for claiming insurance and based on this the claim was repudiated.

The representative of the TPA said that the prescribed treatment for Oesteo Arthritis is physiotherapy, oral medications and wax bath for 15-30 minutes. All these treatments could be taken as an outpatient. He said that the contention is not about the course of treatment but whether the hospitalisation for 16 days (as claimed) was necessary or not.

On analyzing the documents and arguments put forth it was held that the claim deserves sympathetic consideration, The insurer was directed to pay a sum of Rs 25,000/- on exgratia basis.

The Complaint was partly allowed on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1392/2007-08
Shri M.N.Abdul Rahim
Vs
The United India Insurance Co. Ltd

Award Dated : 31.03.2008

Shri M.N.Abdul Rahim had undergone laparascopic cholecystectomy with appendicectomy and Umbilical Hernia repair within nine months of taking the Mediclaim

policy. He claimed reimbursement of hospitalization expenses but his claim was rejected stating that hospitalization was for the management of an ailment which is related to pre-existing condition and hernia falls under 1st year exclusion.

The insurer stated that from the complainant's statement and the discharge summary it was clear that he was suffering from abdominal pain since one year. Hence it was evident hat he was having the illness even before the inception of the policy. The treatment for Umbilical Hernia comes under 1st year exclusion. (4.3). They have repudiated the claim invoking exclusion clause 4.1 regarding pre-existing and condition 4.3viz. first year exclusion

During the hearing, the complainant stated that he had undergone laparascopic cholecystectomy .At that time without asking him the doctors had performed the hernia repair and appendicectomy. During the renewal of his car policy he was asked to give a cheque for a particular amount over phone and he gave the cheque. Subsequently he received a mediclaim policy although he had not submitted any proposal form.

Documents including policy copy, Discharge Summary, Indoor case sheets and repudiation letter were perused. It was established that the claim had arisen within nine months of inception of policy. The insured, a resident of Kodaikanal had gone to a specialist doctor at Coimbatore for the surgery , although it was not an emergency. It appears to have been a planned surgery. As per declaration at the time of admission for surgery, insured had been having abdominal pain since one year and taking medication for Gout.

In the light of the above, the decision of the insurer to repudiate the claim as per the specific policy condition 4.1 and 4.3 cannot be faulted with.

The Complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1355/2007- 08
Shri L S Ranganathan
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 31.03.2008

The wife of complainant who was covered by mediclaim policy for the past six years with Oriental Insurance Co. Ltd, Madurai lodged a claim for surgery undergone in February 2007 relating to treatment of hernia. The insurer stating the disease was a pre-existing one due to earlier surgery during 1991 repudiated the claim.

The insurer stated the claim was repudiated on the grounds of pre-existing illness Sec 4.1 because the insured had already undergone three operations- 2 LSCSs one in 1974 and another in 1975 and again hysterectomy in 1991 and these operations had severely damaged the abdominal wall. He added that Incisional Hernia in the abdominal wall was due to the reason that her abdomen was opened and sutured frequently as a result of which the layers of abdominal wall had weakened, after each surgery.

As per the operation notes it was established that surgery was that of mesh repair for incisional hernia and bulging has happened near the scar of the caesarean. The scar and the swelling near the scar cannot be treated as identical. As per the conditions of the mediclaim policy what is envisaged in Exclusion 4.1, is exclusion of pre-existing diseases. The policy does not exclude pre-existing scars. As stated in the discharge summary, the swelling would have started in the past 4 months or so, whereas the

insurance cover had incepted about four years earlier. In other words, when the policy incepted for the first time, although the scar would have existed, the swelling or hernia would have commenced only after the inception of cover.

The Complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.03.1421/2007-08
Shri. S. Vijayaraghavan
Vs
The National Insurance Co. Ltd.

Award Dated : 31.03.2008

The Complainant underwent cataract surgery “Phacoemulsification with Multi focal Intra Ocular Implantation” and submitted a claim for Rs.47,592.79 to National Insurance Co. Ltd. However, the Insurer had offered only Rs.18,879/-. As per the complainant, there is no condition in the policy issued to him which restricts the amount reimbursable for cataract surgery. He had a cataract surgery done in the right eye in July 2005 when the same multifocal intraocular lens was implanted and the claim was settled in full by his then insurer New India Assurance Co. Ltd. The cataract surgeries were performed in the same hospital both eyes. When already a particular kind of lens has been implanted in one eye, it was essential that the other eye was also implanted with the same lens so that it does not result in imbalance in vision. National Insurance Co. should have settled the full amount of the claim on the same lines as New India Assurance Co. Ltd. who had settled the claim in full, when he had undergone the same kind of the surgery for his right eye two years ago.

The Insurer contended that amount claimed Rs.47,593/- . They had offered an amount of Rs.18,879/- and disallowed Rs.28,714/- since multiple focal IOL was used for cosmetic purposes (restor lens) to avoid spectacles. The lens cost of Rs.33,000/- was not payable and only Rs.5000/- was payable. The amount disallowed was only for cosmetic and non-medical items as per the policy conditions and the settlement was in order. There is a clause in the policy that only reasonable expenses would be reimbursed by the insurer.

The decision of the insurer to restrict the reimbursement of cost of lens to Rs 5,000/- as against a claim of Rs 33,000/-in the absence of any specific policy condition restricting the cost of cataract surgeries is not justified. However, as per the policy, reimbursement shall be of reasonable expenses and the insured also has a duty to ensure that he is not charged excessively for even minor, routine procedures, merely because he has an insurance policy.

To render justice to both parties, the insurer is directed to pay an additional amount of Rs 15,000/- towards cost of the lens on Ex-gratia basis under Sec 18 of the Redressal of Public Grievances Rules 1998

The claim was partly allowed on ex-gratia basis.

Delhi Ombudsman Centre
Case No.GI/31/Bajaj/06
Shri Rahul Agarwal
Vs
Bajaj Allianz General Insurance Company Limited

Award Dated : 06.11.2007

The complaint was heard on 02.03.2007, 06.06.2007 and 05.10.2007. The complainant Shri Rahul Agarwal was represented by Dr. Vinay Agarwal and the Insurance Company was represented by Dr. Vikram, Manager.

Shri Rahul Agarwal had lodged a complaint with this Forum on 14.06.2006 that he was insured with Bajaj Allianze General Insurance Co. Ltd. under Health Guard policy no. OG-06-1104-8401-00000437. His case has been wrongly repudiated as it does not fall under any kind of pre-existing internal cyst. He has requested this Forum that Rs.42514 which he had incurred towards medical expenses should be paid along with 12% interest and Mental Harassment.

At the time of hearing, the representative of Shri Rahul Aggarwal informed the Forum that Shri Rahul Aggarwal was taken ill at Shamli on 11.09.2005 and was moved to City Hospital, Delhi with complaint of vomiting, fever, itches, skin rashes, nausea and loss of appetite. He was moved to Sir Ganga Ram Hospital for diagnosis of Lesser Sac SOL under evaluation and as per the discharge summary of Sir Ganga Ram Hospital the diagnosis was Pseudo pancreatic Cyst- Ruptured; however, as per the clinical report Hydatid Serology is negative. Since Shri Rahul Aggarwal was suffering from vomiting, itching, fever, skin rashes, nausea and loss of appetite, his claim for Rs.42514/- does not fall under the exclusion clause C 2 of the policy and he requested the forum that the claim should be paid. Further, the representative also informed the Forum that Shri Rahul Aggarwal was admitted in Tirath Ram Shah Charitable Hospital on 02.11.2006 where he was denied cashless facility that the Pseudo pancreatic cyst had developed which has to be operated which had developed as a result of trauma 15 months back since this trauma was a result of an accident when he fell down from the motorbike which results in cyst, the Insurance Company is liable to pay the claim. He therefore requested the forum that the sum of Rs.106697/- be paid to Shri Rahul Aggarwal for the treatment in City Hospital, Sir Ganga Ram Hospital and Tirath Ram Shah Charitable Hospital.

The representative of the Insurance Company informed the Forum that Shri Rahul Aggarwal was admitted in City Hospital with complaints of vomiting, fever, skin rashes, nausea and loss of appetite, since doctors were not able to evaluate the cause of disease and hospital did not have facility for carrying out the evaluation, Shri Aggarwal was moved to Sir Ganga Ram Hospital where he was diagnosed for Pseudo pancreatic Cyst- Ruptured and as such it resulted in vomiting since falling from the motorbike and as such the claim was not payable under clause C 2 of the policy under which the medical treatment related to cyst is not payable. However, the representative of the Insurance Company informed the Forum that as per the contention of Shri Rahul Aggarwal that as per the discharge summary of Sir Ganga Ram Hospital Hydatid Serology is negative and the claim should have been paid. He contested that if the reports are negative then there was no need to be admitted in Tirath Ram Hospital on 02.11.2006 for the operation of cyst. This clearly proves that his earlier hospitalization at City Hospital and Sir Ganga Ram Hospital was not covered under the policy exclusion clause C 2. Therefore, his claim for admission at City Hospital, Sir Ganga Ram Hospital and Tirath Ram Shah Charitable Hospital are not payable. However, the contention of Shri Rahul Aggarwal that his trauma of 15 months back is a result of fall from the motorbike as a result of accident and accident have been covered under this exclusion is payable, the Insurance Company representative informed that a disease as a result of accident should manifest within reasonable period and not after 15 months as the earlier policy had already expired on 10.07.2006, they have therefore rightly repudiated the claim.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Rahul Aggarwal was admitted in City Hospital on 12.09.2005 with complaint of vomiting, fever, skin rashes, nausea and loss of appetite and he was subsequently shifted to Sir Ganga Ram Hospital for further management of his disease. As per the discharge summary of Sir Ganga Ram Hospital he was diagnosed for Pseudo pancreatic Cyst- Ruptured and the Insurance Company has repudiated the claim under exclusion clause C 2 of the policy. It is observed from the discharge summary that patient was investigated and USG of whole abdomen, stomach appears dilated with large cystic SOL in relation to tail of pancreas with cystic. This is also considered by the progress report of the hospital where ultra sound and CT scan showed predominantly cystic SOL in region of lesser sore abenting pancreatic tail with adjacent mesentery stranding and moderate ascetic as detailed above. It is further mentioned that in view of the cystic contents and corrugated/ collapsed appearance of SOL possibility of ruptured pancreatic pseudo is likely. Shri Rahul Aggarwal was however admitted in Tirath Ram Hospital on 02.11.2006 where as per the past history of trauma 15 months back by self fall from the motorbike where he gradually had developed complication resulted in case of pain in abdomen and lump in epigastric region which gradually increased in size. He was operated for cyst in the hospital. The contention of Shri Rahul Aggarwal that cyst had developed as a result of trauma 15 months back after fall from motorbike. Although the policy covers the accident resulting into disease but this manifestation of cyst which was removed in November 2006 was not diagnosed at the time of the fall from the bike. The policy can not respond for the ailment which has been suffered 15 months back and can only do so within the policy period which was 11.07.2005 to 10.07.2006 and not by the renewed policy. Earlier admission at City Hospital wherein Shri Rahul Aggarwal had complaints of vomiting, fever, nausea was a result of Pseudo pancreatic Cyst being present, as such the claim has been rightly repudiated by the Insurance Company under clause C 2 of the policy where cyst is excluded in the first two years of the policy. The contention of the claimant that he was not operated for cyst at the time of treatment at Sir Ganga Ram Hospital as the Hydrated Serology was negative, the policy clause C 2 does not mention “surgery” but mentions “medical expenses” which clearly denotes that any medical expenses incurred for cyst related disease are not payable for the two consecutive annual periods and the policy was taken for the first time on 11.07.2005. In view of the foregoing any medical expenses incurred in the first two consecutive annual periods relating to cyst are not payable under clause C 2 of the Health Guard policy and as such Shri Rahul Aggarwal is not entitled for payment of Medical Expenses for hospitalization in City Hospital, Sir Ganga Ram Hospital and Tirath Ram Shah Charitable Hospital. The claims of Shri Rahul Aggarwal has been rightly been repudiated by the Insurance Company.

I am in agreement with the decision of the Insurance Company and I uphold their decision.

The complaint stands dismissed.

Delhi Ombudsman Centre
Case No. GI/381/NIC/07
Shri Brij Kishore Malhotra
Vs
National Insurance Company Limited

Award Dated : 07.01.2008

The complaint was heard on 24.12.2007. The complainant, Shri Brij Kishore Malhotra, was present accompanied by his friend Shri Y.K.Gupta. The Insurance Company was represented by Shri A.N.Chohan, Assistant Manager.

Shri Brij Kishore Malhotra has lodged a complaint with this Forum on 27.03.2007 that he has taken a mediclaim policy No.360700/48/06/8500001040 from the National Insurance Company Limited. M/S.Alankit health Care Limited, TPA of the Insurance Company, is authorized to look after the policy. He was admitted in Sir Ganga Ram Hospital on 06.11.2006. He has requested the Forum that his claim be paid.

At the time of hearing, Shri Brij Kishore Malhotra informed the Forum that he had voluntarily declared about the disease of bladder outflow obstruction to the TPA when cashless facility was to be availed. These diseases were attended to when he was posted to Overseas. Further, if he had this disease, it would not be possible for him to continue the same for 15years. He further informed the Forum that he has taken his first insurance from the National Insurance Company Limited on 15.09.2004 and he has been continuously renewing the policy and there is no gap under the policy on which the claim has arisen as he has earned cumulative bonus of Rs.20000/-. He has requested the Forum that his claim be paid.

The representative of the Insurance Company informed the forum that Shri Brij Kishore Malhotra had a history of cystoscopy in 1980 and 1991, upper GI discomfort and irritable bowel syndrome in 1983 has under gone upper GI endoscopy, LUTS for 1 year since September, 2006, tonsillectomy in childhood. His claim has been rejected on the ground that the disease was pre-existing.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Brij Kishore Malhotra was admitted in Sir Ganga Ram Hospital on 06.11.2006 and discharged on 10.11.2006. As per discharge summary, Shri Malhotra has a history of Cystoscopy in 1980 and in 1991, Upper GI discomfort and irritable bowel syndrome in 1983. He has been undergone upper GI endoscopy. The Insurance Company has rejected the claim on the grounds that the disease was pre-existing. As per M/S.Alankit Health Care Limited letter dated 07.11.2006, there was a gap in renewal of the current policy and the policy has been treated in the first year and the claim was inadmissible in the first year under clause 4.3 of the policy. There are two versions on which the claim has been rejected: (i) Pre-existing disease (ii) Exclusion in the first year of the policy as there was a break in renewal of the policy. It is also observed that Shri Brij Kishore Malhotra had voluntarily disclosed that he had suffered with the problem of bladder outflow obstruction BPE stricture bulbar urethra in 1980 and in 1991 and it was only after 15 years, he has faced this problem again. Nobody can carry the disease with him and he would like that the disease be treated immediately. The contention of the Insurance Company that the disease is pre existing and therefore, they have rejected the claim, I do not agree with the same since during 15 years, there has not been any recurrence of the disease. The policy has been taken in the year 2004 and Shri Malhotra has been operated for this disease in 2006, that is, more than two and a half years of the policy in operation. Further, on examination of the policy, it is observed that there is no break in renewal of the policy as the first policy No. is 360700/48/04/8500693 was issued from 15.09.2004 and the policy number on which the claim is preferred is 360700/48/06/8500001040 issued from 15.09.2006. The policy has also earned cumulative bonus of Rs.20000/-, that is, 10% of the sum insured.

Keeping in view the above facts, I, pass the Award that Shri Brij Kishore Malhotra be paid for his hospitalization at Sir Ganga Ram Hospital on 06.11.2006.

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

Delhi Ombudsman Centre
Case No.GI/363/NIA/07
Shri Rajeev Kumar Tognatta
Vs
The New India Assurance Company Limited

Award Dated : 05.02.2008

The complaint was heard on 23.11.2007 and 07.01.2008. The complainant Shri Rajeev Kumar Tognatta was present along with his Brother-in-Law Shri R.K. Bhagi. The Insurance Company was represented by Ms. Jyoti Bist, Administrative Officer.

Shri Rajeev Kumar Tognatta had lodged a complaint with this Forum on 30.04.2007 that he had taken a Mediclaim Policy with New India Assurance Co. Ltd. He had submitted the claim for his hospitalization to Raksha TPA for Rs.226964/- and the TPA had deducted a sum of Rs.161630/- while settling the claim and paid him the balance amount. He has requested the Forum that the balance amount may be sent to him.

At the time of hearing Shri Rajeev Kumar Tognatta requested the Forum that Sum of Rs.161630/- which has been deducted by the Insurance company should be paid to him, since the Insurance Company has wrongly deducted this amount as there was no exclusion when the policy was taken from United India Insurance Co. Ltd. and the policy has been renewed with New India Assurance Co. Ltd in continuation. Further, he has requested the Insurance Company that the policy no. 312400/48/03/00814 taken on 24.08.2003 should be rectified as far as exclusion for him which has been incorporated under the policy be withdrawn by the Insurance Company, and cumulative bonus be given for his wife and his daughter as per the policy of United India Insurance Co. Ltd. He has requested the Forum that both these issues should be decided by the Hon'ble Forum.

The representative of the Insurance Company informed the Forum that as per the proposal form submitted by Shri Tognatta he has clearly mentioned that he had adverse medical history and he was operated for CAD, based on his medical declaration they had incorporated the exclusion under the policy. Shri Tognatta had also not produced the policy of United India Insurance Co. Ltd., had he done so then the Insurance Company would have inquired the reasons for shifting his policy from United India Insurance Co. Ltd. to New India Assurance Co. Ltd. Further, Shri Tognatta for the first time wrote in January 2007, about the exclusion and cumulative bonus only after the sum of Rs.161630/- was deducted from his claim. Shri Tognatta having accepted the policy for continuous three years could not be rectified at this late stage and he having agreed to the same, the Insurance Company cannot delete the exclusion now. On enquiry by this Forum that the TPA having made the payment of Rs.161630/- earlier and had not Shri Tognatta renewed the policy with them or there would not have been any claim, how would the Insurance Company have recovered this amount from Shri Tognatta? The representative of the Insurance Company informed the Forum that they would have proceeded with the matter after consulting their superior office.

After hearing both the parties and on examination of the documents submitted Shri Rajeev Kumar Tognatta has requested in his complaint that the deduction of Rs.161630/- from his claim amount is illegal and the TPA should make the payment of this deduction. Further, New India Assurance Co. Ltd. should be asked to amend the policy from 24.08.2003 and delete the exclusion mentioned therein since the policy was renewed with them on the same terms and conditions of United India Insurance

Company's policy. The contention of the Insurance Company that the policy could not be rectified since Shri Tognatta has not raised any issue when the policy was renewed with New India Assurance Co. Ltd. and he has accepted the same with the exclusion "Angiography and in consequence of that" for continuously three years. Proposal being the basis of contract and Shri Tognatta having declared the same, I am in agreement with the Insurance Company's exclusion in the policy. The Insurance Company should have been approached by Shri Tognatta when he had received the policy in the year 2003, but he has not done so. Rectification of the policy after 3 years is not possible since proposal form is the basis of contract and the proposal clearly mentioned that Shri Tognatta had the disease of CAD and the Insurance Company has rightly issued the Policy. Since the policy has exclusion the TPA has wrongly paid the sum of Rs.161630/- to him which they have deducted from the subsequent claims of Shri Tognatta. The recourse left to the Insurance Company for this wrong payment would have been to file a case against Shri Tognatta and in case the same would have been decided against him he would not only have to refund the amount but may have to pay other cost also.

I therefore hold that recovery made by the Insurance Company is legitimate and Shri Tognatta has been saved from further costs in case the case was decided against him. Since it is clearly established that there was an exclusion in the policy for which he has been paid the claim and the Insurance Company has therefore rightly recovered the amount. Further, the second issue about the correction of Policy it is based on the details as submitted in the proposal form and being renewed with the exclusions for 3 years, Shri Tognatta has asked the Policy to be corrected from 24.08.2003 only on 19.01.2007. Correction of policy cannot be agreed.

I therefore dismiss the complaint of Shri Rajeev Kumar Tognatta.

Delhi Ombudsman Centre
Case No.GI/415/NIC/07
Ms. Renu Seth
Vs
National Insurance Company Limited

Award Dated : 26.02.2008

The complaint was heard on 04.02.2008. The complainant Ms. Renu Seth was present along with her friend Shri Ashok Puri. The Insurance Company was represented by Shri M.M. Goswami, Administrative Officer.

Ms. Renu Seth had lodged a complaint with this Forum on 29.06.2007 that she had taken a mediclaim policy no. 360102480585000009 (2005-2006) from National Insurance Co. Ltd. for her daughter She has requested the Forum that her claim be paid.

At the time of hearing Ms. Renu Seth informed the Forum that Ms. Divya Seth had seizures and was admitted in Privat Hospital. She faced similar problem when she was 4 years old and for past 18 years she did not have any recurrence of this problem and it was only in the month of January that there was abnormal movement of body and face, stiff limbs, eyes uprolled, tongue bite etc. and subsequently she was shown to doctors and she was admitted on 01.03.2006 in Privat Hospital where she was treated and discharged on 03.03.2006. Since there was no recurrence of the disease during the last 18 years, it is presumed that the same was cured which is quite evident from the policies of National Insurance Co. Ltd. where it will be observed that no claim was preferred on Insurance Company till this claim as she as well as her daughter were earning cumulative bonus. The Insurance Company has repudiated the claim on the

grounds that it was pre-existing disease which is not so as per the certificate given by the doctor dated 22.07.2006 saying that the disease is curable. She has requested the Forum that her claim may be paid.

The representative of the Insurance Company informed the Forum that Ms. Divya Seth was diagnosed for sudden onset of abnormal body movements which is known as Generalized Tonic Clonic Seizures whereas similar complication had arisen at the age of 4 years as evident from the EEG & Brain Map Analysis Report and since there is history of seizures at the age of 4 years and she giving medication for 2 years. The disease was pre-existing and they have rightly repudiated the claim under exclusion clause 4.1 of the policy.

After hearing both the parties and on examination of the documents submitted Ms. Divya Seth was admitted in Privat Hospital, Gurgaon on 01.03.2006 and was diagnosed for sudden onset of abnormal body movements which is known as Generalized Tonic Clonic Seizures. She had similar complication at the age of 4 years and the Insurance Company has repudiated the claim under clause 4.1 of the policy. Dr. Munish Prabhakar, General Physician has mentioned in his certificate dated 22.07.2006 that seizures Disorder disease is completely curable as well as the present ailment has no relation with the previous treatment. Even in the discharge summary it has been mentioned that past history has no relation while recording History and Clinical findings. The Insurance company has drawn the attention to National Institute of Neurological Disorders & Stroke under US Department of Health & Human Services that Epilepsy cannot be cured but it is also clearly mentioned that having a seizure does not necessarily mean that a person has epilepsy. It is nowhere had been established that Ms. Divya Seth had epilepsy and the fact that for the past 18 years there has not been the recurrence of this clonic seizures. It cannot be treated as pre-existing disease. I am of the opinion that the Insurance Company has wrongly repudiated the claim on the grounds that the disease was pre-existing under clause 4.1 of the policy, the disease having cured at the age of 4 years whereas both, the discharge summary as well as Dr. Munish Prabhakar, General Physician mentions that it has no relation with the previous treatment, as such cannot be treated as a pre-existing disease. Accordingly the Insurance Company is liable to settle the claim.

I therefore pass an Award that Ms. Divya Seth be paid for pre and post hospitalization as well as hospitalization expenses at Privat 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/395/NIC/07
Shri Shiv Mohan Mehra
Vs
National Insurance Company Limited

Award Dated : 20.03.2008

The complaint was heard on 18.01.2008 and 14.03.2008. The complainant Shri Shiv Mohan Mehra was present. The Insurance Company was represented by Ms. Promila Kapoor, Deputy Manager.

Shri Shiv Mohan Mehra had lodged a complaint with this Forum on 11.06.2007 that his wife Smt. Rita Mehra was insured with National Insurance Co. Ltd. for mediclaim under policy No. 360400/48/04/8500675. She was admitted in Max Health Care on 29.04.2005 and the claim has not been settled. Subsequently Shri Shiv Mohan Mehra on

20.08.2007 informed the Forum that out of claim amount of Rs.8741/- the Insurance Company has paid a sum of Rs.2400/- and the balance amount is payable. He has mentioned that sum of Rs.920/- towards consumable is payable as well as Rs.281/- for Splint arm sling pouch, Rs.320/- for consulting to Dr. P.N. Kakkar and Rs.320/- for consulting Dr. Nitiraj Oberoi and Rs.4500/- for Walker are all payable. He has therefore requested that Rs. 6341/- be payable.

At the time of hearing, the Forum has examined the bills submitted by Shri Shiv Mohan Mehra, I find that the consumable such as razors etc. for which amount has been deducted is used by the doctors which according to me is payable. Whereas the Splint arm sling pouch bill for Rs.281/- is not payable. Doctors consultation bill for Rs.320/- on 27.04.2005 and Rs.320/- on 08.06.2005 are payable. The Walker for which the bill of Rs.4500/-, Shri Shiv Mohan Mehra had got the Walker and showed to the Forum. It is not a walker, it is basically to be termed as shoe the function is similar to the heel which is attached to the cast in case of leg fracture.

am of the view that this is required to facilitate the treatment of the patient and Smt. Rita Mehra is having fracture of the foot it should be treated as reimbursable.

I therefore pass an Award that the sum of Rs.6060/- should be paid to Shri Shiv Mohan Mehra.

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/342/UII/07
Shri Gyandeep Mangal
Vs
United India Insurance Company Limited

Award Dated : 27.03.2008

The complaint was heard on 16.11.2007, 16.01.2008 and 10.03.2008. The complainant Shri Gyandeep Mangal was present. The Insurance Company was represented by Shri R.K. Sood, Manager.

Shri Gyandeep Mangal had lodged a complaint with this Forum on 28.03.2007 that he had taken a mediclaim policy with United India Insurance Co. Ltd. that his wife Smt. Anita Mangal was hospitalized in VIMHANS from 15.02.2006 to 14.03.2006. In December 2006, Medsave repudiated the claim stating exactly the same reasons to which he had sent the clarifications earlier. He has requested that his claim has been unjustly rejected.

At the time of hearing Shri Gyandeep Mangal informed the Forum that his wife Smt. Anita Mangal was admitted in VIMHANS hospital with migraine with a case of severe daily headache which was progressively increasing in severity and duration since last 3 months. Initially he had shown her to his family doctor who had treated her but there was no improvement in her headache and she had been taken to VIMHANS Hospital under care of superspecialist neurologist who had advised her to be admitted as such she was admitted for 27 days in the hospital. As per Dr. Rajul Aggarwal's certificate dated 05.07.2006, hospitalization was necessary because patient had to gradually taper off the medication she was taking under strict medical supervision and use pharmacological and non pharmacological methods to relieve headache. On enquiry by this Forum that Shri Gyandeep Mangal should submit papers and proof of treatment.

Shri Gyandeep Mangal informed the Forum that the same were not available. He was advised to submit the break up of the bill of VIMHANS hospital when he had informed the Forum that it was a consolidated bill, it does not only relate to room rent includes other services also. The Forum insisted that the break up may be submitted. Shri Gyandeep Mangal has submitted the same on 24.01.2008.

The representative of the Insurance Company informed the Forum that Company had repudiated the claim on the advice of the TPA doctor that the treatment was conservative and discharged after 27 days stay in the hospital. The total bill of the hospital is Rs.110090/- out of which room rent alone is Rs.105300/-. The hospital stay of 27 days for migraine is neither reasonable nor necessary and therefore the claim is not admissible.

After hearing both the parties and on examination of the documents submitted it is observed that Smt. Anita Mangal aged 36 years was admitted in VIMHANS hospital under Dr. S. Dwivedi and Dr. Rajul Aggarwal from 15.02.2006 to 14.03.2006 with complaint of Severe daily Headache, which was progressively increasing in severity exceeding 3 months. History of repeated episodes of diarrhoea and vomiting with intermittent vertigo. Noticeable features of past/ known medical history known case of Migraine. After clinical examination and investigations (which includes Neurological evaluations), the illness was diagnosed as Status Migrainosus. She was treated conservatively under care of Neurologist and psychologist. Keeping in view the seriousness of illness, hospitalization was necessary. In the certificate dated 05.07.2006, Dr. Rajul Aggarwal has informed that the stay in the Hospital was prolonged because the patient had to be gradually tapered off the medications, she was taking under strict medical supervision & use pharmacological and non pharmacological methods to relieve headache. In my opinion explanation given by the Neurologist is satisfactory. On examination of the break up of Rs.3900/- per day charged by the Hospital, it includes bed charges, consultant fee, RMO, Nursing, Diet and Miscellaneous and Telephone, Laundry and Newspaper charges. I find that out of Rs.3900/- per day a sum of Rs.420/- is not payable and accordingly Rs.11340/- (Rs.420 x 27) + Rs.250/- registration that is (Rs.110090 - Rs.11340 – Rs.250) be deducted and the claim of Smt. Anita Mangal be settled.

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/411/ICICI Lomb/07
Shri Kishore Kerpal
Vs
ICICI Lombard General Insurance Company Limited

Award Dated : 17.04.2008

The complaint was heard on 06.02.2008 and 16.04.2008. The complainant Shri Kishore Kerpal was present. The Insurance Company was represented by Shri Sat Prakash, Regional Manager- Legal and Shri Gaurav Gada, Manager- Legal.

Shri Kishore Kerpal had lodged a complaint with this Forum on 27.06.2007 that he had taken a mediclaim policy No. 40344FNB/01365270/00/000 from ICICI Lombard General Insurance Co. Ltd. for Rs.200000/- and a cashless Health card. He has requested this Forum to take stern action against the Insurance Company for harassing him and to pay his claim.

At the time of hearing Shri Kishore Kerpal informed the Forum that he had disclosed to the Insurance Company that he was a heart patient and angioplasty was done in the

year 2001 and it is therefore after thought that they have decided to repudiate his claim. There has not been any non disclosure of material facts and his claim should be paid.

At the time of hearing this Forum enquired from the Insurance Company whether they had received a proposal form from the insured. The representative of the Insurance Company informed the Forum that no proposal form was received however the business was carried and procured as a result of Tele Sales. However, they played the conversation between the sales lady and Shri Kishore Kerpal where besides explaining features of the policy and premium payment details the lady had enquired whether Shri Kishore Kerpal had any medical records. Shri Kishore Kerpal had disclosed that he had no medical records. The Insurance Company contested that Shri Kishore Kerpal had not disclosed that he had undergone angioplasty at Sir Ganga Ram Hospital in the year 2001 and was admitted on 27.07.2001 and discharged on 31.07.2001. Since Shri Kishore Kerpal had failed to disclose the relevant hospitalization, the disease being pre-existing for which he was hospitalized on 22.05.2007 and discharged on 30.05.2007 which is also confirmed by the hospital discharge certificate, they have therefore rightly repudiated the claim.

After hearing both the parties and on examination of the documents submitted it is observed that Shri Kishore Kerpal was admitted in Sir Ganga Ram Hospital on 22.05.2007 and he was known case of Coronary Artery Disease - post PTCA and was diagnosed for Coronary Artery Disease - post PTCA, CVA-left sided hemiparesis. The Insurance Company had repudiated the claim on the grounds that the disease was pre-existing which was confirmed by them by the earlier discharge summary when Shri Kishore Kerpal was admitted in Sir Ganga Ram Hospital on 27.07.2001. Shri Kishore Kerpal during the conversation with the sales lady had not disclosed that he had earlier heart disease. Shri Kishore Kerpal drew the attention of this Forum to IRDA Regulation dated 08.02.2008 wherein it was mentioned that no Insurance product should be sold on telephone. However, as per IRDA (Protection of Policyholders' Interests) Regulations, 2002, the representative of the Insurance Company drew the attention of this Forum to clause 4 (4) where it clearly states that "When a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its cover note or policy. 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 material to the grant of cover". Further in this case information was recorded by the Insurance Company and Shri Kishore Kerpal was not informed of the same as per the IRDA guidelines. Shri Kishore Kerpal informed the Forum that Insurance Company has taken all the original documents otherwise, since he is working in LIC of India he could have been got the claim reimbursed through their organization. In view of Shri Kishore Kerpal being an employee of the Insurance Company, he very well knows the importance of the Proposal Form and non submission of material facts would have prejudice his proposal. Shri Kishore Kerpal knowing well the implication has not disclosed to the sales lady in his conversation that he had undergone angioplasty in the year 2001 at Sir Ganga Ram Hospital which clearly establishes concealment of Material Facts. In view of the forging I am of the opinion that the claim for hospitalization of Shri Kishore Kerpal at Sir Ganga Ram Hospital on 22.05.2007 is not payable since there is non disclosure of material information and he had suffered with Coronary Artery Disease in the year 2001 as such the claim is not payable under clause 3.1 of the policy.

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

Guwahati Ombudsman Centre
Case No : 11-008-0006/07-08
Shri A.K. Dutta
Vs
Royal Sundaram Alliance Insurance Co. Ltd

Award Dated : 06.11.2007

Facts (Statements and counter statements of the parties)

In brief, the complaint is that claim lodged due to hospitalization of Ms. Nayanika Dutta, daughter of the complainant/insured under policy no.CE00008302000101 was repudiated by the insurance company on the plea that the claim papers were not submitted within the stipulated period of time as per condition of the policy. The complainant/insured thereafter prayed for reconsideration of the claim which was also rejected by the insurer.

The contentions of the insurer in reply to the notices issued are inter alia, that the benefits available under the policy issued to the insured was only a sum of Rs.1500/- (daily benefits) payable for everyday of hospitalization, subject to the hospitalization confinement being for a minimum of twenty-four hours. This being the coverage provided under the Hospital Cash Plan Policy, there is no scope for reimbursement of lump sum expenses as claimed by Complainant and the liability of the insurer is restricted only to the hospitalization period from 03.10.2006 to 06.10.2006 @ Rs.1500/- only. Apart from that, as per condition of the policy, the documents are to be submitted by the insured within 10 days from the date of discharge from hospital. The daughter of the complainant was hospitalized on 03.10.06 and discharged on 06.10.06 whereas papers were forwarded to the insurer only on 18.12.06 which is not within the stipulated period of time. Hence, the insurer has repudiated the claim as being excluded by the clause relating to claims procedure.

Decisions & Reasons

The facts involved in the complaint is that the complainant obtained policy no. CE00008302000101 (master policy no.HCSTCB0002) under the above insurer (OP) which was a Health Shield Insurance Policy covering the period from 04.11.05 to 03.11.06. Out of the four insured persons including the complainant Ms. Nayanika Dutta was admitted into Escorts Hospital, New Delhi on 03.10.2006 wherefrom she was discharged on 06.10.06. The complainant alleged that he sent message of hospitalization through e-mail and also requested for sending claim forms to Gurgaon Office of the Company on 03.10.06 by telephone through Airtel no.9954033552 but the insurer had violated the terms of contract and failed to provide him the claim forms in time. He thereafter lodged the claim for Rs.68,851/- which was repudiated by the insurer because of non-complying with the terms of the policy documents.

The insurer has forwarded copy of conditions of the policy under Hospital Cash Plan which is applicable to the policy of the insured.

Now let us see how far the complainant could comply with the aforesaid terms and conditions. According to the complainant, his daughter , Ms. Nayanika Dutta was admitted into Escort Hospital, New Delhi on 03.10.06. He sent the message by e-mail and also requested for sending claim forms to Gurgaon office of the insurance company from Airtel no.9954033552. A copy of the call statement has been furnished wherein serial no.31,32 & 33 are the relevant call records giving information to the

insurance company. Although, the call statement furnished by the insured/complainant shows that on 3.10.06 there were three outgoing calls from Airtel no.9954033552 to 01242380771 at sl. No.31, 32 and 33 but there is absolutely no proof that the aforesaid Telephone no. belonged to the insurer. In the absence of any proof, it is difficult to hold that the complainant contacted the insurer at its Delhi and Gurgaon Office by making telephone calls to the phone no.01242380771. Giving information within 24 hours of hospitalization of his daughter appears to have not been established. That apart as per conditions of the policy, in case of planned hospitalization , the insurer is to be given notice 24 hours ahead of admission of the patient. The daughter of the insured was admitted in Escorts Heart Institute, New Delhi on 3.10.06 and in column no.10 filled up by the attending physician of the Escorts Hospital shows that the patient was suffering from PSVT from December,'05 and was admitted at GNRC Hospital, Assam. This shows that this is not a sudden hospitalization on emergent circumstances and it was a planned hospitalization in continuation of previous treatments. The complainant was aware about requiring such hospitalization and he was supposed to inform the insurer at-least 24 hours ahead of such hospitalization of his daughter which has also not been complied with.

The conditions applicable under the policy was that notice of such hospitalization to the Company was required to be given in writing to the Office of the Company through which the insurance policy was affected. Of course, initial notification can be made by telephone. Giving telephonic information has not been established. The complainant stated in the complaint that he sent message of admission of his daughter by e-mail to the insurer, but copy of the e-mail has also not been furnished nor he could establish anything about sending such message.

The above facts and circumstances prove that the complainant has neither given any information about hospitalization of his daughter Ms. Nayanika Dutta prior to her admission nor he could establish anything about giving information within 24 hours of her hospitalization to the insurer. He has failed to comply with the terms and conditions of the policy. The claim papers were submitted after about two months of discharge of his daughter from the hospital and the insurer has repudiated his claim for his failure to comply with the terms and conditions of the policy. The action of the insurer appears to be quite in order in terms and conditions of the policy and I see absolutely no ground to interfere with the decision of the insurer.

In view of the discussions aforesaid, the complaint of the insured is dismissed.

Guwahati Ombudsman Centre
Case No. : 11-008-0022/07-08
Shaikh Shah Nawaz
Vs
Royal Sundaram Alliance Insurance Co. Ltd

Award Dated : 19.11.2007

Grievance

Shaikh Shah Nawaz lodged this complaint before this Authority against the repudiation of his claim by the insurer/OP in respect of the claim under policy no. HE 00084276000100.

The complainant herein had taken a Health Shied Insurance Policy from the above insurer/OP, covering himself and his family members and the insurer issued policy no. HE 00084276000100 and the period of insurance was from 31.08.06 to 30.08.08. His wife Mrs. Shaikh Sabina Nawaz was also an insured person under the said policy. Mrs. Sabina Nawaz felt severe pain in abdomen on 25.12.06 when she was admitted to

Hospital on 03.01.07 and operated for Cholelithiasis by “LAP Cholecystectomy” at Wockhardt Hospitals, Kolkata. She was first consulted for the disease on 25.12.06 prior to hospitalization and on the advice of doctor admitted on 03.01.07 and thereafter operated for the above disease. After discharge from the hospital, the complainant lodged the claim with the insurer which was repudiated on 23.01.07 stating that “USG report shows small contracted gall bladder with multiple stones. This takes long time to develop and could not have developed over a period of four months from commencement of policy and is pre-existing disease”. The complainant prayed for reviewing the decision but the insurer ultimately repudiated the claim on the same ground.

Reply

The insurer has submitted a letter dtd. 27.07.07 reiterating their stand that the claim was lodged for a pre-existing disease and the same is not tenable under the policy. According to the insurer, the documents were forwarded by them to a panel of doctors who had opined that “As per opinion of our panel of doctors the member is enrolled from 31/08/2006 admitted from Laparoscopy Cholecystectomy. USG shows small contracted gall bladder with multiple stone. Such changes could not have developed over four months and is pre-existing. Hence the claim is not admissible and payable”.

Decisions & Reasons

The copy of the policy was also furnished by the insurance company /OP. The conditions attached to the policy contained an exclusion clause which is described below :

“D. EXCLUSIONS

The Company shall not be liable under this Policy for any claim in connection with or in respect of :

1. a) Pre Existing Disease and any disease, illness, Medical condition, injury, which is a complication of a Pre Existing Disease.
   b) Any heart, kidney and circulatory disorders in respect of Insured Persons suffering from pre-existing Hypertension/Diabetes.

   These Diseases shall however be covered after 5 years of Consecutive insurance of this policy with Us.”

The above clause enumerated in the policy conditions provides the insurer to deny claims for pre-existing diseases, illness and any disease, illness, medical condition, injury, which is a complication of a pre-existing disease and the claim of the complainant was also rejected on the ground that the claim is covered under the above exclusion clause.

Smt. Shaikh Sabina Nawaz, wife of the complainant, was admitted in the Wockhardt Hospitals, Kolkata on 03.01.07 and was operated on 04.01.07 and on the following day she was discharged from the hospital. The documents furnished shows that her disease was diagnosed to be Cholelithiasis and LAP Cholecystectomy was done under general anaesthesia in the aforesaid Hospital. The copy of the Health Shield Claim form submitted by the complainant before the insurer shows that some portions of the form was also filled up by the attending physician Dr. B. Ramana, MS, DNB, FRCS, who treated the patient. The particulars in column no.9 shows that the disease was mentioned as Cholelithiasis and in answer to column no. 11 of the form containing whether “the ailment is a complication of a pre-existing disease or condition ?” , the attending doctor answered the same as – ‘No’. So, according to the attending doctor Ramana who treated and operated Mrs. Sk. Sabina Nawaz, her disease was not pre-existing or a ‘complication of a pre-existing disease’. In answer to column 4 of the form

to be filled up by doctor which reads as “When did the patient start suffering with the complaint?”, the answer to it was described as 25.12.06 and that was the date when the patient was first examined by doctor and suggested for undergoing hospitalization/operation. The discharge summary of the Wockhardt Hospital, Kolkata also contained that —“Gall Bladder anatomy – normal. CBD – undilatd. Cystic duct / artery dissected out, clipped & divided. GB removed from liver bed. Haemostasis secured. No bile leak seen.”

All the above medical records failed to disclose that Mrs. Sk. Sabina Nawaz was operated upon for a disease which was detected only on 25.12.06 when pains developed suddenly and it was not a pre- existing one.

The OP/insurer has forwarded a copy of opinion expressed by one doctor Dr. K. Jothinathan who considered the sonography report of the patient obtained before hospitalization / operation on 26.02.06. However, he has opined as under :

> “Ultrasound abdomen shows no acute features
> Multiple stones could not have formed in 4 months.
> In my opinion this is a pre existing lesion.”

The insurer, basing on the report of their doctor dtd. 02.07.07 rejected the claim holding that the insured was admitted and operated for a pre-existing disease.

Dr. B. Ramana, a specialist having qualifications of MS DNB FRCS examined, operated and treated Mrs. Sk.Sabina Nawaz and according to his findings, it was not a pre-existing disease or a complication of pre-existing disease. Dr. Ramana had the opportunity of going through all documents, physically examined the patient and his finding was that it was not a pre-existing disease. Considering the remarks of Dr. B. Ramana, who treated the patient, the report obtained by OP from a doctor who opined that it was a pre-existing disease appears to be not reliable as he had neither got the opportunity to see the condition of the patient nor he had taken part while treating /operating the patient. Consequently, the claim appears to be not related to a pre-existing disease nor complication of a pre-existing disease. The insurer, shall have to settle the claim in terms of the policy.

The OP/insurer will settle the claims in terms of the policy.

Guwahati Ombudsman Centre
Case No : 14-003-0025/07-08
Sri Kulbhushan Kathpal
Vs
National Insurance Co. Ltd.

Date of Order : 11.12.2007

Grievance

The grievance of the above named complainant is that the claim lodged by him under the above mediclaim policy has not been settled by the insurance company/OP above named even though he has been making representations on a number of occasions. The facts leading to lodging the above complaint is that his father was also a beneficiary under the above policy who fell sick and was admitted at Delhi Heart & Lung Institute on 04.06.06 and treated there till 23.06.06. He submitted the claim before the Insurance Company through the authorized Third Party Administrator (TPA) M/s. Medicare TPA Services (I) Pvt. Ltd. which was not settled and subsequently repudiated the claim on the ground that his father was suffering from Diabetes Mellitus for last 7 years which was pre-existing.

Reply

The Insurer/OP vide letter dtd. 20.07.07 submitted that the father of the complainant/insured Hari Chand Kathpal was suffering from "Dilated Cardiomyopathy and severe left venticular dysfunction together with congestive heart failure (HF), sepsis and Diabetes mellitus" and hospitalized from 04.06.06 to 23.06.06. On receiving the documents, the TPA vide their letter dtd. 30.11.2006 informed that the claim is not payable stating pre-existence of diabetes from seven years whereas policy was running for six years. However, on request from the insured, the case was referred to penal Doctor H.U. Ahmed, who opined that "diabetes is a risk factor of cardiac disease but technically speaking, heart disease is not a complication from diabetes mellitus". After getting such report, the matter was referred back for review but the TPA, M/s. Medicare TPA Services (I) Pvt. Ltd., after reviewing the claim, observed that "complication is a term used only when all organs are affected due to a particular risk factor and hence, the claim is not payable to the complainant". The insurer has also submitted that they requested the complainant to submit the investigation reports as asked for by theMedicare which was not complied with by the complainant.

