Overseas Mediclaim Policy

Bhubaneshwar Ombudsman Centre
Case No. : 11 –002-0116
Sri Suryanarayan Bir Samanta
Vs
New India Assurance Co. Ltd.

Award Dated : 19.10.06

Insured Complainant agent of Life Insurance Corporation of India was covered under Group overseas mediclaim policy for a period of one year commencing from 31-12-2001. with New India Assurance Co. Ltd . The insured under went treatment of mouth cancer and admitted to Talcher Sub Divisional Hospital from 01-11-2001 to 30-11-2001 and Panda Medical Centre ,Cuttack from 01-12-2001 to 17-12-2001. Insured also received the treatment at Acharya Harihar Regional Cancer Center,Cuttack and Tata Memorial Hospital ,Mumbai from 01-06-2003 to 30-09-2003. Insurer repudiated the claim on the ground of Pre existing disease. During Hearing complainant stated that insured had no pre existing disease where as insurer proved with the documents that disease was preexisting.

Hon'ble Ombudsman uphald the repudiation as disease was pre existing and pased a nil award.

Bhubaneshwar Ombudsman Centre
Case No. : 11 –003-0093
Sri Rabindranath Pati
Vs
National Inssurance Co. Ltd.

Award Dated : 20.10.06

Insured Complainant obtained a overseas mediclaim policy for a period of two months i.e from 24-05-2004 to 22-07-2004 with National Insurance Co. Ltd . The insured went to USA to attend a conference at Pennsylvania University. On return journey he was refused permission to board the flight of British Airways to India via UK at Philadelphia airport due to want of transit visa as a resultof which he was stranded in USA for about 22 days. During that period insured incurred medical expenses of U$ 3000 and personal expenses of U$ 8500 . Insurer repudiated the claim as personal liability is not covered under the policy and he was advised to refer the mediclaim to their overseas claim settling agent.

During Hearing Complainant stated that he was stranded in USA due to visa problem insurer is liable to defray his expenses under illness clause of the policy.

Insurer stated that personal liability cover under the policy does not include expenses incurred by the complainant due to over stay of the insured due to visa problem. Moreover insured got the compensation from British Airways vide Bhubaneswar consumer Forum. Complainant has not produced any medical papers for his treatment under taken in USA.

Hon'ble Ombudsman pass a nil award as complainant failed to submit any paper that he had incurred medical expenses of U$ 3000 and policy never states expenses incurred by complainant for visa problem arising out of over stay will be indemnified.

Chennai Ombudsman Centre
Case No. : 11.11.1108/2006-2007
Smt. Swarnalakshmi Yugendran
Vs
The Bajaj Allianz Gen. Ins. Co. Ltd.,

Award Dated : 26.09.2006

The complainant was insured under a Travel Secure Policy issued by Bajaj Allianz Gen. Ins. Co. Ltd. for the period, from 18.05.05 to 01.06.05, covering her trip to Melbourne. She was hospitalised on 29.05.05 at Melbourne with complaints of acute abdomen pain / hypovolaemia due to blood loss and an emergency laparotomy and salpingectomy was done on her. The diagnosis was 'Ectopic Pregnancy'. Her claim was repudiated on the ground that the present claim was for treatment of pregnancy, which is excluded under the policy as per exclusion 2.5.7.

The insurer argued that Ectopic Pregnancy is also a form of pregnancy though the pregnancy does not result into childbirth and also argued that complications arising out of pregnancy directly or indirectly are also excluded under the clause. Hence the repudiation of claim as per Exclusion clause 2.5.7 is in order.

As per medical dictionary the term pregnancy means, a condition of having a growing foetus in the womb of the mother, however Ectopic Pregnancy is an illness which is a pathological and abnormal condition and would never result in child birth, it may be life threatening if unattended, hence requires hospitalization. The Policy excludes only pregrancy resulting to childbirth, hence insurer is wrong in disallowing claim for Ectopic pregnancy. Hence direction was given to the insurer to settle the claim.