Decisions & Reasons

It is seen that the policy was originally issued from 14.05.01 to 13.05.02 and is continuing. The M/s. Medicare TPA Services (I) Pvt. Ltd., repudiated the claim observing as follows :-

"It is the opinion of the claims adjudication department and the doctors Panel, that due to the underlying reasons your claim has been adjudicated to be NO CLAIM in nature and thus not payable under the rules guiding the policy.

THIS IS A 6TH YEAR RUNNING POLICY AND THE PRESENT CLAIM IS FOR ISCHEMIC HEART DISEASE AND CARDIOMYOPATHY WITH DIABETES MELLITUS. WE CAN SEE FROM THE DISCHARGE SUMMARY THAT THE PATIENT IS DIABETIC FOR THE LAST 7 YEARS, WHICH MEANS DIABETES IN THIS CASE IS PRE-EXISTING. SINCE THE PRESENT AILEMNTS ARE ALL COMPLICATIONS OF LONG STANDING DIABETES, THE CLAIM IS NOT PAYABLE".

The TPA appears to have taken the above decision considering the discharge summary of policyholder Sri Bhagat Hari Chand Kathpal who had undergone hospitalisation/treatment at Delhi Heart & Lung institute since 04.06.06 till 23.06.06 wherein the hospital authority diagnosed the disease of the policyholder as follows :-

"Diagnosis :
Type II diabetic mellitus
Dilated cardiomyoathy
Severe LV dysfunction (LVEF 27%)
CHF (stabilized)
Sepsis (controlled)."

Further, the discharge summary also discloses that Mr. Bhagat Hari Chand Kathpal was a known diabetic since seven years on regular treatment. The discharge summary also contained that the policyholder was suffering from diabetes since seven years back from the date of his admission but there is absolutely nothing to disclose on the basis of which the aforesaid comments were made. It is thus difficult to come to a logical conclusion that Mr Bhagat Hari Chand Kathpal was actually suffering from Diabetes since then. The letter dtd. 20.07.07 issued by the above named insured/OP also goes to show that the claim was reviewed and it was referred to their panel doctor H.U. Ahmed for his opinion in the matter. Dr. H.U. Ahmed, however, reported that "diabetes is a risk factor of cardiac heart disease but technically heart disease is not a complication of diabetes mellitus". The insurer and TPA has also not been able to produce any documents that the Heart disease, for which Sri Bhagat Hari Chand

Kathpal was admitted and treated was a complication of diabetes. The policy holder was admitted and treated for heart problems and hence the history of diabetes , if any, was of no consequence. Apart from that, there is also no record to show that the policy holder has concealed anything in respect of his sufferings from diabetes at the time of submission of the proposals. The insurer, has furnished the proposal submitted by the complainant and documents, if any, furnished by his father Sri Bhagat Hari Chand Kathpal, which connected with this claim has not been furnished and so, there is no basis to say that any concealment was made by him. On consideration of all the facts and circumstances, I do not find any justified ground for rejection of the claim by the insurer/OP which needs reconsideration.

The Insurer is directed to settle the claim.

Guwahati Ombudsman Centre
Case No : 11-008-0036/07-08
Mr. Nazim Nesar Ahmed
Vs
M/s. Royal Sundaram Alliance Insurance Co. Ltd

Award Dated : 27.02.2008

Grievance

The grievances of the complaint is that the claim lodged by him under the above policy has been repudiated totally by the insurance company/OP invoking Clause D (1) of the Health Shield Policy. The facts, in brief, is that the complainant procured the above Health Shield Insurance Policy from the above insurer covering the period from 31.03.06 to 30.03.07. The complainant fell ill in the month of July, '06 and taking treatment from local Doctor, he did not find response and accordingly, he contemplated to consult a Cardio-vascular surgeon in New Delhi. Accordingly, he visited New Delhi and consulted the surgeon who advised him to have an operation. Accordingly, he was admitted in Sir Ganga Ram Hospital and undergone the surgery on 21.11.06 and usual claim was lodged with the insurer which was, however, repudiated by the Insurance Company on the ground that he had undergone the treatment for pre-existing diseases which has been excluded by the policy conditions.

Reply

The insurer has also submitted its 'self-contained note' vide letter dated 01.08.07 which discloses that the insured was treated for Varicose Veins Surgery. The note states that on receipt of the claim, the insurer had forwarded the claim documents to their panel of doctors who had opined as follows :-

"Member enrolled from 31.03.06. He was admitted for Varicose veins Surgery. Bilateral varicose veins with pigmentation could not have developed over 8 ½ months and is pre-existing. Hence the claim is not admissible and payable."

The insurer has accordingly repudiated the claim holding that Hospitalisation and treatment of complainant was provided for pre-existing diseases which is not payable.

Decisions & Reasons

The complainant has obtained the Health Shield Insurance Policy bearing no.HE00061953000100.

The policy contained the Exclusion Clauses among others covering the following items.

“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. a. Pre-Existing Disease and any disease, illness, medical condition, injury, which is a complication of a Pre Existing Disease.
   b. Any heart, kidney and circulatory disorders in respect of Insured Persons caused by Hypertension / Diabetes. Pre Existing Diseases shall however be covered after 5 years of consecutive insurance with Us.
2. First Year Exclusions : During the first year of the operation of the Policy the expenses on treatment of
   a. Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in Anus, Piles, Sinusitis are not payable.” etc. etc.

It appears that expenses for Hospitalization and treatment for pre-existing diseases are not payable as it was covered under the Exclusions Clauses of the policy document. The pre-existing disease has been explained by the insurer as follows :-

“Pre-existing Condition : Such diseases/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.”

Now, it is to be seen whether, under the above circumstances, the claim lodged by the complainant is tenable under the policy or not. The Health Shield Claim Form submitted by the complainant for re-imbursement of the expenses for his treatment goes to show that he was admitted in the Sir Ganga Ram Hospital on 21.11.06 wherefrom he was discharged on the following day and the said form further contained the statement that the complainant started suffering from the disease since July/06. He was admitted for treatment of disease “Varicose Veins Bilateral” and there was no history of diabetes and coronary artery diseases but hypertensive.

The complainant was given treatment including surgery such as SFJ ligation with LSV Stripping and multiple Avulsion of Veincose Veins-Bilateral was done on 21.11.06.

It appears that according to the findings of Dr. Rajiv Parakh, Head of Vascular Unit, Sir Ganga Ram Hosptial who treated and operated on the complainant , the disease of the complainant was not pre-existing nor it was a complication of any pre-existing disease. When the complainant was examined, treated and operated by the Head of the Department of Vascular Unit of Sir Ganga Hospital, for the disease “Varicose veins bilateral” who did not say that it was a pre-existing disease or the complication of pre-existing disease, the decision of the Insurer who repudiated the claim considering the reports allegedly submitted by their panel of doctors cannot be said to be fair and justified.

Under such circumstances, it is felt that the insurer should reconsider the matter and settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-003-0153
Sri G. Prakash
Vs
National Insurance Company Ltd.

Award Dated : 25.10.2007

Brief facts : Sri Gampa Prakash and his family were insured under a medi-claim policy issued by National Insurance Co. Ltd., Karimnagar for a sum assured of Rs.50, 000 each. The policy was first taken on 4.4.2001 and renewed every year thereafter. There was a gap of 10 days while renewing the policy in the year 2004 and it was renewed effective from 13.4.2004. His wife Smt. Shobha was admitted to a hospital on 20.11.2004 and was operated for hernia and ovarian cysts on 21.11.2004. A claim for Rs.22, 175/- was lodged with Heritage Health Services Pvt. Ltd. who were Third Party Administrators of the insurers. The claim was repudiated under clause 4.3 of the policy stating that the disease for which claim was lodged was excluded in the first year of insurance. The insured represented to the insurer stating that he had insurance for four years and the claim should be considered. As the insurer refused to settle the claim, the present complaint was filed.

Complainant's contentions: He was having mediclaim policy since 2001 without interruption. He had given cheque for renewal of the policy in 2004 to the Agent well in advance, but it was renewed with a gap of 10 days in 2004. Rejection of the claim by the insurer is not justified.

Insurer's contentions: Hospitalization occurred during the policy period 13.4.2004 to 12.4.2005 which was renewed with a break of 10 days. The renewal has to be effected continuously without break, failing which treatment of hernia and ovarian cysts are not covered under the first year exclusion clause no 4.3 of the policy.

Decision : The insurer's representative stated during the hearing session held on 10.10.2007 that they do condone delay in renewal up to 30 days provided no disease was contracted during the break. The delay in this case was not condoned as the insured did not approach the insurer with a request for condonation of delay. The insurer has not proved that the disease was existing prior to the revival of the policy or during the break period. The insurer has also not brought to the notice of the insured about the facility of condonation of delay, even though such a provision exists. After hearing both sides, it was decided to condone the delay in renewing the policy and the insurer was asked to settle the claim for Rs. 22,175/-.

Hyderabad Ombudsman Centre
Case No.G-11-004-0182
Sri G.P. Monnaiah
Vs
United India Insurance Company Ltd.

Award Dated : 8.11.2007

Brief facts : Sri G.P.Monniah was covered under the Camcomfort group insurance policy issued by UII Co. Ltd., covering the Cancard holders. The period of insurance was from 1.11.2006 to 31.10.2007 and the sum insured for medi claim coverage was Rs.100,000/- for himself and another Rs 100,000 similar amount for his wife. The insured was covered under various policies since 1997, but there was a break of two months in renewal from 1.11.2005 to 31.12.2005. He was admitted to Manipal North side Hospital on 15.4.2007 with pain in the left side shoulder. Total shoulder replacement was done and he was discharged on 18.4.2007. He was again admitted on 21.4.2007 with pain in calf muscle and after treatment was discharged on 25.4.2007. Cashless facility was requested but it was denied. The hospitalization bill for Rs.2,64,084/- was submitted to Medi Assist, the TPA. The claim was repudiated under

4.1 clause stating that the insured's ailment existed prior to the commencement of the policy. The insured represented the matter to the RO of the insurer but to no avail.

Complainant's contentions: He was covered under a medi claim policy for the past ten years. He was covered under a group policy of his employer up to 31.12.2001. He was covered from 1.1.2002 to 31.10.2005 with New India Assurance Co. Ltd. It was then renewed from 1.1.2006 with UII Co. Ltd.. The break in insurance occurred as the Cancomfort insurance was shifted from New India to UII and he remembers having approached New India for renewal in time. The break in insurance was not intentional.

Insurer's contentions: Canara Bank had a tie up with them for issuance of Cancomfort policy commencing from 1.11.2005. The policy was earlier with New India Insurance Company. As there was a change of insurer, they had written to all Cancard holders enclosing the proposal and brochure.

The proposal of the complainant was received by them on 5.12.2005 and they had granted cover from 1.1.2006 which is considered as a fresh insurance due to the break. The complainant suffered an injury to the left shoulder in an accident in the year 2000 and the present hospitalization was a consequence of that injury. Hence, they refused the claim as the ailment was pre-existing.

Decision : The complainant stated that he is an insurance conscious person and he has not received any notice from the UII Co. about change of the insurer. He approached the previous insurer, who directed him to approach UII and hence the delay in sending his proposal to the insurer.

On a perusal of the records, it was observed that the insurers are technically correct in their interpretation of pre-existing condition in the policy. But, considering the continuous insurance from 1997, it was decided to take a lenient view regarding the break in insurance. Hence, it was decided to award an exgratia of Rs. 50,000/-.

Hyderabad Ombudsman Centre
Case No.G-11-008-0158
Smt. S.Vijaya
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 8.11.2007

Brief facts : Smt. Vijaya was insured under a Health Shield insurance policy of Royal Sundaram Alliance Insurance Co. Ltd. The policy was first obtained in 09/2005 and renewed from 29.9.2006 to 28.9.2007 and the sum insured was Rs.100,000. She was admitted into Mallya Hospital, Bangalore on 8.4.2007 with chief complaints of back pain. Laminectomy & Disectomy were done and she was discharged on 14.4.2007. After discharge from the hospital, she lodged a claim for Rs.28,861/-, which was rejected in 05/2007 under pre-existing clause.

Complainant's contentions: She experienced pain for the first time in Nov/ Dec.2006 and as the pain was not substantial, no significant medical treatment was availed and she even undertook a pilgrimage to North India in Feb./Mar.2007. During the tour she had a fall resulting in aggravation of pain. After her return, she consulted a doctor and underwent the surgery. Cashless facility was denied and her bill for reimbursement was also denied much against policy conditions.

Insurer's contentions: The ailment diagnosed was 'degenerative changes with secondary spinal canal stenosis'. The MRI revealed degenerative changes with secondary spinal canal stenosis and hence cashless facility was denied by their TPA. Such an ailment cannot develop in a period of less than two years and hence it must be a pre-existing one. Hence, they rejected the claim.

Decision : The complainant stated that she never had any symptoms of the disease before Nov/ Dec 2006, whereas the policy was taken in Sep.2005. The pain aggravated after a fall during a pilgrimage and did not subside with physiotherapy.

The insurer stated that the disease could not develop in a span of about one year and seven months. The insurer could not submit any evidence to prove that the insured was suffering from the disease prior to the commencement of the policy. Since no proof was submitted, the complaint was allowed and the insurer was directed to settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-008-0147
Sri S.L.N.Simha
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 8.11.2007

Brief facts : Sri S.L.N.Simha had obtained Health Shield insurance for his entire family insuring himself for a sum of Rs.100, 000/- from 13.10.2006 to 12.10.2007. He also covered himself under a Hospital Cash Insurance Policy from 10.2.2007 to 9.2.2008. Both policies were obtained from Royal Sundaram Alliance Insurance Company Ltd., Bangalore. Apart from the above, he was covered under a Medi-claim policy issued by the New India Assurance Co. Ltd., Bangalore for a sum insured of Rs.100, 000/-. He was hospitalized on 3.3.2007 with complaints of chest pain. An Angiogram was done which revealed single vessel disease and he was advised to undergo PTCA. Angioplasty and stenting was done and he was discharged on 7.3.2007. The hospitalization bill amounted to Rs.169, 000/-. He was reimbursed Rs.105,000/- by Medi-Assist India Pvt. Ltd., who were Third Party Administrators for New India Assurance Co. Ltd. The complainant lodged a claim for the balance amount with Royal Sundaram Alliance Insurance Co. Ltd. and the claim was repudiated by the insurer stating that hospitalization was for a pre-existing disease. The claim under Hospital cash also was refused for a similar reason. Aggrieved, the complainant filed the present complaint with this office.

Complainant's contentions: He experienced chest pain and consulted Trinity Hospital, Bangalore on 3.3.2007. The stand taken by the insurers that the disease was a pre-existing one is not justified. He submitted reports of his ECG, Treadmill, Lipid Profile etc., before taking the policies and all these reports were within normal limits.

Insurer's contentions: The Angiography report mentions under LAD –"Type III vessel, Proximal-mid portion has long segmental 85% stenosis." The panel of their doctors opined that the policy being five months old, single vessel disease in a person of 52 years age was definitely pre-existing". In view of the medical opinion, the claim was rejected under pre-existing disease clause of the policy.

Decision : The insured contended that he had undergone TMT, ECG etc. in 06/2006 while obtaining a life insurance policy and the reports did not reveal any abnormality. The insurer contended that the disease could not have developed in five months, as per medical opinion obtained by them.

On a perusal of the records it was observed that the Discharge Summary did not mention about existence of symptoms of the disease in the past and the TMT report was negative. The insurer was not able to prove that the disease was existing before issue of the policy. Hence it was decided to allow the complaint. Therefore, the insurer was directed to settle claim under both the policies i.e. Health Shield and Hospital Cash.

Hyderabad Ombudsman Centre

Case No.G-11-002-0135
Sri A.L.Narasimham
Vs
New India Assurance Co. Ltd.

Award Dated : 15.11.2007

Brief facts : Sri A.L.Narasimham held a mediclaim policy issued by M/s New India Assurance Co. Ltd. for the period from 30.1.2004 to 29.1.2005. The sum insured was Rs.100,000 and he had also earned cumulative bonus of 5% having been insured for previous years also from 30.1.2003 to 29.1.2004. He was admitted to Basavangudi ENT Care Centre; Bangalore from 27.2.2004 to 29.2.2004 for an ailment diagnosed as Bilateral Otosclerosis and underwent Left Stapedectomy. He lodged a claim for Rs.12,874.20 with M/s Medicare Services, TPA, who have repudiated the claim stating that the claim was not admissible under pre-existing condition of the policy.

Complainant's contentions: He stated that he worked in a Public Sector undertaking and took VRS in Nov 2002. In Jan 2003 he had enrolled for medical insurance. He was not having any ailment during his service period and he would have taken reimbursement from his employer if at all any such ailment existed. However, he admitted that he was having a hearing problem for several years but it had not affected his normal life or work. He approached a doctor for pain in ear in Feb 2004 and underwent surgery thereafter.

Insurer's contentions: As per the Discharge Summary of hospital, the complainant had hearing loss in both ears since many years. Even the treating doctor certified in a statement that the insured was having the problem for thirty years. The problem suffered by the insured would come under pre-existing diseases clause and hence they refused payment of claim.

Decision : As per Discharge Summary the insured suffered from loss of hearing in both ears since many years. As per doctor's specific observation, the complainant was having mild hearing problem since thirty years and the problem aggravated in Feb 2004. The insurers also stated that the disease was a chronic one with a long history and was pre-existing as on Jan 2003, when the policy was taken. The insurer's contention was considered to be justified and accordingly, the complaint was not allowed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0133
Sri S. Seshachala
Vs
United India Insurance Co. Ltd.

Award Dated : 19.11.2007

Brief facts : Sri S.Seshachala insured himself, his wife Smt. Meera and daughter Kum. Vidya under a mediclaim policy for a sum assured of Rs.50, 000 each and the period of insurance was from 11.9.2006 to 10.9.2007. He had been insured from 11.9.2005 to 10.9.2006 and previous to that under a Mediguard policy. Smt. Meera was admitted into JSS Institute of Nephrology and Urology, Mysore on 15.11.2006 for ailments diagnosed as Lupus Nephritis, Type II DM, Urethral Syndrome. After treatment she was discharged on 18.11.2006. The claim lodged with M/s Medsave Health, TPA was closed for non submission of required information regarding duration of illness. The complainant appealed to the RO of the insurer, but they also rejected the claim.

Complainant's contentions: All relevant papers were submitted to the TPA, but he claim was rejected.

Insurer's contentions: The insurer stated that their TPA called for information on the exact duration of Lupus Nephritis and DM from the treating doctor. The details were not submitted and the complainant informed them that the treating doctor refused to given such information. Hence, they closed the case.

Decsion : The complainant remained absent but submitted that available prior prescriptions were given to JSS institute and he had no papers to submit. The insurers stated that insurance existed for two years prior to the policy period in which hospitalization took place. According to the Doctor's report obtained by the investigator of the insurance company, the patient was known to be suffering from Type II DM, Lupus nephritis for past four years according to hospital records. As the history reported goes beyond the commencement of the policy, the insurers were found reasonable in rejecting the claim. Hence, the complaint was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0218
Sri. Jonna Vijay Kumar
Vs
United India Insurance Co. Ltd.

Award Dated : 21.11.2007

Brief facts: Sri Jonna Vijay Kumar had obtained a Mediclaim policy from UII Co. ltd., Nirmal for a sum insured of Rs.100, 000/- and the period of insurance was from 9.5.2006 to 8.5.2007. He had first obtained insurance from 9.5.2002 and renewed it continuously He got admitted into Yashoda Hospital, Hyderabad on 21.3.2007 with a complaint of epigastric burning pain and was discharged on 22.3.2007. A claim for Rs.11917/- was lodged with M/s Medsave Health Care Ltd. who are the TPA s for the insurer.. The claim was repudiated on 27.4.2007 stating that insured was admitted into the hospital for only for investigative purposes. The insured represented the matter to the RO of the insurer, but his appeal did not evoke any response from them.

Complainant's contentions: He had continuous coverage under Mediclaim policy for the last five years. He suffered from gastric problem and was admitted into Yashoda Hospital. Investigations were done and he was prescribed medicines for six months. Rejection of claim is not proper.

Insurer's contentions: The hospitalization in 10/2006 was done for health checkup, which is not covered under policy conditions. The hospitalization was for one day and no treatment was given to him during the one day stay in the hospital. Hence, the claim is not admissible.

Decision : The complainant did not attend the hearing session held on 14.11.2007. The insurer contended that if the hospitalization is primarily for diagnosis or diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury for which confinement is required at a hospital/ nursing home, claim is not payable. The insurer contended that the insured had not submitted any papers pertaining to treatment taken prior to hospitalization, when he was experiencing burning pain for 10 days. The discharge summary does not indicate any active treatment which required his stay in the hospital. Hence, the complaint was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-002-0212

Sri Gaurav Malhotra
Vs
New India Assurance Company Ltd.

Award Dated : 3.12.2007

Brief facts : Sri Malhotra was insured by M/s New India Assurance Co. Ltd. under a mediclaim policy from 3.8.2006 to 2.8.2007 for a sum assured of Rs.3, 00,000/-. He was admitted to Krishna Institute of Medical Sciences, Hyderabad from 18.12.2006 to 21.12.2006 where he underwent 'Microdisectomy L5-S1 left' on 18.12.2006. He submitted his claim to M/s Family Health Plan Ltd., the TPA, who has rejected the claim on 5.2.2007 under pre-existing diseases exclusion clause of the policy. The insured appealed to the RO of the insurer on 27.7.2007 enclosing a certificate dated 21.12.2006 from Dr. Diwakar of KIMS which noted that Sri Malhotra was diagnosed as a case of acute intravertebral disc prolapse. The doctor noted " he gave a history of alleged lifting of a crate of drinks, following which he developed pain starting from left lower limb'. The incident was about ten days prior to his first out-patient consultation on 14.12.2006. The insurer's RO received the said certificate but did not revert to the insured, which led the insured to approach this office.

Complainant's contentions: He stated that his claim is genuine and that his pain was not pre-existing. After taking the policy in 08/2006, he had gone abroad in 09/2006 and 11/2006. The incident of getting a jerk in the back was while he was attending a wedding in the UK in the last week of 11/2006. He further stated that had his pain been pre-existing it would have been noted it as chronic and not acute. He sought settlement of his claim of Rs.50775.37 adding that after surgery he is now normal.

Insurer's contentions: They stated that the X-ray of the insured taken on 14.12.2006 (first consultation) had shown degenerative changes in his spine. They also observed overwriting /correction on the prescription of 14.12.2006 in respect of duration of complaint.

Decision : The doctor of TPA presented the original prescription dated 14.12.2006 pointing that the entry of '2 months' was changed to '10 days'. The policy was from 3.8.2006 and even if two months period is taken as correct, it will not affect the claim. The insurers submitted an expert opinion obtained by them which reads as follows:

"It might be possible that this incident might have triggered his symptoms but I personally feel that the disc might have damaged much prior to the incident and this episode might have precipitated his symptoms. Though there is no objective way of confirming the findings."

The surgeon's opinion submitted by the insurer only refers to the possibilities and it is not conclusive to establish that the insured was aware of the symptoms while taking the policy. Since there was nothing on record to show that the insured had symptoms of degenerative changes in his spine, the repudiation of the claim was held to be not justified. Thus the complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-005-0258
Sri G.R.S.Bhavanarayana
Vs
Oriental Insurance Company Ltd.

Award Dated : 20.12.2007

Brief facts: The complaint is about non payment of hospitalisation claims. The complainant had obtained a 'Good Health' medical insurance policy for the period 12.10.2004 to 11.10.2005 covering all his family members for a sum insured of Rs.1

lakh each. The previous policy also was taken from the same company with M/s TTK Health Care as the TPA. The insured lodged three claims in respect of expenses incurred on his mother Smt. Annapurna. The periods of treatment and expenses claimed were as follows:

(i) 9.09.2004 to 08.12.2004 ... Rs.39,397-60
(ii) 9.12.2004 to 08.02.2005 ... Rs.46,763-80
(iii) 9.02.2005 to 28.03.2005 ... Rs.38,050-00

The insurers offered to settle the claim for a reduced amount of Rs.44,823/- but the insured refused to accept such a reduced amount.

The insured contended that his claim is genuine and he is entitled for the full claim.

The insures's side stated that the medi claim policy with them started from 12.10.2003. They also stated that their TPA had settled a claim for Rs.1,02,500/- during their first policy year. The insurer claimed that the bill under item No.(i) was arising out of hospitalization in the previous policy year and hence not admissible.

Decision : The insurer's representative stated that the policy stipulates sub-limits and that they calculated the admissible amount on the basis of policy conditions. The complainant stated that he was not aware of the sub-limits and that he was not explained about the same. It was observed that the insurer had not given replies to the letters sent by the insured and the complaint would not have arisen had the insurer given prompt replies to the letters of the insured. On a review of the bills, the insurer stated that the claimant would be eligible for Rs.53,300/-. In view of the casual approach of the insurer in dealing with the complaint at the initial stages, it was decided to award interest on Rs.53,300/- as per IRDA guidelines.

Hyderabad Ombudsman Centre
Case No.G-11-011-0254
Sri A. John Vijaya Raju
Vs
Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 20.12.2007

Brief facts : The complaint is about non settlement of mediclaim. The complainant had obtained a 'Health Guard' insurance policy from M/s Bajaj Allianz General insurance company for the period 18.12.2005 to 17.12.2006. The sum insured was Rs.50,000. The insured was admitted to Lazarus Hospital, Visakhapatnam on 31.10.2006 with infected swelling on the nape of the neck which was diagnosed as carbuncle. The insured underwent surgery for removal of the swelling and he was discharged from the hospital on 7.11.2006. He lodged a claim for Rs.23,435/- which was rejected by the insurer stating that the insured though being a diabetic had not disclosed the same in the proposal form.

During the hearing session held on 13.12.2007, the insured stated that he had a mediclaim policy with New India Assurance Co., for six years prior to the present insurance policy. He was given to understand that his pre-existing diseases would be covered.

According to the insurer, the insured had not disclosed his diabetic condition in his application for insurance. As per hospital record, he was a known diabetic for one year before surgery. In view of the non disclosure, they rejected the claim under 13(a) of the policy conditions.

Decision : During the hearing session, the insured stated that he shifted from New India Insurance Company to Bajaj Insurance Company as the Insurance Advisor told

him that all pre-existing diseases would be covered. As per doctor's certificate, the insured was suffering from the disease for about a year prior to surgery. Had the insured continued with the old insurer, he would have got the reimbursement. As the insured had been put to a disadvantageous position by shifting from one insurance company to another on the advice of an agent, it was decided to order an ex-gratia relief of Rs.20,000. Thus the complaint was allowed partially.

Hyderabad Ombudsman Centre
Case No.G-11-008-0231
Sri Laxmandas Gogia
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 20.12.2007

Nature of complaint : Non settlement of Medical claim

Brief facts : Sri Lachmandas Gogia, aged about 66 years was insured under a Health Shield Insurance policy issued by M/s Royal Sundaram Alliance Insurance Co. Ltd. for the period 26.3.2006 to 25.3.2007.He was admitted to Yashoda Hospital, Hyderabad on 31.7.2006 with complaints of fever, cough, sputum, SOB for one week etc. He was diagnosed to be suffering from lower respiratory tract infection with sepsis, Bronchiectasis and a reference was also made to the lobectomy of his right lung done in 1959. He was put on ventilator support and had incurred expenditure of Rs.2,37,069/- at the hospital. The TPA refused cashless facility under the pre-exiting disease exclusion clause. The insurer also refused to admit the claim on 25.10.2006.

Complainant's contentions: He submitted that he had been holding medical insurance for several years and had stated about reimbursement of Rs. 42,308/- on 19.9.2003 from the same company for a similar ailment. He contended that he was healthy and fit and thus undertook a pilgrimage to Badrinath. He submitted that treatment undergone by him in 08/2006 was not for a pre-existing disease as alleged by the insurance company.

Insurer's contentions: They stated that Sri Gogia had continuous insurance only from 26.3.2004 and the sum insured including cumulative bonus for the policy year from 26.3.2006 to 25.3.2007 was Rs.130,000/-. They also stated that as per medical records, the insured was a known case of Asthma and Bronchiectasis for the last 20years.

Decision: The complainant admitted there was a break in insurance in Feb-Mar 2004 as the policy expiring on 18.2.2004 was renewed on 26.3.2004.The insurers submitted that payment of a claim in Aug 2003 does not give any additional or irrevocable rights to the complainant to make similar claims in future.

The complainant contended that he was quite well before his trip to Badrinath, but also admitted that he was on medication for lung related problems for several years. The insurer's representative also submitted medical opinion regarding patients with Bronchiectasis and their vulnerability to lung infections. Based on the medical records and literature it was decided to uphold the decision taken by the insurer. Hence the complaint was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-003-0240
Sri Sudarshan Raj Maski
Vs
National Insurance Company Ltd.

Award Dated : 21.01.2008

Brief facts : The complaint is about short settlement of medical claim. Sri Sudershan Raj Maski and his wife Smt. Manjula were insured under a mediclaim policy for the period 16.7.05 to 15.7.06 for a sum insured of Rs.100,000/- each and earned a cumulative bonus of Rs.25,000/- each. Smt. Manjula was admitted to SDMCMS Hospital, Dharwad from 14.12.2005 to 15.12.2005 and a claim for Rs.7224/- was lodged with M/s TTK Health Services Pvt. Ltd., the TPA. The claim was settled in three installments for a reduced amount of Rs.5,810/-.

The complainant stated that this is his first claim in seven years and the insurer disallowed Rs.1414/- for no valid reasons. He sought a compensation of Rs.5000/- from the insurer for the mental agony suffered.

The insurer stated that the hospital showed an amount of Rs. 4064/- amount before discount, but after discount the amount was surprisingly increased to Rs.5014/-. As the available break-up was for Rs.4064/- only, they are not liable for the additional Rs.950/-, they stated. They also added that they disallowed non-medical expenses like admission charges as per policy conditions.

Decision : The complainant did not attend the session but subsequently sent a clarification and a corrected bill from the hospital giving detailed break-up of the bill for Rs.5014/-. The clarification issued by the hospital was found to be satisfactory. Hence, the insurer was directed to pay the difference of Rs.950/- and pre-hospitalization expenses of Rs.323/-. The complaint was allowed partially.

Hyderabad Ombudsman Centre
Case No.G-11-009-0301
Sri K. Madhusudana Rao
Vs
Reliance General Insurance Co. Ltd.

Award Dated : 25.01.2008

Brief facts : The complainant's grievance is about short payment of medical claim. Sri Rao had obtained a Health-wise insurance policy for the period 6.3.2007 to 5.3.2008. The policy covers apart from hospital expenses, other benefits such as recovery benefit, expenses for accompanying person etc. Sri Rao was admitted to a hospital on 2.5.2007 following an injury to his left leg. He was treated at District HQ Hospital, Parlakhemundi, Orissa and was discharged on 13.5.2007. The insured lodged a claim for Rs. 20,608/-, but the insurer settled the claim for Rs. 6858/- only. The insured's complaint is that the deductions made by the insurer are not justified.

The insurer contended that the insured's hospitalisation does not require more than five days. Hence they reduced the bill amount for five days.

Decision : The complainant stated that he remained as an in-patient in a Govt. Hospital only on the advice of doctors and his claim is genuine.

The insurer's side argued that the insured suffered only a soft ligament injury and hence hospitalisation for 11 days was not required as per medical opinion obtained by them. The insurer has not produced any supporting evidence to establish correctness of their decision. The insured confirmed that he had not suffered any bone injury. Hence, it was decided to order for payment of a further amount of Rs.10,000/- to meet the ends of justice. Thus the claim was partly allowed on ex-gratia basis.

Hyderabad Ombudsman Centre
Case No.G-11-004-0359
Sri K. Gangadhar Rao
Vs
United India Insurance Co. Ltd.

Award Dated : 31.01.2008

Brief facts : Sri Gangadhar Rao and his family members were insured under "Mediguard" policy issued by UII Co. Ltd. The sum insured for his wife Smt. Viijaya was Rs.1,50,000/- in 2002-03; Rs.1,75,000/- in 2003-04, Rs.3,00,000/- in 2004-05 and Rs.3,20,000 from 8.4.2005. Smt. Vijaya was admitted into a hospital from 25.4.2005 to 27.4.2005 for evaluation of shortness of breath. In the case sheet it was recorded that she had a history of DM for last two years and history of hypertension detected recently. She underwent haemodialysis and on discharge was advised to continue dialysis twice a week. A claim was lodged for Rs.7,738/-,which was settled by the insurer in 08/2006.Subsequently the claimant applied for reimbursement of three more bills for the periods from (i) 28.4.2005 to 30.3.2006 for Rs.139415/- (ii) 1.4.2006 to 30.10.2006 for Rs.87,370/- (iii) 2.11.2006 to 11.12.2006 for Rs.18,200/- being the amounts incurred on dialysis. Two of these claims were rejected by the insurer stating that there was undue delay in submission of bills.

According to the complainant, his earlier claim for the April 2005 hospitalisation was delayed by the insurers by over fifteen months. He stated that he delayed submission of further bills pending disposal of the pending claim.

According to the insurer, the hospitalisation claim was settled after receiving investigator's report and expert medical opinion. According to them delay in settlement of a previous bill cannot be a reason for not giving prompt intimation about further dialysis.

Decision : Both sides were called for a hearing on 23.1.2008. As per discharge summary given at the time of discharge on 27.4.2005, the patient was advised to undergo dialysis twice a week. Thus the insurers were well aware of the medical condition of Smt. Vijaya. The insurers were found to be not put to any disadvantage by the delayed lodging of claims for dialysis. Hence, the insurer was advised to process and settle the claim as admissible within one month from the date of award. The complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0303
Sri Ghouse Khan
Vs
United India Insurance Co. Ltd.

Award Dated : 8.2.2008

Brief facts : Sri Ghouse Khan and his wife were covered under a hospitalization insurance policy issued by UII Co., Bangalore for the period 8.10.06 to 7.10.07 for a sum insured of Rs.3,00,000/- each. They also earned a cumulative bonus of 20% each. Smt. Naseema was admitted to Manipal Heart Foundation, Bangalore from 14.7.07 to 16.7.07 with complaints of palpitation since 3-4 weeks, flatulent dyspepsia, mild pain in upper abdomen and occasions of breathing difficulty. Sri Khan submitted a claim for Rs. 18,740/- to M/s Family Health Plan, TPA of the insurer. The TPA rejected the claim on 16.8.07 and contended that the hospitalization was only for investigation purposes and not for treatment. Sri Khan appealed to the RO of the insurer, but to no avail.

Decision : The complainant contended that his wife was admitted into the hospital only on the advice of a doctor for investigations and treatment. He also stated that his wife developed blood pressure and palpitation in 06/2007 for which she took treatment from Dr. KSS Bhat, Cardiologist.

The insurer's contention was that the patient's condition on 14.7.07 did not warrant hospitalization as can be seen from the discharge summary.

Both sides were heard on 4.1.2008. During hearing, Mr. Khan stated that his wife was admitted into the hospital after all possible out-patient care had failed to give any relief to her and when she continued to get palpitations on and off. From the record it is evident that the insured Smt. Naseema had at least four claim free years and her HTN is said to be about 2-3 years old. She had consulted doctors and undergone tests and treatment between 27.6.07 and 11.7.2007 including a Holter Monitor. Thus it is clear from the record that hospitalization was not resorted to take undue advantage of the insurance policy. Hence, the insurers were directed to settle the claim for Rs.18, 640/- (after deducting the admission charges of Rs.100/-). The complaint was thus allowed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0361
Sri Chandresh P. Vipani
Vs
United India Insurance Co. Ltd.

Award Dated : 11.2.2008

Brief facts : Sri Chandresh Vipani and his family were insured under a mediclaim policy issued by UII Co. Ltd., for the period 17.5.2007 to 16.5.2008 and the policy was serviced by M/s Medsave Healthcare Ltd., the TPA for the insurer. Sri Vipani lodged a claim with the TPA, claiming an amount of Rs.3,000 for loss of a tooth in an accident. The claim was rejected by the TPA on 12.12.07 stating that the claim did not fall within the scope of the policy.

Decision : The complainant stated that he lost a tooth in a minor road accident and that he got the tooth replaced and submitted bills and other papers, excepting x-ray to the TPA for settlement. As per the contention of the insurer, the complainant did not submit x-ray and they stated that the claim was rejected under 4.7 exclusion clause. According to the investigation conducted by the insurer, the clinic where the insured got treated does not have any beds and round the clock patient care facility is not available.

Both sides were heard on 6.2.2008. The insurer mentioned that for admission of claim, the treatment should be taken in a hospital/ nursing home as defined in clause 2.1 of their policy. From the papers submitted it was observed that the hospital where the insured took treatment was a two-room clinic and does not satisfy the requirements specified under clause 2.1 of the policy. However, it was observed that the insurer was seeking information on proof of accident, x-ray etc., when the claim clearly fell outside the scope of the policy. Therefore, the insurer was directed to pay an ex-gratia amount of Rs.1,000/- to the complainant.

Hyderabad Ombudsman Centre
Case No.G-11-003-0313
Sri V. Pattabhi
Vs
National Insurance Company Ltd.

Award Dated : 22.2.2008

Brief facts : Sri Pattabhi held medical insurance polices from 9.7.03 to 8.7.2007 issued by NIC Ltd. He was hospitalised for heart ailment at Wockhardt Hospital, Hyderabad in 09/2006 and lodged a claim for Rs.2,66,036/-.The claim was rejected by the insurer on 13.3.2007 under the pre-existing disease exclusion clause.. He appealed to the RO of the insurer on 4.7.07 stating that he had undergone a bypass surgery in 1991 and that there was an unintentional break in insurance coverage from 13.7.02 to 8.7.03.

Decision : The complainant contended that the present claim is for atrial fibrillation and it is in no way related to the past treatment. He further stated that atrial fibrillation could occur for healthy persons and it is a degenerative heart condition. He also added that his previous problem was disease of artery and the present one was one of conduction to heart muscles.

The insurers stated that Sri Pattabhi did not have medical insurance during 2002-03 and insurance was effective only from 9.7.2003. The present problem was a continuity of conglomeration of the problems he has got. They rejected the claim in view of the continuity of the problem and discontinuity of the policy.

The complainant stated that he was not claiming for his hospitalisation of 22.9.06 but only for the expenses incurred in pacemaker installation etc. from 27.9.06 to 29.9.06. The insurers submitted that they did not receive the entire medical history. As such, the insured was advised to submit necessary record to the insurer and insurer was asked to process the papers within a month from the date of submission of such information. The claim was admitted for statistical purposes.

Hyderabad Ombudsman Centre
Case No.G-11-005-0385
Sri Y.V.Rami Reddy
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 25.2.2008

Brief facts : Sri Venkata Rami Reddy and his family were insured under a mediclaim policy for the period 16.8.2007 to 15.8.2008. The policy was first obtained in 1997 and was renewed since then without any break. His wife Smt. Vijayalaxmi who was proposed for an amount of Rs.50, 000 in 1997 had earlier undergone surgery for valve replacement in the heart and this fact was disclosed in the proposal. Accordingly rheumatic heart disease was excluded from the scope of the policy. The insured was under constant medical check-up thereafter. On 3.9.2007, the insured was detected to be suffering from mitral stenosis and valve replacement was done. She submitted a claim for Rs.1,82,557/- but the claim was not admitted by the insurer stating that the disease was pre-existing. A complaint was registered with this office against the decision of the insurer.

Decision : The complainant stated that they have disclosed past diseases and nothing was suppressed. He had renewed the policy continuously for 10 years and had not lodged a single claim. He has also stated that the pre-existing disease exclusion clause should not be applied in her case as the policy was in force continuously for more than four years.

The insurers contended that rheumatic heart disease which was pre-existing disease for Smt. Vijayalaxmi was excluded from policy cover and the exclusion is for all years.

The claim was rejected under 4.1 clause of the policy. However, as per the clause, the exclusions are applicable up to 4 years from inception. Since the policy was in force continuously for more than four years, it was held that the insurers are liable to pay the claim.

Hyderabad Ombudsman Centre
Case No.G-11-004-0329
Sri Ashok Kumar Naredi
Vs
United India Insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts : Sri Ashok Kumar was insured under a medi claim policy issued by UII Co. Ltd., for the period from 5.12.04 to 4.12.05 for a sum insured of Rs.5,00,000/-. Sri Ashok Kumar was admitted in to Care Hospital, Hyderabad on 17.11.05, where he underwent Coronary Angiogram and was discharged on 18.11.05. He submitted a claim for Rs.24,207/- with M/s Med Save Health Care, Hyderabad, TPA of the insurer, but his claim was rejected stating that the present ailment was pre-existing as the insured underwent CABG in 1994/95. The complainant contended that he was continuously insured from 1993 and that a claim for heart ailment was paid to him in 03/1994. The insurers rejected the claim stating that insured was covered with them since 1997 only and hence the claim was not admitted.

Decision : The insurers contended that the insured submitted policy copies from 2001 only and the cumulative bonus of 20% indicated in the policy suggested existence of policy since 1997. They claimed that they are unable to trace old records in their office due to shifting of their office.

During the hearing, the complainant submitted that he received a claim cheque from the insurers in 03/1994 for Rs.65,000/-. He also produced copies of Medi claim premium certificate dt. 8.12.93; IT Return for 1994-95; Premium Receipts dated 4.12.95 and 6.12.96. The insurers have not reported any discrepancy in the said papers. The insurers' representative stated that the present ailment was a continuation of the old ailment and hence the claim, if any, should be restricted to the sum assured available in 1994. Since the papers on record prove continuity of insurance since 1993, the insurers were directed to process the claim and settle it.

Hyderabad Ombudsman Centre
Case No.G-11-002-0429
Sri N.K.Adi Murty
Vs
The New India Assurance Co. Ltd.

Award Dated : 18.3.2008

Brief facts : Sri Adi Murty and his wife Smt. Kamala were covered under a medi claim policy issued for the period from 15.4.2007 to 14.4.2008. The policy was in force continuously from 15.4.2005 and Smt. Kamala was insured for a sum of Rs.2,00,000. Smt. Kamala underwent a knee replacement surgery on 23.8.2007 at KIMS, Hyderabad and she was discharged from the hospital on 27.8.2007. A claim for Rs.1,80,000/- was lodged with M/s Good Health Plan Ltd., TPA of the insurer, but the TPA rejected the claim under the pre-existing diseases exclusion clause. Aggrieved, Sri Murty approached this office seeking settlement of the claim.

Decision : The claimant stated that she was having medi claim insurance since 04/2005. She went to USA before the surgery and the cold weather there aggravated her knee problem which was existing for about one year. As per facts of the case, the insured was having medi claim insurance continuously since 04/2005 except for a break of 2 months from 02/2005 to 04/2005. During the hearing the complainant submitted that there was a break in renewal of the policy owing to their US trip and he submitted that his wife was covered under overseas medi claim policy during that period. He submitted a copy of the overseas policy. Further, from the papers it was observed that that the insurance policy for 2004-05 indicated a cumulative bonus of 30% suggesting that the complainant and his wife were insured for 6 years prior to 2004-05. The insurer's representative stated that knee replacement could be a result of degenerative problem. However, the insurer could not submit any evidence to support their argument that the insured was having a knee problem prior to 2005. Based on the records, it was decided to allow the complaint and the insurers were directed to settle the claim.

Hyderabad Ombudsman Centre
Case No. G 11.008.0430
Smt Pranathi Subrahmanyam
Vs
Royal Sundaram Alliance Insurance Co.Ltd

Award Dated : 25.03.2008

Brief Facts of the Case:

Smt. Pranathi Subrahmanyam obtained a Health Insurance policy from Royal Sundaram Allianz Insurance Co.Ltd., covering her family members including her mother-in-law Smt. Parvathi for the period 27.02.2007 to 26.02.2008. The sum insured for Smt. Parvathi was Rs.2,00,000/- with a cumulative bonus of Rs. 30,000/- and Diabetes Mellitus was noted as an excluded disease for her. Smt. Parvathi was seen by the Doctors at Nizam Institute of Medical Sciences, Hyderabad in April 2007 and underwent three cycles of pre-operative chemotherapy before undergoing surgery of Trans-thoracic Esphagectomy on 28.06.2007 at Global Hospital, Hyderabad for Carcinoma Esophagus. A claim was lodged with the insurer for Rs.2,45,733/- on 21.07.2007, which was however rejected by them on 6th August, 2007. The insurer had confirmed that Smt. Parvathi's insurance was in force from 27.02.2006, but contended that her ailment was pre-existing and that the carcinoma could not have developed within the 1year 4 month period the policy was in force.