Chennai Ombudsman Centre
Case No. : 11.12.1169/2006-2007
Smt. Dabala Bharathi
Vs
The ICICI Lombard Gen. Ins. Co. Ltd.,

Award Dated : 11. 10.2006

The complainant represented that she was covered under Overseas Leisure Travel Insurance policy issued by ICICI Lombard for the period, from 12.10.2005 to 09.01.2006 for her trip to USA. After reaching USA, she contracted cough. Hence she consulted the local doctor. The Doctor diagnosed the reason for her cough to be Asthma and he advised for some more investigations. She submitted necessary claim papers; however, the insurer repudiated the claim on the ground that her disease was a pre-existing one.

The insurer contended that Asthma couldn't be developed within a short period and the complainant must have been suffering from Asthma for quite some time prior to the inception of the policy. She might not be aware of the same and no treatment would have been taken for that disease. The insurer pointed out that their policy covers pre-existing disease, only on two situations viz. 1) To relieve the acute pain or 2) under life threatening conditions. But in this case the treatment was given for Asthma and no indication either it was given for relieving of acute pain or under life threatening condition. Hence they repudiated the claim.

Documents were perused and observed that cough may be one among the symptoms of Asthma and no conclusive evidence by way of medical records, was produced by the Insurer to prove that Asthma was pre-existing before inception of the policy. The forum pointed out to the Insurer that they have issued the policy without a medical test. Though the patient had cough during September '05, no substantiating evidence was produced by the insurer to establish the cough of the complainant during the month of September, has a direct relation with the diagnosis of Asthma. Hence direction was given to the Insurer to settle the claim as per policy terms and conditions.

Chennai Ombudsman Centre
Case No. : 11.02.1008/2006-2007
Shri. S. Swaminathan
Vs
The New India Assurance Co. Ltd.,

Award Dated : 27.10.2006

The complainant represented that he and his spouse were covered under Overseas Mediclaim Policy with New India Assurance Co. Ltd, B.O 710701 Chennai from 21.05.2004 to 14.10.2004, for 147 days. He left for USA on 21.05.2004 and returned to India on 20.09.2004, prior to the expiry of the policy period, hence he requested the Insurer to refund the balance premium amount for the un-expired period. However, the Insurer rejected his request on the ground that the premium was collected for the Trip band of 121-147 days, the actual stay of the complainant in abroad was 123 days which falls within the said trip band on which basis the premium was collected.

The insurer contended that the total stay of the insured in abroad was 123 days and the premium had been collected on trip band basis for the band 123-147 days. They also stated that the complainant itself has clearly mentioned in the proposal form that 'with provision for refund in case returning earlier'. Since the insured returned from US after a stay of 123 days, which falls within the trip band period, the insurer expressed their inability to refund the premium.

The forum pointed out that though the insured has fulfilled the general condition 1(iii) of the policy, the insured was in abroad for 123 days, which falls within the trip band period i.e. 123-147. The Forum stated that the insured had incurred the same premium, so the insurer need not refund the premium. Hence, this forum dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.02.1059/2006-2007
Shri. S. Swaminathan
Vs
The New India Assurance Co. Ltd.,

Award Dated : 27.10.2006

The complainant represented that he and his spouse were covered under Overseas Mediclaim Policy with New India Assurance Co. Ltd, from 17.09.2005 to 14.01.2006, for 120 days. He left for USA on 17.09.2005 and returned to India on 16.12.2005, prior to the expiry of the policy period, hence he requested the Insurer to refund the balance premium amount for the un-expired period. However, the Insurer rejected his request on the ground that the premium was collected for the Trip band of 91-120 days, the actual stay abroad was 91 days which falls within the said trip band on which premium was collected.

The insurer contended that the total stay of the insured was 91 days and the premium had been collected on trip band basis for the band 91-120 days. Since the insured returned from US after a stay of 91 days, which falls within the trip band period, the insurer expressed their inability to refund the premium.

The forum pointed out that though the insured has fulfilled the general condition 1(iii) of the policy, the insured has traveled for 91 days, which falls within the trip band period i.e 91-120. Under the circumstances, as per policy provisions, the insured incurs the same premium. So the insurer need not refund the premium. Hence, this forum dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.12.1263/2006-2007
Smt. Prema Nagarajan
Vs
ICICI Lombard Gen. Ins. Co. Ltd.

Award Dated : 27.02.2007

The complainant Smt. Prema Nagarajan had taken a Travel Insurance policy from ICICI Lombard Gen. Ins. Co. Ltd from 01.09.2005 to 27.02.2006 for her visit to USA and she was informed by the representative of the Insurer that in case of her early return to India, she will be eligible for refund of difference in premium. She fell sick in USA and the Insurer settled her claim. Since, she had returned to India early, she made a claim with the Insurer for the refund of excess premium for the un-expired period of risk. However, the Insurer did not settle it.

The Insurer contended that the premium would not be refunded once a claim has been made under the policy. Hence, they have repudiated as per the policy condition No.7 that clearly states that no refund is payable once a claim has been made under the policy. Since, in this case the complainant already made a claim and got settled under this policy, hence refund will not be made for early return.

This Forum perused the documents and found that the Insurer had acted as per the policy terms and Condition No.7. Hence, this Forum dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.07.1350/2006-2007
Smt. Baghyalakshmi
Vs
TATA AIG Gen. Ins. Co. Ltd

Award Dated : 29.03.2007

The Complainant Smt V. Baghyalakshmi was covered under Travel Guard policy with M/s TATA AIG General Insurance Co. Ltd., for her visit to USA for the period from 22.03.2006 to 17.09.2006. She fell sick in USA and took treatment for the same, which cost her US$ 132.69. She preferred a claim with the insurer for US$ 132.69, but the insurer admitted only US$ 32.69 and disallowed US$ 100 for the reason of deductible. She represented to the insurer that the reduction of US$ 100 is arbitrary, unreasonable and disproportionate. The Insurer did not consider her representation.

The Insurer contended that they have clearly mentioned the deductibles of USD 100 on the face of the policy and irrespective of the claim amount the deductible is applicable. The Insurer also contended that since they cover high risk and face more claims under OMP policy, they have made the deductibles as 100 USD .

The Forum perused the documents and observed that he had preferred a claim under the benefit of Accident & Sickness Medical expenses and the insurer also admitted the liability under the said benefit. The Policy wordings are very clear that the claim under this benefit is subject to deductible of US$ 100 and the same was also clearly spelt out in the definition. Subjecting policies to deductibles was an accepted practice followed in insurance, by all the insurers for various reasons, which include elimination of small losses as well as prompting the insured to become extra careful in risk minimization efforts. The insured is not justified in objecting to the same at the time of settlement of his claim. Hence, the complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. : GIC/173/ICICI/11/07
Madhu Banati
Vs
ICICI Lombard

Order dated: 3.1.07

FACTS : Smt. Madhu Banati had taken an overseas travel policy in December'04 to visit her unmarried daughter working in Michigan, USA. During her travel to west coast USA, she developed an ailment in her right eye due to inflammation which was noticed on 31.1.05. M/s Coris America, Florida was contacted for servicing under the policy and her claim was registered. She informed the insurer and M/s Coris America about the treatment through emails and phone calls. She was assured that her claim shall be reimbursed. On arrival back in India in May'05 she filed claim at BO Chandigarh for reimbursement of expenses incurred on treatment undergone by her. The claim was rejected vide letter dated 23.9.05 on the plea that the disease was pre-existing. She contended that she never suffered from any ailment in her right eye, although her left eye was given TTT treatment and medication, that too upto June'04. The damage to her left eye occurred in the form of reduced vision which was irreversible. She stated that no details of pre-existing diseases were asked for prior to taking of the policy. She sought intervention of this forum for settlement of claim amounting to $ 1258.89 along with compensation for harassment.