Smt. Parvathi's appeal to the Insurance Company was rejected on December 18, 2007. Aggrieved by this stand of the insurers, Smt. Parvathi approached this office on 11th February 2008.

The insurers had reiterated that their decision to reject the claim was justified and also raised another major objection citing their policy condition which reads as under:

DISCLAIMER :

"It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the insured for any claim hereunder and such claim shall not within 3 calendar months from the date of such disclaimer have been the subject matter of suit in court of law or pending reference with Ombudsman, than the claim shall for all purpose be deemed to have been abandoned and shall nor thereafter be recoverable hereunder."

The insurers contended that the limit available as per policy condition above was exhausted and the insured has forfeited her rights to seek reimbursement under the policy as she did not approach the ombudsman within 3 months from 6th Aug 2007, the date of rejection of claim.

DECISION

Very little merit was found in the insurers' argument that Smt. Parvathi's illness was existing prior to 27.02.2006 whereas as per records available she got the symptoms (difficulty in swallowing) about a month before her first consultation in April 2007. Her son and daughter-in-law, both medical doctors, reside with her. The treatment was taken up immediately after the first consultation of 10.04.2007. The treating doctor (Dr. Raghunadha Rao) has given his opinion that the cancer was unlikely to have existed for more than a few months before the diagnosis. There is nothing on record to establish or even indicate that Smt. Parvathi's ailment was existing as of 27.02.2006. It was held that the insurers have grossly erred by relying on far fetched surmises and presumptions in rejecting the claim, through their two letters of 6.8.2007 and 18.12.2007.

As regards the insurers other objection concerning the time limit for approaching the Ombudsman, it was held that the present proceedings before this office were under the Redressal of Public Grievances Rules, 1998 which provided for filing complaint within one year from the date of rejection of representation to the insurer and thus the objection had no merit.

As seen from the chronology of events, the claim was made on 21.07.07 within one month from the date of surgery. The request dated 27.11.07 for reconsideration of the decision was rejected by the insurer by the regret letter dated 18.12.07. If this is considered as the final repudiation by the insurer, the complaint to this office on 11.02.2008 is within 3 months. Considering that the insurer did not bother to guide the complainant regarding the procedure and time limit to obtain proper redressal of her grievance as per IRDA regulations it may be fair and equitable to hold that the present complaint is not hit by the "Disclaimer " Clause.

The following judicial decisions about the necessity for liberal interpretation of the provisions were relied upon.

1. Hon'ble Delhi High Court in the case of Sri Ashok Kumar Dhingra Vs. Oriental Insurance Co., Ltd., (Civil Writ No. 876/2002, No. AIR2004 Delhi 161)
2. Secretary, Thirumurugan Co-operative Agricultural Credit Society Vs. M. Lalitha (Dead) through L.RS and other (2004) ISCC305) 2003 (TLS) 38703 – Civil Appeal 92 to 1998.
3. Spring Meadows Hospital and another V. Harjol Ahluwalia through K.S. Ahluwalia and another (1998) 4 SCC39
4. H.N. Shankara Shastry Vs. Asst Director of Agriculture, Karnakata – Civil 2253 of 1999, - 2004 (TLS) 39799

In view of the above, it was held that the complainant is entitled to the settlement of the claim. The complaint was allowed and the insurer directed to settle the claim for Rs. 2,30,000/-

Hyderabad Ombudsman Centre
Case No. G 11.003.0382
Sri P Ramanadham
Vs
National Insurance Co. Ltd

Award Dated : 25.03.2008

Brief Facts : Shri P Ramanadhan and his wife were insured under a Health Insurance policy issued by National Insurance Co.Ltd., for a sum insured of Rs. 1,00,000/- each His wife was admitted to Yashoda Hospital and he incurred an expenditure of Rs. 1,43,716/- A claim was lodged for Rs. 1,35,000/- being the sum insured together with cumulative bonus. The claim was settled for Rs. 94, 580/- and the reasons for deduction were not given.

Decision : The insurers submitted that the policy issued had sub limits under the heads (1) room rent and nursing charges (2) Doctors and surgeons fees (3) Cost of medicines, investigations, OT charges etc and the claim allowed was in accordance with terms and conditions of the policy. The insurers also submitted that as per clause 4.16 of the policy they were not liable to pay for expenses in connection with external /durable equipment. It is held that the complaint is by the insured under RPG rule and insurers cannot raise the issue of alleged excess payment. A copy of the policy was placed on record and the policy was issued in accordance with insurers Head Office circular dated 23.03.2007. It is observed that the insurers Third Party Administrators applied the clauses of policy stipulating limits and thus deductions made were in order. The Third Party Administrators had not bothered to intimate to the complainant how the claim payable was arrived at. The insurers also took an inordinately long time to give a response. The insurers and Third Party Administrators had not properly communicated to the claimant giving rise to this grievance and therefore the insurers were directed to pay an amount of Rs. 5000/- for the lapses in handling the claim and grievance. The complaint regarding deduction of claim was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-04-0437
Sri V.V.Ram Prasad
Vs
United India Insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Sri V.V.Ram Prasad and his family were covered under a medical insurance policy for the period 4.4.07 to 3.4.08. Sri Ram Prasad had earned a cumulative bonus of 15% (3 previous policy years being claim free) while other family members had 25% bonus (5 years claim free). He was admitted to Care Hospitals, Hyderabad from 27.10.07 to 5.11.07 and underwent surgery ‘Laparoscopic Gastric Bypass under GA’. The diagnosis was metabolic syndrome. He has a history of HTN and DM and known Hypothyroidism. On 30.11.07, M/s TTK Health Care Services Pvt. Ltd., TPA of the insurers have refused the request for cashless facility on the plea that obesity related expenses are not payable by insurance. His appeal to the insurance company was not replied to. Hence this complaint.

Decision : Sri Ram Prasad stated that he incurred an expenditure of Rs.1,87,786/- and sought directions for reimbursement of the same. The insurers stated that they did not reject the claim and that they would examine the claim as per policy conditions on submission of claim form and supporting documents.

A hearing was held on 26.3.2008. During the hearing, the insurers’ representative submitted that they did not receive the original bills and claim for reimbursement together with treatment details. The complainant confirmed that original bills were with him as on the date of hearing. The complainant was asked to submit all papers to the

insurer for processing and the insurer was directed to process the papers and dispose of the same within two months from the date of the order. The complaint was admitted for statistical purposes.

Hyderabad Ombudsman Centre
Case No. G 11.004.0398
Sri Visweswariah Prof. V
Vs
United India Insurance Co. Ltd.

Award Dated : 31.03.2008

Brief Facts : Prof Visweswaraiah and his wife Sunanda Devi were covered under an Andhra Bank Arogyadaan Policy issued by M/s. United India Insurance Co.Ltd., for the period 16.08.2005 to 15.08.2006. Smt. Sunanda Devi was hospitalized at Apollo Hospitals from 20.11.2005 to 30.11.2005 and at Sigma hospital from 14.12.2005 till her death on 23.12.2005. Two claims for Rs. 26,259/- and Rs. 65,781 were lodged with the insurance company. Both the claims were rejected by the insurers Third Party Administrators invoking the pre-existing diseases exclusion.

Decision : The insurers contended that the insured was covered for only 3 months and Smt Sunanda was a known case of HTN. DM, CAD, Rheumatic Arthritis, diabetic nephropathy and Chronic Kidney disease. She was admitted to hospitals for management of ulcer in the mouth and digestive tract with erosive gastritis which was due to prolonged medication due to various pre-existing conditions. It is observed that Smt. Sunanda Devi was admitted under the department of Cardiology for possible drug induced gastritis. Treatment and care given included those from Cardiology, rheumatology and gastero- enterology. Though the insurers might have a technical point that admission and treatment arose only due to pre-existing conditions only. In view of the same the insurers are directed to pay 20% of amount incurred at Apollo Hospital. The insurer pointed to the treatment papers of Sigma Hospitals and pointed that she was a case of Acute Renal failure and chronic kidney disease. The complainant submitted that the cause of death was sepsis and UTI. The insurers contended that sepsis and UTI arose only out of long term, health conditions and their complications and submitted a doctor's opinion in support. It was held that the complications developed may or may not necessarily be linked to her pre-existing conditions. In view of the above the insurers are directed to pay 15% of expenses incurred at Sigma hospitals. The complaint is partly allowed as ex-gratia for Rs.15,119/-.

Hyderabad Ombudsman Centre
Case No. G 11.004.0417
Smt. Shah Damayanti Khushal Das
Vs
United India Insurance Co.Ltd.

Award Dated : 31.03.2008

Brief Facts : Smt. Damayanti Khushaldas was insured under an individual mediclaim policy issued by United India Insurance Co.Ltd., for the period 06.02.2006 to 05.02.2007. She was admitted to hospital where she underwent total abdominal hysterectomy on 06.01.2007. The claim was rejected stating that the treatment taken by Smt. Damayanti fell under 1st year exclusion of the policy.

Decision : The complainant submitted that she reached menopause 8 years ago and as there was bleeding she underwent tests at Indo American Cancer Centre which revealed “Adeno Carcinoma Endometrium”. It is observed from the policy that it excludes in the 1st year of insurance “Hysterectomy for Menorrahgia or Fibromyoma”. The hysterectomy undergone by the complainant is not with this diagnosis but with Adeno Carcinoma Endometrium. The insurers were advised to review and upon review they submitted that the present claim having arisen due to Cancer related problems was payable. In view of the insurers agreeing to admit the claim they are directed to settle the claim without further delay.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-079/2007-08
Smt.V.A.Shajida Patla
Vs.
The Oriental Insurance Co. Ltd.

Award Dated : 03.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998. The complainant Ms.Shajida Patla had taken a Universal Health Insurance policy covering himself, her spouse and children. During the currency of policy her husband was hospitalized the claim for which amounting to Rs.6260/- was disallowed by insurer on the ground that the pre-existing disease was not disclosed in the proposal. The repudiation was only on the ground that Sri.Sulaiman, the complainant’s husband was suffering from Asthma before taking policy which was not disclosed while taking policy. But the petitioner’s case is that the treatment was not taken for Asthma but for some other disease which has contracted during policy period. The photocopy of discharge card is produced by the insurer, which shows diagnosis as VF, HTN, Hypocalcaemia and Hypomatremia. It can be seen that none of these four disease have any connection with Asthma. The investigation report produced by insurer also states that he was not admitted for treatment of Asthma but for hypertension and Hypocalcaemia. From the above discussion it is very much clear that he has not undergone any treatment for Asthma during the period of admission. Exclusion clause 3.1 excludes only reimbursement for pre-existing disease. It is clear that even if one is having any ailment, he can take a policy but claim will be admissible in respect of disease contracted during the policy period. Also there is no specific column in the proposal saying that he was in good health while taking policy and he was not having any existing disease. As the reimbursement was for treatment of a disease contracted during the policy period the complainant is eligible to get the amount of insurance claim. An award is passed directing the insurer to pay the claim amount of Rs.6260/- with 8% interest till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-118/2007-08
Sri. Bino Elias
Vs
United India Insurance Co. Ltd.

Award Dated : 04.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant was issued with a medi claim policy covering the period from 23.7.06. On 2.3.07 he was admitted at PVS Memorial hospital. After endoscopy he was discharged

on 3.3.07 and claim for reimbursement of expenses was rejected by the insurer on the ground that the hospitalization was only for endoscopy and no active line of treatment was taken from the hospital. The patient was admitted in the hospital only for one day for check up and on discharge medicines were prescribed for one month. From the discharge summary it looks that the admission was solely for conducting test and no treatment was done from the hospital. After the test he was advised to take medicine for one month. It was submitted by the insurer that as per clause 4.10 of exclusion clause all admission merely for diagnostic purpose and investigation are excluded from the purview of policy. As the policy condition is very specific about is exclusion clause the insurer is justified in repudiating the claim and the repudiation is therefore upheld and complaint is dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-106/2007-08
Sri.K.Gopinathan Nair
Vs
United India Insurance Co. Ltd.

Award Dated : 04.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant Sri.Gopinathan Nair has been issued a Medi claim insurance policy and he has been renewing it since 1999. While so, in December 2006 he underwent an Off pump coronary artery bypass grafting at MIMS hospital, Kozhikode and the claim was rejected by the insurer on the ground that life assured was a known diabetic, which he has disclosed while taking policy and diabetes being a risk factor for CAD, the claim will fall under exclusion clause 4.1 and hence they have repudiated the claim. It was submitted on behalf of insurer that on account of diabetes CAD may develop. Also treatment was not only for CAD, but for diabetes also and hence if at all the claim is to be admitted the expenses are to be apportioned in the ratio 1:1 and only half the amount of bill relates to CAD.

The certificate of Chief Cardiac Surgeon, MIMS hospital, Kozhikode states that “complainant underwent off pump artery bypass grafting with 3 grafts... He gave no past history of heart disease”. From this it is clear that treatment given at MIMS is for defect of artery only. It is well known that diabetes is caused due to disfunctioning of pancreas. Here the operation was not done on pancreas; of course diabetes may be a risk factor for CAD. Here the disease for which he was treated is for a disease or condition of artery and not of pancreas, and the condition was not pre-existing. Of course during the course of treatment some medicine would have been given to control diabetes. But the treatment was given only as a part of treatment to artery disease. The surgical expense itself exceeds the sum assured of Rs.1.2 lakhs of the policy. As per exclusion clause disease or injuries existing at the time of inception of policy alone is excluded. The risk factor will not come within the purview of the exclusion clause. Of course diabetes is a risk factor as far as CAD is concerned. But even a person who is not having diabetes may have heart disease. More than that diabetes is not a condition or disease or injury pertaining to heart or coronary artery. It is a condition relating to pancreas and hence by no stretch of imagination it can be said that coronary artery disease was a pre-existing one. The repudiation made is faulty and is to be reversed. An award is passed directing the insurer to pay the sum assured of 1.2 lakhs with interest at 8% till date of payment and cost of Rs.5000/-.

Kochi Ombudsman Centre

Case No. : IO/KCH/GI/11-005-162/2007-08
Sri.K.S.Pillai
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 05.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. The complainant Sri.K.S.Pillai was issued an individual medi claim policy to cover himself and his family members w.e.f. 27.10.04 and it was subsequently renewed on 27.10.05. While the policy was in force he was admitted in hospital and treated for diabetes mellitus. The claim was rejected on the ground that the illness was existing before taking the policy and therefore the insurer is not entitled to make any payment. It was submitted by the insured that as the policy was renewed on 27.10.05 the insurer is bound to honour the claim. If the illness was existing before taking policy they should not have revived the policy on 27.10.05. Here the contention of the insured is that as the policy was renewed on 27.10.05 and the policy is now inforce and hence he is eligible for reimbursement. He never refuted the fact that the disease was pre-existing. In his letter to this forum also he never denied the fact that the illness was pre-existing. He has also given in writing to the investigating officials deputed by insurance company that he was suffering from diabetes mellitus since 2003 and he is still taking treatment for the same. The discharge certificate issued by hospital also shows that the illness was not a sudden development but a gradual development as a result of diabetes. As insurer was able to prove with clinching evidence that the treatment was taken for an illness which was in existence before taking policy and as the policy condition is very specific about its exclusion clause the insurer is justified in repudiating the claim and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-125/07-08
Sri.Jayaprakash P. C.
Vs
The Oriental Insurance Co.Ltd.

Award Dated : 29.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant had taken an individual medi claim policy covering himself, his wife and children. During the currency of policy his wife was admitted in hospital for treatment relating to pregnancy. On undergoing ultrasonography test 3 Gestational sacs were seen inside the cavity. The pregnancy was at an early stage and as advised by doctor the triplets were reduced into two by embryo reduction. The claim was repudiated on the ground that the treatment was for a condition relating to pregnancy which is an exclusion as per policy condition. It was submitted on behalf of insurer that embryo reduction was done purely by way of risk management in order to facilitate delivery and there was no life threatening situation and as such the treatment relate to maternity treatment only, which is an exclusion as per policy condition.

The certificate issued by treating doctor indicate that wife of complainant had triplets in early stage of pregnancy and as such pregnancy can go to abortion or premature delivery and new borns will required neonatal intensive care for a long period. From the discharge card it is clear that as 3 embryos were originated in the uterus, doctors considered that the pregnancy was risky and she was advised to reduce embryos into

two and so embryo reduction was done. This certainly relates to pregnancy. There is no case that she had any other complication. Hence medical intervention was done only as to the pregnancy and that too for smooth delivery. The policy condition is very specific about its exclusion clause which states that any treatment arising from or traceable to pregnancy, child birth, miscarriage etc. are excluded for the purview of policy. Since the peril is not covered by the policy, the repudiation is upheld and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-144/07-08
Sri.K.Narayanan Namboodiri
Vs
The Oriental Insurance Co.Ltd.

Award Dated : 30.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complaint is against repudiation of a claim under a medi claim insurance policy. Sri.Manoj Namboodiri, the son of the complainant had taken a medi claim insurance policy for the benefit of himself and his family members. The policy was taken on 20.3.01 from Angamaly branch of insurer and it was renewed at Bombay office in 2002. But on expiry it was not renewed in time, it was renewed only on 16.6.03 after a lapse of 79 days. While the policy was inforce a claim was raised for treatment of Smt.Rethie Devi, wife of complainant, for expense relating to treatment of renal calculus. The claim was repudiated on the ground that the illness was existing since 2002, and there was a brake of 79 days, the policy issued after renewal in 2003 is a new policy and not a continuation of policy issued in 2001.

The complainant himself had admitted that the patient was having renal calculus in 2002 and have taken treatment for the same. But his contention is that in 2002, the disease was fully cured and the present kidney stone is a new stone and not a continuation of previous stone. But it can be seen from the hospital report that she is a known case of Renal Calculus since 2001. Though the kidney stone was removed in 2002, the fact remains that the condition of forming renal calculus is still there, though by an operation the stone was managed and hence the disease is the one existing since 2001. There was a gap of 79 days in renewing policy in 2003, so the policy issued after renewal in 2003 can be treated as a new policy only and not the continuation of policy issued in 2001. The treatment was given for a pre-existing disease which is a specific exclusion as per policy condition. The complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-157/07-08
Sri.C.P.James
Vs
United India Insurance Co. Ltd.

Award Dated : 31.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant who is having a medi claim policy for the last 15 years has undergone treatment from Little Flower Hospital, Angamaly since 25.1.07. He was admitted there on 30.1.07, GI endoscopy was done on 31.1.07 and discharged on 31.1.07. The claim

for reimbursement of hospital expenses was repudiated on the ground that there was no active line of treatment and the patient was admitted only for GI endoscopy. As per policy condition any hospitalization merely for diagnostic purpose not followed by any active line of treatment is not covered under the policy. The hospital records states that "upper GI endoscopy performed on 31st Jan.07. "Normal". After endoscopy he was advised to meet doctor on general OP. It also shows that in the endoscopy everything was found normal. No further treatment was given or medicine prescribed after endoscopy. The complainant himself had admitted that no medicine was taken while he was admitted in the hospital. Hence it is clear that admission was only for investigation and no ailment or improper condition was diagnosed on such investigation. As policy condition is very clear about its exclusion clause the complainant is not entitled to get the claim and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-195/07-08
Sri.K.C.Maney
Vs
United India Insurance Co. Ltd.

Award Dated : 13.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. Dr.Majo Kakkassery, a Dentist, was covered by a medi claim policy taken by his father from United India Insurance Co. On 21.1.07 at 0.00 hrs he was taken to Amrita Institute of Medical Sciences and after primary treatment and investigation he was discharged on 23.1.07 diagnosing the ailment as upper respiratory tract infection. The claim was repudiated on the ground that the nature of treatment was of an OP nature and no hospitalization was required for the treatment imparted at the hospital. Aggrieved by the decision of insurer, the complainant approached this Forum for justice. The complainant has stated that at the time of admission the condition of patient was very serious and in order to rule out the possibility of some serious disease like rat fever, malaria, pneumonia etc. he was admitted in the hospital and carried out investigation such as ECG, blood test, urine test, X-ray etc. As these tests were conducted as part of treatment to rule out some serious illness rat fever, malaria etc. and not conducted as a routine test he is eligible for reimbursement of entire expenses spent by him.

The certificate issued by Dr.Rema Pai is produced which states that the patient was brought to hospital with cough, body ache and very high fever. The condition of patient was so weak so that he had to be monitored periodically. Medical report also shows that he was having a temperature of 104 degree F. It was also stated that the patient was afebrile during hospitalization. It was suspected the possibility of having any other disease. He was brought to hospital in midnight itself. Hence it can be seen that the treatment given was requiring inpatient treatment. Hence he is entitled for that reimbursement of hospital charges, cost of medicines. From the hospital records it looks that investigations were done to rule out the possibility of any serious ailments such as rat fever, malaria etc. But the reports of all these investigations were negative. As per Cl.4.10 of policy condition such charges are not payable. What is payable is hospital charges, room charges, nursing charges etc. which amounts to Rs.791/- as per bills produced; which can be rounded at Rs.800/-. An award is passed directing the insurer to pay a sum of Rs.800/- with 8% interest since date of claim till payment with a cost of Rs.200/-.

Kochi Ombudsman Centre

Case No. : IO/KCH/GI/11-004-196/07-08
Sri.M.S.Anilkumar
Vs
United India Insurance Co. Ltd.

Award Dated : 16.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant's mother Smt.Arathy Sreedharan is covered under a medi claim policy since 1976. She had undergone treatment at Lourde's Hospital from 7.7.06 to 13.7.06 and 17.10.06 to 25.10.06 for Diabetes Mellitus and Nephropathy. The claim was repudiated on the ground that the claim was pre-existing since 15 years. The complainant has stated that in the medical reports it was wrongly noted that she was having diabetes for 15 years, but she was having diabetes only for last 5 years and the mistake was rectified by the doctor who treated her. It was also submitted that he was getting reimbursement of claim since 2004 for treatment of his mother, and only claim for the year 2006 was repudiated by the insurer.

The only material relied on by the insurer in repudiating the claim is the history given in the discharge summary for the treatment done from 7.7.06 to 13.7.06 which shows that she was having diabetes for 15 years. No other material is relied on by insurer. Of course as per Cl.4.10 of policy condition pre-existing disease will not be covered under the policy. But it is not known who has given the history, the patient herself or any other person. It was also not stated that the patient was under treatment of the doctor. Such a mere statement is of no use to show that she was having diabetes mellitus for such a long period. If such an observation is in the case sheet, the matter supporting the case sheet must be produced. The claim preferred by the complainant in 2004 was admitted by the insurer. In LIC of India Vs.Joginder Kaur and Others, the National Consumer Disputes Redressal Commission has observed that an unproved case history recorded by some person on date of admission would not be a cogent and convincing evidence to repudiate the claim unless it was coupled with medical report. In Aviva Life Insurance Co.td. Vs.T.Umavathi also the National Commission has reiterated the same position. Hence claim is repudiated without any evidence. The repudiation is faulty and claim is to be admitted. An award is passed directing the insurer to pay an amount of Rs.4642/- together with an interest at 8% till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-0054-275/07-08
Sri.R.Venkiteswaran
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 21.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant has taken a medi claim policy covering his family members since 5.10.01 and has been renewing the same regularly. His son had undergone treatment from 31.3.07 to 21.4.07 from an Ayurvedic eye hospital and a claim for Rs. 22360/- was submitted to the TPA. The claim was repudiated on the ground that the treatment was taken from a private hospital.

It was submitted on behalf of insurer that mediclaim policies have undergone so many changes in 2006, and as per changed condition for Ayurveda/unani/homeopathi treatment reimbursement will be allowed only if treatment is taken from a Govt. Medical college hospital. These changes have the approval of IRDA and as such no variation is allowed from these rules. The new changes have come w.e.f. 1.10.06 and the current

policy was revived on 5.10.06 and hence they are justified in repudiating the claim. But it was submitted on behalf of the complainant that as per policy conditions issued to them such restrictions are not there and even if such a restriction are there they are not binding on them. Admittedly the obligation of insurance co. is a contractual obligation. The current policy was issued w.e.f. 5.10.06 and in an earlier occasion claim in respect of ayurvedic treatment from the same hospital was admitted by the insurer. Now the contention of the insurer is that as per the new policy condition ayurveda treatment from a Govt. medical college is only admissible. The complainant produced copy of policy document issued to her which does not contain such restrictive clause. The genuineness of copy of policy document was not disputed by the representative of insurance co. He only says that he cannot say on what date new policy condition was incorporated in the policy document. It is clear that as per policy document produced, ayurveda treatment is also covered even if it was not from a Govt. hospital. Of course the insurer might have changed their policy condition with the approval of IRDA. But that condition was not informed to the insured by incorporating in the policy. There is absolutely no document to show that such a condition was brought to the notice of insured at the time of revival on 5.10.06. Hence the complainant is eligible to get the reimbursement and insurer is directed to pay Rs.22360/- to the claimant with 8% interest.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-168/07-08
Sri.S.Rajayyan
Vs
The New India Assurance Co.Ltd.

Award Dated : 27.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant has taken medi claim insurance policy from 20.4.04 covering himself and his family members. While the policy was inforce his wife Smt.Mable has undergone treatment from 6.6.05 to 8.6.05 and from 29.9.06 to 2.10.06 and from 20.10.06 to 24.10.06. But these claims were repudiated on the ground that the treatment was for a pre-existing illness which is excluded from the purview of policy. The contention of insurance co. is that the first claim was raised for treatment of hypertension and dyslipidaemia for the period from 6.6.05 to 8.6.05. In the application for cash less service the treating doctor has certified that the illness was existing for 2 years. As the policy was commenced on 20.4.04, this illness is a pre-existing disease and hence they have rightly repudiated the claim. As no complaint was received against this repudiation they have treated the claim as abandoned. The second claim was for treatment of the same disease from 29.9.06 to 2.10.06 and 20.10.06 to 24.10.06. As the first claim is not payable the second is also not payable as both the claims were for treatment of same illness.

It was submitted by the claimant that he has not abandoned the first claim. On getting the repudiation letter dated 1.8.05 he has sent a letter on 31.8.05 along with a certificate from treating doctor Lally Alexander, to the effect that the disease is pre-existing only for one year followed by a reminder dtd.9.11.05. But no reply was received by him so far. The copy of certificate dtd.23.8.05 by treating Dr.Lally Alexander and copies of letter dt.31.8.05 and 9.11.05 were produced by the complainant. It looks that he has obtained the certificate from the treating doctor only to show that the disease was pre-existing only for 1 year as against 2 years as claimed by the insurer. Hence there is no point in the contention of the insurer that the claim is abandoned. The claim is therefore open. Also no material was produced by the insurer

to prove that the illness was pre-existing since 2 years other than a mere statement in the application for cash less benefit. Though it was signed by treating doctor, the same is not supported by any proof. On what basis this information was received is not known, who has given this statement, the patient herself or her relatives also is not known. In LIC of India Vs.Joginder Kaur. National Consumer dispute Redressal Commission has pointed out that an unproved case history recorded by some person on the date of admission would not be a convincing evidence to repudiate a claim unless it was coupled with medical report for the treatment. On the other hand in the certificate dt.23.8.05 the treating doctor has certified that the illness is pre-existing only for 1 year. As the policy is commenced on 20.4.04, the illness is not a pre-existing one and is an illness contracted after commencement of policy. Hence the contention of the insurer that the disease is a pre-existing one is faulty and the complainant is eligible to get the amount claimed. The second claim is also repudiated on the same ground of pre-existing illness. As the first illness is not a pre-existing the second is also not pre-existing and the complainant is eligible for second claim also. An award is therefore passed directing the insurer to pay both the claims amounting to Rs.15074/- with 8% interest since the date of respective claims.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-194/07-08
Sri.Reji
Vs.
United India Insurance Co. Ltd.

Award Dated : 28.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.Reji was continuously covered by Medi claim policy since 2001. While the policy was in force, he was admitted in hospital on account of Ureteric colic left/Conservative on 27.4.07. During the period of admission, on taking ultra sound scanning UVJ Calculi with obstruction and small renal calculi were detected. The claim raised for Rs.1297/- was repudiated by the insurer on the ground that the hospitalization was for a period of lessthan 24 hrs and also the nature of treatment do not warrants for inpatient treatment. In the bill earlier time of admission was noted as 12 p.m. which was later changed to 12 a.m. only to make duration of hospital stay more than 24 hrs.

The claim was repudiated by the insurer on two grounds. The period of hospitalization is less than 24 hrs and also the treatment can be imparted as an out patient and no inpatient treatment was required. All tests conducted for diagnostic purpose and hence the amount spent for diagnostic tests are not reimbursable. The contention of complainant is that he was brought to hospital on 26.4.07 at midnight and was discharged at 10 a.m. on 28.4.07 and he was there in hospital about 34 hrs.

The discharge summary shows that he was admitted on 27.4.07 at 12 a.m. and was discharged on 28.4.07 at 10 a.m. The test report of haemotology and biochemistry shows that the test was conducted on 27.4.07 at 7.25 hrs. It also shows that at the time of test he was admitted in bed no.108 of ward AB. Hence it is evident that he was admitted sometimes before 7.25 on 27.4.07. The certificate of Manager of hospital also shows that Sri.Reji was admitted at the early morning of 27.4.07. The time of chart opening at Causality is clearly shown in the bill as 00:16:42 on 27.4.07. There is no dispute to the fact that he was discharged at 10 a.m. on 28.4.07. At the time of hearing the representative of insurer also admitted that he was in the hospital for more than 24 hrs. Hence the contention of insurer that the period of hospitalization is less that 24

hrs is not standing. The other contention of the insurer is that hospitalization was primarily for investigation and there is no active line of treatment which warrants hospitalization. The complainant had submitted that he was brought to hospital at midnight on 26.4.07 and on reaching there IV fluid was administered. The fact that IV fluid was administered was not disputed by the insurer in the self contained note. IV fluid cannot be administered without admission as an inpatient. Hence the contention of insurer that hospitalization was not necessary also is not standing. Also there is no case that X-ray and lab examinations and diagnostic studies were not consistent with the ailment for which treatment was given. From the above discussion it is clear that the repudiation is faulty and the complainant is eligible to get reimbursement of the amount spent for treatment. An award is passed directing the insurer to pay an amount of Rs.1297/- with interest 8% till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-004-253/2007-08
Sri.P.P.Vincent
Vs
United India Insurance Co. Ltd.

Award Dated : 30.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant has taken a policy which covers himself and his family members. His son Mr.Ervin Vincent was admitted in K G Hospital on 24.5.06 and was treated for infected Umbilical Sinus. The claim was repudiated on the ground that the treatment was for umbilical sepsis due to infected umbilical sinus which is a congenital disease. It was submitted by the complainant that the treatment was not for umbilical sinus but for umbilical sepsis and sepsis is not a congenital disease and hence he is eligible fore reimbursement. It was argued on behalf of insurer that though the treatment was for umbilical sepsis, the sepsis had developed from umbilical sinus which is a congenital disease. As per policy condition clause 4.8 congenital disease is exempted form the purview of policy and hence they have rightly repudiated the claim.

The claim was repudiated on the ground that the treatment will come under the specific exclusion clause mentioned in the policy. Medical certificate has been produced; where diagnosis made was shown as “umbilical sepsis infected umbilical sinus”. The treatment given was stated as “Excision of sinus”. From the discharge summary it is clear that he was admitted with pain and swelling and discharge from umbilical sinus and swelling of umbilical sinus and treatment was given was excision of sinus. Hence it is clear that though the treatment started only after the development of sepsis the ailment was due to umbilical sinus and the actual operation was excision of sinus to avert sepsis. Sepsis can be permanently averted only by the excision of sinus. The cause of sepsis was sinus itself. As the policy condition is very specific that all congenital disease are excluded from policy, the decision of insurer to repudiate the claim is correct and complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-008-239/2007-08
Sri.K.Sasikumar
Vs
Royal Sundaram Alliance Ins. Co. Ltd.

Award Dated : 11.12.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.Sasikumar was issued with a Hospital Cash Insurance Policy w.e.f. 11.8.06, while the policy was in force he had developed some stomach complaints which is diagnosed as Carcinoma Ascending colon Stage IV and undergone 5 course of chemotherapy by admission in the hospital. The claim was repudiated on the ground that the treatment was for a pre-existing illness. It was submitted by the insurer that chemotherapy was taken for carcinoma ascending colon which was in IVth stage. As per American Medical "Bailey & Love's"24th edition" it usually takes 18 months to 2 years to spread the cancer covering the entire circumference of the colon. According to American Cancer Society usually it takes 10 to 15 years for the development of abnormal cells to grow into colorectal cancer. As the policy was taken only 9 months, the treatment is for a pre-existing disease and as per policy condition all pre-existing disease whether it was known to the patient or not is not covered under the policy.

In this case the petitioner's definite case is that at the time of taking policy he had no symptoms at all. The symptoms arose only in May 2007. Policy commenced in August 2006 and hence the symptoms were manifested only after 9 months of taking policy and hence the disease is not pre-existing.

The decision of insurer in repudiating the claim is mainly based on the opinion of their panel doctor. His report says that in the detailed guide on colorectal cancer American Cancer Society says that from the time of the first occurance of abnormal cells it usually takes to 10 to 15 years for them to develop in to colorectal cancer. Also as per Bailey & Love's Surgery book it takes usually 18 to 24 months for the entire circumference to be involved. But it is relevant to note that the spread time stated as not accurately or certainly, but as usually. There are several types of cancer. Some may be acute, some may be chronic. The period of spread is mentioned by way of generalization and not as a definite duration. In order to arrive at a conclusion they only relied upon the opinion of their panel doctor who has not seen or treated the patient and also they have not taken any evidence from the treating doctor. The hospital report itself says that symptoms had developed only one month before the diagnosis, i.e., only after 9 months of taking policy. Also what is stated in the guide mentioned above is relating to cancer in rectosigmoid junction. Here cancer is not at rectum or sigmoid colon but only on ascending colon. Hence the insurer has failed to prove convincingly that the treatment was taken for a pre-existing illness. As per policy condition he is eligible for Rs.1500/- for each 24 hrs of hospital confinement. The patient was admitted in the hospital for a total of 14 days for 5 course of chemotherapy and he is eligible for a reimbursement of Rs.21000/- . An award is passed directing the insurer to pay Rs.21000/- along with interest @ 9%.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-138/2007-08
Sri.Raveendran Nair M.K.
Vs
National Insurance Co. Ltd.

Award Dated : 28.12.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant is the holder of medi claim policy issued on 25.8.06 through Bank of Baroda under Baroda Health Scheme covering himself and his family members. While the policy was in force his son was admitted to hospital. The claim was not settled so far instead they sent letters one after another asking to submit some documents or

other. Later an amount of Rs.4383/- was allowed out of the claimed amount of Rs.9832.20. The Manager of the insurance company, who appeared for hearing, submitted that there is no dispute regarding the bill amount and underwriting office has already been issued instruction to honour the claim and they have no objection in passing an award for the balance amount. In the result an award is passed directing the insurer to pay a sum of Rs.9832.20 together with interest at 8% till payment. Rs.4383/- paid by cheque on 3.8.07 is credited towards the award amount on that day.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-307/2007-08
Sri.Augustine Roy
Vs
United India Insurance Co. Ltd.

Award Dated : 10.01.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant had insured himself and his family members under Universal Health Insurance Policy through a Charitable Institution, Win Centre, Eramallur for the period from 14.9.06 to 13.9.07. During the coverage of policy he preferred 3 claims for hospitalization of his father in 3 different hospitals for the same disease. The claim was repudiated on the ground that the illness was pre-existing. It was submitted by the claimant that the illness was not a pre-existing one and they came to know about the illness only when the patient was admitted in Jishy Hospital on 29.1.07.

The repudiation was made only on the ground that the disease was a pre-existing one. The patient was admitted in 3 different hospital in quick succession for the same illness. He was first admitted in Jishy Hospital from 29.1.07 to 1.2.07, at Lourde Hospital from 6.2.07 to 9.2.07 and at Lisie Hospital from 9.2.07 to 13.2.07. From the above it is clear that there was a continuous treatment. The final diagnosis was Coronary Artery disease. In the clinical history provided from Jishy Hospital it was stated that “complaint of chest pain radiating to left upper limb – 1 day”. “History of similar symptom since one year”. On the basis of that it was taken that the patient had a CAD for one year. But what is stated is that chest pain radiating to left upper limb is only for one day. History of similar symptom is for one year. But it is to be noted that all chest pain need not be due to heart disease. Other evidence relied on by insurer is the opinion of a medical practitioner, who opined after verifying all the reports that “it is an old case slowly occurring one and taken 2-3 years to manifest. The illness can be existed prior to the commencement of policy. The smoking and alcohol intake helps to worsen the condition”. Here also the doctor has opined that it can be (may be) a pre-existing one. But it is to be noted that the opinion of the doctor who had an opportunity to assess the ailment has not been sought as to the age of illness. Hence it is doubtful whether the illness was pre-existing. If at all it is a pre-existing one there is no evidence to show that the patient was aware of it and he has taken any treatment for the same. Of course CAD may be a slowly developing one, but when it has ripened into a disease also is doubtful. The material relied on by the insurer in repudiating the claim is not sufficient enough to say that it was pre-existing disease. The complainant is eligible to get he benefit under the policy and insurer is directed to pay Rs.9597/- along with interest at 8% since date of claim till payment.

Kochi Ombudsman Centre

Case No. : IO/KCH/GI/11-002-342/2007-08
Sri.V.M.Joseph
Vs
New India Assurance Co. Ltd.

Award Dated : 11.01.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant and his family members were covered under Medi claim policy for the period 22.9.06 to 21.9.07. On 21.5.07, the complainant Sri.Antony Jose was hospitalized for severe back pain and neck pain. The claim was repudiated on the ground that there was no active line of treatment which requires admission at hospital and also whether the period of hospitalization is for morethan 24 hours could not be ascertained.

The repudiation was on two grounds. As the time of admission and discharge was not available in the discharge summary it was not possible to ascertain whether there was 24 hours hospitalization. There was no active line of treatment. Hospitalization was only for diagnostic purpose and only some oral analgesics were given at hospital which could have done on an OP basis. As this is a specific exclusion, as per policy condition, the insurer repudiated the claim. The complainant's case is that his son was admitted at Cochin Hospital for severe back pain. On taking MRI scan, the advice was only surgery or traction for six months. On referring to Neurologist, Neurologist also recommended the same line of treatment. As they are not prepared for a surgery, some pain killer was prescribed for temporary relief which they have not purchased. Hence it looks that though he was admitted in the hospital there was no active line of treatment. The admission was only for diagnostic purpose. As the policy condition is very specific about its exclusion clause the insurer is justified in repudiating the claim. The complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-321/2007-08
Sri.Thomas Varughese K
Vs.
New India Assurance Co. Ltd.

Award Dated : 16.01.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant an employee of LIC is covered by Group Mediclaim policy along with his family members for a sum assured of Rs.80,000/-. While the policy was inforce his wife was admitted in the hospital for treatment of Sleep Apnoea. While settling the claim the cost of CPAP machine was disallowed on the ground that it was not covered under the scope of policy. Aggrieved by this the complainant approached the Forum. It was submitted by the complainant that in a similar case Consumer Forum have held that cost of CPAP is payable. Also as per policy condition cost of pacemaker, artificial limb, etc are covered under the policy. As CPAP is a life saving machine he is eligible for reimbursement.

The contention of insurer in repudiating the claim is that CPAP is a Permanent machine and it will not come under any of the items (a) to (d) of policy schedule, where reimbursement is allowed. As per policy condition only cost of items such as artificial limbs, pacemaker, etc which are exclusively used and expended for the person concerned, are eligible for reimbursement. It is to be noted that a pacemaker is permanently fixed to the body. Artificial limbs cannot be used by other persons. These are meant exclusively for the person concerned, permanently fixed to their body. But as far as CPAP machine is concerned it is not permanently fixed to the body. It is only a machine to augment breath during sleep. A machine, which can be used by number

of persons. As the cost of CPAP machine is not specifically mentioned as being reimbursable, the cost of CPAP machine will not come under the purview of policy. Hence the complaint is unsustainable and therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-289/2007-08
Sri.M.Sudevan
Vs
United India Insurance Co. Ltd.

Award Dated : 23.01.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.M.Sudevan had taken a medi claim policy for a sum of Rs.15000/- in 2003. At the time of revival the sum was enhanced to Rs.one lakh restricting coverage for pre-existing disease to Rs.15000/-. He was hospitalized from 22.2.07 to 27.2.07. The claim was allowed only for Rs.15000/- and the balance amount was disallowed on the ground that the treatment was for a pre-existing disease.

But it was submitted by the complainant that the treatment taken was for liver cirrhosis that too which was not a pre-existing one. Also he was not told of the restriction of Rs.15000/- for the existing disease. However, the insurer has produced a letter submitted by the complainant to the insurer that he is willing to renew the policy subject to the condition that the claim for pre-existing diseases will be restricted to Rs.15000/-. Now the question is to decide whether the treatment was for a pre-existing disease. The pre-existing disease as per policy condition are (1) CAD (2) Diabetes and (3) Hypertension. As per hospital records diagnosis was for 6 ailments 1) CAD 2) S/P CABG in 2004 3) Type II diabetes 4) Dyslipidemia 5) Cirrhosis of liver and 5) Mild protatomegaly. Hence it is clear that apart from pre-existing diseases Liver cirrhosis and Mild protatomegaly was also diagnosed. A number of medicines were prescribed at the time of discharge. Under the caption course in the hospital it states that medical Gastroenterelogy consultation was done for esophageal varices and EVL done. Hence it is clear that on diagnosing liver complaint active treatment were given. Hence it is clear that treatment was taken for disease other than pre-existing diseases. On a scrutiny of bills submitted it can be seen that an amount of morethan Rs.10,000/- rupees were spent for treatment of Liver cirrhosis. Hence the partial repudiation is faulty and insurer is directed to pay the balance amount of Rs. 6410/- together with an interest of 8% since date of payment along with a cost of Rs.500/-.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-286/2007-08
Smt.Mallika Rajan
Vs
United India Insurance Co.Ltd.

Award Dated : 24.01.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant is having medi claim insurance with United India Insurance Co. since 2000. While the policy was in force, the complainant sustained a stroke which was treated at Vijaya Hospital from 10.11.06 to 15.11.06 and also at Santhigiri Ayurveda Hospital from 17.11.06 to 4.12.06. The claim was repudiated on the ground that the illness was due to a pre-existing disease.

The claim was repudiated as some data discrepancy was noted in hospital records. In the discharge card of Santhigiri Ayurveda Hospital it was mentioned that the insured was a known case of Hypertension since 10 years. The representative of TPA discussed with the treating doctor at Vijaya Hospital who also confirmed that she was hypertensive. Based on these details claim was repudiated as hypertension is a contributive factor for stroke. The contention of the complainant is that in the discharge summary history of hypertension is wrongly mentioned as 10 years instead of 10 days which was later rectified. It was submitted on behalf of the insurer that the history of hypertension was corrected in order to mislead the insurance co. The complainant was directed to obtain and produce copy of case sheet. Copy of case sheet was produced where it was shown in the column present complaint and history “sudden onset”. No where it was shown that the patient was a hypertensive for 10 years. Though the doctor of Vijaya Hospital has stated that the patient was hypertensive he has not given any history of illness whether it was existing for 10 years or 10 days. The insurer was not able to substantiate with valid proof that the treatment was taken for a pre-existing disease. An award is therefore passed directing the insurance co. to settle the claim of Rs.29641/- with 8% interest till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-385/2007-08
Sri.P.P.Thomas
Vs
United India Insurance Co. Ltd.

Award Dated : 06.02.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant was having a medi claim policy along with his wife Smt.Annie Thomas for the last six years for a sum insured of Rs.125000/- each. While renewing the policy he was eligible for a cumulative bonus at 30% on each life. He has also requested for an increase in sum assured by Rs.25000/- on his own life. However the renewed policy was issued for a SA of 1.75 lakhs and 1.5 lakhs that too with an enhanced premium by Rs.1083/-. He has sustained a loss of Rs.12500/- each in S.A. and also Rs.84/- each in premium payment. Aggrieved by this he approached this Forum for justice.

The contention of insurance co. is that due to heavy loss in medi claim insurance so many changes were effected in mediclaim insurance and also premium h as been considerably increased. The S.A. has been fixed as multiples of Rs.25000/- only. In the present case the complainant is eligible for a sum assured of Rs.162500/- each under the old scheme by payment of premium for a sum assured of Rs.125000/-. But under the new scheme there is no slab for a sum assured of Rs.162500/- and hence new sum assured was fixed as Rs.150000/- each. It was also submitted that instead of allowing bonus by way of increase in sum assured the system of no-claim discount in premium was introduced. In order to mitigate the problems of policy holders it has been permitted to fix the sum assured at the next higher level.

In the self contained note it was conceded by the insurer that the complainant is eligible for a S.A. of Rs.162500/- each on payment of premium for Rs.125000/-. As there is no S.A. slabs for Rs.162500/- the new S.A. is to be fitted as Rs.175000/- each. Hence the complainant is eligible for a sum assured of Rs.175000/- each on payment of premium for a sum assured of Rs.125000/- and also premium for Rs.12500/- on each life. It was also conceded that premium for SA of Rs.125000/- is Rs.6578/- Rs.150000/- is Rs.6661/- and SA of Rs.175000/- is Rs.7661/-. Hence by interpolation premium for

Rs.12500/- will come to Rs.500/- only. Hence the complainant is eligible for a SA of Rs.17500/- each on payment of premium of Rs.6578/- + Rs.500/- i.e., Rs.7078/- -actual premium collected is Rs.7245/-. Hence balance Rs.167/- is to be refunded. An award is therefore passed directing the insurer to issue a policy covering the SA of Rs.175000/- each for complainant and his wife at a premium of Rs.7078/- and to refund Rs.167/- as excess collection made along with a cost of Rs.1000/-.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-308/2007-08
Sri.C.O.George
Vs
National Insurance Co. Ltd.

Award Dated : 07.02.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant was covered under the medi claim insurance policy for a sum assured of Rs.30000/- from 22.3.06 to 21.3.07. On 29.12.06 he was admitted at Elite Mission Hospital with a history of Hit of (L) knee joint while playing football and ACL Tear (L) knee and was discharged on 31.12.06 advising exercise and knee cap wearing. The claim was repudiated on the ground that the treatment was that of an OPD nature and he was admitted in hospital only for diagnostic purpose which is a specific exclusion as per policy condition.

The complainant had claimed an amount of Rs.5970/- towards hospital charges out of which Rs.5500/- is for MRI knee, Rent Rs.210/- admission fee Rs.20/-, consultation fee Rs.140/-, nursing charges Rs.90/- and hospital charges Rs.10/-. From the bill submitted it looks that there was no active line of treatment from hospital. No medicine has given or treatment has taken. The hospital records also certify this. The discharge card also shows that he was advised on discharge some exercise and wearing knee cap. No medicines were prescribed. Hence it is clear that he was admitted in the hospital only for diagnostic purpose and no active line of treatment was given. The exclusion cl.4.10 of policy condition is very specific that such diagnostic charges are not covered by the policy. The claim is unsustainable and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-338/2007-08
Sri.C.L.Davies
Vs
United India Insurance Co. Ltd.

Award Dated : 07.02.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant is covered under Mediguard policy which commenced on 16.6.06. During the currency of policy he was admitted in hospital from 24.11.06 to 30.11.06 for treatment of CAD. The claim for Rs.10982/- was repudiated on the ground that the illness was pre-existing and hence they are not liable to make any payment for treatment of CAD. The investigation conducted by the insurance co. reveals that the complainant on 6.1.06 consulted a Cardiologist Dr.Rajesh of AIMS and had taken medicine prescribed by Dr.Rajesh. The Insurance co. has referred the entire case file to Dr.Satheesh for an expert medical opinion, who opined that the case was not a very

light one and the illness might have been in existence at the time of taking policy. On the basis of this they arrived at a conclusion that the illness was a pre-existing one and the claim was repudiated accordingly.

It was submitted by the complainant that he never had any heart ailments before taking policy. He was first admitted on account of heart diseases only on 24.11.06 as a patient of Cardiologist Dr.G.Rajesh . On 6.1.06 he was admitted in the hospital in connection with a Road Traffic Accident and he has consulted only in orthopaedic department. As a part of these check up the Cardiologyst might have examined him, but he have not taken any medicine as presented by a cardiologist.

The decision of the insurer in repudiating the claim is mainly based on the fact that he has consulted Dr.Rajesh a Cardiologist on 6.1.06, about five months before taking policy. They have also produced an OP card bearing No.604467. But the same OP No. is also shown in the hospital report for treatment following RTA. The hospital records very clearly shows that on 6.1.06 he was treated in the hospital following a road traffic accident only. He was given TT, injection, suturing done and was also admitted in W.No.30 of Dr.Shamsudeen of Orthopaedic dept. During that treatment he might have consulted a Cardiologist. But as per hospital records no medicines seems to have prescribed by the Cardiologist. The Cardiologist gave an impression as Negative- on stress test for reversible Ischemia. Hence the documents produced by the insurer is of no use to suspect that he had CAD before taking policy.

At the time of hearing the complainant has submitted that he used to conduct general check up frequently as he is residing very near to AIMS and the charges for whole body check up is only Rs. 1500/-. He has undergone such a check up on 31.5.06. In the questionnaire as against the query main complaints it was mentioned that “No complaints”. If he had any complaints or chest pain he would have definitely mentioned here, as the check up was done on a date prior to taking policy. This also shows that he had gone for a general check up only and was not having any complaints on that day. The results of the check up from various depts. also certify that he was not having any heart problem and also no medicines were prescribed following the check up. Hence it is very clear that the assumption made by the insurer that the illness was a pre-existing one is faulty and the repudiation is therefore set aside. The insurer is directed to pay the amount of Rs.10982/- with 8% interest till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-312/2007-08
Smt.C.P.Narmada Raj
Vs
National Insurance Co. Ltd.

Award Dated : 21.02.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant’s husband Sri.Rajendran Pillai K was a member of Road Safety club Pvt. Ltd. The club had taken a personal accident policy for its members from National Insurance Co.Ltd. covering the period from 16.7.05 to 15.7.06. On 22.6.06 Sri.Rajendran Pillai died on a road accident and as per policy condition the complainant is eligible to get Rs. 2 lakhs, being the insurance amount. Thought he claim was preferred on 23.6.06 it was not settled so far. Aggrieved by this the complainant, nominee under the policy approached this Forum for justice.

On 12.2.08 a letter dated 5.2.08 issued by Divisional Office of insurer was received in this office stating that they have received settlement note and the claim will be settled

shortly. The Manager who appeared on behalf of insurance co. for hearing submitted that the discharge voucher was already issued and they will make payment on getting duly signed discharge form. The amount claimed is Rs.2 lakhs and there is no dispute to that. But it is to be noted that the claim was lodged on 23.6.06 and the amount ought to have been given within one month. Hence an award is passed directing the insurer to pay an amount of Rs.2 lakhs with 8% interest p.a. since 1.8.06 and a cost of Rs.1000/-.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-390/2007-08
Sri.Santhosh C U
Vs.
New India Assurance Co. Ltd.

Award Dated : 04.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.Santhosh and his wife Anjana Santhosh were covered by a medi claim policy issued by New India Assurance Co.Ltd. During the currency of policy Smt.Anjana Santhosh was hospitalized from 12.1.07 to 21.3.07 at Assissi Holistic and Research Centre and treated for varicose ulcer. The claim was repudiated by the insurer. Aggrieved by this Sri.Santhosh approached this Forum.

The claim was repudiated on the ground that the nature of treatment imparted does not warrant hospitalization and also that the treatment protocol is of the one not covered by the policy and the hospital from where treatment was taken does not come under a hospital defined as per policy conditions. The doctor is not a qualified doctor. It was submitted by the insurer that the hospital was not a registered hospital and it was registered only under Literary Scientific and Charitable Societies Act 1955. The Director of the Institute is having her doctorate in Alternative Medicine only. The treatment protocol is a special type of treatment called Jivadhara, a new holistic medical system which is a combination of Acupuncture and Electropathy which includes prayer therapy also.

Policy condition cl.2.1 defines hospital or nursing home which states that the institution need not be registered under local authorities when conditions as per Cl.(b) are satisfied. Here there is no case that condition as per cl.(b) is not satisfied. The only contention is that the hospital is not registered under local authority. As the hospital is having facility for treatment of 100 patients, the registration is not required as per conditions laid down by Cl.(b). Hence this contention of insurer is not tenable. Another contention is that the doctor is not having the required qualification as defined by the policy condition. But it is to be noted that the policy condition only says that the person must hold a degree or diploma of a recognized institution and is registered by Medical council of respective state. Here the doctor who treated the patient is an MD PhD. She is having a degree in Alternative medicine and also she has registration of Medical Council, registration no. being 5451. Hence there is no point in the contention of the insurer that the patient was treated by a doctor who has no sufficient qualification as per policy condition. The type of treatment given to patient was a combination of Acupuncture and Electropathy. Physiotherapy also was employed. This system of treatment was also not excluded as per condition. Hence the decision of insurer in repudiating the claim is faulty and insurer is directed to settle the claim for Rs.17621/- with 8% interest till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-379/2007-08
Sri.K.V.Satheesan
Vs
New India Assurance Co. Ltd.

Award Dated : 11.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant and his family are covered by a medi claim policy for the period from 8.7.07 to 7.7.08. On 4.8.07 the complainant's wife Sobha had fallen down in the bathroom and sustained some injuries. She was admitted in a hospital on 7.8.07 and was discharged on 8.8.07. The claim for Rs.3684/- was repudiated on the ground that the nature of illness and treatment given do not warrant hospitalization. It was submitted by the insurer that out of a bill of Rs.3684/- only Rs.54/- was spent for medicines and the balance amount was spent for X-ray, CT scan, room rent, etc. Soon after conducting such tests she was discharged. Though the accident occurred on 4.8.07 she was taken to hospital only in the evening of 7.8.07 and after taking X-ray and scanning on the next day she was discharged. From the hospital reports submitted it looks that she was admitted in the hospital only for conducting tests such as X-ray and scanning. Soon after getting the reports of the tests she was discharged. Only a meager amount of Rs.54/- was spent for medicine. No active line of treatment was given from the hospital. These tests could very well be taken as an out patient. Also all the test reports are normal. As per policy condition hospitalization merely for diagnostic purpose are not covered by the policy. As the hospitalization was only for diagnostic purpose the repudiation action can be justified and is to be upheld. The complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-287/2007-08
Sri.K.A.Thomas
Vs
United India Insurance Co. Ltd.

Award Dated : 13.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant was issued with a medi claim policy w.e.f. 17.2.06 covering himself and his family members. In the complaint it is stated that his wife Smt.Clara Thomas was admitted and treated at Kasturba Medical College, Manipal for treatment of cancer. But the claim was repudiated by the insurer on the ground that the illness was preexisting. In the discharge summary it was shown that the patient was having pain in abdomen since 1 ½ years and also vomiting since 3 months. The investigating officer also reported that the patient was already under treatment at Mercy Hospital, Payyannur and Pariyaram Medical College. These are the evidence based on which the claim was repudiated. But it was submitted by the complainant that the cancer was detected only in Aug.06 and her earlier treatments were for hypertension and cardiac disease. At the time of taking policy the insured was not a cancer patient.

The claim was made in respect of expenses incurred for treatment and surgery of cancer in stomach from 14.9.06 to 5.10.06. It looks that before that she had taken treatment at Kasturba Medical College, Manipal from 8.2.05 to1 12.2.05 at the ENT Dept. and from 23.8.06 to 8.9.06 at Cardiology Dept. Hospital records shows that she was treated for DM, Sinusitis and Hypertension and not for cancer. Detailed check up was done at that time. If she had any such complaint in stomach at that time it would

have been disclosed to the doctor and it would have been diagnosed. But there is nothing in the reports suggesting that she had stomach pain at that time. Hence it is clear that cancer was developed only after 8.2.05. The next admission was on 14.9.06. Hospital reports shows that CT scan was taken and she was found to have Gastro instinstinal stranal tumour and surgery was advised. Hence it is clear that CT scan was done and tumour was found only sometime in Agu.06. Hospital records also show that she was having abdominal pain for around 1 ½ years with vomiting for 3 months. This is only a general statement. Even if it is accepted vomiting had developed only since Jun 2006. Pain may occur due to various reasons. Hence it can very well be assured that at the time of taking policy the insured was not aware that she was having such an ailment. As the insurer failed to prove with clinching evidence that the illness was a pre-existing one the repudiation is set aside and an award is passed directing the insurer to pay the sum of Rs.50000/- with 8% interest till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-008-391/2007-08
Sri.Peethambaran T
Vs
Royal Sundaram Alliance Insurance Co.Ltd.

Award Dated : 18.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.T Peethambaran and his wife were insured by Medi Safe Insurance Policy of Royal Sundaram Alliance Ins.Co.Ltd. During the currency of policy he was admitted at PVS Hospital, Kozhikode for Disc prolapse and his claim for reimbursement of hospital expenses was repudiated by the insurance co.

The repudiation was made only on two grounds. As per disclaimer clause, any complaint against repudiation must be lodged within 3 months of repudiation and also there was no active line of treatment from the hospital, which require hospitalization. The hospitalization was only for investigation and the treatment imparted can be done on an OP basis. The complaint was made before Ombudsman after one year from date of repudiation. The complaint is not therefore entertainable as per RPG Rules also. They are justified in repudiating the claim as per RPG Rules and as per policy conditions.

As per policy condition it looks that complaints has to be made within 3 months of repudiation. The claim was first repudiated on 25.7.06 by the underwriting office. A representation made against by this was turned down by letter dated 5.10.06. As against repudiation an appeal was preferred on 18.10.07. The Grievance Cell reviewed the same on merit and confirmed repudiation on 3.11.07. It being an appellate forum no period of limitation is prescribed for preferring an appeal. The appellate forum repudiated the claim after examining its merit and not because the complaint was made after 3 months. Hence the repudiation made on 3.11.07 is to be treated as final repudiation. As the complaint was lodged before Ombudsman in Dec.07, the contention of insurance co. that the complaint is time barred as per policy condition and RPG Rules is not standing. Another contention of insurer is that there was no active line of treatment and all the treatment imparted can be done on an OP basis. The discharge summary shows that he was discharged with a direction to remain always in bed for 7 days. He was also put on traction for 3 days on advice of a specialist who was former professor and Head of Dept. of Orthopaediac, Medical College Hospital, Kozhikode. For a person who was directed to keep on bed for 7 days after discharge and that too

after traction for 3 days, we cannot say that there was no active line of treatment and treatment can be done on an OP basis. The repudiation is therefore not sustainable and insurance co. is directed to pay the hospital bill of Rs.7647/- with 9% interest and cost of Rs.1000/-.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-008-386/2007-08
Sri.Lalan G P
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 18.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant is having a Medi safe insurance policy covering himself and his family for the period from 18.8.07 to 17.8.08. On 25.9.07 he was admitted in hospital following a fall on the ground. The claim was repudiated on the ground that the nature of treatment was such that it could have been taken as an OP. The contention of insurer is that the treatment is not covered under the policy as it falls under exclusion clause. There was no active line of treatment except the conservative treatment of bed rest with ordinary drugs and this could have been done on an OP basis. The hospital records produced show that he was diagnosed to have Sacroiliac strain and treated conservatively by bed rest and Analgesic Anti Inflammatory drugs. He was discharged with advice to continue further treatment on OP basis. X-ray taken also shows no serious ailments. It look that there was no special treatment except giving some pain killers and anti inflammatory drugs and the treatment come under exclusion clause. The repudiation made is correct and is to be upheld.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-348/2007-08
Sri.K.T.Joseph
Vs
National Insurance Co. Ltd.

Award Dated : 24.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant Sri.K.T.Joseph has taken a medi claim policy from National Insurance Co.Ltd. while the policy was inforce he was admitted and treated for Lumbar Spondilysis at Medical Trust Hosptial, Ernakulam from 19.1.07 to 24.1.07. The claim was repudiated on the ground that there was no active line of treatment which requires hospitalization. His appeal before Grievance Cell produced no result and as such he approached this Forum for justice. By this time insurance co. admitted the claim and paid an amount of Rs.10618/- by cheque dated 29.2.08 deducting an amount of Rs.989/- as if the amount was spent for a preexisting disease, diabetes mellitus.

The complainant was having the policy right from 16.3.99 and it was renewed continuously. However it was submitted by the insurer that there was a break in renewing the policy in 2003 and they also produced copy of proposal form dated 14.3.03 collected at the time of renewal. The premium receipt produced also shows that there was break of 1 day in renewing the policy and hence the policy issued on 17.3.03 is to be treated as a new policy only. The patient was admitted in hospital on 19.1.07. The hospital records produced shows that the insured had a history of DM for last 5 years. As the policy was commenced only on 17.3.03, diabetes mellitus is a pre-existing disease and the recovery of Rs.989/- towards treatment of DM is in order.

However it is to be noted that he was admitted in hospital on 19.1.07 and claim application has submitted on 10.2.07 with all required documents. But the payment was made only on 6.3.08 that too after prolonged follow up. Hence an award is passed directing the insurer to pay an interest @ 9% on the sum of Rs.10619/- from date of complaint till 6.3.08 with a cost of Rs. 500/-.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-360/2007-08
Sri.Reji P Thomas
Vs
United India Insurance Co. Ltd.

Award Dated : 28.03.2008

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant and his family members were covered by a medi claim insurance policy. During the currency of policy he was admitted in hospital on 13.6.07 for some ayurvedic treatment. Aggrieved by the rejection of claim by the insurer he approached this Forum for justice. The main contention of insurer in repudiation of claim is that the nature of treatment do not require any hospitalization. During his stay in hospital he was treated only with some oil massage which could have been done on an OP basis. The insured had a history of some ailment for which he had taken treatment from a hospital within a couple of months of the inception of policy. But no claim was raised for this treatment. As the treatment was taken as a follow up treatment the ailment might have developed before taking policy and hence this is a preexisting illness. As treatment particulars of hospital treatment done in 2006 were not produced, time was given upto 28.3.08 to produce treatment particulars. The records produce shows that no treatment was taken prior to 2006. By the mere fact that the claim was not preferred, it cannot be taken as preexisting disease. Another ground of repudiation is that the patient was given only some oil massage which would have been taken on an OP basis. But the hospital records produced shows that it was not mere application of oils. Navara and herbs were applied by way of massage using decaution of Kurunthotty and Amukkuram. It is a specialized treatment. It is an established fact that during such treatment the body will become tender. Hence it cannot be done on an OP basis. The repudiation of claim on this ground is unsustainable and has to be reversed. An award is passed directing the insurer to pay the claim amount of Rs.12250/- with 8% interest.

Kolkatta Ombudsman Centre
Case No. 015/11/004/NL/04/2007-2008
Smt. Sutapa Roy Barman
Vs.
United India Insurance Co. Ltd.

Award Dated : 15.12. 2007

Facts & Submissions :

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

The petitioner, Smt. Sutapa Roy Barman stated that she took a Mediclaim Insurance Policy from United India Insurance Co. Ltd. in continuity of her previous insurance since 05.05.2001 in respect of Sri Mani Bhusan Barman Ray, her father and Smt. Gita Barman Ray, mother. Before that Shri Mani Bhusan Barman Ray was covered under a Mediclaim Policy of National Insurance Co. Ltd., Division – XVIII, Kolkata for the period 05.07.2000 to 04.05.2001 and prior to that from 05.05.1997 to 05.05.2000 Shri Mani

Bhusan Barman Ray was covered under a Group Mediclaim Policy of the same Division of National Insurance Co. Ltd. The complainant's father had a feeling of sickness for which he took advice from house physician, Dr. Pannalal Saha because the patient was under his treatment since 2004. After his visit to Dr. Saha, he was advised by the doctor for admission in Apex General Hospital. Accordingly, he was admitted in the hospital on 08.06.2005. After necessary treatment he was discharged from the hospital on 10.06.2005.

In the Discharge Summary the patient was advised to take Nephrological consultation and therefore, the patient consulted Dr. A. R. Nandy. After discharge from the hospital on 20.06.2005 and after completion of the treatment, the complainant submitted a claim with all necessary documents to the insurance company's TPA M/s. Medicare TPA Services (I) Pvt. Ltd. for payment of claim.

The TPA on receipt of the claim documents issued several letters to the petitioner stating therein the reasons for repudiation of the claim. The rejection of her claim by the TPA was mainly on the following two reasons:-

a) The patient stated to the Dr.A. R. Nandy, Nephrologist, the first attending physician, that he was having HTN since 1998, i.e. disease was pre-existing;

b) As per documents of United India Insurance Co. Ltd. the Mediclaim coverage started from May 2001 and there was no coverage prior to May 2001.

The petitioner represented to the insurance company against repudiation of the claim contending that the patient was covered under insurance policy for a long time since 1997, the cause of repudiation of the claim due to the reasons that there was no coverage prior to May 2001 was not tenable. Moreover, the cataract claim with respect to the Insured Patient was paid by the insurance company in 2003. Regarding prescription of Dr. A. R. Nandy with respect to hypertension for 7 years and Nephropathy which was diagnosed as Hypertensive Nephropathy, the complainant stated that her father was suffering from hypertension for last one year (as per prescription of Dr. Pannalal Saha dt.07.06.2005) but Dr. A. R. Nandy in his prescription dt.20.06.2005 had wrongly mentioned it as 7 years and in support of it the petitioner also submitted a certificate of Dr. P. L. Saha while submitting her representation to the insurance company. As the insurance company did not consider payment of the claim, the petitioner submitted her petition for relief without mentioning any quantum in the 'P' form..

The insurance company submitted their self-contained note dt.21.09.2007 wherein they stated that the instant claim had been repudiated by their TPA M/s. Medicare TPA Services (I) Pvt. Ltd. vide letter dt.28.09.2005 and dt.19.09.2007 as the disease was existed prior to inception of the policy. The insured had responded that they had earlier policy with National Insurance Co Ltd. from the day prior to the inception of the disease. Accordingly, the TPA had requested the insured to provide details of the previous policy as well as the claim history duly certified by the previous Insurer. But the Insured failed to do so. The insurance company once again confirmed that if the Insured could provide satisfactory evidence duly certified by the previous insurance company that the cover was in existence prior to the existence of the disease; the insurance company would consider the claim.

In absence of any such record the insurance company had to deny their liability as per policy exclusion clause no.4.1 as pre-existing disease.

The insurance company also stated that as per their internal guidelines they were unable to accept the contention of the complainant with regard to the declaration given

in the doctor's prescription for existence of the disease for last 7 years was wrong, as they considered it as an after thought i.e. after rejection of the claim.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. The complainant stated that though she had given the proof for existence of the policies from 5.5.1999, still her father was actually covered even before that period by the Society which took master policy for all the employees.

Keeping this in view and also keeping in mind that there was a proof of existence of the policy from 5.5.1999 and that 7 year period mentioned by the doctor only was an approximation in the light of the complainant claiming that there was previous cover for her father, Hon'ble Ombudsman held that the treatment was done for a disease which was not pre-existing.

Under the circumstances, this office held that the claim was payable and accordingly the insurance company was directed to pay the claim as per the policy conditions.

Kolkatta Ombudsman Centre
Case No. 149/11/002/NL/06/2007-2008
Shri Sital Prosad Halder
Vs
The New India Assurance Co. Ltd.

Award Dated : 04.02. 2008

Facts & Submissions :

The petition was filed against non-settlement of a Mediclaim on the ground that the maximum liability for eye treatment was restricted to Rs.70,000/-in one year.

The petitioner, Sri Sital Prosad Halder stated that he was issued a Mediclaim Policy for sum inured of Rs.80,000/- and he submitted a claim for Rs.57,741/- for his eye treatment to the insurance company on 03.10.2006 and this claim was still pending in spite of various communication and request letter submitted to the insurance company.

The complainant further stated that the Medicare TPA Services (I) Pvt. Ltd. the TPA of the insurance company gave unjustified reason for the refusal of the claim that the maximum total liability for eye treatment was restricted to Rs.70, 000/- for one year against all the mediclaim policies issued on or after 03.01.2006. The complainant failed to understand as to why medicare gave such causeless reason when he had a sum insured of Rs.80,000/- under policy issued by The New India Assurance Co. Ltd. Although, the complainant represented to the insurance company for payment of his claim amount on several occasions, but the insurance company did not consider his claim. He, therefore, filed this petition without mentioning any relief in the relevant column of the 'P' form.

The insurance company submitted their self-contained note dt.23.10.2007 in a prescribed format enclosing therein the detailed cause of repudiation of the claim as under:-

i) The claimant lodged a claim for Rs.57, 741/- under a Mediclaim Policy issued by the present Insurer;

ii) The claimant got 2 claims for the expenses incurred for treatment of his eyes from another policy with National Insurance Co. Ltd;

iii) The policy from this Insurer was after the patient contracted the disease for which the claim with the insurance company was made;

iv) The claimant had two mediclaim policies – one with National Insurance Co. Ltd. under a group policy and other individual with the New India Assurance Co. Ltd;

v) The detection of the disease was prior to the inception of the policy taken from The New India Assurance Co. Ltd. which restricted the sum insured limit for the specific disease up to the first insurance policy only and not the total sum insured for the two policies;

vi) The claim for residual amount, i.e. the amount beyond the limit of the 1st policy was considered inadmissible as per the scope of the mediclaim policy as the policy specifically excluded the disease contracted prior to inception of coverage under second policy. The second policy was treated as enhancement of sum insured for the disease / risk not occurred prior to taking the policy, but not for the disease contracted already;

vii) The review of the claim was done by the TPA but no alternative decision could be found out;

viii) When a disease was contracted during the policy period with specific sum insured, the admissibility of the expenses incurred for treatment of the same was limited to that sum insured only taken prior to detection of the disease and not after detection of the same.

In the circumstances the insurance company stated that the decision taken in repudiation of the claim was absolutely rational and justified in terms of the scope of the individual policy and the claim made by the claimant had no merit.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. Since the representative of the Insurance Company did not attend the hearing, it was decided to deal with the matter on an exparte basis. From the facts available, it was found that the individual Mediclaim Insurance Policy was taken after the first operation was performed in January, 2006. Therefore, the insurance company held that the eye ailment was contracted before the inception of the policy. According to them, the second policy i. e. individual mediclaim policy is treated as enhancement of sum insured for the disease or risk not occurred prior to taking the policy. Therefore, the insurance company held that the repudiation of claim was correctly made by their TPA.

The complainant was informed that he should have mentioned the material fact i.e. operation which took place in January, 2006 in the proposal form, so that the insurance company had the option at the time of underwriting risk which ailment had to be included and which one had to be excluded from the scope of the cover. Since the insurance contract was based on utmost good faith, any non-disclosure of the material fact on the part of the insured would lead to the contract becoming voidable. Therefore, he was asked whether he had mentioned anything in regard to his health in the proposal form or not at the time of hearing. The complainant categorically stated that he did not mention the same. Therefore, even if the policy was a continuous one, the excess cover when taken had to be supported by a proposal form with correct statement with regard to health. Since this had not been done, this office had no alternative, but to agree with the decision of the insurance company in repudiating the

same. Therefore, it was held that the insurance company had correctly repudiated the claim.

Kolkatta Ombudsman Centre
Case No. 189/11/002/NL/06/2007-2008
Shri Om Prakash Banka
Vs.
The New India Assurance Co. Ltd.

Award Dated : 08.02. 2008

Facts & Submissions :

The complaint was filed against repudiation of a claim on the ground that Incisional Hernia was due to caesarian section done before policy inception.

The petitioner, Sri Om Prakash Banka stated that he took a Mediclaim Policy for the period 14.08.2002 to 13.08.2006 covering self and his family members, in continuity of his previous insurance policy since 14.08.2002. The petitioner submitted a hospitalization claim to the insurance company for operation of Hernia on 30.05.2006 in case of his wife Smt.Sujata Banka insured under the said policy. The complainant also stated that his wife underwent Caesarian Operation in 1998.

The insurance company's TPA on receipt of the claim documents repudiated the claim on 18.09.2006 on the ground that the policy was incepted since 2002 and the present claim was for repair of Incisional Hernia which developed along the incision due to caesarian section done in 1998. As the causative factor for the Hernia was there prior to the inception of Policy, the claim was not payable.

On receipt of the repudiation advice the petitioner submitted his representation to the Insurer stating that although caesarian operation was done in 1998 but the disease Hernia was contracted only 6 to 7 months before the date of operation and therefore, his claim should be considered for settlement. The insurance company, after receiving his representation, wrote to the TPA for review of the claim and the TPA upheld the decision of their repudiation of the claim and the insurance company also communicated the same to the petitioner vide their letter dt. 29.05.2007. The complainant not being satisfied on the review decision of the insurance company filed this petition for relief of Rs.29,023/- plus interest up to date.

The insurance company submitted their self-contained note on 03.10.2007. The insurance company stated that the date of inception of the first policy was 14.08.2005 covering the insured patient, Smt. Sujata Banka for a sum insured of Rs.60,000/- with cumulative bonus 15%. The detection of the disease by the attending Dr. Anjula Binaykia was done on 02.05.2006.

On 25.05.2006, Dr. N. R. Chakraborty advised for operation of Incisional Hernia in lower abdomen and repair of Incisional Hernia along with Umbilical Hernia with ligation was done by Dr. N. R. Chakraborty on 30.05.2006.

Dr. N. R. Chakraborty on 18.08.2006 certified that caesarian section operation was done on 17.01.1998. The TPA Medicare TPA Services (I) Pvt. Ltd. repudiated the claim on 18.09.2006 due to the reasons that Incisional Hernia developed along the incision for caesarian section done in 1998.

The insurance company received request for reconsideration from the complainant on 23.112006 and referred the claim to their TPA for review on 02.01.2007 and the TPA on 16.01.2007 confirmed that the claim stood as "No Claim" as the present ailment was origin from incision in 1998, which was 'Pre-existing' and this decision of repudiation was based on panel doctors' opinion.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. From Butterworth's Medical Dictionary it was clear that Hernia had happened due to pre-existing of the scar and that occurred due to a caesarian operation. Therefore, the scar was pre-existing, but Hernia did not happen. Hernia was also not a disease. It was a peculiar anatomical event which took place due to a cavity or due to a scar that was inflicted due to an operation. Therefore, Hernia might occur at any time in the case of a human body, if a scar already existed. Hernia once again might happen at the same scar or it might not happen at all.

Under the circumstances, since the policy was a second year policy, this office held that expenses incurred due to Hernia operation were payable and it could not be treated as pre-existing disease by invoking exclusion clause no.4.1 in this case. Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim.

Kolkatta Ombudsman Centre
Case No. 181/11/003/NL/06/2007-2008
Shri Anil Kumar Sharma
Vs
National Insurance Co. Ltd.

Award Dated : 25.02. 2008

Facts & Submissions :

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

The petitioner, Shri Anil Kumar Sharma stated that he had submitted a hospitalization claim to the insurance company covering the complainant and his wife for the period 18.02.2005 to 17.02.2006 for a sum insured of Rs.2,00,000/- with respect to the complainant and Rs.1,00,000/- for his wife. But the insurance company rejected the claim due to the reasons of pre-existing disease under clause 4.1 of the standard Mediclaim Policy as enumerated in their letter Ref.101600/Mediclaim dt.24.05.2007.

The complainant disagreed with the contention of the insurance company in denying the medical benefits to which he was entitled and made submissions that the complainant never suffered or admitted in the hospital for treatment of HTN/DN or any ailment prior to the inception of the policy. So there was no pre-existing ailment.

That at the time of application for issue of Mediclaim Insurance Policy, the Insurer's agent advised the complainant to get medical reports conducted and these were submitted in original to the insurance company and based on it the insurance company issued a Mediclaim policy. Therefore, the repudiation clause No.4.1 is not applicable to his claim.

That in the night of 01.05.2005 the petitioner was admitted to B. N. Birla Heart Research Centre as per doctor's advice due to sudden onset of constant headache, BP and uninterrupted vomiting causing Cerebral SAH and as per hospital record and other reports it revealed that he was admitted in the hospital for cerebral SAH and not for treatment of any pre-existing disease.

That once when sign of DM and HTN appeared in random test by Dr. Balaram Prasad, sometimes in March 2005, he was orally advised to maintain diet and reduce stress, when he went to meet the doctor for his son because during that period his younger son was suffering from severe Pericardial Infusion in heart and admitted to B. M. Birla Heart Research Centre under life risk which he could not bear. After his discharge the complainant became normal but felt uneasiness. After that, he consulted Dr.Balaram

Prasad on 20.04.2005. Therefore, the complainant stated that he had always disclosed the material information to the insurance company and if he had suffered from any pre-existing disease he would have also communicated the same as and when required. But since insurance company did not consider payment of the claim even after his representation to the insurance company dt.12.02.2007, he filed this petition for a relief of Rs.54,326/-.

The insurance company had submitted their self-contained note dt.29.11.2007 giving under writing the claim details with respect to the claim of the complainant.

In the self-contained note the insurance company stated that the patient Shri Anil Kumar Sharma aged about 62 years having business took first Mediclaim policy w.e.f. 18.2.2005 for a sum insured of Rs.2,00,000/- and it was subsequently renewed from 18.02.2006. The insured lodged a claim under policy No.101600/48/04/85/000/06459 issued for the period 18.02.2005 to 17/02.2006.

At the time of proposing the Mediclaim insurance by Shri Anil Kumar Sharma, medical documents were submitted.

Regarding claim details the insurance company submitted that the Insured Shri Anil Kumar Sharma first admitted in B. M. Birla Heart Research Centre on 02.05.2005 and discharged on 04.05.2005 and finally diagnosed suffering from AC Coronary Syndrome with headache and hypertension and the duration of hypertension could not be specified from the documents submitted by Shri Anil Kumar Sharma. Prescription dt.01.05.2005 showed Type II D.M., HTN with high blood pressure 190/100. C. T. Scan Report dt.04.05.2005 showed impression of mild subarachnoid haemorrhagic (SAH) which also suggested CT angiography as per Dr. Balaram Prasad. Further the patient took admission at Apollo Gleneagles Hospital on 05.05.2005 and discharged on 07.05.2005. The patient took readmission at BMBHRC on 07.05.2005 and discharged on 11.05.2005 with the ailment of continuing headache and he took discharge from the hospital on risk bond. As per treatment summary of Apollo Gleneagles Hospital, Kolkata, it reveals that HTN present and provisional diagnosis was SAH + ACOM. The first discharge certificate of BM Birla showed acute coronary syndrome with headache with hypertension.

The TPA, M/s. FHPL wrote in their information sheet as per prescription of Dr.Balaram Prasad, DM was detected prior to 18.02.2005 i.e. before inception of the policy and HTN on 18.03.2005 i.e. within 30 days from the inception of the policy. Doctor also wrote that the ailment was related to DM which was pre-existing disease and HTN to be excluded as it was detected within 30 days of the insurance policy. The summary sheet of the TPA also indicated that the HTN is a recognized predisposing factor for AC Coronary syndrome and Ischemic heart disease required some time to develop; it could be assumed that the disease condition was prevalent before the inception of the policy and hence, the claim was repudiated under clause 4.1 of the standard mediclaim policy. After the representation and requests received from the Insured the entire claim was further scrutinized by FHPL and they finally submitted their medical observation which revealed that the possibility of the pre-existing disease along with material information can not be ruled out and there has been gross discrepancies in the documents submitted and information provided by the Insured and therefore as per opinion of Dr. Kaushik Ghosh, Medical Officer, the claim was repudiated.

Further from the prescription of Dr. Balaram Prasad dt.20.04.2005 it was observed that the patient was first attended by him on that date and from the physical history as written by Dr. Balaram Prasad, the insurance company came to know that the blood sugar as detected six weeks before and the blood pressure once on 18.03.2005 and advised for a Car-dace 2.5 daily with diabetic diet.

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 facts placed before us, it was found that the insurance company issued the policy after taking into consideration all the stipulated medical tests and medical reports from the insured. We also find that the insurance authorities came to a conclusion that the disease must have existed before the inception of the policy because the same happened within 5/6 months after the policy was incepted. It was observed that the patient was suffering from HTN and DM which had not been adduced by any proof to show that the complainant that the disease existed prior to inception of the policy. Mere existences of symptoms during the policy period did not allow the insurance company to come to a conclusion of a particular disease as pre-existing as being causative of those symptoms. We were, therefore, unable to agree with the decision of the insurance company in repudiating the claim. Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim within 15 days.

Kolkatta Ombudsman Centre
Case No. 162/11/003/NL/06/2007-2008
Smt. Madhu Saraf
Vs
National Insurance Co. Ltd.

Award Dated : 25.02.2008

Facts & Submissions :

This petition was filed against repudiation of Mediclaim on the ground of first year exclusion.

The petitioner, Smt. Madhu Saraf stated that the complainant was having a Mediclaim Policy for last 6 years without any break from subsidiaries of General Insurance Co., i.e. firstly from The New India Assurance Co. Ltd. and thereafter from National Insurance Co. Ltd. without any claim. In the year 2005-2006 the policy was renewed with National Insurance Co. Ltd. and she had given her name in place of her husband as a policyholder. But the National Insurance Co. Ltd. while issuing such policy did not allow cumulative bonus.

Master Harsh Vardhan Saraf, the complainant's son was hospitalized on 22.05.2006 for tonsillectomy and submitted necessary claims incurred for the treatment of her son to the insurance company. But the TPA of the Insurer, M/s. Family Health Plan Ltd. on receipt of the claim documents asked the Insured to submit them the previous insurance policies in order to consider the admissibility of the claim. However the claim was rejected by the TPA on 27.06.2006 followed by insurance company's letter dt .27.07.2006.

The complainant not being satisfied with the decision of repudiation submitted this petition for monetary loss of Rs.45,431/-.

The insurance company submitted their self-contained note dt.04.10.2007 received by us on 21.11.2007.

In the self-contained note, the insurance company stated the followings:-

i) The Insured Smt. Madhu Saraf along with her husband, mother and son had taken a Mediclaim Policy with S.I. of Rs.1,00,000/- each and with respect to her son Rs.50,000/- w.e.f. 23.07.2005 to 22.07.2006. This policy was first incepted on 23.07.2005. Previously this policy was with New India Assurance Co. Ltd. as per declaration given under para 10 of the proposal form by the Insured;

ii) Master Harsh Vardhan Saraf, son, was hospitalized on 22.05.2006 for treatment of Adeoidectomy and Tonsilectomy. The Insured submitted the claim on 05.06.2006 to the TPA;

iii) The claim was rejected vide Insurance Company's letter dt. 27.07.2006 and dt. 01.09.2007 on the ground that the claim fell under 1st year exclusion clause of the given mediclaim policy. Since the renewal status of the above policy was different with the previous policy of New India Assurance, the insurance company had requested the Insured to submit the previous policy copies. In spite of repeated reminders the Insured did not submit the same.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. As the representative of the insurance company did not attend; this office proposed to deal with the matter on an ex-parte basis.

On going through the details of the policy condition No.4.3 which gave the names of the diseases for which the policy cover was not available in the 1st year exclusion clause of the policy. It had been observed that the disease Adenoidectomy and Tonsillectomy was not in the list of 1st year exclusion. Even this office did not find that Adenoidectomy and Tonsillectomy were mentioned in the policy as excluded at the time of issuance of the policy and therefore, it could not be treated as excluded under the policy condition No.4.3 when the policy was in force with National Insurance during the period 2005-2006. Further, this office did not find that the name of the insured who was the son of the complainant as mentioned in the previous policies issued by the New India and was also subsequently continued with National Insurance for the year 2005-2006.

Keeping in view the above, Hon'ble Ombudsnan did not think that decision of repudiation was correctly taken by the insurance company. Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim within 15 days.

Lucknow Ombudsman Centre
Case No.G-43/11/01/07-08
Shri. Kedarnath
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 27.03.2008

Complaint filed by the complainant insured against respondent insurance co. for restricting his claim to original sum insured on his mediclaim policy.

Facts : The complainant insured had covered himself and his wife for 1 lac each since 2003 continuously. During the year 2005-2006 policy he enhanced the SI from 1 lac to 2 lacs only. In 2007, he submitted a bill for treatment of CRF and dialysis for Rs. 1,12,329/- to the respondent Co. for settlement. The Co. paid a sum of Rs 1 lac(original SI) stating that CRF was preexisting at the time of enhancement of SI. Hence the sum of Rs.12,329/- was denied to him.

Findings : A prescription dated 5.1.04 confirms that the complainant was suffering from CRF in the year 2004 i.e. Prior to enhancement of SI in the year 2005 and hence restricting the claim to original SI appears to be in order. However, it is a matter of record that neither the revised mediclaim guidelines were incorporated in the policy, nor any terms and conditions provided to the insured and neither did the schedule of the policy explicitly state that any preexisting disease would be restricted to original SI. Hence this condition was not in the knowledge of insured.

Decision : Under the above circumstances the stand of the Co. was not justified. They were directed to pay the balance amount of Rs.12329/- only.

Mumbai Ombudsman Centre
Case No. : GI-710 of 2006-07
Miss Hitakshi Vyas
Vs
The New India Assurance Co. Ltd.

Award Dated : 01.10.2007

Smt. Alpa G. Vyas was covered under Hospitalization & Domiciliary Hospitalization Benefit Mediclaim Policy No.141802/48/05/20/7005112 issued by the New India Assurance Company Limited for the period 09.10.2005 to 08.10.2006 with 10% accrued CB with no exclusions. Smt. Alpa G. Vyas was admitted to Life Care Hospital from 08.06.2006 to 12.05.2006. She expired on 23.06.2006. The TPA M/s. MD India Healthcare Services Pvt. Ltd. sent letters dated 19.08.2006, 04.09.2006 & 19.09.2006 requesting the claimant to provide additional information / documents / clarifications at the earliest with a note stating that if the above information is not received by them within 15 days, the claim file will be closed under "Claim not pursued by Claimant". Finding no response from the claimant the claim was repudiated vide their letter dated 19.10.2006.

Miss Hitakshi Vyas, Complainant, Aged 13 years alongwith her Uncle Shri Vipul G. Vyas, appeared and deposed before the Ombudsman. Shri Vipul Vyas submitted that his sister Ms.Alpa G. Vyas had taken a mediclaim policy from New India Assurance Co. Ltd. She expired on 23.06.2006. After her death they had submitted all the relevant papers to the Company. However, they received two letters from the TPA dated 19.08.2006 and 19.09.2006 requesting for some additional documents which he submitted on 26.09.2006. Shri Vyas requested for the settlement of his sister's claim.

The New India Assurance Co. Ltd. was represented by Shri S.V. Jadhav, Branch Manager and the TPA, M/s. MD India Healthcare Services Pvt. Ltd. was represented by Dr. K.K. Mishra. Shri S.V. Jadhav submitted that since they did not receive the papers requested for, the claim was set aside due to non receipt of necessary documents. The agent was informed time and again but no response was received. He submitted that on getting the necessary requirements they are ready to process the claim.

The Claimant was advised to submit necessary documents to the Company and the Insurer was asked to settle the claim and inform this office within 10 days.

In view of the decision taken during the hearing, The New India Assurance Co.Ltd. has sent a letter dated 28.09.2007 to this office stating that the claim has been settled by their TPA M/s. MD India Healthcare Services (P) Ltd. vide cheque No.109140 drawn on Bank of India for Rs.20,229/-. They have also sent a copy of the Discharge Voucher signed by the claimant Miss Hitakshi Vyas for the said amount.

In view of the claim being settled, the claim of Miss Hitakshi Vyas for reimbursement of hospitalization expenses incurred for her mother late Smt. Alpa G. Vyas in respect of Policy No.141802/48/05/20/7005112 stands disposed of.

Mumbai Ombudsman Centre
Case No. : GI-113 of 2007-2008
Shri Choudhary Nagaram Ghisaji
Vs
The Oriental Insurance Company Ltd.

Award Dated : 10.10.2007

Shri Choudhary Nagaram Ghisaji along with his family was covered under the Mediclaim Family Floater under Policy No.121600/48/06/936 for Sum Insured of Rs.50,000/-. Shri Choudhary Nagaram Ghisaji was hospitalized at Shah Surgical Hospital & Maternity Home Pvt. Ltd. Kandivali (West), Mumbai, from 25.10.2006 to 31.10.2006 for Acute Gastro Entrities. M/s. Raksha TPA Pvt. Ltd. repudiated the claim stating the claim has been termed non-tenable as the said hospital was depanelled for both cashless and reimbursement of claims and hence the claim stands non payable.