FINDINGS : The insurer informed that Associated Retinal Consultants Livonia MI had been consulted and they mentioned that complainant had pre-existing disease in the left eye. Based on this information the claim had been repudiated. While it was a fact that pre-existing disease was to be excluded for payment under Mediclaim policy, it was also a fact that such pre-existing diseases were covered if the treatment was given on critical basis and cannot be deferred till the insured returns to Republic of India. The diagnostic treatment report from Associated Retinal Consultants Livonia MI states as follows "She does have some inflammation in right eye mostly interior segment. I do not see any retinal involvement except the api-retinal membrane. I suggested increase the Pred Forte to every hour for next week. If there is no improvement consideration would be given to a subtanon injection of canalog".

DECISION : Held that the treatment required by the complainant was of emergent nature in USA and required immediate medical attention. It was ordered that admissible amount of claim be paid to the complainant.

Hyderabad Ombudsman Centre
Case No. : G 11.007.0132
B.P.Rangaraj
Vs

Tata AIG General Insurance Co.Ltd.

Award Dated : 31.10.2006

Sri B. Rangaraj Parthasarathy, who retired from ONGC in 1991, had taken a Travel Guard Insurance Plan before leaving for US during August 2005 for a period of 180 days. While he was in US, during November 2005 he had an acute infection of gall bladder (Acute Cholecystitis) and got admitted at a private hospital on 14.11.2005. He was then operated for removal of Gall Bladder on an emergency basis. The insurer repudiated the claim on 28.02.2006 under Exclusion No.2 “the policy does not provide benefit for any expenses incurred directly or indirectly in respect of any pre-existing condition or any complication arising from it”.

The insured contended that rejection of claim by the insurance company is not justified as acute cholecystitis develops due to bacterial infection which may be blood borne and not related to Gall Stones. Such acute infection in gall bladder is unpredictable and needs emergency surgery as opined by his family physician.

Insurer contended that on scrutiny of papers it was observed that the insured was having a past medical history of Gallstones and Kidney stones and the ultrasound scan of the abdomen showed positive for gallstones and thickening of the gallbladder wall consistent with acute cholecystitis.

While the overseas policy commences on 23.08.2005, the insured had consulted doctors at Mallya Hospital on 10.07.2002, 14.12.2002 and 09.12.2004, when the following findings were noted:

Cholelithiasis, Renal Calculus, enlarged prostate’

Cholelithiasis, Renal Calculus, enlarged prostate’

Multiple gall bladder calculi+sludge, Renal Calculus, enlarged prostate’

Held

During the hearing the complainant confirmed the above details. The issue before me is whether the insurers were right in rejecting the present claim. Having perused the test reports of Mallya hospital, the treatment papers from USA and the medical opinions submitted supporting the respective contentions; I find the insurers were correct in the interpretation of the policy wordings and the consequent rejection of the claim. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0114
Matam Subrahmanyam
Vs
New India Assurance Co.Ltd.

Award Dated : 09.11.2006

The complainant purchased an Overseas Mediclaim Policy from the insurer to cover himself and his wife on their visit to the USA in June 2005. He developed severe pain in the right ring finger during his stay abroad sometime in September 2005. He made several attempts to contact the insurers claims settling agent, M/s Coris International, whose number was printed on the policy document. There was no response from the TPA either to his telephone calls or to the e-mails sent to them. He had no other alternative but to bear the terrible pain and postpone treatment till his return to India, since he could ill-afford to take treatment abroad. Since he was put to tremendous inconvenience he was entitled to receive compensation of Rs. 5000/-.

The complainant was treated shabbily by not only the TPA agent but also the Regional Office of the insurer. The aggrieved complainant expected a line of response from the Regional Office for his 2 letters.

Held

I hold that the complainant is justified in seeking some compensation for the expenses incurred in making phone calls, correspondence etc. I direct the insurers to pay an amount of Rs.1,000/-(Rupees one thousand only) to the complainant towards the same. The complaint is admitted.

Hyderabad Ombudsman Centre
Case No. : G 11.012.0170
Shri G L.L. Aparanji
Vs
ICICI Lombard Gen Ins. Co.Ltd.