Shri Choudhary Nagaram Ghisaji was hospitalized at Shah Surgical Hospital & Maternity Home Pvt. Ltd. from 25.10.2006 to 31.10.2006 for Acute Gastro Enteritis with Dehydration and he preferred a claim to the Company for reimbursement of expenses incurred by him. He has produced medical reports, doctor's prescriptions and medical bills for the expenses incurred by him. However, on the analysis of the case and the documents produced at this Forum reveals the repudiation of the claim is made by the TPA due to the notification received from the Insurance Company instructing them to depanel the said hospital for both cashless and reimbursement of claim, and hence they have repudiated the claim vide their letter dated 07.04.2007. Notification of depanelment of certain hospitals/nursing homes are sent to the TPA, but the same notification should also be sent to the Insured, otherwise, how will the insured know about the depanelment of certain hospitals. This notification was sent to the TPA, but no intimation/notification was sent to the Insured. The insured has produced a List of Hospitals which was given to him with the policy and Shah Surgical Hospital & Nursing Home is also included in the list. We cannot fault the Insured for being admitted to the said hospital for taking treatment as he had no knowledge that the said hospital was depanelled. However the Insurance Company has pointed out that he has not informed about hospitalization to the TPA/Company within the stipulated time as prescribed in the policy. This is certainly a lapse on the part of the Complainant. Had he informed in time, the Company could have informed him about the status of the hospital.

In the facts and circumstances of the case, the total rejection of claim by The Oriental Insurance Company Ltd. is not justified and it will be appropriate to allow 75% of the admissible expenses to settle the dispute.

Mumbai Ombudsman Centre
Case No. : GI- 104 of 2007-2008
Shri Sudhir R. Sanghvi
Vs
New India Assurance Co. Ltd.

Award Dated : 12.10.2007

Shri Sudhir R. Sanghvi was covered under Mediclaim Policy No.111700/48/05/84503 Shri Sanghvi was hospitalized from 07.09.2006 to 10.09.2006 for Acute Cholecystitis. When the claim for Rs.1,05,772/- was submitted by Shri Sudhir R. Sanghvi for his hospitalization and treatment, M/s. Raksha TPA Pvt. Ltd. partially settled the claim for Rs.66,494/- disallowing an amount of Rs.39,278/- towards excess surgeons fees and operation theater fees with a remark stating "Rs.60,000/- professional fees is a high charge. Reasonability clause has been applied to this item of the charges incurred in the treatment and an amount of Rs.30,000/- is payable. Operation theatre charge of Rs.18,000/- is high charge. Reasonability clause has been applied to this item of the charges incurred in the treatment and an amount of Rs.9,000/- is payable. Other deductions towards Glucon D - Rs.153/-, Powder - Rs.75/- and Rs.50/- towards registration charges were also deducted. An amount of Rs.39,278/- was deducted from the claim amount.

Analysis of the case reveals that Shri Sudhir Sanghvi was admitted to Criti Care Hospital on 07.09.2006 with fever, pain in the abdomen, vomiting, nausea and anorexia and was diagnosed as Acute Cholecystitis. He took his discharge against medical advise on 08.09.2006. On 08.09.2006 itself he got himself admitted to Shrikhande Clinic and an emergency operation was performed under general anesthesia by Dr. V.N. Shrikhande and Dr. Anand G. Nande for Laparoscopic Cholecystectomy. He was discharged on 10.09.2006.

The TPA settled the claim for Rs.66,494/- as against his claim of Rs.1,05,772/- mainly on the ground that the surgeon's charges and operation theatre charges were quite high compared to even top-class hospitals in the city. The Company submitted the tariff chart for the said surgery and operation theatre charges of different hospitals. The TPA submitted the tariffs for the said surgery of three reputed and recognized hospitals namely, Lilavati Hospital, Bhatia Hospital and H.N. Hospital On going through the Tariff Chart, it is observed that the fee for the surgeon's charges and operation theatre charges in these hospitals were comparatively much lower than the fees charged by hospital under which the insured had undergone the same operation. However, the Insured submitted bills of other patients who had undergone the same operation in other hospitals.. The bill from Brahma Kumaris' Global Hospital and Research Centre shows the Doctor's fees as Rs.54,100/- and O.T, charges as 10,800/-. The bill from Jaslok Hospital shows the Doctor's fees as Rs.58,000/- and O.T. charges as 7,200/-. We have looked into the two cases cited by the Complainant as well as the present case taking into consideration the surgeon charges, anesthesia charges and operation theatre charges.

Taking an overall view of the rates quoted by other hospitals, the charges allowed towards surgeon charges, anesthesia charges and operation theatre charges by the Insurer seems to be reasonable. However, looking to the other two cases quoted by the Complainant which were settled by the Insurer and the Insured had to undergo an emergency operation, I am inclined to allow an additional amount of Rs.11,000/- to settle the dispute, in addition to what has been paid to the Complainant.

Mumbai Ombudsman Centre
Case No. : GI- 223 of 2007-2008
Regina Shaikh
Vs
New India Assurance Co. Ltd.

Award Dated : 15.10.2007

Smt. Regina Shaikh was covered under Mediclaim Policy No.112500/48/05/85158 along with her son issued by the New India Assurance Co. Ltd. Smt. Regina Shaikh underwent a Bilateral Cataract operation at Bhargava Nursing Home.

When the claim for Rs.1,32,074/- was submitted by Smt. Regina Shaikh for her Bilateral Cataract operation, M/s. Raksha TPA Pvt. Ltd. partially settled the claim for Rs.82,074/- disallowing an amount of Rs.50,000/- invoking Reasonability Clause and paying an amount of Rs.40,000/- package per eye for cataract surgery.

Analysis of the case reveals that Smt. Regina Shaikh was admitted to Bhargava Nursing Home from 10.11.2006 to 14.11.2006 for bilateral cataract surgery. The TPA settled the claim for Rs.82,074/- as against her claim of Rs.1,32,074/- mainly on the ground that the cataract operation charges of Rs.65,000/- per eye was quite high compared to even top-class hospitals in the city. In other words, the dispute is only on the quantum of claim. Even considering that, the TPA and the Company felt that the

charges were higher and therefore, they went by the policy conditions which governs the payment being reasonably and necessarily incurred. The TPA submitted the tariffs for the said surgery of a few reputed and recognized hospitals namely, Lilavati Hospital, Bombay Hospital, Drushti Eye & Ratinal Centre, Aditya-Jyoti Hospital, Asian Eye Institute & Wockhart Eye Hospital. On going through the Tariff Chart, it is observed that the charges in these hospitals were comparatively much lower than the charges by the hospital under which the insured had undergone the same operation. However, the Insured also submitted supporting documents like the Price List of other hospitals like Wockhardt Hospital and Lilavati hospital where eye surgery package works out to more or less the same as charged by Bhargava Nursing Home. Smt. Regina has also submitted two bills of different persons who had undergone the same operation and where the TPA M/s Health India Bhaichand Amoluk Insurance Services Pvt. Ltd. connected with The New India Assurance Co.Ltd. has settled the bill for Rs.1,32,153 and another bill was settled by M/s. Paramount Health services Pvt. Ltd. connected with M/s. National Insurance Company Ltd has settled the bill for Rs.1,31,930/-. She has also produced two certificates from Alcon Laboratories (I) Pvt. Ltd. where it states that New Technology lens ReSTOR costing Rs.35,000/- each has been implanted on Mrs. Regina Shaikh in both the eyes. Her argument is that the Insurer has settled the claim of another insured person for the same operation, then why her claim is not fully settled? She is right in questioning the Company. The Company should issue directives in such matters and inform the insured the package in the case of such operations. The Insurance Company is directed to clarify their position in this issue.

The Complainant has produced a copy of the claim discharge voucher of the claim settled by the TPA of the same Insurer where an amount of Rs.1,32,158/- was allowed without applying the Reasonability Clause. The Insurer cannot have two different standards while settling the claim of different policyholders. In view of this, the Company's stand of disallowing Rs.50,000/- by applying Reasonability Clause is not sustainable.

In the facts and circumstances of the case and the documents submitted to this Forum, the Insurer is directed to settle the full claim of the Insured.

Mumbai Ombudsman Centre
Case No. : GI-160 of 2007-2008
Shri Devasagayam E. Robinson
Vs
The National Insurance Co. Ltd.

Award Dated : 17.10.2007

Shri Devasagayam E. Robinson and his wife Smt. Kumar Robinson had a mediclaim Policy No.270907/48/04/8500000144 from National Insurance Co. Ltd. His dispute with the Company was the quantum of claim settlement. His wife was admitted to Kottakkal Arya Vaidya Sala Ayurvedic Hospital & Research Centre, Kottakkal, Kerala from 23.11.2004 to 08.12.2004 and 16.02.2005 to 10.03.2005 for treatment of Parkinson's disease. Shri Robinson had submitted a claim for Rs.38,974/- to the Company. Subsequently, an amount of Rs.20,599/- was settled disallowing an amount of Rs.18,375/-

The amount of Rs.18,375/- was disallowed by the Company stating that the above was not covered as they are not related to treatment and ailment. The Company sent him a letter dated 22.05.2006 stating that an amount of Rs.540/- has been settled towards Physiotherapy charges. However, they disallowed Diet Charges - Rs.4,213/- as per the terms & conditions of the policy and Room Charges of Rs.11,840 as these charges

have been raised by the hospital against the services like water, electricity, sanitation, security, ward boys, lift etc.

Analysis of the case and the documents produced at this Forum reveal that the Insurer has deducted Rs.11,840/- towards room charges and Rs.4,213/- towards diet. Stating that these charges are not admissible under the policy and hence disallowed. Certificates produced from Kottakkal Arya Vaidya Sala gives a clarification and states that the room charges such as electricity, water supply, ward boy services and cleaning which are essential for the treatment and compulsorily payable by all admitted patients and not optional. It is a part of Room Charges. Room charges and diet charges are inevitable if a patient is to be admitted to an hospital or nursing home. According to clause 1.0 of the policy term and conditions which state as under.:

“In the event of any claim/s becoming admissible under this Scheme the Company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by on behalf of such Insured Person, but no exceeding the Sum Insured in aggregate mentioned in the schedule hereto

A) Room, Boarding Expenses as provided by the hospital/nursing home”

The terms of the policy very clearly provide for reimbursement of hospitalization charges. A room in a hospital can not be utilized without power, water, security, ward boys and staff in the hospital. The Insurance Company’s denial of such expenses are not justified as these charges are very much part of the room, boarding and nursing expenses. The Company has gone by the wordings noted in the bill and not by the spirit behind it. In view of this, the stand of the Insurance Company is not tenable.

Mumbai Ombudsman Centre
Case No. : GI- 122 of 2007-2008
Shri Davinder Singh Chandhok
Vs
Oriental Insurance Co. Ltd.

Award Dated : 18.10.2007

Shri Davinder Singh Chandhok alongwith his wife were covered under Mediclaim Policy No.121800/48/06/3319 Smt Ravinder Kaur Chandhok was admitted to Beramji’s Hospital for treatment of Lumbar Slip Disc with Right Sciatica and Cervical Spondylosis from 31.07.2006 to 11.08.2006. When the claim for Rs.57,810/- was submitted M/s. Raksha TPA Pvt. Ltd. partially settled the claim for Rs.26,670/- disallowing an amount of Rs.31,140/- on the grounds that hospitalization stay for the last 7 days is not justified as no active treatment was done during the last 7 days and hence deducted Rs.31.140/-

Analysis of the case reveals that Smt. Ravinder Kaur Chandhok was admitted to Beramji’s Hospital for treatment of Lumbar Slip Disc with Right Sciatica and Cervical Spondylosis The indoor case papers reveal that the patient was admitted with pain in lower back with pain radiating to right leg since about 4 ½ months and is acute since 2 days with great difficulty in sitting and standing for more than 5 minutes. Can’t walk without support and climbing stairs is next to impossible. Patient was brought to this hospital on chair. Pain in lower back is associated with tingling numbness and heaviness in right leg and is not reduced by rest and pain killer. The Complainant has produced a letter from Beramji’s Hospital where Doctor’s charges as a package for 12 days treatment is charged for this treatment which includes follow ups, consultations and routine OPD treatment given for 3 months, if required, after discharge from the hospital. It also states that when out patients final bill is prepared the treatment

charges are covered under the mentioined headings which covers (1) Dr. Beramji's consultation + visit + treatment charges, (2) Physiotherapist treatment charges and (3) equipment usage charges.

The hospital authorities has issued a clarification to the TPA in this regard. They have stated that all charges are for treatment for 12 days stay at hospital and they quoted the rates for each disease and further stated that while preparing the final bill the treatment charges are covered under 3 headings. 1 Dr. Beramji's Consultation + Visit + treatment charges. 2. Physiotherapist treatment charges. 3. Equipment usage charges

It has also been mentioned that all follow-ups consultations & routine OPD treatments given, if required, during 3 months after discharges is free. However, the bill raised by them have some more charges then stated above. They have also not justified how the package is worked for the present patient. The mediclaim policy covers only 60 days period after hospitalization whereas in the present package includes 90 days period. It is further stated in the policy conditions that the company will reimburse all such expenses which are reasonable and necessarily incurred by the Insured person.

In view of the above facts and circumstances, I am of the opinion to allow 75% of the admissible expenses to settle the dispute in the present case.

The above case was posted for hearing on 17.10.2007. The Complainant came for deposition but the representative of the Insurance Company was absent.

We had requested the Company in our Form PIV asking for a self contained written statement on 13.07.2007. We are sorry to state that we have not received even the statement alongwith the their comments on the complaint.

We had written to the Company on 14.9.2007 regarding the hearing to be held on 17.10.2007. When we contacted the Divisional Manager, he asked whether it is not enough if the TPA attends the hearing as the TPA only handles the matter and accordingly M/s. Raksha TPA was asked to attend the office.

As per RPG Rules, 1998, the Complainant has to send a representation to the Company regarding his grievance and the Company is expected to examine the case looking to the complaint and the additional information supplied by the aggrieved party. The view taken by your office is not acceptable and shows a lack of concern and also keeps the Forum in the dark as to whether the Company has reviewed the matter in the light of the complaint.

The Contract of Insurance is between the Insured and the Insurance Company and the TPA is only a service provider engaged by the Insurer and he is allowed to assist the officer representing the Company. We thought it proper to bring the matter to your notice so that you can take appropriate action. Here, we may add, invariably we are not getting the written statement from your office.

Mumbai Ombudsman Centre
Case No. : GI- 150 of 2007-2008
Dr. Manish K. Shah
Vs
The United India Insurance Co. Ltd.

Award Dated : 18.10.2007

Dr. Manish K. Shah alongwith his wife Smt. Jyotika M. Shah were covered by a Mediclaim Policy No.21400/48/06/20/00000537 for a was issued by The United India Insurance Co. Ltd., D.O.No.14. Smt. Jyotika M. Shah met with a vehicular accident on 21.10.2006 and sustained a complex fracture of shaft of humerus. She was admitted to Bhatia Hospital on 23.10.2006 and was operated on 24.10.2006. She was discharged

on 26.10.2006. A claim for expenses incurred was submitted to United India Insurance Co. Ltd., D.O.No.14. The total claim submitted was for Rs.99,917/- The TPA M/s. Medicare Services India (P) Ltd. settled the claim for Rs.73,996/- disallowing an amount of Rs.25,921.:

Dissatisfied with the partial settlement of the claim, he approached the Grievance Cell of the Company vide his letter dated 18.04.2007, seeking full settlement of the claim. Aggrieved by the decision of the Company, the Insured approached this Forum, seeking interference of the Ombudsman in the matter for settlement of full claim.

After perusal of the records parties to the dispute were called for a hearing on 17.10.2007 at 4.00 P.M.

On contacting the Company to bring along papers relating to the case while coming for the hearing, they have informed us that a decision has been taken to settle the claim for the balance amount of Rs.25,921/-. They have informed this office vide a fax received on 16.10.2007 that the Company has decided to settle the total claim for an amount of Rs.98,565/-

In view of the settlement by the Insurance Company, the complaint is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI – 102 of 2007-2008
Shri Bipin Ramji Shah
Vs
Oriental Insurance Company Limited

Award Dated : 24.10.2007

Shri Bipin Ramji Shah was covered under the Mediclaim Policy No.111700/002/48/80169 for the period 29.07.2005 to 28.07.006 for sum insured Rs.2,00,000/- with C.B. 20%. The inception of the policy was from the year 2003. He was admitted to Jaslok Hospital & Research Centre from 13.06.2006 to 14.06.2006 and underwent an Endovenous Laser Therapy for Varicose Veins. He preferred a claim to the Company.. The TPA, M/s Heritage Health Services Pvt. Ltd. repudiated the claim under exclusion clause 4.1 of the policy terms & conditions. .

On going through the material on record it is observed that Shri Bipin R. Shah was admitted to Jaslok Hospital on 13.06.2006 and diagnosed Left Leg Varicose Veins. The History & Clinical Findings mentioned in the discharge card is - No illness in patient. Case of Varicose Veins – 4 months. The History Sheet of Jaslok Hospital & Research Centre reads as – H/o Varicose veins for Endovenous Laser – since 5 months – Doppler laser of left leg shows incompetent of SF Junction. Incompetent perforators seen. In the History Sheet of Jaslok Hospital the duration “since 5 yrs.” appears to have been overwritten and changed to “5 months”. The Endovenous Laser Therapy for Varicose Veins was performed at Jaslok Hospital on 14.06.2006 and the Findings read as under:

“The left Sapheno-Femoral (S-F) junction show incompetence. The Left Great Saphenous Vein (GSV) shows moderate dilatation. Incompetent peforators are seen as follows – in mid ankle measuring 4.3 mm, upper ankle measuring 5.0 mm.

A certificate by Dr. Paresh R. Pai states “Overweight. Family H/o varicose veins. Varicose veins left leg since 2000. 2 episodes of bleeding & pigmentation since 3 years – non healing ulcer – 3 months – now healed”.

The TPA repudiated the claim by invoking exclusion Clause No. 4.1 of the policy terms and conditions in support of the certificate issued by Dr. Paresh R. Pai. The insured

produced a certificate dated Nil on the letterhead of Dr. Paresh R. Pai stating the following.

“The Report submitted by us on 16.05.2006 of Bipin R. Shah was wrongly given of another person. The correct Report of Bipin R. Shah is as under:

Varicose Veins (L) leg is since 2006

2 Episodes of bleeding & pigmentation is from last 4 months”

However, in this certificate the signature does not tally with the case paper of Dr. Paresh R. Pai dated 16.05.2006. This certificate has been submitted to over write the earlier history. He has also produced a certificate dated 06.03.2007 from Dr. Narayan A. Karnam, R.M.P., certifying that he is suffering from varicose veins since February, 2006. On 24.10.2007, he has produced a case paper dated 01.03.2006 from Dr. Narayan A. Karnam, R.M.P. Prior to these papers, he has produced no other case papers. These certificates are not of much value as he has produced the same after hospitalization and rejection of claim.

From the above analysis and documents on record the contention of the Insurance Company to treat it as pre-existing seems to be justified. Any correction of original history, which is clearly written, merely by issuing another letter, is not tenable. Under the circumstances, there is no justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-283 of 2007-2008
Rohinton R. Patel
Vs
United India Insurance Co. Ltd.

Award Dated : 26.10.2007

Shri Rohinton R. Patel alongwith his mother Smt. Daulat Patel was covered under Individual Mediclaim Policy No.020300/48/04/20/00006688 issued by United India Insurance Company Limited, His mother was covered for sum Insured 1,25,000/- with CB 50%. Smt. Daulat Patel was admitted to Reges Bone & Joint Care for Left Knee Implant. Shri Rohinton R. Patel submitted the claim for hospitalization to the Company The Company had requested him to provide them with the Sticker and Invoice of the implants in the left knee. Shri R.R. Patel informed the Company that the invoice and receipt of implants were included in the hospital bill given by the Doctor.

Shri Rohinton Ratan Patel appeared and deposed before the Ombudsman. He stated that his mother Smt. Daulat Ratan Patel was hospitalized from 30.08.2005 to 05.09.2005 for Left knee operation. A knee implant was performed and he submitted the claim to the Company in October 2005 for which he has not received the claim. The company had asked him to submit the sticker and invoice of the implants in the left knee. He was unable to submit the same as it was purchased by the Doctor who performed the operation. The Company approached the Doctor for the same but since it was after 10 months after the operation, the Doctor was also unable to provide the same. He requested the settlement of claim.

United India Insurance Co. Ltd. was represented by Shri B. Mishra, Sr. Divisional Manager, D.O.3. He submitted that Smt. Daulat Ratan Patel was covered for a sum Insured of Rs.1,25,000/- with cumulative bonus of Rs.62,500/-. An amount of Rs.1,14,800/- has been sanctioned towards the claim. However, Rs.85,000/- towards knee implant charges and Rs.17,720/- towards bulk medicine are not paid as the

insured has not submitted the money receipts for the same. However, a cheque for an amount of Rs.1,14,800/- is being sent to the insured.

Shri Rohinton R. Patel stated that since the invoice for the knee implant is not available and bulk medicine were given by the Doctor, he has no objection for settlement of claim excluding the above items.

The Company was asked to pay the amount as discussed and inform the particulars of payment within 7 days.

We have received a letter dated 29.10. 2007 from United India Insurance Company Ltd., D.O.3, stating that they have settled the claim for an amount of Rs.1,14,800/- vide cheque No.006570, dated 22.08.2007, towards the hospitalization of Smt. Daulat Patel during the period 30.08.2005 to 05.09.2005.

Mumbai Ombudsman Centre
Case No. : GI – 254 of 2007-2008
Shri Harmesh R. Mistry
Vs
Royal Sundaram Alliance Insurance Company Limited

Award Dated : 26.10.2007

Shri Harmesh R. Mistry, his wife Smt. Bharati Mistry and son Master Dhruv Mistry were covered under Health Shield Insurance Policy No.HW00001643000100 taken from Royal Sundaram Alliance Insurance Company Limited.. Smt. Bharati Mistry was hospitalized at Parmar Hospital for Infiltrating Duct Carcinoma Right Breast (Breast Cancer) He preferred a claim with the Company which was repudiated stating that a malignant breast lump of size 4.5 x 3.5 x 3 cm takes longer time to develop and could not have developed within 3 months from commencement of policy and is pre-existing.

On going through the records, the insured had taken a policy from Standard Chartered Bank through Royal Sundaram Alliance Co. Ltd. for sum insured Rs.1.5 lakhs for a period 01.08.2005 to 31.07.2006. Thereafter, the policy was renewed by the Company for the 2nd year for the sum insured of Rs.1.5 lakhs and sent to him, which the insured requested for cancellation as he could not afford the high premium. The Company cancelled the policy vide their letter dated 14.08.2006. The Insured took a policy from GE Country Wide for sum insured Rs.1.00 lakh for a period 13.08.2006 to 31.07.2007. The Company's contention is, since he cancelled the policy and took a fresh policy, there is no continuity and have treated the hospitalization for breast cancer which has occurred only after 3 months of inception of policy. The contention of the Insurance Company is wrong as the inception of the policy is from 01.08.2005 to 31.07.2006 and his present policy is from the date 13.07.2006 to 12.07.2006. There is no break in the policy. The present policy has to be taken in continuation of his earlier policy and the policy period comes to 1 year and 2 months before the date of hospitalization. As such, the hospitalization of Smt. Mistry for Breast cancer is after 14 months of the inception of the policy.

The Insurance Company has rejected the claim on grounds of pre-existing disease. On going through the notings of the case summary & discharge records of Parmar Hospital where the insured was admitted from 13.10.2006 to 21.10.2006, it states that Smt. Bharati Mistry was admitted with Infiltrating duct carcinoma Right Breast. Biopsy already done on 4.10.2006 by Dr. Bhawisha R. Ghugare. Patient herself had detected right breast lump accidentally around 21.9.2006 by herself on self examination. Taken opinion of General Practitioner and Oncosurgeon, went for FNAL – turned to be negative. Still not convinced, she opted for excision biopsy which turned to be

Infiltrating duct carcinoma right breast. It is, therefore, evident that the Insured had first noticed the lump on her breast around 21.9.2006. The Insurance Company has repudiated the claim stating that the policy is in force from 13.07.2006. Hospitalization has happened on 13.10.2006. i.e. 3 months from commencement of policy. The commencement date of the policy should be taken as on 01.08.2005 and hospitalization is after 14 months. There is no break in the policy.

In view of the above facts, the repudiation of the claim by the Insurer is not tenable.

Mumbai Ombudsman Centre
Case No. : GI-226 of 2007-2008
Smt. Bernice Colaco
Vs
The New India Assurance Co. Ltd.

Award Dated : 30.10.2007

Smt. Bernice Colaco was covered under mediclaim Policy No.111200/48/05/86106 issued by New Indian Assurance Co. Ltd. Smt. Bernice Colacao was admitted to Vrundavan Hospital & Research Centre Pvt. Ltd., Goa with Hypertension, Diabetes, breathlessness and acute gastritis on 18.09.2006 at 11.45 P.M. and was discharged on 19.09.2006 at 5.30 P.M. M/s Raksha TPA repudiated her claim invoking clause 2.3 She was again admitted to Hinduja Hospital with headache, pain in the abdomen and backache M/s Raksha TPA repudiated this claim invoking Clause 4.10

Smt. Colaco was admitted at Vrundavan Hospital with HTN, DM, Acute Gastritis and Bronchial Asthma with Infection. The treatment administered to her in the hospital was IV fluids, IV Emeset, IV Penzole, IV Baclum, IV Decadiaon, Inj. Deriphylline, Tab. Glycomet, Tab. Shelkal & Tab. Menopace. Nebulisation with Duoline Budecorl was also given. As she had not completed the specified 24 hrs. hospitalization the claim was rejected.

Smt. Colaco was again admitted to Hinduja Hospital on 13.10.2006 with headache, pain in the abdomen and backache and was diagnosed as Fundic & Corpus Gastritics, DM, Hypothy H/o Pituitary Microadenoma with Cervical Spondylosis Esophagus Gastro Duodenoscopy was also done. Smt. Bernice Colaco has a history of pituitary microadenoma since 1994. In the case papers of Hinduja Hospital - Clinical features and investigations show she was suffering from headache since 1 month, low back ache and abdomen pain mostly upper abdomen. All the reports submitted by her have shown normal readings except MRI of the Brain & Spine the Impression given “Essentially normal study of pituitary fossa. Screening spine sequence reveals mild posterior disc bulge at C5/6”. However, being a patient of pituitary microadenoma, she got herself admitted. Esophagus gastro duodenscopy was also performed. No doubt these medical tests conducted at the hospital could have been done on OPD basis, however looking at her past history of ailments, she did not want to take any chance and was kept in the hospital for observation.

Under the facts and circumstances of the case, I intend to award her an ex-gratia amount of 50% of the claim admissible for her hospitalization at Hinduja Hospital during the period 13.10.2006 to 20.10.2006.

The claim of Smt. Bernice Colaco for her hospitalization at Vrundavan Hospital & Research Centre, Goa, from 18.09.2006 to 19.09.2006 is not tenable.

Mumbai Ombudsman Centre

Case No. : GI-292 of 2007-2008
Shri Sukhveer Rameshwar Shastri
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated : 31.10.2007

Shri Sukhveer Rameshwar Shastri has a Health Shield Insurance Policy No.H000005583000103 for sum insured Rs.1.00 lakh from Royal Sundaram Alliance Insurance Co. Ltd. His dispute with the Company was the quantum of claim settlement. He was admitted to Mahima Hospital & Polyclinic & ICCU. He was operated for Fistula in ano on 11.03.2007. Shri Sukhveer R. Shastri submitted a claim for Rs.21,968/- to the Company. The Company settled the claim for Rs.10,000/-.as per policy conditions. He approached the Company for the balance payment of Rs.11,968/-. Getting no response from the Company, he approached this forum with his grievance.

On going through the documents submitted, Shri Sukhveer R. Shastri had taken a Health Shield Insurance Policy for Sum Insured Rs.1.00 lakh. He was admitted to Mahima Hospital & Polyclinic & ICCU from 10.03.2007 to 13.03.2007. He was diagnosed for Fistula in ano and a Fistulectomy was performed on 11.03.2007. He submitted a bill for his hospitalization and post care for a sum of Rs.21,968/-. The Company vide their letter dated 22.03.2007, settled his claim for Rs.10,000/- as per policy terms and conditions which read as under:

"The Claim amount payable towards the treatment of following : Piles, Fistula, Fissure, Tonsilitis, Sinusitis 10% of the Sum Insured subject to maximum of Rs.30,000/-

The policy terms & conditions very clearly states that for the above operation of Fistulectomy, 10% of Sum Insured is payable. The Insured is insured for Sum Insured of Rs.1.00 lakh and as per the policy terms and conditions, the Insurer has reimbursed Rs.10,000/- being 10% of the sum insured towards hospitalization expenses. Under the circumstances, the Insurer is justified in reimbursing 10% of sum insured towards hospitalization expenses to the Insured.

Mumbai Ombudsman Centre
Case No. : GI-295 of 2007-2008
Dr.Smt. Chaula M Doshi
Vs
The United India Insurance Co.Ltd.

Award Dated : 01.11.07

In the matter of above complaint, the facts are as under:

Dr.Smt.Chaula M Doshi, along with her husband, two children and mother-in-law, had a Mediclaim Policy. The Policy was issued without any exclusions for every one except Smt.Vijayalaxmi in whose case both Cataract and Hypertension were excluded. She was hospitalized at for treatment of HT c Bronchitis c IHD and from 28.9.2006 to 29.09.2006 for Unstable Angina. When Smt.Chaula M Doshi preferred a claim , it was settled for Rs. 14433/-, the reason for deduction of the balance claim amount was that investigation related to heart ailment not covered as per policy. Then Smt.Doshi approached the Office of the Insurance Ombudsman, Mumbai, with her letter dated 9.7.2007 and the parties were called for a hearing 19.10.07. Dr. Mahesh Doshi, husband of the complainant, on due authorization from her, appeared and deposed before the Ombudsman. He stated that his mother, Smt.Vijayalaxmi, suffered from a very rare

disease, Idiopathic Pulmonary Arterial Hypertension (IPAH). He further contended that although his mother was admitted with symptoms of Hypertension and IHD, these were due to the Primary disease (PAH) which she suffered from and hence his claim should be settled in full. Shri S K Das, the Insurer's representative stated that the partial settlement was made for Smt.Vijayalaxmi's Hospitalisation at Matangi Hospital for Bronchitis. As per the policy conditions, Hypertension and Cataract were excluded. Hence any ailment related to Hypertension would also fall under the said exclusion. Hence he defended the Insurer's decision.

A deeper scrutiny after study of various documents revealed that the policy was issued with the declaration of HTN and cataract for which there was a clear exclusion in the policy . In the context of this exclusion, it would be appropriate to note that the Company rejected the claim initially as it was for IHD. Under such circumstances, this Forum does not find any fault with the action of Insurer in repudiating the claim of Dr.Smt.Doshi, partially, based on the Hospital Records submitted while at the time of claim. They had settled the claim in respect of expenses incurred at the Matangi Nursing Home on the basis of the diagnosis which was 'HT c Bronchitis' taking it as a treatment for Bronchitis disallowing expenses for treatment of HTN. Hence the Insurer's decision was upheld.

Mumbai Ombudsman Centre
Case No. : GI- 112 of 2007-08
Shri Vinod H. Parmar
Vs
The New India Assurance Co. Ltd.

Award Dated : 07.11.2007

Shri Vinod H. Parmar along with his mother was covered under Mediclaim Policy No.150306/34/06/20/00000515. Shri Vinod H. Parmar submitted a claim for the hospitalization of his mother, Smt. Shanbai H. Parmar to Jehangir Hospital, Pune for Coronary Artery Bypass Grafting. He requsted for a Pre Cashless approval for Rs.1,85,000/- The TPA, Medi Assists India Pvt. Ltd. granted approval for Rs.1,03,500/- on 08.04.2007. The Final bill for claiming the sum insured of Rs.1,25,000/- was sent. The TPA Medi Assists India Pvt. Ltd. sent a fax canceling pre-authorisation of cashless facility since the patient was suffering from Hypertension since last 15 years. The claimant was asked to pay the hospital bills before discharge.

Shri Vinod Parmar, Complainant, appeared and deposed before the Ombudsman. He submitted that his mother Smt. Shantibhai Parmar was admitted to Jehangir Hospital on 30.03.2007 for uneasiness and after Angiography she was advised for coronary Artery Bypass surgery. Pre cashless approval for Rs.1,03,500 was given by the TPA, M/s. Mediassists and the insured was again hospitalized on 09.04.2007 and operated and he submitted final bill for Rs.1,25,000. He was surprised to see that Mediassists had sent a fax stating that pre-authorisation of cashless facility stands cancelled as the insured was suffering from Hypertension since 15 years. He further submitted that his mother had mild hypertension since 3-4 years, which were controlled by diet restrictions. He pleaded for full settlement of his claim.

The Company was represented by Vijayendra Thorbole, Branch Manager, submitted that the insured has been covered under policy since 7 years but Discharge summary of the hospital reveals Hypertension since 15 years. Cashless facility was sanctioned earlier since this information was not reported. He further submitted that the complainant has not yet submitted his claim papers and he has approached the Ombudsman without filing a formal claim to the Insurance Company.

The complainant was advised to submit the claim papers to the Insurer and also give the proof for the onset of the Hypertension. With this direction the present complaint was closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-167 of 2007-2008
Smt.Daxa K Shroff
Vs
The New India Assurance Company Limited

Award Dated : 14.11.2007

Shri Ketan Navin Shroff was covered under a Mediclaim Policy. Shri Shroff was admitted for Acute Infective Diarrheoea and Dehydration with Chronic Liver Parenchymal disease. He was admitted a second time for the period from 4.11.2006 upto 14.11.2006 on which date, unfortunately, he expired. When Smt.Daxa K Shroff preferred a claim for the said hospitalisations with the Insurer, while the claim for the first hospitalization of Late Shri Shroff was settled, the Third Party Administrator of the Company M/s Raksha TPA, repudiated the claim for Rs. 83,306/- towards reimbursement of expenses for the second hospitalization , by invoking clause 4.1 of the mediclaim policy. Their contention was that as per the Consultation Papers submitted by Smt Shroff pertaining to Shri Ketan Shroff, dated 9.11.06, his liver disease was more than five years of duration which falls prior to the policy .Smt.Daxa K Shroff approached this Forum, and parties were called for hearing on 10.10.07.

Smt. Shroff was admitted in the hospital from 14.10.06 to 20.10.06 and the Insurance Company settled the claim. When he was again admitted for a second time in the hospital for Liver Cirrhosis, the claim was rejected based on the doctor's certificate where it was mentioned that the patient was having Chronic Liver Disease for more than five years. The point was clarified by the doctor subsequently but the company did not agree for settlement.The New India Assurance Company Representative submitted for settlement of this claim, they had asked the party to submit the indoor case papers, which were not received by them. Based on the letter from the treating doctor, they have rejected the claim as chronic liver disease was for more than five years which is prior to the inception of the policy.

On scrutiny, it was found that the New India Assurance Company has not taken cognizance of the subsequent letters issued by the doctor stating that it would be absolutely wrong to conclude that the patient was a known case of chronic liver disease and the present cirrhosis manifested due to acute systemic infection. While the Insurer has accepted this contention of the doctor, they have refused the further opinion/contention of the doctor terming them to be 'second intentions'. The repudiation of the claim is, therefore, not sustainable.

Mumbai Ombudsman Centre
Case No. : GI-373 of 2007-2008
Shri Sarju B. Saini
Vs
Bajaj Alliance General Insurance Co. Ltd.

Award Dated : 14.11.2007

Shri Sarju B. Saini alongwith his wife Smt. Brijbala Saini were covered under Mediclaim Policy No.OG-07-1901-8401-00000699 by The Bajaj Alliance General Insurance Co.

Ltd. His wife Smt. Brijbala Saini was having severe headache for which she was admitted in Dev Nursing Home under Dr. Rajesh Yadav from 18.04.2007 to 24.04.2007. Since the problem persisted, he admitted her to PD Hinduja National Hospital & Medical Research Centre after undergoing CT Scan & MRI Test. She was admitted from 13.05.2007 to 19.05.2007 and was operated for Colloid Cyst. He preferred a claim to the Company. The Company repudiated the claim under exclusion clause C.11 stating that in the Discharge summary of PD Hinduja Hospital it states that the patient is diagnosed of having Colloid Cyst which is congenital in nature. Medical expenses incurred towards treatment of congenital disease is a standard exclusion as per exclusion clause C-11. Shri Sarju Saini represented his case to the Grievance Cell and also produced certificates issued by Dr. Rajesh Yadav and the Operating Surgeon Dr. B.K. Mishra stating that the Cyst was not a congenital disease.

Aggrieved by their decision, Shri Sarju Saini approached this Forum for justice. However, in the meantime, we have received a letter from the Company stating that they have reconsidered the claim of Shri Sarju Saini for hospitalization of his wife, Smt. Brijbala Saini and have settled the claim amount of Rs.1,11,250/- vide cheque No.744955, dated 9th October, 2007, as full and final settlement of his claim under policy No.OG007-1901-8401-00000699.

As the dispute for the claim settlement has been resolved, the complaint is closed.

Mumbai Ombudsman Centre
Case No. : GI-408 of 2007-2008
Shri Dilip Mali
Vs
The Oriental Insurance Company Ltd.

Award Dated : 15.11.2007

Shri Dilip Mali who was covered under the Mediclaim policy issued by The Oriental Insurance Company Ltd. He had approached the Office of the Insurance Ombudsman seeking intervention of the Ombudsman in settlement of his claim under policy No.121300/48/07/2989. Smt Sonal Mali, was admitted to Dr. Sankhe's Vijaya Maternity and General Hospital on 12.01.2007 for Primary Infertility and had undergone Hystero-Laparoscopy. M/s. Raksha TPA repudiated the claim by their letter dated 21.02.2007 stating that as per the standard policy terms and conditions any expenses related to Infertility is non payable under exclusion clause 4.8.

The analysis of the case reveals that the Company rejected the claim on the basis that the primary cause for the surgery was Primary Infertility hence as per the exclusion clause 4.8 of the mediclaim policy the claim was not payable. The main dispute between the Insured and Insurer is on the meaning of the words "Sterility" and "Infertility". Let us examine the meaning of these words according to the Oxford Dictionary.

Infertility – means unable to reproduce
Sterility – means not able to produce children
According to Oxford concise Medical Dictionary the words means –
Infertility – Inability in a woman to conceive
Sterility - Inability to have children, either due to Infertility or deliberately induced by surgical procedures as a means of contraception.

According to the Insured, his grievance is that the word "Infertility" is not mentioned in the exclusion clause 4.8 and only the word "Sterility" is mentioned and according to

him the claim should be settled. We should also examine the cause of hospitalization. According to the Discharge Card, Smt. Sonal Mali was hospitalized on 12.01.2007 and Infertility Hystero-laproscopy was performed on 13.01.2007 and discharged on 14.01.2007. Smt. Sonal Mali, as such did not get admitted to the hospital due to any sickness or emergency health problem. She was admitted to the hospital for the sole purpose for evaluation of her problem for not conceiving. As such, she was unable to conceive. According to the insurer, the intention of the contract is not to cover infertility or sterility, as the same bear uniform meaning – the former relating to inability to conceive and the latter indicating to absent capacity to conceive.

In view of the above, the contention of the Insurer is tenable.

Mumbai Ombudsman Centre
Case No. : GI- 49 of 2007-2008
Shri Rajendra Daftary
Vs
New India Assurance Co. Ltd.

Award Dated : 19.11.2007

Shri Rajendra Daftary was covered under Mediclaim Policy No.110800/48/06/20/70001602 for sum insured Rs.5 lakhs Shri Rajendra Daftary was hospitalized at Lilavati Hospital & Research Centre and underwent surgery for Perianal Abscess.

When the claim for Rs.1,19,280/- was submitted by Shri Rajendra Daftary for his hospitalization and treatment, the TPA, M/s. Medi Assist India Pvt. Ltd partially settled the claim for Rs.61,103/- disallowing 50% of the claim amounting to Rs.59,640/- towards excess Doctors' charges and Operation Theatre charges.

Analysis of the case reveals that Shri Rajendra Daftary was admitted to Lilavati Hospital & Research Centre from 10.06.2006 to 17.06.2007 for surgery of perianal abscess. The TPA settled the claim for Rs.61,103/- as against his claim of Rs.1,19,280/- mainly on the ground that the surgeon's charges and operation theatre charges were quite high and particularly this minor surgery does not require the patient to be hospitalized for 7 days. In other words, the dispute is only on the quantum of claim sanctioned which could not satisfy the Insured. The TPA submitted the tariff chart for the said surgery from five reputed and recognized hospitals namely, Lilavati Hospital, Hinduja, Wockhardt, Bhatia Hospital and S.R. Mehta Hospital On going through the Tariff Chart, it is observed that the fee for the surgeon's charges and operation theatre charges were low. Let us compare the tariff submitted by Lilavati Hospital to the Insurance Company and the actual amount collected by the Hospital from the Insured (Patient) where he had undergone surgery.

Under Intermediate Category	**Tariff submitted to Insurance Company**	**Actual Amount collected from the Insured (Patient)**
Surgeon Charges	Rs. 2,800/-	Rs. 46,000/-
Operation Theatre Charges	Rs. 7,000/-	Rs. 13,500/-
Anaesthetist Fees	Rs. 6,400/-	Rs. 10,500/-
Total	Rs. 26,200/-	Rs. 70,000/-

From the above, it is seen that under the above heads the total amounts to Rs.26,200/- whereas the hospital has charged the Insured Rs.70,000/-. The Insured has undergone

the surgery for which the hospital bill was submitted and settled by him. If the Company and TPA find that the charges for the above heads are high, they should take up the matter with the hospital as they have a tie up with the said hospitals for which tariffs are provided for different surgeries. The insured has submitted the bill from the hospital and it is a clear and valid bill for which he is requesting the full reimbursement of his claim.

Under the circumstances, it would be appropriate for the Insurance Company/TPA to take up the matter with the concerned hospital instead of penalizing the Insured. The policy condition does not indicate any cap on the fee charged by the hospital and Lilavati Hospital being one of the hospitals taken into consideration by the TPAs while comparing the charges for reasonability, in view of this, settlement of claim by 50% reduction is not justified. The Insurer is directed to settle the admissible expenses as per the claim lodged by the Complainant.

Mumbai Ombudsman Centre
Case No. : GI-734 of 2006-2007
Shri Jumma Azizuddin Kasamali
Vs
The New India Assurance Company Limited

Award Dated : 23.11.2007

Shri Jumma Azizuddin Kasamali , along with his family consisting of his wife and mother, was covered under the mediclaim policy. Smt Habibeh, wife of the complainant was hospitalized at Meena Nursing Home, Kandivali (West), Mumbai, from 19.12.2005 to 30.12.2005 for Enteric Fever with Jaundice and was treated conservatively. When Shri Kasamali submitted his claim to the Company, the TPA, repudiated the claim on grounds of Clause 5.7 of the Mediclaim Policy conditions Aggrieved he approached this Forum and a joint hearing was fixed and the parties to the dispute were called on 15.11.2007.

Shri Jumma Azizuddin Kasamali submitted that his claim for his wife's hospitalization at Meena Nursing Home, Kandivali, for the period from 19.12.05 to 30.12.05 has been rejected by the Insurer without any investigation. He appealed to the Ombudsman to consider his case favourably.

The New India Assurance stated that they had appointed an investigator who found that the said hospital was always closed . The pictures of the closed hospital were produced before the Forum. Also, the Insurer had received another certificate , from Dr.Maredia wherein he has stated that the claimant's wife was under his treatment for Pyrexia and URTI for the period from 19.12.05 to 30.12.05 on an OPD basis and this is the same period for which the claim was made by Shri Kasamali. Shri Jana, therefore, defended the decision of the company to repudiate the claim as fraudulent.

The relevant records have been perused. An analysis of the case reveals the dispute is resting on the authenticity of the Insured's hospitalization at Meena Nursing Home. The records produced before this Forum prove that sufficient and cogent evidences have been put forth by the Company against the Hospital/Hospitalisation of Smt.Habibeh, which gives valid grounds to deny the claim.

In view of this, no relief could be made available to the Complainant from this Forum, he was directed to seek relief from any other Forum, which he deems fit. The case was treated as closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-356 of 2007-2008
Shri Sunder N Phatnani
Vs
The New India Assurance Company Limited

Award Dated : 23.11.2007

Shri Sunder N Phatnani, along with his wife, was covered under a Mediclaim policy. Shri Phatnani was admitted to Nair Hospital for evaluation of dysphagia (difficulty in swallowing) where, he underwent some diagnostic tests When Shri Phatnani preferred a claim for the expenses incurred by him .the TPA repudiated the claim invoking clause 4.1 and clause 4.10 of the mediclaim policy stating that Shri Phatnani suffered from dysphagia for the last 30 years, which made it pre-existing and that hospitalization was mainly for investigation purpose. Hence being aggrieved at the decision of the Company, Shri Sunder Phatnani, approached this Forum and both the parties were called for a hearing on 19.11.2007. Shri Sunder N Phatnani stated that he never knew about the disease although he had to take water to swallow solid food since many years but he never knew that he was suffering from dysphagia. He appealed to the Ombudsman to consider his case favourably so that his claim be settled by the Insurance Company. The Insurer's representative stated as per the discharge card, patient was suffering from dysphagia since last thirty years. Hence it was pre-existing. Also, Shri Phatnani's hospitalization was only for diagnostic purpose.

The analysis of the rejection of the claim by The New India Assurance Company Limited would reveal that the Company has gone by the medical records .

An analysis reveals that Shri Phatnani under went the pathological tests on the advice of Dr. S J Bhatia of Nair Hospital. The applicability of clause 4.10 has to be seen with reference to the questions viz., whether the charges that were incurred were for tests done primarily for diagnostic purpose and whether the tests done were consistent with or incidental to diagnosis and treatment. From the history noted in the discharge card of the hospital, Shri Phatnani was a case of Dysphagia. It is evident that he was hospitalized for investigations for further evaluation and was prescribed medicines and advised further tests as part of the investigation process. Hence, it can be concluded that the tests done on Shri Phatnani were consistent with and incidental to the diagnosis and treatment. Hence the Insurer's decision was held not tenable.

Mumbai Ombudsman Centre
Case No. : GI- 360 of 2007-2008
Shri Tilagar S. Naidu
Vs
United India Insurance Co. Ltd.

Award Dated : 30.11.2007

Shri Tilagar S. Naidu was covered under Mediclaim Policy No.121401/48/05/20/00002402 for the period 31.03.2006 to 30.03.2007 for sum insured Rs.1 lakh issued by the United India Insurance Co. Ltd. Shri Tilagar S. Naidu was hospitalized at Date Surgical & Maternity Hospital from 29.07.2006 to 31.07.2006 for Fistula in Ano. When the claim for Rs.15,656.95 was submitted by Tilagar S. Naidu for his hospitalization and treatment, the TPA, M/s. Med Save Health Care Ltd. partially settled the claim for Rs.14,084/- less by Rs.1,572.95

Shri Thilagar S. Naidu appeared and deposed before the Ombudsman. He submitted that he was hospitalized for Fistula in Ano from 29.07.2006 to 31.07.2006 for which he

submitted a claim of Rs.15,656.95. However, the TPA, M/s. Med Save Health Care Ltd. partially settled the claim for Rs.14,084/- disallowing Rs.1,572.95. He stated that he submitted all the bills and his claim for the full amount should be settled. Regarding his grievance for the current policy where the Insurer has charged 100% loading and deducted the cumulative bonus of 10% to Nil., he was advised to take up the matter with the Insurer as this matter is not entertainable at this Forum.

United India Insurance Co. Ltd. was represented by Smt.Vijaya K. Prasath, Asstt. Manager. She stated that the TPA has admitted that there was some discrepancy in the calculation of the claim amount and that there was some dispute regarding two bills. She promised that she would be taking up the matter and her office would be settling the balance admissible claim.

We have received a letter dated 29.11.2007 from the Company stating that Medsave Healthcare Ltd. (TPA) has settled the balance claim amount of Rs.1,400/- for the hospitalization of Shri Thilagar S. Naidu for the period 29.07.2006 to 31.07.2006. As Insurer has agreed to settle the claim, the Complaint is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI- 329 of 2007-2008
Shri Vinod B. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 06.12.2007

Shri Vinod B. Shah took an Individual Mediclaim Policy No.111700/48/06/20/70002650 with sum insured Rs.3/- lakhs for the period 03.07.2006 to 02.07.2007. Shri Vinod B. Shah was admitted to the Kottakkal Arya Vaidya Sala, Ayurvedic Hospital and Research Centre, Kottakkal on 05.11.2006 and was discharged on 17.11.2006 after the course of treatment for Amlapitham (Digestive Disorder). When he preferred a claim under the Policy, the Third Party Administrator, M/s Raksha TPA repudiated the claim invoking clause 4.10 of the mediclaim policy. Their contention was that the Ayurvedic therapy which included Kashaya Vasthy, Pizhichil, Thailadhara, Abhyangam, all these procedures comprise of external application of medication and does not require any special medical observation during or post procedure and are therefore done on OPD basis. After perusal of the records parties to the dispute were called for a hearing on 27.11.2007.

The papers which have been brought on record state that the Insured underwent Ayurvedic treatment from Kottakkal Arya Vaidya Sala, Ayurvedic Hospital and Research Centre, Kottakkal and took treatment from 05.11.2006 to 17.11.2006. Ayurvedic therapy which included Kashaya Vasthy, Pizhichil, Thailadhara, Abhyangam were given. The treatment was in the form of massage etc. and oral medications and no emergency was reported before hospitalization. The Complainant has also not produced any medical documents for treatment taken prior to hospitalization.

The Complainant admitted that he had earlier got himself admitted in the same hospital from 02.04.2006 to 20.04.2006 for the same treatment of Amlapitham and his claim was settled. This points to the fact that his was a case of complete diagnosis done well before the second hospitalization and in fact, the line of treatment was also available in the said stream of medicine. Therefore, it was a conscious decision by Shri Vinod Shah to avail the treatment in the same hospital.. Unfortunately under the terms of the Mediclaim policy his claim would fall under clause 4.10 where hospitalization is not justified and there was no serious emergency of some health problem. The Insured was

capable of undertaking a journey to Kottakkal to receive a special treatment. It is also to be noted that both the Complainant and his wife were admitted in the same hospital during the same period both the times except some difference during the second hospitalization and the line of treatment was same in both the cases.

After thorough examination of the papers submitted by the Complainant and the Company it was found that Shri Vinod B. Shah was confined to hospital for about 13 days and the line of treatment given was oral medications, oil therapies with certain dietary and physical restrictions which were repetitive 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 – 264 of 2007-2008
Shri Visariya Devchand Keshavji
Vs
The New India Assurance Co.Ltd.

Award Dated : 10.12.2007

Shri Visariya Devchand Keshavji was covered under the Mediclaim Policy No.112500/48/06/20700/11485 for the period 29.07.2006 to 28.07.007. The inception of the policy was from the year 1998. He was admitted to Ramakrishna Mission Hospital from 18.10.2006 to 27.10.2006 for Acute Severe Cellulitis. M/s Raksha TPA Pvt. Ltd. repudiated the claim under exclusion clause 4.1 of the policy terms & conditions. A joint hearing was fixed and the parties to the dispute were called on 19.11.2007 at 3.00 P.M..

The Admission Form of the hospital states that he was admitted with complaints of swelling of leg with ulceration and redness – no major illness, L/E serious discharge + swelling + redness. The Origin: Duration: Progress (O.D.P.) is mentioned as No previous surgery, No H/o TB, DM, Asthama, Jaundice. Pt. Had H/o filariasis 5-6 months back and had taken medicines for the same. The Medical Treatment sheet for treatment on 18.10.2006 states – with pre h/o Filariasis 10 days which appears to have been overwritten but initialed . Taken Rx 5-6 months. On the noting for day 21.10.2006 by Dr.Modi states Pt. Has chronic filarial . According to the Insurer the Complainant had chronic filarial cellulities meaning very old ailment. This does not prove that the disease was prior to inception of the policy. The inception of the policy was on 29.07.1998. There is a gap of eight years from date of disease to the inception of policy. About the point raised by the Insurer that filariasis is 15 years history on page No.4 of Indoor case paper – there has been overwriting to 10 days but the same has been initialed by the attending Doctor. If there is a doubt by the Insurer about the overwriting, they should ascertain the same with the hospital.

From the above analysis and documents on record the contention of the Insurance Company to treat it as pre-existing is not justified. The repudiation of claim under Clause 4.1 is not tenable.

Mumbai Ombudsman Centre
Case No. : GI- 123 of 2007-2008
Shri Vinod C Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 11.12.2007

Shri Vinod C Shah, alongwith his wife, was covered under a Mediclaim Policy Smt Sushila V Shah was admitted to Jaslok Hospital for Endovenous Laser Treatment for Varicose Veins from 31.10.2006 to 01.11.2006, the TPA of the Insurer, paid Rs.1,02,000/- out of the total claim of Rs.1,20,000/- stating that they have settled the same as per package rate signed by the Hospital with them for treatment of Varicose Veins. Dissatisfied with the above settlement, Shri Vinod C Shah represented his case to the Office of the Insurance Ombudsman vide his letter dated 12.5.2007, seeking the Ombudsman's intervention in the matter for settlement of his full claim.

After perusal of the records parties to the dispute were called for a hearing on 10.12.2007. Shri Vinod C Shah submitted that when Cash-less facility was applied with the TPA, for Rs.1,20,000/-, they paid only Rs.1,02,000/-. So, he had to pay the balance of Rs.18,000/- from out of his pocket at the time of his wife's discharge from the hospital. He appealed for settlement of the balance amount of his claim. The New India Assurance Company was represented by Shri V S Swamy, ABM. He submitted that Rs.18,000/- was disallowed as per the reasonability clause.

A circular issued by the same hospital confirms the charges per leg as Rs. 60,000/- per leg. A copy of the Pre-authorisation Request form states the total expected cost of hospitalization as Rs.1,20,000/- and it is signed by a doctor of the said Hospital.

The TPA settled the claim for Rs.1,02,000/- as against Shri Shah's claim of Rs.1,02,000/- mainly on the ground that they could not reimburse the amount exceeding the package rate and that the above hospital, Jaslok Hospital, is their tariff network hospital and that they had settled the above amount as per package rate signed for the treatment of varicose veins by the above Hospital.

It is unfortunate that the New India Assurance Company Ltd. did not think it proper to verify the tariff rate with the Hospital before partial rejection of the expenses incurred by Shri Shah. Also, they have not taken into consideration, either the letter issued by Dr. Shoaib F Padaria where he had stated about the package per leg (As Rs.60,000/-) nor the circular in this regard of Jaslok Hospital which clearly enunciates the charge per leg as Rs.60,000.

Hence, there is no reason to disallow a part of the expense necessarily charged by the Hospital and incurred by the claimant.

In view of the above facts and circumstances, partial repudiation of the claim by the New India Assurance Company was not tenable.

Mumbai Ombudsman Centre
Case No. : GI- 123 of 2007-2008
Shri Vinod C Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 11.12.2007

In the above mentioned Award, the Insurer was directed to settle the balance amount of Rs.18,000/- to the complainant towards the expenses incurred by him for his wife's hospitalization for the period from 31.10.2006 to 1.11.2006. The TPA, M/s TTK Healthcare Services Private Limited, vide their letter dated 8.1.2008 have informed us that during the policy period from 17.7.2006 to 16.7.2007, a total amount of Rs.133790/-, for three claims, was settled, leaving a balance of only Rs.16,210/- which is less than Rs.18,000/-. Accordingly, the Order is amended and should be read as under:

ORDER

In view of the facts as above, the New India Assurance Co.Ltd., is directed to settle an amount of Rs.16,210/- being the actual balance in the policy, in addition to the amounts already settled by them on Policy No. 111800/48/06/20/7000441 to Shri Vinod C Shah for the hospitalization of his wife from 31.10.2006 to 1.11.2006 for treatment of Severe Varicose Veins. There is no order for any other relief. The case is disposed of accordingly.

The above case was posted for hearing on 17.10.2007. The Complainant came for deposition but the representative of the Insurance Company was absent.

We had requested the Company in our Form PIV asking for a self contained written statement on 13.07.2007. We are sorry to state that we have not received even the statement alongwith the their comments on the complaint.

We had written to the Company on 14.9.2007 regarding the hearing to be held on 17.10.2007. When we contacted the Divisional Manager, he asked whether it is not enough if the TPA attends the hearing as the TPA only handles the matter and accordingly M/s. Raksha TPA was asked to attend the office.

As per RPG Rules, 1998, the Complainant has to send a representation to the Company regarding his grievance and the Company is expected to examine the case looking to the complaint and the additional information supplied by the aggrieved party. The view taken by your office is not acceptable and shows a lack of concern and also keeps the Forum in the dark as to whether the Company has reviewed the matter in the light of the complaint.

The Contract of Insurance is between the Insured and the Insurance Company and the TPA is only a service provider engaged by the Insurer and he is allowed to assist the officer representing the Company. We thought it proper to bring the matter to your notice so that you can take appropriate action. Here, we may add, invariably we are not getting the written statement from your office.

Mumbai Ombudsman Centre
Case No. : GI- 303 of 2007-2008
Shri Arun Kantilal Doshi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 12.12.2007

Shri Arun Kantilal Doshi was covered under Individual Mediclaim Policy No.121100/48/06/2480 for the period 25.09.2005 to 24.09.2006. Shri Arun K. Doshi was hospitalized at Breach Candy Hospital Trust from 01.02.2006 to 05.02.2006 for Unicompartmental Knee Anthroplasty. When the claim for Rs.2,47,787/- was submitted by Shri Arun K. Doshi for his hospitalization and treatment, M/s. Raksha TPA Pvt. Ltd. partially settled the claim for Rs.1,96,390/-. They disallowed an amount of Rs.51,397/-. Out of surgeon's fees of Rs.1,00,000/- which included anesthesia charges, assistant charges and visit charges, the TPA settled Rs.60,000/- and other items amounting to Rs.11,397/- were disallowed. Reasonability clause has been applied.

As per the hearing, the dispute of the Insured with the Insurer is for an amount of Rs.35,000/- (Rs.25,000/- Surgeon's fees and Rs.10,000/- Assistant charges).

The TPA have made comparison with other reputed hospitals. It is well known that the hospitals are having various fee charts for different surgeries and broadly they are classified into major and minor. Even considering that the TPA and the Company felt that the charges were higher and therefore, they went by the policy conditions which

governs the payment being reasonably and necessarily incurred. The Company submitted the comparative data of surgeon's fees for the said surgery of different hospitals. The TPA submitted the comparative surgeon's charges for the said surgery of four hospitals .

Taking an overall view of the surgeon's fees quoted by other hospitals, the Insurer has settled Rs.50,000/- disallowing Rs.25,000 towards Surgeon's fees and 10,000/- towards Assistant charges. The Complainant produced a settlement advice from Medi Assist, TPA, pertaining to The New India Assurance Co.Ltd. for a similar ailment where the patient was admitted to Lilavati Hospital and the treating Doctor was Dr. Arun Mullaji and the Surgeon's fee was settled for Rs.1,01,050/- without applying the Reasonability Clause. Though the TPA and Company are different, but the Company is a Public Sector Company and the TPA is a licensed TPA

In view of this, the stand of the Insurer for deducting charges under Reasonability Clause is not sustainable. The Insurer is directed to settle the balance amount deducted.

Mumbai Ombudsman Centre
Case No. : GI- 364 of 2007-2008
Shri Kohli Inder Singh
Vs
The New India Assurance Co.Ltd.

Award Dated : 13.12.07

Shri Kohli Inder Singh alongwith his wife Smt. Jasbir Kaur Kohli were covered under Mediclaim Policy No.110900/48/05/90770 for the period 20.12.2005 to 19.12.2006. Smt Jasbir Kaur Kohli was admitted to Beramji's Hospital for treatment of Bilateral Osteoarthritis of Knee Joint with Sciatica from 27.11.2006 to 08.12.2006.

When the claim for Rs.54,050/- was submitted by Shri Kohli Inder Singh for hospitalization and treatment of his wife, M/s. Paramount Health Services Pvt. Ltd., TPA, vide their letter dated 15.01.2007 repudiated the claim on the grounds that during hospitalization no active line of treatment was given and hence for the said ailment treatment not justified for hospitalization and hence the claim is not admissible.

A letter dated 3rd December, 2007, from The New India Assurance Co.Ltd. was received by this office with reference to the hearing on 28.11.2007. Regarding reference of a similar case pertaining to Smt. Krishnadevi Narula whose claim was settled on similar line of treatment as of Insured's, the Company states that Smt. Krishnadevi Narula was given traction say 6-8-10 kgs for which hospitalization was justified as the same cannot be taken on an outdoor patient. As regards the case of Smt. Jasbir Kaur Kohli, the Company maintains the same stand of rejection of claim under clause 4.10.

Analysis of the case reveals that Smt. Jasbir Kaur Kohli was admitted to Beramji's Hospital for treatment of Bilateral Osteoarthritis of Knee Joint with Sciatica from 27.11.2006 to 108.12.2006. The indoor case papers reveal that the patient was admitted with pain in knee since about 6 months with inability to sit/stand and walk for more than 10 minutes. Great difficulty in squatting and is forced to take support while climbing up & down stairs. Associated with pain in lower back with pain radiating to both calf with sensation of heaviness and numbness. X-Ray knees: Knee joint spaces appear reduced, more at medial compartments. Cervical: C5-6 space appears reduced. L.S. Spine: Changes seen at lumbar cervical vertebrae in the form of marginal osteoporosis The Treatment from 27.11.2006 to 08.12.2006 was complete bed rest.

Myossal oil for LA. TENS on Knee and both legs, Ultra on Knee and back Autiplast on knee. From 29.11.2007 Physiotherapy treatment was given with exercises. The Complainant has produced a letter dated 20.12.2006 from Dr. R.F.Beramji certifying that “Mrs. Jasbir Kaur Kohli had been admitted at the above hospital on 27.11.2006 for treatment of Osteoarthritis of Knees with Bilateral Sciatica and Spondylosis of spine. As he c/o pain in knee since about 6-7 months with inability to sit/stand and walk for more than 10 minutes. Patient had great difficulty in squatting and was forced to take support while climbing up and down stairs. Patient also c/o associated pain in lower back with pain radiating to both calf with sensation of heaviness and numbness since 2-3 months. And hence was hospitalized in above hospital for conservative line of treatment with intensive physiotherapy.

Shri Kohli Inder Singh has also produced copies of Claim Settlement Voucher in respect of two similar cases pertaining to Oriental Insurance Co. Ltd. where the claim has been settled. It is to be noted that each case has its own merit for settlement or rejection and without studying the indoor case papers it is not proper to comment on the case. However, looking at the age of the patient and her condition before her hospitalization the total rejection of the claim in not justified. Taking all the facts on record it will be proper to strike a balance to settle the claim for 80% of the admissible expenses.

Mumbai Ombudsman Centre
Case No. : GI- 316 of 2007-2008
Shri Bhanu S. Desai
Vs
The New India Assurance Co.Ltd.

Award Dated : 13.12.2007

Shri Bhanu S. Desai alongwith his wife Smt. Kumudini B. Desai were covered under Mediclaim Policy No.111200/48/06/20/70005097 for the period 07.08.2006 to 6.08.2007. Smt Kumudini B. Desai was admitted to Jaslok Hospital & Research Centre with Gastric Motility Disorder with Depression from 21.08.2006 to 29.08.2006. When the claim for Rs.79290/- was submitted by Shri Desai for hospitalization and treatment of his wife, Raksha TPA repudiated the claim under clause 4.1 & 4.10 of the policy terms and conditions stating that the disease was pre-existing and the line of treatment and investigation does not warrant hospitalization.

Analysis of the case reveals that Smt. Smt Kumudini B. Desai was admitted to Jaslok Hospital for treatment of Gastric Motility Disorder with Depression from 21.08.2006 to 29.08.2006. She was admitted with complaints of dryness of mouth and eyes with chronic constipation. The noting of the progress record and treatment sheet of 22.08.2007 states that “Digital evacuation > 20 years”. The progress record and Treatment sheet reveal that Smt. Desai during her entire hospitalization from 21.08.2006 to 29.08.2006 was treated orally with medicines and given enema for constipation.

Shri Desai has produced certificates from Dr. Deepak N. Desai dated 18.08.2006 wherein he states that Smt. Desai was under his treatment for colitis & irritable colon from March 2006 and advised her to consult a specialist for further investigation and if necessary for hospitalization. A certificate from Dr. Samir R. Shah states that Smt. Desai had to be hospitalized for further treatment as it was impossible to manage her at home because of her weakness and inability to walk. A certificate from Dr. Samir R. Shah, dated 06.01.2007 states she had difficulty to evacuate stools and the investigations were all negative apart from solitary rectal ulcer. She however remained

well till 2006 and had to be admitted with a four months history of weakness, inability to walk and severe constipation with depression.

According to the Treatment sheet of the hospital, Smt. Kumudini Desai was under oral treatment. She was treated with tablets and enema for relief. The Raksha TPA vide their letter dated 21.02.2007 informed the Claimant the reasons for rejection. However, looking to the age of the Complainant and her pre-hospitalization condition, I am inclined to allow 50% of the admissible expenses on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI-401 of 2007-2008
Shri Laxman G Bhagchandani
Vs
The National Insurance Co.Ltd.

Award Dated : 14.12.2007

Shri Laxman G Bhagchandani, along with his wife, Smt. Meena, was a member of a Mediclaim Policy. Smt.Bhagchandani, was hospitalized and underwent Surgery for Ventral Hernia. When Shri Bhagchandani preferred a claim towards the expenses incurred, the TPA repudiated the claim, on the ground that “the patient underwent cholecystectomy operation four years back.” According to the document received from Insurance Company , there was no claim for the same and the hernia was due to previous cholecyctectomy operation.” Aggrieved, Shri Bhagchandani approached the Insurance Ombudsman and sought justice. After perusing the records, both the parties were given an opportunity to present their case at the personal hearing on 4.12.2007. The complainant submitted that a claim was not made for his mother’s earlier operation for cholecystectomy. Hence he requested for payment of the present claim. The National Insurance Company was represented by Shri Prakash R Kotian, AO. He submitted that Smt Meena Bhagchandani has undergone cholecystectomy operation four years back as per the hospital discharge summary and the present ‘ventral hernia’ is due to the previous cholecystectomy operation and as per Clause 4.1 of Policy conditions, the claim falls under pre-existing condition and so was not paid.

As per the Hospital Papers of Breach Candy Hospital Trust, the following notings are seen: “ Chief Complaints: C/o Swelling Right Side Abdomen since one year. Past History : Cholecystectomy 4 years back. Diagnosed as Ventral Hernia.” Also, under the head, “local examination”, there is a diagram indicating the scar of previous cholecystectomy wherein Ventral Hernia had developed.

‘Ventral hernia’ is a hernia through the abdominal wall. If stretching and thinning of an abdominal scar occur, pressure from the abdomen may cause protrusion of part of the gut. It is then protected only by a layer of thin scar tissue’. Here, in order to decide whether Cholycystectomy was pre-existing to the policy or not, it was necessary that the concerned hospital papers be submitted. During the hearing, Smt.Bhagchandani’s son had stated that the related papers were not traceable and that he would try and trace them. However, even after waiting for sufficient time, no hospital papers pertaining to the previous surgery of Smt.Bhagchandani were received by this Forum. In view of the above analysis, the Insurer’s decision to repudiate the claim was upheld.

Mumbai Ombudsman Centre
Case No. : GI- 259 of 2007-2008
Shri Prashant S. Vakilna
Vs
The New India Assurance Co. Ltd.

Award Dated : 17.12.2007

Shri Prashant S. Vakilna alongwith his wife Smt. Rupal P. Vakilna were covered under Mediclaim Policy No.121000/48/05/20/70050651 for the period 31.08.2005 to 30.08.2006 issued by The New India Assurance Co.Ltd.. Smt. Rupal P. Vakilna was admitted to Smruti Nursing Home for Abdominal Hysterectomy from 29.06.2006 to 05.07.2006. Shri Vakilna submitted a claim for Rs.90,235/- to the Company. As he did not receive a reply to his various representations, he took up the matter with the Grievance Cell of the Company vide his letter dated 24.01.2007 and marked a copy to the CMD.

However, as per the documents on record, the TPA, M/s. Medi Assist India Pvt. Ltd. wrote to the Complainant on 06.10.2006, 24.10,2006 and 13.11.2006 requesting him to submit various documents viz. Indoor Case papers, Original Discharge Card, Clarification on Overwriting in final bill and First consultation recommending surgery. The Company on receiving his letter dated 24.01.2007, took up the matter with the TPA and also wrote to Shri Vakilna on 06.03.2007 requesting him to submit the said documents.

The company finally wrote to him on 20.07.2007 agreeing to settle the claim for Rs.79,057/-, disallowing Rs.10,000/- from the final bill issued by Smruti Nursing Home as the operation charges and the total amount has been overwritten, Rs.800/- for which there is no prescription for medical bill of Sangeeta Medical Store and Rs.659/- as this amount pertains to pre-hospital bill which is not allowed as the same is 30 days before hospitalization and does not come under the scope of the policy terms and conditions. Company has agreed to settle the claim for Rs.79,057/- overlooking the above requirements.

Shri Vakilna was also shown Bill No.1055, dated 05.07.2006 from Smruti Nursing Home wherein at No.5 Operation charges Rs.35,000/- is written and on another copy of the bill of the same number and date the amount of Rs.25,000/- is written.

Shri Prashant S. Vakilna after the hearing agreed to the settlement of the Company for an amount of Rs.79,057/-.

Mumbai Ombudsman Centre
Case No. : GI – 464 of 2007-2008
Shri Nissar Dharamsey
Vs
The New India Assurance Co. Ltd.

Award Dated : 20.12.2007

Shri Nissar Dharamsey alongwith his wife and daughter were covered under the Mediclaim Policy No.110800/48/05/83455 for the period 30.09.2005 to 29.09.2006. The inception of the policy was from the year 30.09.2005. His daughter, Miss Zeenat Dharamsey was admitted to Jaslok Hospital from 17.02.2006 to 19.02.2006 for Calculous Cholecystitis. He preferred a claim to the Company for the treatment at the said hospital. The TPA, M/s Medi Assist India Pvt. Ltd. repudiated the claim under exclusion clause 4.1 of the policy terms & conditions.

On going through the documents on record it is observed that Ms. Zeenat Dharamsey was admitted to Jaslok Hospital from 17.02.2006 to 19.02.2006 for Calculous Cholecystitis. The History Sheet of the hospital records the present symptoms as c/o intermittent pain – 2 years. The case summary & discharge records also mentions pain in abdomen – 2 years. The Discharge card also states recurrent bouts of epigastric pain with Vx 2 yrs. The Histopathology report of the hospital gives the diagnosis as

Chronic Cholecystitis & Cholithiasis. Dr. Balsara's examination report dated 15.02.2006 discloses recurrent epigastric colic relieved by cyclopam and no h/o Jaundice since last 2 years and diagnosis "Chronic Calculous Cholecysssstitis".

Let us examine what is Cholecystitis. Cholecystitis is an inflammation of the gallbladder. Acute cholecystitis is the sudden inflammation of the gallbladder that causes abdominal pain. Chronic cholecystitis is inflammation of the gallbladder that lasts a long time. It is caused by repeated attacks of acute cholecystitis. Damage to the walls of the gallbladder leads to a thickened, scarred gall bladder. Ultimately, the gallbladder can shrink and lose its ability to store and release bile. Gallstones alone can cause episodes of pain without any infection.

The Complainant has repeatedly mentioned in his various letters that the Resident Doctor has wrongly mentioned the duration of illness as 2 years instead of 2 months. During the hearing he had mentioned that the Discharge card was corrected to 2 months and initialed by the resident doctor. However, no corrections in the documents are acceptable after the claim is submitted.

From the above analysis and documents on record the contention of the Insurance Company to treat it as pre-existing as per the history noted in the hospital record is justified. The repudiation of claim under Clause 4.1 is tenable.

Mumbai Ombudsman Centre
Case No. : GI-190 of 2007-2008
Shri Vallabh C. Shah
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Datd :31.12.2007

Shri Vallabh C. Shah was issued a Health Shield Insurance Policy No.HA00001501000100 for sum assured Rs.1.00 lakh with C.B.Rs.60,000/-. The inception of the policy was from 30.09.2003. Shri Vallabh Shah was admitted to Nulife Hospital for Hepatitis C. virus infection from 20.05.2006 to 22.05.2006. He preferred a claim for Rs.1,58,225/- to the Company which was repudiated vide their letter dated 26.09.2006 giving the cause of repudiation as pre-existing disease.

On analysis of the documents, Shri Vallabh C. Shah was hospitalized in April 2006 under Dr. Chetan Shah for convulsion and during investigation he was diagnosed as Sero HCV positive and Dr. Patrawala was consulted and Shri Shah was put on Tab.Rabetol and Inj. Interferon 80 mcg (24 injections) course. He had giddiness on 11.04.2006 and investigation revealed HCV infection with raised Liver Enzymes. He continued his treatment from April 2006 as outpatient. He was admitted to Nulife Hospital from 20.05.2006 to 22.05.2006 with Low grade fever, nausea and vomiting. During his hospitalization he was given Tab. Rabetol 200 mg before dinner and Inj. Interferon (once a week). No treatment for fever given. The temperature readings show normal readings. The line of treatment given was oral medications and injections. In the discharge card it is mentioned as c/o low grade fever, nausea, vomiting. No h/o abdominal pain.

The Complainant states that he had Ulcer and was given blood transfusion in the year 1988. According to the Insurer the history of blood transfusion in 1998 is a causative and predisposing factor for HCV infection, which exist before purchasing of the policy. The claim was repudiated on the following grounds:-

1. Policy is in force from 30.09.2003

2. H/o blood transfusion in 1988 was noted (This may be the causative and predisposing factor for HCV infection, which exist before purchasing of policy). He had not disclosed this in the proposal form dated 23.09.2003.
3. Present hospitalization is also considered as treatment of pre-existing disease. Hospitalization for pre-existing disease is outside scope of policy.

The policy condition states that 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:

"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".

Though it is not proved that the patient was infected by Hepatitis C virus due to blood transfusion or subsequently by any other means, but the Insurer can set aside the Insurance Contract, for non-disclosure of material information which was vital for this case.

In the light of the above analysis this Forum does not find any conclusive ground to differ from the Company's decision.

Mumbai Ombudsman Centre
Case No. : GI-197 of 2007-08
Shri Nainesh V. Bengali
Vs
United India Insurance Co. Ltd.

Award Dated : 31.12.2007

Shri Nainesh V. Bengali was covered under a Mediclaim policy No.020500/48/05/06077 for period 01.01.2006 to 31.12.2006 issued by United India Insurance Company Limited, for a Sum Insured of Rs. 5 Lakhs. Shri Nainesh Bengali was hospitalized at Bombay Hospital & Medical Research Centre from 06.10.2006 to 08.10.2006 for Obstructive Sleep Apnea. Shri Nainesh Bengali filed the claim for the said hospitalization. The TPA of the Company Family Health Plan Ltd. repudiated he claim on the grounds that the hospitalization is for the investigation and evaluation of the ailment only..

As per the documents produced at this Forum, Shri Bengali first consulted Dr. Amita Nene on 28.09.2006 and advised him urgent hospitalization with certain tests. In the History sheet of Bombay Hospital it is mentioned "non-addict – no past h/o HT, DM, IHD, PTB. C/o snoring – 2 weeks, severe choking at night – 2 weeks – nocturnal gasping at night c breathlessness c chest heaviness especially at night – 2 week – unregular sleep – 10 days – morning headache – 10 days – day time drowsiness – 10 days. In the noting, CPAP machine was used for treatment during his hospitalization. On discharge – The use of CPAP every night was recommended. He purchased a CPAP machine on 07.12.2006 for Rs.43,875/-.

A certificate from Dr. Amita Nene states – "Mr. Nainesh Bengali's sleep apnea is very severe and C-PAP (Continuous Positive Airway Pressure) is the only recommended treatment for such a severe sleep apnea. He must use CPAP machine every night for immediate effect. Without, the use of this machine, his sleep apnea can be potentially fatal and can have serious life threatening complications".

Let us examine what is “Apnea” – According to Taber’s Cyclopedic Medical Dictionary – Apnea means - Temporary cessation of breathing. Apnea may result from reduction in stimuli to the respiratory center - (as in over breathing, in which carbon dioxide content of the blood is reduced), from failure of the respiratory center to discharge impulses (as in voluntary breath-holding). Apnea episodes may result in bradycardia, hypoxia, respiratory acidosis, and death.

The TPA repudiated the claim vide letters dated 06.01.2007 and 16.05.2007 on grounds that the hospitalization was for investigation and evaluation of the ailment. However, it is evident, that the ailment of the insured was very grave and non-treatment of the same could lead to more complications in the future. Looking at the graveness and seriousness of the situation, Dr. Amita Nene recommended hospitalization and on discharge from hospital, CPAP was recommended to be used every night. CPAP machine is the only remedy for this ailment through which the patient gets the quantum of oxygen required for his body during sleep.

Shri Nainesh Bengali has produced copies of vouchers from National Insurance Co. Ltd., The New India Assurance Co. Ltd. and The Oriental Insurance Co. Ltd. wherein the Companies have settled the claim of other claimants for the hospitalization and purchase of CPAP machine.

In view of the above facts and documents produced at this Forum, the claim of Shri Nainesh V. Bengali for his hospitalization and purchase of CPAP machine is tenable.

Mumbai Ombudsman Centre
Case No. : GI – 861 of 2006-2007
Shri Melhi Dinshaw Irani
Vs
The New India Assurance Co.Ltd.

Award Dated : 31.12.2007

Shri Melhi Dinshaw Irani was covered under Medicalim Policy No.111700/48/05/85783 taken from The New India Assurance Co.Ltd. The inception of the policy was from the 01.03.1989. Melhi Dinshaw Irani was hospitalized at Bomanjee Dinshaw Petit Parsee General Hospital from 12.11.2006 to 15.11.2006 for Gastro Oesophageal Ulcer with Hiatus Hernia. He preferred a claim with the Company for Rs.34,476/- which was repudiated by their letter dated 21.11.2006 under clause 4.1.

On going through the documents submitted to this Forum, in the Pre-authorization Form the provisional diagnosis is mentioned as “? Aspirin induced Gastric erosion / Ulcer”. In Past History – Hypertension - 40 years and Cardiac Ailments – 10-15 years. In the History Sheet it is mentioned h/o HTN with IHD on Rx – Cholecystectomy – 2-3 years back. In the Doctor’s Orders it is recorded as “Probable Aspirin induced Gastric erosion / ulcer”. As it is noticed in the Pre-authorization Form there is a “?” and in the Doctor’s Orders the word “Probable” is used in regard to “Aspirin induced Gastric erosion / ulcer. It is evident from the above, that it is not known that Aspirin was the cause of the present ailment. A certificate from Dr. Sharukh A. Golwalla dated 24.11.2004 (before the present hospitalization) states as under:

“This is to certify that Mr. Mehli Irani was admitted to the B.D. Petit Parsi General Hospital for Haematemesis. He was having stable Ischaemic Heart Disease, but was NOT taking Aspirin for the last 2 years.”

It is evident from the above certificate that Shri Mehli Irani had stopped taking Aspirin two years prior to 24.11.2004 i.e. he had stopped taking Aspirin from November 2002 i.e. 4 years prior to his present hospitalization. Also the Company has not provided any

proof that “Aspirin” was the cause of Ulcer in his case. The point to be noted is also that the inception of the policy is from 01.03.1989 i.e. for more than 18 years.

In the light of the above, the insurer cannot avoid liability under clause 4.1 in the present case citing pre-existing disease and Tab Aspirin which the patient was taking for HT/IHD was the cause of the present ailment. The repudiation of the claim by the Insurer is not justified.

In view of the above facts, the repudiation of the claim by the Insurer is not tenable.

Mumbai Ombudsman Centre
Case No. : GI – 562 of 2006-2007
Shri Sarosh B. Patel
Vs
The United India Insurance Co. Ltd.

Award Dated : 07.01.2008

Shri Sarosh B. Patel and his wife have a Mediclaim Policy No.020300/48/04/02715 from The United India Insurance Co. Ltd. Shri Sarosh B. Patel was hospitalized at B.D. Petit Parsee General Hospital from 26.06.2005 to 28.06.2005 and underwent hernia operation for which he submitted a claim for Rs.Rs.39,940/-. The Insurance Company repudiated the claim stating that the said policy had specific exclusion relating to Hernia and hence the claim cannot be considered under the policy.

On going through the documents submitted to this Forum, Shri Sarosh Patel had first taken a mediclaim policy from United India Insurance Co. Ltd. for himself and his wife from 09.08.1994 with sum insured Rs.65,000/- each. He renewed this policy till 09.08.2002 to 08.08.2003. On 07.08.2002 he submitted a proposal for sum insured for Rs.1.00 lakh. Due to age, he and his wife were asked to undergo certain medical tests. He was issued a fresh policy for Rs.1.00 lakh each for policy period 12.08.2002 to 11.08.2003 with certain exclusion for himself and his wife. For Shri Sarosh Patel the exclusion were Hernia and Refractory error. The next year he renewed the fresh policy with sum insured Rs.1.00 lakh but did not renew his old policy. He continued with the policy with sum insured Rs.1.00 lakh and the policy with sum insured Rs.65,000/- has lapsed. He submitted a claim 27.06.2005 for Hernia operation. The Insurer repudiated the claim stating that he had taken a fresh policy with exclusions and not renewed his original policy of Rs.65,000/-. Nowhere in the proposal form it was mentioned about the increase in sum insured was 35,000/- and hence a fresh policy for Rs.1 lakh was issued with exclusion of Hernia and Refractory error in his case. As he has not renewed the original policy of Rs.65,000/-, the benefits under that policy has expired with the expiry date of the policy and hence the Insurer has not paid the claim due to exclusion of Hernia. It is a well known fact that Insured generally signs the form on the dotted lines but he should read the contents to ensure that he is signing the proposal form which contain what he desires. Unfortunately this did not happen in the present case. However, it will be unjustified to deny the benefit of earlier policy of Rs.65,000/-. The earlier policy renewal date was 09.08.2002 and the new 1 lakh policy had commenced from 12.08.2002 i.e. after a gap of 4 days, which can be condoned to get the benefit for renewal. Keeping the above fact and analysis it will be in the interest of justice to settle the claim for the basic Sum Insured of Rs.65,000/- on ex-gratia basis and pay the admissible expenses.

Mumbai Ombudsman Centre
Case No. : GI – 171 of 2007-2008
Shri Arvind D. Bodara
Vs

Oriental Insurance Company Limited

Award Dated : 14.01.2008

Shri Arvind D. Bodara and his wife Smt. Meeta A. Bodara were covered under Mediclaim Policy No.121700/48/2007/5708 for the period 22.03.2005 to 21.03.2006 for sum insured Rs.1,00,000/- . The original date of inception of the policy for Smt. Meeta Bodara was from 22.03.2005. Smt. Meeta A. Bodara was admitted to Lilavati Hospital & Research Centre from 13.05.2005 to 16.05.2005 for complaint of Prolapsed Intervertebral Disc and underwent Bilateral Microlumbar surgery on 14.05.2005. He preferred a claim to the Company for the treatment at Lilavati Hospital & Research Centre. The TPA, M/s Raksha TPA Ltd. repudiated the claim under exclusion clause 4.1 of the policy terms & conditions.

The Clinical Data mentioned in the discharge card is - 10 days back h/o severe pain while getting up – pain radiating to L leg - later started radiating to right leg. Radiating to both lower limbs h/o tingling in both lower limbs left & right leg. In the case paper of Dr.P.S. Ramani it is mentioned that Doctor was consulted and Smt. Bodara was advised bed rest. The Complainant was asked to produce previous case papers but he has failed to produce the same.

Raksha TPA has repudiated the claim under Clause 4.1 on following grounds

1. The History of ailment and severity of problem are not corroborating
2. The policy is only 50 days old it appears that the ailment may have been present before the inception of policy

Let us examine the above points. Smt. Bodara underwent Microlumenectomy. The history of symptoms mentioned is 10 days. On the second day of admission at hospital she underwent the operation. A person with Prolapsed Intervertebral Disc usually suffers with bouts of back pain. The pain would often be severe and usually comes on suddenly. The pain is usually eased by lying down flat, pain killers and often physical treatments are given by way of physiotherapy. According to the explanation for Surgery of Prolapsed Disc on the internet –

“Surgery may be an option in some cases. As a rule, surgery may be considered if the symptoms have not settled after about six weeks or so. This is the minority of cases as in about 9 to 10 cases, the symptoms have eased off and are not bad enough to warrant surgery within about six weeks”.

Most surgeries of this nature are avoided due to the high risk of the spine. Only in cases where the patient does not respond to any type of treatment and as a last resort, undergo this surgery. Thus there is a possibility that Smt. Bodara might have suffered from prolapsed disc for long period before undergoing surgery.

The second point raised by the TPA is that the policy is only 50 days old. Smt. Meeta Bodara was insured from 22.03.2005 and consulted Dr. P.S. Ramani on 12.05.2005 and underwent the operation for prolapsed disc on the very next day i.e. on 13.05.2005. There are no previous case papers, consultation papers, reports etc. submitted by the Complainant. There is a noting in the case paper of Dr. Ramani stating that Doctor was consulted and she was advised bed rest, but the Complainant has failed to produce any previous papers. Under such a situation when the Complainant has not produced any of the medical papers or other consultation papers prior to 12.05.2005/hospitalization as mentioned in the noting papers of Dr. Ramani and also by his letter dated 27.12.2007, in such a situation what has been stated by the Insurer seems to be logical.

Under the above circumstances, there is no justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI- 474 of 2007-2008
Smt. Naju N. Kothari
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 14.01.2008

Smt. Naju N. Kothari was covered under Individual Mediclaim Policy No.121200/48/06/5498 for the period 17.01.2006 to 16.01.2007 issued by The Oriental Insurance Co. Ltd. Smt. Naju N. Kothari was hospitalized at Nanavati Hospital from 05.11.2006 to 11.11.2006 for Fracture of Right Ankle. She submitted a claim for her hospitalization. The TPA settled an amount of Rs.74,888/- as cashless and subsequently settled amounts of Rs.4000/-, Rs.5,514 and Rs.1,020/- towards the claim as full and final settlement. The amounts disallowed were Rs.20,000/- towards excess surgeon's fees and Rs.3,800/- towards excess anesthetist charges. Reasonability clause has been applied towards the excess surgeon's fees of Rs.20,000/- and Rs.3,800 towards anesthetist charges.

As per the hearing, the dispute of the Insured with the Insurer is for an amount of Rs.23,800/- (Rs.20,000/- Surgeon's fees and Rs.3,800/- Anesthetist charges).

The TPA have made comparison with other reputed hospitals. It is well known that the hospitals are having various fee charts for different surgeries and broadly they are classified into major and minor. Even considering that the TPA and the Company felt that the charges were higher and therefore, they went by the policy conditions which governs the payment being reasonably and necessarily incurred.

Taking an overall view of the surgeon's fees quoted by other hospitals, the Insurer has disallowed Rs.20,000 towards Surgeon's fees and Rs.3,800/- towards Anesthetist charges. Though the cashless facility was allowed but the TPA made a payment of Rs.74,888/- and the rest was paid by the Insured at the time of her discharge from hospital. The Insured has undergone the surgery and treatment at Nanavati Hospital which is one of the well known hospitals in the City for which the hospital bill was submitted and settled by her. If the Company and TPA find that the charges are high, they should take up the matter with the hospital instead of pruning the surgeon's fees and anesthetist charges. The insured has received the bill from the hospital and it is a clear and valid bill for which she is requesting the full reimbursement of her claim.

The policy condition does not indicate any cap on the fee charged by the Surgeon/Anesthetist. In addition to it, since in this case cashless facility was allowed by the TPA, therefore, they should have negotiated with the hospital for the charges. What they could not achieve through the hospital they asked the Insured to pay and get reimbursement. No arbitrary and unilateral decision can be imposed under such a condition. I am not inclined to approve this approach of the TPA

In view of this, the stand of the Insurer for deducting charges under Reasonability Clause is not sustainable. The Insurer is directed to settle the balance surgeon's fees of Rs.20,000/- and anesthetist charges of Rs.3,800/- as per the claim lodged by the Complainant.

Mumbai Ombudsman Centre
Case No. : GI-380 of 2007-2008
Shri Jain Phutermal M. Shah
Vs
National Insurance Company Ltd.