Award Dated : 19-01-2007

Smt. G.L.L. Aparanji (G.Lavanya), was insured under the Global Trotter Overseas Individual travel Insurance policy for the period 22.10.2005 to 18.02.2006. The policy covered expenses incurred by the insured for availing immediate medical assistance on account of any injury or illness sustained or contracted while abroad. She was admitted to Minnesota Heart Clinic on 24.01.2006 with chief complaints of palpitations. She incurred an expenditure of U.S.$ 3440.20 towards hospitalisation expenses. She lodged her claim with the insurers, who rejected the claim on the ground that “the insured’s medical condition is result of the pre-existing condition of palpitations and tachycardia.”

The complainant stated that

i) She first felt symptoms of palpitations on 1.11.2005 which lasted for around 5 minutes. She had another episode of palpitation on 24.11.2005 which lasted for around 3 to 4 hours. This time too the feeling subsided on taking food and milk. A similar attack recurred on 30.11.2005 which lasted for a few minutes and subsided with the intake of food. On all occasions, since the problem reduced automatically, she did not consult any doctor / hospital. This was the first time she experienced such symptoms.

ii) Again on 24.1.2006 there was a repetition of the same symptom and she was taken to Minnesota Hospital where she was diagnosed to have palpitations and tachycardia

She was perfectly healthy and fit at the time of taking the policy and even during the better part of her stay abroad. It was only during the end of her stay that she developed these symptoms. Even on her return to India she did not have any further episodes of palpitations and never consulted any doctor for these symptoms.

Held

It appears the insurers have not applied their mind while arriving at the conclusion that the disease was pre-existing. They quote the treating doctor’s noting that the patient had several episodes of palpitations on various dates during her stay abroad. The Hospital records reveal that she faced the symptoms first on 1.11.2005. In the column relating to Cardiac Risk factors, the same treating doctor has noted in the negative for prior history of heart disease. The insurer’s panel doctor stated during the hearing that Mitral Valve Prolapse, the problem with which she was suffering, is not sudden and develops over a period of more than one year. Once again the insurers appear to be

short-sighted. The treating doctor observed “given that I hear a mid-systolic click I would like to obtain an electrocardiogram to rule out mitral valve prolapse……Given the brevity of the symptoms as well as how infrequently they occur, I would not like to put her on medication…” This observation clearly reveals that the doctor himself is not sure whether she has mitral valve prolapse and recommended further diagnostic tests to rule out the existence of the same. The insurer’s panel doctor was asked whether the patient was aware of the palpitations when the insurance policy was purchased. No conclusive reply was forthcoming. I am inclined to give benefit of doubt to the complainant. The insurers are directed to honour, process and pay the claim as per terms and conditions of the policy.

Hyderabad Ombudsman Centre
Case No. : G 11.12.0178
Sri Anand Veer Singh Saksena
Vs
ICICI Lombard Genl.Ins.Co.Ltd.

Award Dated : 22-01-2007

Sri Saksena purchased an Overseas Travel Insurance from M/s. ICICI Lombard General Insurance Co Ltd to cover his trip to USA from 25.5.06 to 20.06.2006. The sum insured under the head “Medical cover” was US$ 50,000, with a deductible of US$ 100. He fell sick and was admitted to a hospital in the USA from 12.06.2006 to 16.06.2006. Against a claim of US$ 26,831, the insurers paid only US$7,150/ stating that there were certain riders to the Insurance policy by which the claim payable in respect of a person aged 56 years and above gets limited.

The complainant submitted that the limiting riders were made known to him only after three days of his being in the hospital in the USA. He had received, by e-mail, the set of details on limitations while in emergency care in the hospital. He also submitted that had the insurance policy indicated the said riders at the time of the issue of policy, he might not have undertaken the journey. He wanted to know if the insurers expected his family to pull him out of the emergency treatment he was undergoing, on receiving their mail with details of the riders.

Held

The complainant submitted that he was given, as the policy contract, only one document called Policy details which noted (i) his date of birth and (ii) Medical cover sum insured : US $ 50,000/- He also submitted a copy of the e-mail sent on 16th June 2006 to him on behalf of ICICI Lombard recording the claim reference number and communicating the claims procedure.