Award Dated : 14.01.08

Shri Jain Phutermal M. Shah, was covered under the Mediclaim Policy of National Insurance Company Limited for a sum insured of Rs.50,000/- for the period 12.8.2005 to 11.8.2006. The Sum Insured was enhanced to Rs.2,00,000/- under Policy from 17.8.2006 to 16.8.2007 leaving a gap of 7 days. The Angiography was done on 14.8.2006 and he was admitted at P.D. Hinduja Hospital and underwent Heart Surgery on 20.8.2006 for which he lodged a claim with the company for an amount of Rs.2,12,231/-. The Company expressed their inability to entertain the claim vide letter dated 10.10.2006 stating that the policy commenced from 17.8.2006 and the date of admission to the hospital was 14.8.2006.

Aggrieved with the decision of the company, he approached the Ombudsman vide letter dated 21.8.2007 stating that he was covered under the Mediclaim policy since 2002 and he had enhanced the sum insured from Rs.50,000/- to Rs.2,00,000/-. He had asked for enhancement of the Sum Insured and the medical examination was conducted on 29.7.2006. The policy renewal premium was sent to National Insurance on 3.8.2006 before 8 days in advance by Cheque No.606219 but the cheque was deposited by the company on 15.8.2006 as they had not received the medical report. He stated that he was eligible for claiming the expenses and the company should at least consider payment of Rs.50,000/- plus bonus of Rs.2500/- with 18% interest. He had written to the Regional Office also but had not received any positive reply. He sought the intervention of this Forum for intervention in the matter of settlement of his claim with the company.

A joint hearing was held with the company and the complainant on 6th December, 2007. During the personal hearing, the representative of the company submitted that he was insured for Rs.50,000/- upto 2005-2006 and the Sum Insured was increased on 17.8.2006 to Rs.2 lacs. The Dev.Officer brought the cheque without the medical reports on 3.8.2006 and he was informed that without the reports the policy will be renewed for the existing Sum Insured of Rs.50,000/- for which he did not agree. On 16th Aug, 2006 the reports were received and a fresh policy was issued from 17.8.2006 leaving a gap of 7 days. Meanwhile the Insured underwent Angiography on 14th August, 2006 and it was revealed from the reports that he was suffering from IHD and Gall Bladder stone, which was not disclosed by him in the Proposal Form. Hence the claim was rejected as the hospitalization took place during the break period.

The stress test done for pre-medical examination was positive and hence IHD becomes an exclusion. The delay in renewing the old Sum Insured was due to the Development Officer taking back the cheque. Due to the technical problem a delay of 7 days had occurred. However, the Ombudsman advised the company to pay the claim on the original Sum Insured with cumulative bonus to resolve the dispute to which both the parties agreed. The Insurer is directed to process the claim for Sum Insured of Rs.50,000/-. Pursuant to the Hearing, the company has informed this Forum that they have settled the claim for the original Sum Insured of Rs.50,000/- plus cumulative bonus of Rs.2,500/-. The Insured has discharged the voucher and the company has issued a cheque No.007159 dated 10.1.2008 drawn on Bank of India for Rs. 52,500/- in full and final of the claim. In view of the settlement, the complaint, is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI - 334 (2007-2008)
Shri Suresh Dodekar

Vs

The Oriental Insurance Co. Ltd.

Award Dated : 16.01.2008

Shri Suresh Dodekar had a mediclaim policy from The Oriental Insurance Company Limited. Bearing No.121300/48/06/2006 for period from 20.07.2005 to 19.07.2006 for a sum insured of Rs.1,00,000/-. He was admitted to Nivaran Orthopaedic Centre from 16.06.2006 to 23.06.2006 for Acute Lumbar Disc Prolapse (R) Sciatico. Shri Suresh Dodekar had submitted his claim on 26.06.2006 to the TPA. The TPA had written to him vide their letters dated 11.07.2006, 14.08.2006, 25.09.2006, 20.10.2006 & 20.11.2006 for submission of reason for not intimating the claim. As he had not replied to them, they have treated his claim as closed.

Aggrieved by their decision, Shri Suresh Dodekar approached this Forum, seeking the intervention of the Ombudsman in the matter of settlement of his claim.

Shri Suresh Dodekar appeared and deposed before the Ombudsman. He submitted that he was hospitalized from 16.06.2006 to 23.06.2006 for backache. As soon as he was discharged he had submitted his claim on 26.06.2006. He requested that his claim should be settled.

The Oriental Insurance Company Ltd was represented by Mrs. Laiju Marar, Assistant Manager and Dr. Pravin from Raksha TPA. Mrs. Marar submitted that the TPA had repudiated the claim under clause 5.4 and the Hospital was a black listed hospital. She stated that they had written to the claimant on 11.07.2006, 14.08.2006, 25.09.2006 & 20.10.2006 requesting him to submit the reason for not intimating the claim. Since he had not replied to their various letters they had closed the file.

When the Company was questioned whether the Insured was intimated the List of the black listed hospitals, her reply was in the negative.

Shri Dodekar stated that he had sent a fax on 22.06.2006 informing the Company regarding his hospitalization.

Shri Dodekar was requested to reply to the query raised by the Company regarding the reason for not intimating the claim within 48 hrs. and the Company was asked to look into the claim afresh and inform their decision to this Forum accordingly.

As per instruction of this Forum, we have received a copy of Claim Settlement Voucher from Raksha TPA, dated 14.01.2008, addressed to the Claimant, Shri Suresh Dodekar, enclosing Cheque No.240953, dated 14.01.2008, drawn of Union Bank of India for Rs.26,360/- towards settlement of his claim.

In view of the claim being settled, the complaint is closed at this Forum.

Mumbai Ombudsman Centre

Case No. : GI-717 of 2007-2008

Shri T R Gopalakrishnan

Vs

The New India Assurance Co.Ltd.

Award Dated : 17.01.2008

The complainant, Shri T R Gopalakrishnan, along with his wife, was covered under a Mediclaim Policy. There was an exclusion of Diabetes Mellitus and related ailments, in respect of Shri Gopalakrishnan, from the scope of the Policy. On 23rd September, 2005, Shri Gopalakrishnan was hospitalized and treated for CAG - TVD When Shri he preferred a claim for the same, the TPA, rejected it as they felt that the ailment was a complication of Diabetes Mellitus, which was excluded from the scope of the Policy. Thus, Shri Gopalakrishnan approached the Forum of Insurance Ombudsman.

A Joint Hearing was called for but the complainant did not turn up and the Company's deposition was taken. The New India Assurance Company was represented by Shri Shyam R Mishra, A.O. He submitted that the claim of Shri Gopalakrishnan was rejected under clause 4.1 of the Policy conditions which excludes pre-existing diseases. In one of the medical documents, it has been stated that Shri Gopalakrishnan was a diabetic for 20 years. Diabetes and related ailments were excluded from the Policy cover in respect of Shri Gopalakrishnan and the present complaints, CAG and TVD were complications of DM and hence, he justified the Company's action of rejecting the claim.

By experience, it has been found that Diabetes Mellitus is one of the major risk factors for IHD problems and the exclusion provided on the policy excluded payment for consequences attributable thereto or accelerated thereby or arising therefrom. In view of the above, the Company has rejected the claim by invoking clause 4.1 of the Policy conditions. However, looking to the history of the mediclaim policy, the complainant was earlier covered under a group policy by his employer and the present individual policy from December, 2001, and as the present hospitalization was not for IHD but for diagnosis Coronary Angiogram, the reimbursement of hospitalization expenses excluding medicines for treating Diabetes Mellitus, on an ex-gratia basis to was allowed to resolve the dispute.

Mumbai Ombudsman Centre
Case No. : GI-313 of 2007-2008
Shri Madhukar P. Desai
Vs
The New India Assurance Co. Ltd.

Award Dated : 17.01.2008

Shri Madhukar P. Desai was covered under the mediclaim policy No.111300/48/06/20/70000786 for sum insured Rs.1.5 lakhs, issued by The New India Assurance Co. Ltd.. The inception of the policy was from 25.09.1997. He had preferred a claim for Rs.3,04,048/- for surgery of Coronary Artery Bypass Graft (CABG) undergone at the Asian Heart Institute, Mumbai, during the period 21.03.2007 to 29.03.2007. The Third Party Administrator of the Company, M/s Raksha TPA repudiated the claim under clause 4.1, vide their letters dated 24.04.2007 and 17.07.2007 stating that as per the hospital records the patient was suffering from Diabetes Mellitus since 1997, hence diabetes falls prior to inception of the policy.

The main contention of the Insurer is that Shri Madhukar Desai was suffering from Diabetes before the inception of policy. The inception of the policy was from 29.05.1997. He underwent a Bypass Surgery on 22.03.2007 i.e. 10 years from the date of the inception of policy. No where in the record/documents produced at this Forum, the exact date or month is given when the Insured had diabetes. Only the year is given as 1997. With this, it is difficult to ascertain the exact date of having diabetes. Another point to be noted is that the insured had undergone Angiography in April, 2004 and when he lodged a claim he was asked to produce a certificate from the Doctor who performed the Angiography certifying since when the patient was suffering from Diabetes Mellitus. Dr. Bharat V. Darvi, who performed the Angiography in April 2004 issued a certificate dated 19.05.2004 stating that Shri Desai was suffering from Diabetes Mellitus since 1997 and on submission of the certificate, the claim was paid.

From all the above noting and in the absence of any evidence procured to prove that the insured had diabetes before the inception of policy, there is no reason to believe that the patient was suffering from Diabetes prior to the inception of the policy. The

conclusion made by the TPA in their repudiation letter is unsubstantiated by facts and documents other than the Hospital History Sheet and Discharge Summary. Though the heart ailment might be contributed by Diabetes but it has not been proved by the Company substantially that Diabetes existed prior to taking policy to justify pre-existence of illness as per clause 4.1. Hence the benefit of doubt goes in favour of the Complainant.

Mumbai Ombudsman Centre
Complaint No.GI-516 of 2007-2008
Shri.Shashikant P.Wagh
Vs
The United India Insurance Company Limited

Award Dated : 18.01.2008

Mr.Shashiaknt Wagh and his wife were covered under the mediclaim policy from The United India Insurance Company Ltd for a sum insured of Rs.95,000 each vide policy no.1609000/48/17/20/00000118.Mrs.Lata Wagh got admitted to the Sahyadri Hospital at Pune on 1.6.2007 for total knee replacement surgery and was operated on 2.6.2007. When Mr.Wagh preferred the claim, the Company rejected the same under the pre-existing clause of 4.1. Mr.Wagh represented stating that he was continuously insured with United India and that his claim should be viewed sympathetically. The company however upheld their stand of repudiation and aggrieved by this the complainant approached this forum for redressal.

After perusing all the relevant documents, both the parties to the dispute were called for personal hearing on 4.1.2008 at Ombudsman, camp,Pune. On scrutiny of the case, it is revealed that Mr.and Mrs.Wagh were covered under the mediclaim policy of the United India Insurance Company Ltd continuously for about 11 years. At the time of renewal thereafter there has been a delay of about 23 days because of which the Company has treated the policy as fresh. However, from the documents submitted to this forum, it is observed that the history of knee pain is given as 2 months in some places, 4-5 months in some other place and one and half year in one other place. The Company has not produced any documentary evidence to prove the pre-existing but has chosen to rely on the history that is beneficial to them. Moreover as the policy was in force for almost 10 claim free years prior to the break in insurance, the benefit of doubt is given to the complainant and the Company is directed to pay 80% of the admissible claim.

Mumbai Ombudsman Centre
Case No. : GI – 417 of 2007-2008
Shri Dhananjay Kumar Sinha
Vs
The New India Assurance Co.Ltd.

Award Dated : 23.01.2008

Shri Dhananjay Kumar Sinha was covered under Hospitalization & Domiciliary Hospitalization Benefit Policy No.149100/48/06/20/70007030 The inception of the policy was from the 12.09.2006. Shri Dhananjay Kumar Sinha was hospitalized at Breach Candy Hospital Trust from 26.02.2007 to 28.02.2007 for Mandibular Cyst Lt. Side of Mandible. He preferred a claim with the Company for Rs.67,226/- which was repudiated by the TPA, M/s.Paramount Health Services Ltd. vide their letter dated 22.05.2007 under clause 4.1. He represented again to the Grievance Cell for settlement of his claim. The New India Assurance Co. Ltd. also repudiated his claim

vide letter dated 06.06.2007 rejecting his claim on the same grounds. In the proposal form dated 12.09.2006, Shri Dhananjay Sinha had answered to Question 14 of the proposal form.

b) Have you ever suffered from dental problems? : Yes

c)Specify same : - I had infection in left lower mandible in 1995

However, the policy document issued to him for sum insured Rs.5.00 lakhs for policy period 12.09.2006 to 11.09.2007 does not mention any exclusions. As per the proposal form, the insured had stated that he had an infection in left lower mandible in 1995 which was treated and cured. During the hospitalization at Breach Candy Hospital Trust from 26.02.2007 to 28.02.2007 for Mandibular Cyst Lt. Side of Mandible in the Case Resume the chief complaints mentioned is - c/o pain & discharge from it – Lt. Lower mandibular region. Diagnosed Lt. Sided lower mandibular cyst admittted for Sx. Past history – had similar complain 10 years back. Sx done. Pt. Cured that time. It is evident from the noting that the insured had a problem 10 years back but was cured. In the present ailment he had developed a cyst wherein surgery was required to remove the cyst. Though the Insurer has not mentioned the exclusion for the ailment the party had suffered but this does not make the general exclusion 4.1 inoperative i.e. all the diseases / injuries prior to incept of policy are not covered and the present problem is the same problem he had in 1995 and hence categorized as pre-existing.

Looking to the facts and circumstances of the case, the rejection of the claim by the Company is tenable.

Mumbai Ombudsman Centre
Case No. : GI-458 of 2007-2008
Shri Madhav Lad
Vs
The United India Insurance Company Limited

Award Dated : 23.01.2008

Mr.Madhav Lad and his family were covered under the mediclaim policy from the year 1998 first from The New India Assurance Company Ltd and thereafter from The United India Insurance Company Ltd Mrs.Pooja Lad, wife of the complainant was admitted first to Triveni Nursing Home for fever and chills and thereafter to Mukund maternity & Surgical Nursing Home for CRF, HTN and inf.wall Myocardial Infarction. When the claims were preferred, the Company rejected them under pre-existing clause. The complainant represented stating that the Company had earlier settled his claims for renal failure in the year 2004 after initially denying it under pre-existing and thereafter paid after submitting a medical certificate from the attending doctor regarding the onset of the renal problem. The Company however reiterated their stand of repudiation and the complainant approached this forum for redressal.

After perusal of records, both the parties were called for hearing on 9.1.2008 for a personal hearing. The analysis reveals that the first claim for the hospitalization to Triveni Nursing Home was for only observation and no active line of treatment appears to have been given there. Hence the Company's repudiation is tenable. However the second hospitalization was for treatment of chronic renal failure, Hypertension and myocardial infarction. Moreover the Company has settled the claims for the same disease in the past and hence cannot now repudiate taking shelter under pre-existing clause. The Insurance Company was directed to settle the second claim for the hospitalization expenses incurred at Mukund Hospital.

Mumbai Ombudsman Centre

Case No. : GI- 554 of 2007-2008
Smt. Sonia Pahwa
Vs
The New India Assurance Company Limited

Award Dated : 31.01.2008

Smt. Sonia Pahwa was covered under Hospitalization & Domiciliary Hospitalization Benefit Policy No.111700/48/06/20/70009257 for the period 01.01.2007 to 31.12.2007 issued by The New India Assurance Co.Ltd.. Smt. Sonia Pahwa was hospitalized at Lilavati Hospital Research Centre from 03.04.2007 to 05.04.2007 for treatment of Left Lower Ureteric Calculi and underwent Cystoscopy with left URS with DJ Stenting. She submitted a claim for her hospitalization wherein the Surgeon's fee mentioned was Rs.80,500/-. The TPA partially settled her claim disallowing Rs.30,500/- as excess Surgeon's fee. As per the hearing, the dispute of the Insured with the Insurer is for an amount of Rs.30,500/- towards Surgeon's fees which was not settled.

Smt. Sonia Pahwa was hospitalized at Lilavati Hospital Research Centre from 03.04.2007 to 05.04.2007 for treatment of Left Lower Ureteric Calculi and underwent Cystoscopy with left URS with DJ Stenting. She received a bill from the hospital wherein Rs.80,500/- was charged towards Surgeon's fee. Smt. Sonia Pahwa paid the hospital bill through credit card. The TPA settled her other expenses and partially settled the Surgeon's fees. The Surgeon's fees of Rs.80,500/- was partially settled for Rs.50,000/-, disallowing Rs.30,500/- as excess Surgeon's fee and invoked Reasonability Clause. The TPA has submitted Tariffs for surgeries at Lilavati Hospital. As per Grade 3 Surgery for a Super Deluxe Class the Surgeon's fees (for TPA patients) is Rs.50,000/- The Surgeon's fees for self payee patients are "As agreed between the Doctor and Patient". The insured had also written to Lilavati Hospital seeking billing clarification with regard to the Surgeon's fee. She received a letter dated 27.07.2007 from Director Finance, Lilavati Hospital as under

"This is with reference to your letter dated 13.07.2007, we would like to inform you that, you were admitted in Super Deluxe Class as SELF PAYEE patient under the care of Dr. Shailesh Raina. You had under gone Grade III surgery operated by Dr. Shailesh Raina. It is clearly mentioned in our hospital tariff sheet that the surgeon charges are negotiable for self payee patients admitted in Super Deluxe Class. Accordingly, Dr. Shailesh Raina (Surgeon) has clearly mentioned his operating fees as Rs.80,500/- in operation Theater Sheet the same has been charged to you."

From the above letter it is clear that for Super Deluxe room the surgeon's fee is negotiable. From the rate chart it is clear that the hospitalization charges are different depending upon the category of the room occupied by the patient. Regarding the contention by the insured that she had paid the hospital bill including surgeon's fees of Rs.80,500/-, it is pertinent to note that according to Common Law and Insurance Law, the insured is at all times expected to behave like a prudent person in her transactions with the people she comes across with. The Company has reimbursed the Surgeon's fee as per the tariff sheet of the hospital for grade III surgery for super deluxe class. In terms of the policy condition, the Company is liable to reimburse only expenses, which are reasonably and necessarily incurred by the insured in respect of treatment of the ailment, subject to the maximum sum insured under the policy. In the circumstances, there is no justifiable reason to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-343 of 2007-2008
Shri Kamal Kumar Barjatya

Vs

The New India Assurance Co.Ltd.

Award Dated : 04.02.2008

The complainant, Shri Kamal Kumar Barjatya, was covered under a Mediclaim Policy. There was an exclusion of Diabetes Mellitus and related ailments, in respect of Shri Barjatya from the scope of the Policy. On 1st May, 2006, Shri Barjatya was hospitalized for Heart Surgery at the Breach Candy Hospital, Mumbai, and was discharged on 12th May, 2006. When Shri Barjatya preferred a claim for the expenses incurred by him, the TPA of the Company , initially rejected the claim vide letter dated 15.6.2006 as they felt that the ailment was a complication of Diabetes Mellitus, which was excluded from the scope of the Policy. When Shri Barjatya submitted a representation dated 10.7.2006 along with his family doctor's certificate, the TPA settled the claim for 70% of the eligible amount excluding 30% vide letter dated 18.8.06,. The Insured represented for full settlement of the claim to the Insurance Ombudsman.

A hearing was called for on 15th January, 2008. Shri Kamal Kumar Barjatya stated that the Company agreed to settle for 70% of the sum insured. But that was not acceptable. The company was represented by Shri S N More, Sr.Divisional Manager. He stated that as per policy conditions, Diabetes was an exclusion and expenses related to the same were not paid.

As regards the effect of diabetes on the entire system, it is quite clear that Diabetes Mellitus is one of the major risk factors for IHD problems and the exclusion provided on the policy excluded payment for consequences attributable thereto or accelerated thereby or arising therefrom. In view of the above, the Company has rejected the claim by invoking clause 4.1 of the Policy conditions .

In view of the above facts and analysis, there is no justifiable reason to interfere with the decision of the Insurer. However, whatever has already been sanctioned by the Company should not to be recovered. The case was disposed of accordingly.

Mumbai Ombudsman Centre

Case No. : GI-938 of 2006-2007

Shri Anilkant Prabhulal Rupani

Vs

The New India Assurance Co. Ltd.

Award Dated : 04.02.2008

Shri Anilkant Prabhulal Rupani was covered under the mediclaim policy No.111200/48/06/20/70001454 for sum insured Rs.1.0 lakh, issued by The New India Assurance Co. Ltd. The inception of the policy was from 05.05.1989. He had preferred a claim for Rs.56,818/- for his hospitalization at Saifee Hospital for HT, DM, CAD with CCF from 15.09.2006 to 23.09.2006. The Third Party Administrator of the Company, repudiated the claim stating that as per the hospital records the patient was suffering from Diabetes Mellitus for last 22 years, hence diabetes falls prior to inception of the policy and as Diabetes is proximate cause for present ailment the said claim therefore stands non payable under exclusion clause 4.1 of the standard mediclaim policy.

Shri Anilkant Prabhulal Rupani submitted that the Inception of the policy is from 05.05.1989 to 04.05.1990 under Scheme "A" and Category of Table of Benefits was "III" which was taken from the United India Insurance Co. Ltd. The policy for the next year was taken from 18.05.1990 to 17.05.1991 with a gap of 14 days. Thereafter from 2001-2002, he has increased the sum assured from Rs.50,000/- to Rs.1,00,000/- He stated that he had a bypass operation in the year 1991 for which the claim was paid. Thereafter two claims have been paid in 2005 and 2006. He stated that when he

submitted a claim for his hospitalization during the period 15.09.2006 to 23.09.2006, the Company rejected the claim under clause 4.1 stating that he had diabetes for the last 22 years. He stated that since his previous claims have been paid, this claim should be settled.

During the Hearing the Insurer was asked to settle the claim as per the sum insured under category A-III of the policy terms and conditions with C.B. which was taken during the year 1989 since United India Insurance Company Ltd. had paid the claim in the year 1991 for CABG. The Company settled the claim and the complaint was closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-444 of 2007-2008
Shri Haridas Sanghvi
Vs
The New India Assurance Company Limited

Award Dated : 06.02.2008

Mr.Haridas Sanghvi has been covering himself and his wife under the mediclaim policy of The New India Assurance Company Ltd for a sum insured of Rs.100000 right from the year 2000 with exclusion of Diabetes Mellitus and its complications for Mr.Haridas Sanghvi. In the year 2004-05, he has enhanced only his sum insured to Rs.300000. The claim arose under policy no.111200/48/05/84171 when Mr.Sanghvi got admitted to Nanavati Hospital for complaints of chest pain and underwent CABG. When Mr.Sanghvi preferred the claim, the Company rejected it under pre-existing clause stating that heart ailment being a complication of Diabetes Mellitus is excluded from the scope of coverage of policy. The complainant, Mr.sanghvi however represented stating that the blood reports taken at Bombay Hospital prior to his taking the policy was normal and that he was not diabetic. The Company upheld their stand of repudiation and aggrieved by this the complainant approached this forum for redressal.

After perusal of the documents both the parties to the dispute were called for a personal hearing on 16.1.2008. The analysis of the case reveals that for reasons known best to him, the complainant has chosen to enhance only his sum insured in the year 2004-05. Although denied by him, the hospital papers show him to be a known case of diabetes and on tablet semidianil, which is a diabetic medicine. Further the policy, which is a legal contract, has been issued to the complainant excluding Diabetes Mellitus and all its complications right from inception and the complainant has not raised any objection and has renewed it on the same lines year after year. However as Diabetes Mellitus is not the only cause for heart ailments although it is one of the risk factors for the same, the Company was directed to settle the claim for 80% of the admissible expenses for the original sum insured of Rs.one lac with accrued bonus.

Mumbai Ombudsman Centre
Case No. : GI - 571 of 2007-2008
Shri Victor D'Souza
Vs
The Oriental Insurance Company Limited

Award Dated : 07.02.2008

Shri Victor D'Souza alongwith his wife Smt. Florinda D'Souza and his son Shri Peter M.J. D'Souza were insured under mediclaim policy issued by The Oriental Insurance Company Ltd. The inception of the policy is from 23.03.2000. Smt. Florinda D'Souza was admitted to Sushrusha Citizen Hospital for Cirrhosis of Liver from 27.12.2006 to 31.12.2006. She was again admitted to Pikale Hospital on 08.03.2007 and expired the

same day. Cause of Death was given as Liver Cirrhosis with Severe Anemia and Septicemia. The Company repudiated the claim invoking clause 4.8.

On going through the documents submitted at this Forum, Smt. Florinda D'Souza was first admitted to Sushrusha Citizen Hospital for Cirrhosis of Liver from 27.12.2006 to 31.12.2006. The Diagnosis mentioned in the hospital records as k/c/o Cirrhosis of liver since 2005. There is a noting in the consultation paper dated 20.01.2006 of Dr. Aniruddha Y. Phadke wherein it is mentioned as "ALD /PHT" (Alcoholic Liver Disease and Pulmonary Hyper Tension). She was again admitted to Pikale Hospital on 08.03.2007. She was unconscious when admitted to hospital and was having chest pain at home. She was k/c/o cirrhosis of liver with ascitis and h/o anemia. She expired on 08.03.2007 and cause of death was given as Liver Cirrhosis with Severe Anemia and Septicemia.

A certificate dated 04.04.2007 was submitted by the Complainant from Dr. A.Y. Phadke which states:

"Mrs. Florinda D'Souza was first evaluated as an outpatient on 20.06.2005. She was diagnosed to have cirrhosis and ascites. The tests for viral markers to ascertain the etiology of liver disease were negative".

From the facts of the case it is evident from the above certificate that the cause of Cirrhosis of Liver was due to alcohol and any other cause of infection was ruled out. Under the circumstances, the repudiation of claim by the Insurer under exclusion clause 4.8 is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-358 of 2007-2008
Shri Sudhir Sonecha
Vs
The New India Assurance Company Limited

Award Dated : 07.02.2008

Mr.Sudhir Sonecha had covered himself, his wife and his daughter under the medicalim policy of The New India Assurance Company Ltd for a sum insured of Rs.100000 and 50,000 respectively. The claim arose under the policy no111900/48/06/20/70004952 when Mr.Sudhir Sonecha got admitted to Parth Hospital with complaints of vomiting, giddiness and weakness to the left side. When the complainant preferred the claim, the Company rejected it under pre-existing clause of 4.1 stating that the cerebral ataxia suffered by the complainant is directly related to Diabetes Mellitus and as the same is already excluded from inception, the claim falls beyond the scope of policy coverage. The complainant however represented the matter supporting it with a medical certificate from his doctor stating that he was suffering from Diabetes Mellitus only since last one year and that he was not on any medication and Diabetes Mellitus may not be the only contributing factor for cerebral ataxia. The company upheld their rejection and the complainant aggrieved by this, approached this forum for redressal.

After due perusal of all the relevant documents, both the parties to the dispute were called for a personal hearing on 14.1.2008. The analysis of the case reveals that the claim had occurred in the second year of the policy. Although the complainant vehemently denied the history of Diabetes Mellitus, the medical papers submitted by him shows him to be diabetic and without any treatment. However, although Diabetes Mellitus is one of the major risk factors for diseases like heart ailments, renal problems

and circulatory disorders, it cannot be stated as the only reason for occurrences of these diseases more so when the complainant is not proved to be a case of long standing Diabetes Mellitus. Hence the Company was directed to settle 50% of the admissible expenses to the complainant by this forum.

Mumbai Ombudsman Centre
Case No. : GI-275 of 2007-2008
Shri Jehangir Dalal
Vs
The Oriental Insurance Co.Ltd.

Award Dated : 12.02.2008

Shri Jehangir R Dalal, had an individual mediclaim policy under No. 111400/48/2007/806, for himself and his family consisting of his wife and minor son . Shri Dalal's son, Master Farzaan, was hospitalized at the Masina Hospital for the period from 3.11.06 to 6.11.06 for treatment of 'Left side Undescended Testes' and Orchiopexy was done. When Shri Dalal preferred a claim for the expenses incurred by him towards the above hospitalization, the Third Party Administrator of the Company, refused the claim on the ground that the same is not admissible as per Clause 4.8 (complaint of external congenital anamoly which is not payable) of the policy conditions. Not satisfied with the decision, Shri Dalal approached the Office of the Insurance Ombudsman, Mumbai. A heariang was held on 8.2.08. The complainant, Shri Jahangir Dalal submitted that his claim was rejected on the grounds that it was a congenital ailment while doctors treating his son have certified that it was an acquired ailment. He pleaded that his claim was legitimate. The Insurer was represented by Shri Sachin Khanvilkar, AO. He submitted that the claim arose in the second year of the policy and it was rejected as per Exclusion Clause 4.8 and 4.1 of the policy as the ailment was an external congenital anamoly and hence of a pre-existing nature.

From all available records and inferences and medical connotations, while this Forum agrees with the Panel Physician of the Insurer that the condition of Master Farzaan 'seems' congenital in nature, the questionable point is how far can the present anomaly be called an external defect. As the Paediatric Surgeon, Dr.Nargish Barsivala has remarked, she could not feel the testis either in scrotum or inguinal region and even the USG of the abdomen was not much helpful. Even the birth reports of the child suggest that he was a healthy baby. Such deficiencies as these, though congenital, go undetected unless a problem is faced, as in the present case when the parents came to know something was wrong with their child only after he complained of stomach ache. Also, no responsible parent would have waited for seven long years to get the defect rectified had he known about the same before hand. In view of this, the benefit of interpretation was given in favour of the complainant.

Mumbai Ombudsman Centre
Case No. : GI-577 of 2007-2008
Shri Marshall Fernandes
Vs
The New India Assurance Co. Ltd.

Award Dated : 14.02.2008

Shri Marshall Fernandes, his wife Smt. Mary M. Fernandes and his daughter Ms. Evita M. Fernandes were covered under Mediclaim Policy No.112800/48/05/75472 for period

31.05.2005 30.05.2006. The inception of the policy was from 31.05.2001. The Sum Assured was Rs.2,00,000/- each.

Shri Marshall Fernandes lodged a claim for Rs.1,17,851.75 for the hospitalization and treatment of his daughter Ms. Evita Fernandes from 25.11.2005 to 26.05.2005 at Holy Family Hospital for Chronic Renal Failure. His daughter had to regularly undergo dialysis. The claim was repudiated by the TPA, M/s TTK Healthcare Services Pvt. Ltd. vide their letter dated 31.12.2005 under clause 4.1.

Ms. Evita Fernandes was covered under Mediclaim policy since 31.05.2001. Before the inception of the policy, Ms. Evita Fernandes was hospitalized at Holy Family Hospital from 06.04.2001 to 10.04.2001. The diagnosis on the Discharge card is Young HT, dilated cardiomyopathy, being investigated for pheochromocypoma. This hospitalization was not mentioned in the proposal form and the Company issued a mediclaim policy with no exclusions. Thereafter, Ms.Evita Fernandes was hospitalized from 15.09.2005 to 03.10.2005. The Diagnosis given was – A case of HTN + cardio myopathy with ESRD on haemodialysis for A.V. fistula Sx. A claim amount of Rs.55,946/- was settled by the Insurer. The Company has informed that Ms. Evita Fernandes was admitted to the same hospital and her earlier hospitalization was never disclosed to the Insurance Company neither while taking the insurance policy nor while filing the first claim in 2005. The claim was settled as per the papers submitted.

The present claim arose when the insured was admitted from 25.11.2005 to 26.11.2005 at Holy Family Hospital While submitting the documents, a copy of discharge card for earlier admission from 06.04.2001 to 10.04.2001 at Holy Family Hospital was also produced. This new fact came to light while submitting the papers for the present claim. Under the said circumstances the TPA repudiated the claim by their letter dated 31.12.2005 under exclusion clause 4.1 as pre-existing disease. In the facts and circumstances of the case, there is no justifiable reason to interfere with the decision of the Insurer. The decision of the Insurer is Upheld.

Mumbai Ombudsman Centre
Case No. : GI-566 of 2007-2008
Shri Sanjay Goradia
Vs
The New India Assurance Company Limited

Award Dated : 15.02.2008

Shri Sanjay G. Goradia was covered under Mediclaim Policy No.111700/48/06/20/70005962 with sum insured for Rs.5 lakhs & C.B. Rs.85,000/- for the period 05.10.2006 to 04.10.2006. Shri Sanjay Goradia was admitted to Bombay Hospital & Research Centre from 17.10.2006 to 06.11.2006 and underwent a Bypass Surgery on 25.10.2006. He submitted a claim for Rs.5,85,000/-, out of which Rs.2,60,000/- was settled (Rs.2,39,000/- as Cashless and Rs.21,000/- was reimbursed to him). He requested the Insurer to settle the balance claim amount. The Company repudiated the balance claim amount stating that the Hospital papers of Bombay Hospital clearly states that he was a known case of HT since 6 years, which dates back before the sum insured was enhanced by Rs.3 lakhs.

Let us examine the narration of history and clinical presentation from Bombay Hospital. He was admitted to Bombay Hospital on 17.10.2006. The History sheet mentions – c/o chest discomfort, c/o nausea at night. Pt. had a sense of discomfort in chest in upper region, was associated with nausea. He had a bout of vomiting and went to HN Hospital where his BP was recorded as 210/130. Was given some medication and advised hospitalization, but Pt. refused and came today to Bombay Hospital for the

same. – k/c/o DM/HT – recently diagnosed – not taking any medicines. The continuation sheet of Bombay Hospital dated 17.10.2006 at 19.15 A.M. mentions k/c/o DM – 1&1/2 years, HT – 6 years – no medication. His BP recording was 150/110. Diagnosis - chest pain / evaluation – k/c/o DM/HT. Risk factor – DM + HT, Obesity – Sedentary life style. He underwent a Bypass Surgery on 25.10.2006. Dr. S.S. Bhattacharyya in his noting on 20.10.2006 in the hospital records has mentioned c/o TVD with good Lv. – DM/HT recently detected. He was given Tab. Ecosprin – 150 mg., Clopivas – 75 mg., Cardace – 5 mg and Atorlip – 10 mg. to control his BP during his hospitalization. Thus there appears to be some contradiction between what was reported at the time of admission on 17.10.2006 and what has been mentioned by Dr. S.S. Bhattacharyya in his noting dated 20.10.2006. The Complainant has not submitted any medical evidence for the onset of HT. To resolve such dispute i.e. contradiction in the history of HT recorded in hospital, requires further investigation including cross examination of the Doctors who recorded the above noting. This Forum with a limited jurisdiction is not empowered to summon the hospital & Doctors. In view of this, the complaint is closed at this Forum with a liberty to the claimant to approach some other appropriate Forum for resolving his complaint.

Mumbai Ombudsman Centre
Case No. : No. GI – 500 of 2007-2008
Shri Amritlal C. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 18.02.2008

Complainant, alongwith his wife Smt. Padmavati was covered under Mediclaim Insurance Policy of New India Assurance Co. Ltd. & was enjoying 25%CB. Complainant reported a claim Lumbar Canal Stenosis surgery underwent by his wife for which she was hospitalised in Bhatia Hospital. . In the hospital papers, the history of Laminectomy of 20 years back was noted. Based on this history, the claim of the Complainant was rejected by the Insurance Company under the pre-existing clause 4.1 as well as non-disclosure of material facts. Not satisfied with the stand taken by the Insurance Company, the complainant approached this Forum for intervention in the matter. Both the parties to the complaint were called for a joint hearing. After taking into consideration, the oral depositions of the parties to the complaint and all the documents submitted to this Forum, analysis of the case revealed that the Policy was without any Exclusions. The hospital records made available to this Forum revealed that the patient was diagnosed for Lumbar Canal Stenosis. All the documents submited to this Forum indicated that the insured had undergone the surgery of Laminectomy in the past. . It is also admitted by the insured that he had not disclosed this surgery which his wife had undergone 20 years ago.The Insurer has taken the opinion from their Medicolegal Cosultant, who opined that “present ailment, as per orthopedian’s letter may not be a complication of previous history , but the exclusion of laminectomy would have been attracted had the proposer disclosed the ailment at the time of taking policy as the tendency for this type of ailment is since last more than 20 years.” It was noted that the first Laminectomy was performed 20 years back. The Forum noted that Smt. Padmavati was enjoying 25% CB. Discharge Card stated that patient was suffering from backpain only since last one month prior to admission. There were no major complaints brought to the notice out of the previous surgery during last five years of the Policy. Since the surgery was performed 20 years back and no future complications were brought to the notice, the Forum directed the Company to settle the claim at 80% of the admissible expenses and balance 20% was fixed as penalty on the

insured for not disclosing the material facts i.e. operation of Laminectomy, to the Insurance Co.

Mumbai Ombudsman Centre
Case No. : GI-632 of 2007-2008
Smt.Gunavanti Punamiya
Vs
The New India Assurance Co.Ltd.

Award Dated : 19.02.2008

Shri Jayantilal Punamiya, had an individual mediclaim policy for himself and his wife, for the period from 1.3.2004 to 28.2.2005. Shri Punamiya was hospitalized at the S.L. Raheja Hospital and later, the Bombay Hospital, for the period from 10.2.2005 to 11.2.2005 (Raheja Hospital) and from 11.2.2005 to 14.2.2005, on which day he expired (Bombay Hospital), for treatment of 'Acute Pancreatitis'. When Smt.Gunavanti Punamiya, wife, preferred a claim for the expenses incurred towards the above hospitalizations, the Third Party Administrator of the Company refused the claim on the ground that the same is not admissible as per Clause 4.8 of the policy conditions stating that as per their panel doctor, the insured was a known acohol consumer which gave rise to severe pancreatitis. Not satisfied with the decision, Smt.Punamiya approached the Office of the Insurance Ombudsman, Mumbai, and both the parties were given an opportunity to present their case at the personal hearing on 13.2.08. Shri Kalpesh Punamiya, son of the complainant, stated that his father was only an occasional drinker, for the last 8-10 years and not a chronic alcoholic. The New India Assurance Co. Ltd., was represented by Shri SK Ziauddin, DM. He stated that from the hospital records, it could be ascertained that the patient was an alcohol consumer and his severe acute pancreatitis was due to ethanol(in alcohol). Hence, he justified the decision of the Insurer. The Company's rejection came under Excl. Clause 4.8 which speaks about any disease connected with abuse of alcohol being excluded from the scope of the policy. The fact remains that the Late Shri Punamiya's habit of drinking, would have certainly aggravated the position.

The past history of alcoholism would be a pre-disposing factor and if the system has been damaged progressively with alcohol intake it would no doubt be a vulnerable case. It is also noted from the hospital papers that he had previous attack of pancreatitis 8 years back and therefore the claim would also attract clause 4.1(pre-existing illness) as the policy was in operation only for the past 5 years. A question would also arise whether the same was disclosed at the time of policy inception.

In view of the above facts and analysis, the decision of New India Assurance Company to repudiate the claim of Smt. Gunavanti Punamiya as per exclusion condition 4.8 of the Policy,was upheld.

Mumbai Ombudsman Centre
Case No. : GI – 607 of 2007-2008
Mr. Pravin Pandit
Vs
The New India Assurance Co. Ltd.

Award Dated : 20.02.2008

Mr. Pravin Pandit was the policyholder of the New India Assurance Co. Ltd. since 2002. He lodged a claim in respect of his wife who was admitted in Lilavati Hospital for complaints of headache, heaviness of chest and giddiness. Her claim was rejected by

TPA on the grounds of exclusion 4.10 of the Policy, stating that the complaints for which she was hospitalised do not warrant hospitalisation as no active line of treatment was given to her during entire admission and was just kept there for observations. Also, she was treated with oral medicines and few investigations were carried out, which could have been done on OPD basis. Not satisfied with the decision of the Company, she approached this Forum for justice. The hearing was accordingly conducted. Complainant argued that his wife was a kidney patient and admitted on doctor's advices. The analysis revealed that no new diagnosis was done by hospital as it mentioned that Post transplant with GRAFT dysfunction with GERD which was already pre-existing before hospitalisation and the patient was on medication for the same. It was observed that she was hospitalised for the complaints of headache, pain in chest, giddiness and was administered only oral medicines for the present as well as pre-existing ailment. During hospitalisation number of pathological tests and investigations were carried out, which could have been done on OPD basis. As the condition of patient was stable at the time of admission, there was no emergency as such. The treating doctor confirmed that she was kept under observation and certain investigations were carried out in the hospital to check whether those were the symptoms of underlying major problems and when it was proved otherwise, she was discharged. In view of these observations, the Respondent's decision of repudiation of claim was upheld.

Mumbai Ombudsman Centre
Case No. : GI-101 of 2007-2008
Smt. Hemlata R. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 21.02.2008

Smt. Hemlata R. Shah had a mediclaim Policy No.112500/48/06/20/70020577 from The New India Assurance Co. Ltd. for sum insured Rs.3 lakhs covering policy period 29.07.2006 to 28.07.2006. The Policy was through KVO Seva Samaj Group Mediclaim Policy. Her dispute with the Company is the quantum of claim settlement. She was admitted to Bhatia Hospital for Left Eye Cataract surgery from 18.01.2007 to 20.01.2007 and the amount claimed by her was Rs.32,625/-. The TPA, M/s Raksha TPA settled an amount of Rs.17,500/- directly to the Hospital as cashless. She later underwent Right Eye Cataract surgery at Manav Welfare Trust on 29.01.2007. She submitted a claim for Rs.22,276/-. The TPA settled an amount of Rs.17,500/-. She wrote to the company for the settlement of the balance claim amount.

On going through the documents submitted to this Forum, Smt. Hemlata R. Shah had a mediclaim Policy for sum insured Rs.3 lakhs covering policy period 29.07.2006 to 28.07.2007. During the said policy year, she had enhanced the sum insured from Rs.2 lakhs to Rs.3 lakhs. According to exclusion clause 4.3 of the Company, during the first year, cataract surgery is not covered. Thus the claim for cataract surgery is covered under the previous policy year where the sum insured was for Rs.2 lakhs. According to the MOU signed between The New India Assurance Co. Ltd. and K.V.O. Seva Samaj, the amount payable under cataract surgery for the policy year 2006-2007 is Rs.17,500/- in total payable under the sum insured of Rs.2,00,000/-. Accordingly, the Company has settled an amount of Rs.17,500/- as cashless for her Left Eye cataract surgery she underwent on 20.01.2007 at Bhatia Hospital. They have also reimbursed an amount of Rs.17,500/- for her Right Eye cataract surgery that she underwent on 29.01.2007 at Manav Welfare Trust. The Company has settled the claim in total as per

the MOU signed with KVO Seva Samaj. The Company is justified in repudiating the claim for the balance amount.

Mumbai Ombudsman Centre
Case No. : GI-523 of 2007-2008
Smt.Rekha Sharma
Vs
United India Insurance Company Limited

Award Dated : 21.02.2008

Mrs.Rekha Sharma had covered herself under the mediclaim policy of The United India Insurance Company Ltd vide policy no.21200/48/05/02582. The claim arose under the policy when Mrs.Rekha Sharma got admitted to Astha Maternity & Surgical hospital for an emergency caesarean operation. After delivery, she experienced abdominal distention, which was not relieved even after treatment and was therefore shifted to Bhatia hospital that diagnosed the condition as ceacal ulcers and she was treated successfully. When Mrs.Rekha Sharma preferred the claim, the company rejected it stating that the abdominal distention was a complication of the pregnancy and resultant delivery. The complainant however represented stating that she was not claiming for her maternity treatment but only for ceacal ulcer resulting in the abdominal distention, which was in no way related to the delivery. The Company upheld the rejection and aggrieved by this, the complainant approached this forum for redressal.

After perusal of all the relevant documents, both the parties to the dispute were called for a personal hearing on 11.01.2008. The analysis of the case reveals that after the emergency caesarean section and subsequent delivery, the complainant appears to have been in good health. It was only thereafter that she experienced abdominal distention. Further, the initial treatment given at Astha Hospital had not helped her and she had to be shifted to a higher hospital where after various investigations, she was diagnosed to be suffering from ceacal ulcers and treated. The Company had not sought any expert panel doctor's opinion and has unilaterally decided. After being instructed by this forum, the Company obtained medical opinion from a leading gynecologist and also medical legal consultant. Both were in favour of the complainant and hence the case was reverted back to the Company for their necessary action. The compliant was disposed off accordingly.

Mumbai Ombudsman Centre
Case No. : No. GI – 585 of 2007-2008
Shri Navinchandra R. Shah & Geeta N. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated : 22.02.2008

Complainant, alongwith his wife Smt. Geeta was covered under Mediclaim Insurance Policy of New India Assurance Co. Ltd. Smt. Geeta was advised to undergo VAGINAL HYSTERECTOMY by Doctor of Ashwini Maternity & Surgical Hospital. Complainant availed Cash-less facility from TPA. TPA disallowed Rs.12,000/- against Reasonability Clause – excess Surgeon's fees. Aggrieved by the partial payment of claim, Complainant approached this Forum for intervention. A joint Hearing was to be held with the Company and the Complainant. However, no official of Company appeared & deposition of the Complainant was taken. Company submitted their Written Statement alongwith justification for not allowing full Surgeon's fees. Analysis of the case

revealed that the dispute was only for the quantum of claim. As per the procedure, the hospital applied for pre-authorisation from TPA. Hospital received authorisation letter wherein TPA approved the amount, restricting the Surgeon's fees at Rs.12,000/- only. Hospital authorities informed the insured that they have sent enhancement letter to TPA and are confident that they will get an approval for the same. During this period hospital and Complainant repeatedly tried to obtain further sum sanctioned, telephonically, but they did not receive any feed-back from TPA. Finally, at the time of discharge, Complainant had to pay Rs.12,000/- extra towards surgeon's fees, which was not allowed by TPA. Hospital authorities informed complainant to recover this amount under reimbursement facility. Accordingly, insured claimed this amount alongwith other medical bills under reimbursement scheme. TPA disallowed excess surgeon fees paid by the insured separately to the hospital. When the matter was examined in the Forum, it was surprised to notice as to why these issues were not taken up by this Network Hospital with TPA before giving discharge. Since the complainant had availed cash less facility from TPA and as the hospital was their network hospital, he should have not paid anything extra to the Hospital seems to be logical, but at the same time it was also unfair to pass such responsibility to the Insured. Generally, when hospital refuses to discharge the patient before payment of extra bill, the insured is helpless but to pay the amount and release the patient. Forum felt that such matters need to be resolved between TPA and hospital. The customers should be suitably advised of the arrangement between TPA and hospital and also be guided that he should not pay anything extra other than non-medical charges. For any increase in medical expenses, the hospital should take up the matter with TPA and should resolve the same amicably. It was directed that the Respondent to reimburse Rs.12,000/- to the Complainant.

Mumbai Ombudsman Centre
Case No. : GI-503 of 2007-2008
Ms.Jayashree T. Kamble
Vs
Royal Sundaram Alliance Insurance Company Limited

Award Dated : 27.02.2008

Ms.Jayashree T Kamble had covered her mother Smt.Pushpa Kamble under the health shield policy of the Royal Sundaram Alliance Insurance Company Limited

Vide policy no. HS00113228000100 through their telemarketing team. The claim arose under the policy when Smt.Pushpa Kamble got admitted to Sanjjevani hospital with symptoms of cough,IHD,Interstitial Lung Disease and H.T. When Ms.Jayashree preferred the claim, the Company rejected it stating that the policy was in its fifth month of operation and according to the medical papers the illness suffered by the insured were pre-existing prior to the inception of the policy. They further stated that the complainant had not disclosed these pre-existing illnesses of her mother at the time of taking the insurance. The complainant however represented that the policy was issued to her through telemarketing where she was not required to fill in any proposal form and hence there was no issue of non-disclosure. Further till her admission to the hospital, she did not know about the illness of her mother and the only symptom that her mother had was chronic coughing. The Company however upheld their stand of repudiation and aggrieved by this the complainant approached this forum for redressal.

After due perusal of all the relevant documents both the parties to the dispute were called for a personal hearing on 18.1.2008. Analysis of the case reveals that the policy was issued to the complainant through the telemarketing division of the Company

where no proposal forms are collected at the time of insuring and the premium is directly debited to the clients account. Therefore the company cannot take shelter under suppression of material facts or non-disclosure of material facts for repudiation of the claim. However it is noted from the medical records submitted to this forum that Smt.Pushpa is a chronic tobacco chewer and that her cough has been chronic since last five to six months. It also cannot be denied that a progressive disease like the interstitial lung disease cannot develop over such a short time. As the policy was only in its fifth month of operation, the Company's decision was sustained on pre-existing clause and the compliant was disposed off accordingly.

Mumbai Ombudsman Centre
Case No. : GI-031 of 2007-2008
Balu S. Chauvan
Vs
The New India Assurance Company Limited

Award Dated : 05.03.2008

The New India Assurance Co. Ltd., Chennai Divisional Office No.712500 was tied up D.O. for servicing Citibank Credit Cardholder for Personal Accident and Mediclaim Insurance. Master Policy called GOOD HEALTH POLICY was issued to M/s. Citibank to cover credit card holders. Shri Balu S. Chauvan and his wife Smt. Laxmi B. Chauvan were covered under Good Health Policy Certificate No.712500/08549/ GH September 2004. The inception of the policy was from 01.09.2004 for a sum insured of Rs. 50,000/-. Smt. Laxmi B. Chauvan was detected T.B. and she had to undergo various tests and was hospitalized for considerable time and was under medication. Unfortunately, Smt. Chauvan expired on 16.12.2004 due to T.B. Shri Balu Chauvan preferred a claim to the Company for a sum of Rs.14,156/- for the hospitalization and treatment of his wife Smt. Laxmi Chauvan for T.B prior to her demise. The TPA M/s. TTK Healthcare Services Pvt. Ltd. informed the Complainant vide their letter dated 23.08.2005 alongwith a letter from the Company dated 16.02.2005 canceling the coverage of insurance of his wife and refunding an amount of Rs.503/-. He received a subsequent letter dated 05.12.2005 that the policy of Late Smt. Laxmi B. Chauvan is being cancelled and the Company is unable to accept claim under cancelled policy.

It is pertinent to note that Smt. Laxmi Chauvan had already been suffering from the symptoms of the said ailment, prior to inception of the policy and the said claim is liable to be rejected under pre-existing diseases exclusion clause 4.1 of Good Health Mediclaim Policy. Moreover, as per Exclusion clause 4.2, any disease contracted during the first 30 days would be excluded from the scope of coverage as the hospitalization took place on the 2nd day itself of policy coverage.

Owing to the above facts of the case, the claim of Shri Balu S. Chauvan is not tenable even if the Company agrees for revocation of the cancelled policy.

Mumbai Ombudsman Centre
Case No. : GI-031 of 2007-2008
Balu S. Chauvan
Vs
The New India Assurance Company Limited

Award Dated : 05.03.2008

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Owing to the above facts of the case, the claim of Shri Balu S. Chauvan is not tenable even if the Company agrees for revocation of the cancelled policy.

Mumbai Ombudsman Centre
Case No. : GI – 562 of 2007-2008
Mrs. Gauri D. Patil
Vs
The New India Assurance Co. Ltd.

Award Dated : 07.03.2008

Mrs. Patil availed Mediclaim Policy from The New India Assurance Co. Ltd. Her husband Mr. Dilip was hospitalised in P.D. Hinduja National Hospital & Medical Research Centre with the complaints of backache with radiation to both lower limbs since six months, pain in both knees, swelling and pigmentation of both lower limbs since one year. He was admitted on the advices of his treating doctor. Initially, TPA approved Cash less benefit but subsequently on the day of discharge, the said facility was denied by them on the ground of exclusion 4.10 of the Mediclaim Policy, as it was observed that the general condition of the patient was stable at the time and during the entire period of stay in the hospital. Thus it was indicated that there was no emergency, he was not given any active treatment during the entire admission period. Also during hospitalisation, the claimant was investigated which could have been done on OPD basis. Not satisfied with the decision taken by the Company , Mrs. Patil approached this Forum for intervention. After perusal of the relevant records, the parties to the dispute were called for personal hearing. After taking into consideration, the oral depositions and all the documents, the analysis of the case revealed that Mr. Patil was under the treatment of his treating Doctor since last two months prior to hospitalisation, for back pain, multiple joint pain with walking difficulty and also Vericose Veins left leg. Dr. Kulkarni advised to get the patient admitted in the hospital as the progress to his treatment was very slow and needed further evaluation. During hospitalisation, no surgery was done. In the documents, there was no mention of any symptoms/emergency which would warrant hospitalisation. TPA made their stand clear

on the issue of cash less facility, which was sanctioned earlier and denied afterwards. They stated that the claimant was diagnosed with L1-2 PID with left L1 radiculopathy and applied for cash-less facility. The patient was to be admitted for medical management and traction and cashless was given for traction. But later the admission was found only for investigation purpose hence cashless was rejected. It was revealed from the hospital papers that there was no emergency as such for admission to the hospital and the diagnosis was already known and no fresh diagnosis was arrived at and only oral medications were administered during the hospitalisation. All these tests could have been done on OPD basis and based on these points, the Insurer rejected the claim and as such their stand was considered as justified. However, looking to the pain, the patient was undergoing and as there was no relief from the oral medicines, for which he was taking treatment, the treating Doctor advised for further evaluation of the underlying problem. In view this, Forum awarded relief to the complainant by way of 50% of the admissible claim, on ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI-679 of 2006-2007
Smt Poonam B. Gugliya
Vs
The United India Insurance Co. Ltd.

Award Dated : 07.03.08

The brief facts of the case are as follows:

Smt Poonam B. Gugliya had taken two mediclaim policies for sum insured of Rs. 50,000/- each from M/s. Bajaj Allianz General Insurance Co. Ltd. under policy No.OG-06-2001-8403-00000010 and Group Mediclaim issued by M/s. Unique Mercantile India Pvt. Ltd. through United India Insurance Co. Ltd. under Policy No.021800/48/05/21/00000111. Her daughter, Ms. Trupti B. Gugliya, aged 12 years was hospitalized at International Centre for Cardio Thoracic and Vascular Diseases, Chennai on 02.06.2005 and underwent an operation for Device closure of VSD on 03.06.2005. She was discharged on 04.06.2005. The total claim amount submitted to Bajaj Allianz General Insurance Company Ltd. was Rs.1,67,904/-. Bajaj Allianz settled the claim of Rs.50,000/- as per the sum insured. When Smt. Poonam Gugliya submitted the claim papers to Unique Mercantile Services Pvt. Ltd., they sent a letter dated 13.02.2006 to the Insured alongwith a letter dated January, 2006 from United India Insurance Co. Ltd. repudiating the claim stating that the insured was discharged from the hospital on 04.06.2005, but the claim was preferred to M/s. Unique Mercantile India Pvt. Ltd. alongwith hospitalization bill on 31.08.2005. As the claim must be filed within 30 days from the date of discharge from the hospital, we regret our inability to settle this claim as per condition No.5.4 of the Group Mediclaim Policy. Aggrieved by their decision, the Insured approached this Forum for the intervention of the Ombudsman in the matter of settlement of her claim.

Shri B.S. Gugliya, husband of Smt. Poonam Gugliya, the Complainant, appeared and deposed before the Ombudsman. He submitted that he had two mediclaim policies, one from Bajaj Allianz for Rs.50,000/- and another from United India Insurance Co. Ltd. through M/s. Unique Mercantile India Pvt. Ltd. for Rs.50,000/- He stated that before his daughter was admitted to hospital he had sent an intimation to the Insurance Company about the said treatment. He stated that his daughter was hospitalized at International Centre for Cardio Thoracic and Vascular Diseases, Chennai on 02.05.2005 and underwent an operation for Device closure of VSD on 03.06.2005. She was discharged on 04.06.2005. When he submitted the case papers to M/s.Unique Mercantile India Pvt.

Ltd., they advised him to first submit the claim papers to Bajaj Allianz. Bajaj Alliaz General Insurance Co. Ltd. settled the claim and as soon as the original papers were returned to him he submitted the papers to M/s. Unique Mercantile India Pvt. Ltd. United India Insurance Co. Ltd. rejected the claim due to late submission. He stated that he had intimated the Company in advance and requested that the claim be settled.

The United India Insurance Co. Ltd. after hearing the complainant's plea for late submission, informed this Forum that the Company was ready to reopen the case on getting the requirements and they would process the claim.

The payment was made by the Company.

Mumbai Ombudsman Centre
Case No. : GI-512 of 2007-2008
Shri.Harsh Tikam Soneji
Vs
The New India Assurance Company Limited

Award Dated : 07.03.2008

Mr.Tikam Soneji was covered under the policy of The New India Assurance Company Ltd vide no.142000/48//05/70056275 for a Sum Insured of Rs.200000. The claim arose under the policy when Mr.Tikam Soneji was admitted to the Hinduja hospital for complaints of imbalance whilst walking, tingling sensation and numbness of the upper limbs. He was diagnosed to be suffering from ossification of the posterior longitudinal ligament with lumbar stenosis. When the claim was preferred, the Insurance Company having found reference to an earlier treatment for similar complaints from one Dr.Deopujari way back in July, 2005 insisted on submission of the said first consultation note. The policy was in force from the year 2003. As the complainant could not submit the same, the claim was rejected on non-compliance ground. Aggrieved by this, the complainant approached this forum for redressal.

After perusal of all the relevant records, both the parties to the dispute were called for a personal hearing on 23.1.2008. The analysis of the case shows that Mr.Tikam Soneji had been under the treatment of one Dr.Deopujari for the same complaint way back in the year 2005 but as the insured had expired, the family members were not in a position to submit those records, However, as the claim now in dispute was also for the same illness, the earlier papers were essential for the Company to decide about the admission of the claim. It is observed from the submitted papers that the Company has not made any efforts to procure medical documents to either substantiate the pre-existing or admissibility of the claim. The TPA have only engaged in lengthy correspondence without any result. The forum therefore reverted the case back to the company and directed them to resolve the matter appropriately at their end.

Mumbai Ombudsman Centre
Case No. : GI- 270 of 2007-2008
Shri Lalitbhai Mody
Vs
The New India Insurance Company Limited

Award Dated : 07.03.2008

Mr.Lalitbhai Mody and his wife Mrs.Bharti ben Mody were covered under the mediclaim policy of The New India Assurance Company Ltd initially for a sum insured of Rs.100000. Thereafter it was increased by Rs.50,000 and whilst renewing the policy under which the present claim has arisen, the sum insured has been again enhanced

by Rs.150,000. Both the complainant and his wife were subjected to a medical examination after which the sum insured was enhanced. The policy was issued to Mrs. Bhartiben Mody after duly excluding osteoarthritis,Diabetes Mellitus and all its complications for the enhanced sum insured of Rs.150000. The claim arose under the said policy when Mrs. Mody was admitted to Breach Candy hospital for complaints of breathlessness and tiredness whilst walking and she underwent PTCA. When the claim was preferred the Company paid only the initial sum insured of Rs.150000 with relevant CB and did not pay the increased sum insured of Rs.150000 as it carried the exclusion of Diabetes Mellitus. Their contention was that the heart problem suffered by the insured was a direct complication of diabetes. Aggrieved by this decision, the complainant approached this forum for redressal.

After perusal of the documents both the parties to the dispute were called for a personal hearing on 22.2.2008. The analysis of the case reveals that Mrs.Bharti Mody was a diabetic at the time of increasing the sum insured. Although the complainant argued that she was diabetic only 3 months prior to her hospitalization for her heart claim, the same cannot be accepted as her Glysolated haemoglobin level showed her to be suffering from uncontrolled Diabetes Mellitus. Hence Diabetes Mellitus being one of the major risk factor for heart ailments and the same being excluded along with its complications for the enhanced limit, the decision of the company was found tenable.

Mumbai Ombudsman Centre
Case No. : GI – 238 of 2005-2006
Mr. Ankur R. Merchant
Vs
United India Insurance Co. Ltd.

Award Dated : 12.03.2008

Mr. Ankur R. Merchant availed Mediclaim Insurance Policy from United India Insurance Co. Ltd. covering himself and his mother Smt. Devyani R. Merchant. They were covered under the Policy since 1997. Smt. Devyani R. Merchant was covered for Sum Insured Rs.1,00,000/- under the Policy with CB 20% an exclusion “Convulsions recurrent left side – Hyperglycaemia”. The claim arose under the Policy when Smt. Merchant was hospitalised in S.L. Raheja Hospital where Left forefoot amputation surgery was performed on her. When the complainant preferred a claim for reimbursement of expenses incurred, TPA of the Insurer rejected his claim on the ground that it was falling under exclusion, which was appearing on the Policy. Not satisfied with the decision taken by the Insurance Company, Mr. Ankur Merchant approached this Forum, for intervention in the matter. After perusal of the relevant records, the parties to the dispute were called for personal hearing. Complainant Mr. Ankur Merchant appeared and deposed before the Ombudsman. He submitted that there was no exclusion on the Policies which were incepted from 1997. Thereafter, when the Company settled one claim in the year 2002 for DM and since then they imposed an exclusion of DM on all the renewal policies. In the year 2006, Company issued the Policy without any exclusion. Insurance Company contended that since Hyperglycaemia is specifically excluded under the Policy and the complications of Diabetes, Retinopathy & Diabetic foot are directly related to Hyperglycaemia, the claim is not tenable under the Policy and hence, the same was rejected. During the hearing, the Insurance Co. was asked to submit the justification for applying exclusion on the Policy. Insurance Co. clarified that the exclusion under the Policy was appearing due to system error and the same was rectified by passing the corrective endorsement. Insurance Co. requested their TPA to process the claim.

Mumbai Ombudsman Centre
Case No. : GI-726 of 2006-2007
Shri Tarachand B. Shewakramani
Vs
The New India Assurance Company Ltd

Award Dated : 13.03.08

Smt. Sati Shewakramani, was covered under the Mediclaim policy issued by The New India Assurance Co. Ltd.17.3.1999. Smt. Shewakramani, was hospitalized from 7.10.2005 to 11.10.2005 at Mahavir Medical Research Centre for treatment of Malaria. When a claim was preferred for Rs.15,815/-, the TPA of the company, M/s Medi Assist settled the claim for Rs.12,036/-. Shri Tarachand Shewakramani, vide letter dated 23.1.2007 complained to the Ombudsman.

On intervention by the Ombudsman's office, the company vide their letter dated 8.2.2007, have informed this Forum that the claim was for Rs.15,815/- and the TPA settled the amount of Rs.12,036/- as full and final settlement as per terms and conditions of the policy by deducting the following amount:

1) Rs.1,155/- had not been paid because the bill produced for the same was not related to present ailment for which the person was hospitalized though it falls under the period of post hospitalization.
2) Rs.2,364/- had not been paid because the bill produced for the same was not related to present ailment for which the person was hospitalized and had been deducted under reasonable and customary basis.
3) Rs.60/- Registration charges not admissible.
4) Rs.200/- Consultation for DM not payable as same was not related to present ailment for which the person was hospitalized.

As regards the medicines an amount of Rs.2364/- from the date of discharge i.e. 11.10.2005 onwards have been disallowed and the medicines include Himatrine, Cobadex, Shellcal etc. The Complainant's contention is that these medicines have been prescribed by the treating doctor in the discharge card and are definitely a part of helping the patient recover from the weakness caused due to Malaria. It may be pointed out here that the Mediclaim Policy reimburses only those expenses which are "necessarily and reasonably incurred" and excludes expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Physician. In this case, vitamins were necessary as part of the treatment and was suggested by the treating doctor as per the discharge card for recovery of the patient as the platelet count had come down due to Malaria. It is also noted that the policy is in inception since 17.3.1999 and there are no exclusions in the policy. The company is directed to reimburse the cost of medicines/vitamins as prescribed by the treating doctor in the discharge card.

As regards the dispute in respect of Investigation and Lab Charges amounting to Rs.1155/-, though it falls under the period of post hospitalization, the amount was deducted as it was not related to the present ailment. The Insured has mentioned that during the follow up visit on 20.10.2005, after discharge from the hospital, Dr. Gidwani, the treating doctor had advised her to do a Stress Test but as her condition was weak, her family doctor, Dr. Vaishali S. Naik, advised blood test. As post hospitalization expenses should follow the discharge advice, medicines, investigations and follow up treatment by the treating doctor are usually the charges which are paid for upto 60

days period. Stress Test is not related to Malaria and the blood tests were done on the advice of the family physician and not the treating doctor, hence the amount is not payable.

As regards the disallowance of Rs.200/- towards Consultation, it is noted that the Insured was a k/c/o HTN and DM and as per the certificate of Dr. Vaishali S. Naik dated 24.2.2006, she had been a case of Diabetes Mellitus and Hypertension since April 2003 and was on regular treatment and the Insured after discharge from the hospital had consulted Dr. Vaishali S. Naik. It is observed that in the present case, the Insured had consulted her Family Physician, Dr. Vaishali S. Naik, and therefore, Consultation Charges of Rs.200/- for Diabetes was not payable as it was not relating to the ailment for which the Insured was hospitalized.

In the facts and circumstances, The New India Assurance Company Ltd., is directed to reimburse the cost of medicines/vitamins as advised in the discharge card towards the expenses incurred by Shri Tarachand Shewakramani, in respect of the hospitalization of his wife Smt. Sati Shewakramani.

Mumbai Ombudsman Centre
Case No. : GI – 568 of 2007-2008
Mr. H.G. Kolarkar
Vs
The New India Assurance Co. Ltd.

Award Dated : 17.03.2008

Mr. Kolarkar was covered under Mediclaim Insurance Policy with New India Assurance Co. Ltd. since 2000. He was admitted in Dr. K.G. Deshpande Memorial Centre for NIDDM, Systemic Hypertension, IHD. His claim was rejected by TPA on the grounds of exclusion 4.1, i.e. pre-existing, as the history of Diabetes Mellitus since last 15 years was mentioned in the cash-less application form by the doctor. Not satisfied with the decision of the Insurer he approached this Forum for justice. Accordingly hearing was held at Nagpur Camp. The analysis of the case revealed that he was insured with New India since 2000 and during last 7 years, not a single claim was lodged by him. In the hospital CABG surgey was performed on him. It was noted that complainant was suffering from DM since last 15 years, especially prior to the date of proposal. He confirmed that the same was disclosed in the proposal form but Insurance Co. did not take note of the same and no exclusion was put on the Policy. He contended that since he had disclosed the ailment in the proposal form, his claim should not be rejected on the grounds of condition 4.1. It was held that Policy condition 4.1 excludes all the pre-existing diseases, prior to first inception of the Policy, whether disclosed or not. As such irrespective of whether the person discloses the pre-existing ailment or not, terms & conditions of the Policy will remain. Condition 4.1 superceded the contention of the complainant. Also DM is known as one of the major risk factor for cardiac problem. The complainant was suffering from the same, since pretty long duration of 15 years. In view of this Insurer's rejection was considered as valid. But at the same time looking to the facts and circumstances that since policy had run over 7 years and no claim stated to have been reported during these years for DM, Insurance Company was directed to settle 75% of the admissible expenses on Ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : No. GI – 626 of 2007-2008
Dr. Ms. Thrity D. Patel

Vs

National Insurance Co. Ltd

Award Dated : 31.03.2008

Mr. Jamshed D. Patel, brother of the Complainant was covered since 1997 under Mediclaim Policy of National Insurance Co. Ltd. He was admitted in Medical Nursing Home with the complaints of chest pain associated with vomiting and ghabhrahat and treated for the same, for which he preferred a claim. TPA of the Insurer repudiated his claim under clause 4.1 i.e. pre-existing clause. They contended that before taking the first Policy, the patient was suffering from IHD and the present disease is connected with previous disease .i.e. pre-existing. Pre-existing disease is not payable under the Mediclaim Policy. Not satisfied with the decision of the Company, complainant approached this Forum for intervention. After perusal of the relevant records, the parties were called for personal hearing at Nagpur Camp. All the documents submitted to this Forum were scrutinised. The dispute was on two major points. 1) The argument of the Complainant that while taking out the first Policy, heart ailment was disclosed in the proposal form and the exclusion of the same was not mentioned on the policy. Also, condition No.4.1 will not apply to the current Policy as the first inception year of the Policy was 1997 and there was no such clause prevailing at that time 2) Insured was hospitalised for Jaundice and DM and Heart problem were also existing. The analysis of the record showed insured had undergone CABG in the year 1988, which means the ailment of IHD was pre-existing since 1988.. Complainant alleged that even after disclosing the IHD in the proposal form, the Insurance Co. had issued the Policy without any exclusions. The complainant could not produce any documentary evidence to substantiate her argument. It was held that condition 4.1 of the Mediclaim Policy, excludes all the pre-existing diseases, prior to first inception of the Policy. As such, merely by disclosing the pre-existing ailments in the proposal form, complainant should not assume that these ailments are covered under the Policy. Also Mediclaim Insurance Contract is an annual contract, and is governed by terms, conditions and exclusions prevailing at the time of renewal of the Policy. If there are any changes/modifications in the terms, conditions and exclusions, the same modified version will apply to the Policy which is in force at that particular period of time. Thus, the Policy of 2006-07 will attract all those terms, conditions & exclusions which are in existence in 2006 and will not governed by the conditions/exclusion of 1997. Hence, the contention of the Insured that exclusion 4.1. of the year 2007 will not apply for the Policy found as not justified. As per Discharge Card, the patient was admitted in the hospital mainly for the complaints of chest pain, vomiting and ghabrahat. These are the major symptoms of Heart ailments. It was observed that the hospitalisation was required mainly for the complaints of Heart ailment. The complainant had stated in the hearing that the patient was hospitalised for Jaundice with DM & HT pre-existing. But , in Discharge Card it was revealed mild Icterus. As such, it cannot be said that the major complaint for which patient was hospitalised was Jaundice. Decision taken by the Respondent was upheld.

Mumbai Ombudsman Centre

Case No. : GI – 741of 2007-2008

Mr. Sumatilal C. Shah

Vs

The New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Mr. Sumatilal C. Shah, alongwith his wife, was the Mediclaim Policy-holder of New India Assurance Co. Ltd., since 1999. Mr. Shah was admitted in Dr. Balabhai Nanavati Hospital with the complaints of pain and swelling in legs. When he submitted the claim for reimbursement of hospitalisation expenses, TPA of the Insurer rejected his claim under Clause 4.10 of Mediclaim Policy. They contended that the patient was hospitalised for Gout and had undergone treatment for the same. But, the line of treatment given during hospitalisation included only oral medication with investigations, which does not warrant hospitalisation and could have been taken on OPD basis. Since the treatment administered did not justify hospitalisation, the claim was repudiated under exclusion 4.10. Aggrieved by the decision of the TPA/Company, Mr. Shah approached this Forum for intervention. After perusal of the relevant records, both the parties to the dispute were called for personal hearing. The Complainant submitted that he had swelling and intolerable pain in legs and as a reason could not even walk or sleep. Initially, he took some local medicines but could not get any relief and as such took the treatment on OPD basis at Dr. Balabhai Nanavati Hospital and as there was no improvement, on the advices of Nephrologist of Nanavati Hospital, he was admitted there and treated for the same. During the hearing, the Insurance Co. was advised to review the case in the light of the submission made by the Complainant. Subsequently, TPA of the Insurer informed this Forum that they have settled the claim of the Complainant.

Mumbai Ombudsman Centre
Case No. : GI – 248 of 2007-2008
Mrs. Jayshree Kothari
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Complainant was covered with New India since 2004, with an exclusion of Heart/IHD and Asthma & Broncihits and Exclusion 4.3 for 3 years. She was admitted in Bhargava medical Centre for the treatment of acute exacerbation of Interstitial Lung Disease. Her claim was rejected by TPA, stating that present ailment is related to pre-existing ailment as well as exclusion appearing on the Policy. Not satisfied with their decision, she approached this Forum for justice, stating that she was treated for ILD and not for Asthma/Bronchitis, hence her claim becomes payable. The hearing was scheduled to be held, but she remained absent due to her ill health, but the deposition of the Company was taken on the record. Analysis of the record revealed that in support of their decision Company took the opinion of their panel doctor, who justified the Stand of the Insurance Co. The dispute in the Complaint was regarding the exact nature and scope of the disease ILD vis-à-vis Bronchitis/Asthma. Treating doctor of the complainant stressed that she was diagnosed and treated for ILD and not for Bronchitis. It was held that both ILD and Bronchitis/Asthma are the diseases of Lungs, which was also endorsed by the treating doctor of the Complainant. Bronchitis/Asthma patients also reveal the most of the symptoms for which the patient was admitted. Bronchitis/Asthma of longer duration may develop into ILD and as such there may be a possibility that present ailment was the complication of Asthma/Bronchitis. It was held that since the complainant was already suffering from the lung disease, before inception of the Policy, the same attracts exclusion on the Policy as well as exclusion 4.1. Hence the decision of the Respondent was upheld.

Mumbai Ombudsman Centre
Case No. : GI- 304 of 2007-2008
Shri Rajesh H Gosalia
Vs
The United India Insurance Co. Ltd.

Award Dated : 31.03.2008

Shri Rajesh H Gosalia , alongwith his two sons, was covered under a Mediclaim Policy Master Harsh R Gosalia, the son of the complainant, was admitted to the Bhatia Hospital, Mumbai, for 'Rt. Gynaecomastia subcutaneous Mastectomy' . When Shri Rajesh H Gosalia, preferred a claim for the expenses incurred for the above hospitalization and treatment, the TPA regretted the claim stating that after review of all available documents and taking into consideration the panel doctor's view, the matter has been adjudicated to be 'no claim' in nature and thus nothing was payable

Dissatisfied, Shri Gosalia represented to the Office of the Insurance Ombudsman and parties to the dispute were called for a hearing on 25.2.2008. The complainant submitted that his son's surgery was by no means cosmetic in nature. He said that the surgery was done as the enlargement had become more prominent and his son was experiencing pain . The United India Insurance Co. Ltd., was represented by Shri Ramesh A Visapure, AO. He stated that the claim was repudiated under clause 4.5 of the policy terms and conditions which excludes surgeries done with a cosmetic purpose. The Ombudsman directed the Respondent to get an expert medical opinion on the matter of dispute and get back to this Forum in fifteen days.

The panel doctor of United India Insurance Company Limited has opined that Gynaecomastia is not a specific disease and that it occurs in young males as a result of hormonal imbalance. Taking this view into consideration, the Insurer has made the claim inadmissible as per clause 4.5 of the policy conditions. On scrutiny, it was found that Master Harsh was experiencing pain due to the enlargement of the right side breast which necessitated a visit to the doctor which resulted in further surgery. Again, as could be seen in the photograph, he has a prominent white patch on his face. However, the family had not gone in for any cosmetic surgery for removal of the same. Shri Gosalia's contention that the mother had also undergone a surgery for removal of lumps from the breast and hence the parents' anxiety for the child is understandable. Dr.Sunawala's statement that the excised tissue did not reveal any malignancy/tumour is well taken; however, this point has come to light only after the surgery and later, the biopsy. In view of the above facts and circumstances, the repudiation of the claim by the United India Insurance Company was set aside.

Mumbai Ombudsman Centre
Case No. : GI-443 of 2007-2008
Shri A V S Murthy
Vs
The New India Assurance Co.Ltd.

Award Dated : 31.03.2008

The complainant, Shri A Venkata Sadananda Murthy, was covered under a Mediclaim Policy for the period from 27.1.2007 to 26.1.2008, for a Sum Insured of Rs.2,00,000/-, which was later enhanced by another 65,000/-. There were no exclusions mentioned in the Policy. On 9th July, 2007, Shri Murthy was hospitalized and treatment was given for

Acute Renal Failure .When Shri Murthy preferred a claim for the expenses incurred by him towards the above hospitalization, the TPA rejected the claim vide letter dated 14.8.2007 as they felt that the ailment was a complication of Diabetes Mellitus and Hypertension, which the patient was suffering since 20 years making it pre-existing in nature. Hence, as per clause 4.1 of the policy conditions, the claim was rejected. When Shri Murthy represented to the Ombudsman, the parties to the dispute were called for hearing on 22nd February, 2008. The complainant did not turn up. Smt.Jayashree Ramani represented the New India Assurance Co. Ltd. She stated that the claim was repudiated under clause 4.1 of the policy terms and conditions, which excludes pre-existing conditions. Further, she stated that the claimant was suffering from Diabetes and Hypertension for the last 20 years and both these diseases are major risk factors for Renal Failure and A V Dissociation, for which the present claim is made.

The claim file, with the relevant documents, has been scrutinized at this Forum. . The complainant has opined that when his claim in the year 2001 for Angioplasty was settled by the Insurer, pre-existing ailment cannot be a ground for repudiation of the present claim. The complainant has not denied the present history of DM and HT and has been consistently harping on the point that they were under control. In order to ascertain the correct duration of HT and DM, as the history recorded during the earlier and present hospitalization was different, a letter, was sent to the complainant to provide evidence for the onset of DM and HT. A reply was received and in this, instead of giving the correct information, the complainant has mentioned that as per the new guidelines, pre-existing diseases are covered after four years of a continuous policy . In view of the facts and analysis , the decision of the Company was upheld.

However, the New India Assurance Company was directed to settle 50% of the admissible expenses incurred by the Insured, on an ex-gratia basis.

Mumbai Ombudsman Centre
Case No. : GI-639 of 2007-08
Shri Ramakant P. Desai
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Shri Ramakant P. Desai was covered under an Individual Mediclaim Policy No.112700/48//06/20/70000002 from The New India Assurance Co. Ltd. for the period 01.04.2006 to 31.03.2007 for a sum insured of Rs.5.00 lacs with C.B. 2.00 lacs. Shri Ramakant Desai was reportedly covered under Mediclaim Policy since 1994.

Shri Ramakant P. Desai submitted a claim for Rs.1,63,910/- for his treatment of Bilateral Osteoarthritis at Cartigen Healthcare Pvt. Ltd. from 02.03.2007 to 22.03.2007. This treatment was carried out for 21 days. When he submitted his claim to M/s.TTK Healthcare Services Pvt. Ltd., his claim was refused on the ground that the said treatment was taken on OPD basis.

The documents produced to this Forum have been perused. According to Shri Desai, he started getting a shooting pain all of a sudden while sitting. He consulted Dr. Ravindra G. Khedekar, Orthopedic Surgeon, and was asked to undergo a MRI scan of the right knee. According to a Certificate by Dr. R.G. Khedekar, he stated – “Clinically he was having acute medial cartilage injury which was confirmed by the MRI dated 25.01.2007. He was advised local cold compression, analgesic, anti-inflammatory and arthroscopy management for the same”. He also consulted Dr. N.S. Laud, Orthopaedic

Surgeon. A certificate by Dr. N.S. Laud states " On clinical examination, I found he has a deformity in both knee joints with pain and restricted motion. The X-ray shows evidence of medial and patello femoral compartment osteoarthritis. He was advised physical and drug therapy. In view of his deformity and x-ray evidence of medial and patello femoral osteoarthritis with loss of terminal motion in the knee, I had suggested to him a bilateral Total Knee Replacement to correct the deformity, and offer good pain relief for long term basis. In the meantime he should take physical and drug therapy as advised".

According to Shri Desai, he consulted Dr. V.G. Vasista, Retd. Wing Commander and CEO of Cartigen Healthcare Centre which deals in non-invasive scientifically proven treatment of Osteoarthritis through the genesis of RFQMR (Rotational Field Quantum Magnetic Resonance). According to this treatment, it is a procedure entailing daily exposure of the affected knee for one hour for 21 days. He took treatment for both his knees from 02.03.2007 to 22.03.2007 from the Cartigen Healthcare Centre on OPD basis.

As per the policy condition, Shri Desai had undergone treatment for osteoarthritis of his knees at the Cartigen Healthcare Centre entailing daily exposure of the affected knee for one hour for 21 days on OPD basis. He was not admitted to any hospital. Since the Policy specifies minimum period of hospitalization of 24 hours, which has not been fulfilled in this case, there is no merit in the complaint.

Mumbai Ombudsman Centre
Case No. : GI-614 of 2007-2008
Dr.(Ms.) Mithoo Rabadi
Vs
United India Insurance Company Limited

Award Dated : 31.03.08

Dr.(Ms.) Mithoo Rabadi, was insured with the United India Insurance Company Ltdfor the period 3.3.2006 to 2.3.2007 for a Sum Insured of Rs.3,00,000/- with 34% Cumulative Bonus. She was covered under the Mediclaim Policy since 1993. She was hospitalized at The B.D. Petit Parsee General Hospital for Tenosynovitis of Tibialis Posterior with Supra. Fracture from 21.8.2006 to 22.8.2006 and Severe Dilated Cardiomyopathy, from 24.9.2006 to 8.10.2006 for which she lodged a claim with the company.

Not receiving any response from the company, Dr.(Ms.) Rabadi vide her letter dated 30th November, 2007 represented to the company stating that two separate claims relating to her hospitalization were submitted on 14.11.2006 and 22.11.2006. Regarding the clarification of diabetes history, she had submitted the discharge card copy of B.D. Petit General Hospital which clearly states her history of diabetes mellitus since past 3 years and she was insured under the policy since 1993. Moreover, diabetes has no relevance to the ailment suffered.

Aggrieved with the company she approached the Ombudsman on 11.12.2007 21.11.2006 seeking intervention in the matter of settlement of her claims with the company.

The Company was directed to process the claim as per history recorded in the discharge card as it has been clearly mentioned DM since 3 years and on Rx and no history of IHD/HTN/Bronchial Asthama. In case of any doubt they have a liberty to

investigate the claim and to intimate their decision to the party with a copy to the Ombudsman's forum within 10 days.

Pursuant to the Hearing, the Company has informed vide letter dated 28.3.2008 that they have settled the claim of Dr.(Mrs.) Mithoo Rabadi, for an amount of Rs.71,213/- as full and final settlement of the claim based on the papers submitted. Accordingly, claim disbursement voucher is sent to the Insured and have confirmed that the voucher duly discharged by the Insured is received by them. In view of the settlement, the complaint, is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-706 of 2007-2008
Shri Jeevan Shivdasani
Vs
The New India Assurance Company Limited
Award Dated : 31.03.2008

Mr.Jeevan Shivdasani and his wife, Mrs.Veena Shivdasani were covered under the mediclaim policy of The New India Assurance Co.Ltd for a Sum Insured of Rs.50,000 each from the year 1998. The claim arose under the policy no.111200/48/06/20/7003243 when Mr.Jeevan Shivdasani got admitted to the Bombay Hospital for complaints of generalized weakness and shortness of breath. The Company rejected his claim stating that the diagnosis and treatment of Mr.Shivdasani was for HIV infection and hence beyond the scope of the policy. Mr.Shivdasani however represented stating that he was treated for bronchitis during the hospitalization and that the policy only excluded treatment for AIDS and not HIV infection even if he were treated for HIV infection.. The company after seeking panel doctor's opinion reiterated their stand of repudiation and aggrieved by this, the complainant approached this forum for redressal.

After perusal of all the relevant documents, both the parties to the dispute were called for a personal hearing on 11.3.2008. The analysis of the case reveals that Mr.Jeevan Shivdasani was already under the treatment of one Dr.Panikar who has referred him to Dr.M.B.Agarwal – haemato-oncologist with the history of Diabetes since 1998, Retro viral infection, renal impairment, herpes zoster infection 18 months ago, history of recurrent loose motions. On careful study, all the presenting symptoms of the complainant are all opportunistic infections that are predominantly seen in patients with HIV infection. In fact the doctors have conducted various investigations methodically to zero in on the HIV infection diagnosis and as all treatment and complications of AIDS and HIV infection are clear exclusion under the policy, the decision of the Company is tenable and does not require any intervention.

Mumbai Ombudsman Centre
Case No. : GI-185 of 2007-2008
Shri Narasimhs Sharma
Vs
Royal sundaram Alliance Insurance Co.Ltd.
Award Dated : 31.03.2008

Mr.Narasimha Sharma had covered himself under the health shield policy from the Royal Sundaram Alliance Insurance Co.ltd for a sum insured of Rs.100000 through the telemarketing team of the Company. The claim arose under the policy no. HE00008223000102 when Mr.Sharma got admitted to the Holy Family hospital for chest discomfort where he under went CAG followed by PTCA. When Mr.Sharma preferred the claim, the company rejected it under misrepresentation and pre-existing clauses.

Their contention was that the scrutiny of the medical papers of Mr.Sharma revealed him to be a diabetic since 6-7 years and the complainant did not declare this at the time of taking the insurance. Further heart ailment being a direct complication of Diabetes Mellitus, the same was treated as pre-existing. The complainant represented stating that as the policy was issued through the telemarketing team of the Company, where he was not asked to fill in any proposal form, the issue of non-disclosure does not arise. Further he voluntarily disclosed the history of Diabetes Mellitus to the hospital authorities and hence his claim should be considered. The Company however reiterated their stand of rejection and aggrieved by this the complainant approached this forum for redressal.

After perusing all the relevant documents, both the parties to the dispute were called for a personal hearing on 18.2.2008. The analysis of the case reveals that Mr.Sharma was a known case of diabetes since last 6- 7 years and the policy was only 2-3 years old. The Company's stand of misrepresentation and non-disclosure does not hold water as the policy was issued through the telemarketing team without obtaining any proposal form. However, as the complainant was diabetic for 6-7 years prior to the commencement of the insurance and as it is medically accepted that long standing Diabetes Mellitus is one of the major risk factors for heart ailments, the Company's decision to repudiate the claim is tenable.

Mumbai Ombudsman Centre
Case No. : GI- 676 of 2007-2008
Shri Ramesh C Ganesan
Vs
The United India Insurance Company Limited

Award Dated : 31.03.2008

Mr.Ramesh C Ganesan had covered himself along with his parents under the mediguard policy of The United India Insurance Company Ltd for a sum insured of Rs.200000 each, since July 2005. The claim arose under the policy no. 21900/48/06/12/00000190 when Mr.Ganesan, father of the complainant got admitted to Netra Retina and Laser Centre for complaints of diminished vision in the right eye and was treated for sub foveal choroidal neovascular membrane. The Company rejected the claim stating that the problem suffered by the insured was an age related one and aggravated by the Diabetes Mellitus already suffering by the insured and hence pre-existing. Further they also went on to say that the treatment could have been taken on OPD basis and hence not tenable on this ground also. The complainant however represented his case, supporting it with his doctor's certificate justifying hospitalization and other literature about the illness and treatment. The Company after obtaining a medical opinion reiterated its rejection and aggrieved by this, the complainant approached this forum for redressal.

After perusal of all the documents, the parties to the dispute were called for a personal hearing on 13.3.2008. The analysis of the case reveals that the insured was suffering from Advanced Macular Degeneration where new blood vessels start growing under the retina and suddenly start bleeding thus affecting the vision. The treatment is by way of laser and visudyne injections. The literature submitted by the complainant himself confirmed this treatment to be a day care procedure not needing hospitalization. Further the policy was only in its second year of operation and that the problem as the name goes is age related degenerative illness and not of sudden origin. Hence the decision taken by the Company in rejecting the claim was found to be in order and did not require any interference by this forum and the complaint was disposed off accordingly.

Mumbai Ombudsman Centre
Case No. : GI- 267 of 2007-2008
Shri.Shashi kumar Mehra
Vs
The Oriental Insurance Company Limited

Award Dated : 31.03.2008

Mr.Shahikumar Mehra was covered under the mediclaim policy of The Oriental Insurance Company Ltd right from the year 1995. The claim arose under the policy no124200/48/2007/4127 when Mr.Mehra got admitted to Shah Eye Clinic for right eye p.p vitrectomy with removal of the dropped IOL with sceleral fixation of IOL. The Company stated that the hospitalization was for complications arising out of the earlier cataract surgery undergone by the complainant 10 years before and unless the exact details of the cataract operation were submitted by the complainant for deciding about the admissibility of the claim, the claim cannot be paid. The complainant represented stating that the earlier cataract operation was done in a charitable hospital and hence no records can be given but however as the policy was for more than 10 years his present claim should be paid. The Company however upheld their stand of rejection and aggrieved by this the complainant approached this forum for redressal.

After perusal of all the records, both the parties to the dispute were called for a personal hearing on 5.2.2008. The analysis of the case reveals that the claim under dispute was for removal of the dropped Intra Ocular Lens implanted at the time of the earlier cataract surgery and also for sceleral repair and vitrectomy. The policy was more than 10 years old and so was the history of the earlier cataract surgery making it a borderline case. However it should be noted that the earlier surgery was done in a charitable hospital, which does not preserve records of such old surgeries. Further the policy was also in force for approximately the same duration. The Company instead of producing any documentary evidence for proving preexistence has relied upon some unreasonable calculation for deciding the admissibility of the claim. As the policy was also continuously in force for almost the same duration, the benefit of doubt was given to the complainant and the Company was directed to settle the claim.