In the document titled “Policy Details” I note that there is a specific column titled “Special terms and conditions” and no entry is made there. The insurers’ representative at the hearing could not explain as to why no entry was made in the column provided on the Policy details sheet regarding the special conditions under which the claim was sought to be limited. The insurers, if they wanted to impose any riders ought to have mentioned them here.

The e-mail noted above does not make any mention that it was reiterating the sub-limits noted in the policy; Instead it gives an impression that the matter of sub-limits was being conveyed for the first time. I find it strange that the insurers reduced their Claim payment based on some special conditions which were neither highlighted in the policy details nor were given to the insured till the claim was reported.

The insurers' representative submitted that the sheet Policy Details was only Part-I of the insurance contract and that policy has to be read together with the other parts. The complainant on his part could have enquired with the insurers on the other Parts of the contract when he received only one sheet with a heading 'Part-I'.

In these circumstances I find that both the parties have not acted in full diligence. The lapses on insurers' part are more serious and generally an insured has little choice in the course of the treatment especially when the treatment is of an emergency nature in a foreign land. However, it is also to be noted that the choice of Room is generally made on the insured's behalf.

In view of all the above, I hold that the insurers are not entitled to limit the claim (except on the Room rent) by imposing any riders in the present case. I observe that the total treatment cost amounts to US $27,696 consisting of 5 bills. The Room rent incurred was $18032 and the insurers had allowed only $6400 at $1600 per day, thus disallowing $11,632/. The insurers ought not to have put any restrictions on the tests and treatment undergone especially since they had not put anu special conditions in the main policy and had also not supplied the full contract wordings. I direct the insurers to settle the claim at US $ 16,064/ being $ 27,696 less $ 11,632. I note that the insurers had already paid $ 7,150. Thus they shall release the balance $ 8,914/-.

The complaint is partly allowed as above.

Kolkata Ombudsman Centre
Case No. : 729/11/012/NL/12/2005-06
Dr. Sushil Chaudhury
Vs
ICICI Lombard General Insurance Company Ltd.,

Award Dated : 29.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding partial repudiation of claim under Overseas Leisure Travel Insurance Policy.

FACTS/SUBMISSIONS

The complainant stated that he bought "Overseas Leisure Travel Insurance", valid world-wide for the period 06.05.2005 to 20.07.2005, with a medical cover of $100,000. While in USA, he fell suddenly ill with intestinal obstruction and had to be admitted to the Emergency of the Dartmouth – Hitchcock Medical Clinic on 13.05.2005, under intimation to the insurance company. The complainant was diagnosed with possible bowel obstruction with a question of an abnormality in the right lower quadrant. The complainant was discharged on 17.05.2005. A follow-up colonoscopy on 13.06.2005 and subsequent biopsy revealed 'severe atypical dysplasia, suspicious for invasive adenocarcinoma' of the terminal ileum. Then gastroenterologist and the surgeon advised emergency surgery, which was also informed to the insurance company. Accordingly, the complainant was readmitted to same clinic on 08.07.2005, where he underwent necessary operation and procedures. The complainant was discharged from the clinic on 16.07.2005 with instruction of follow-up visit after one month. He was advised complete rest and not to undertake any long/ journey/ flight for at least 6-7 weeks after the surgery. In the circumstances, the complainant requested the insurance company on 30.06.2005 to extend the insurance cover for another one month. However, the insurance company did not respond and, as a result, the complainant was forced to buy an insurance for one month in USA at a high premium of $ 381.12. The total actual clinical bill was for $ 48,913.34. However, at the request of

the complainant, the clinic allowed 40% discount and reduced the final bill to $29,348. Out of this, the insurance company paid only $5,754. Subsequently, the insurance company denied payment of the balance claim alleging that the disease treated for was related to a twenty year old Crohn's disease. Being aggrieved by non-payment of the balance claim despite several representations to the insurance company, the complainant approached this forum seeking relief of $23,594 being the balance amount payable to the clinic, $ 2000 being the ad-hoc payment made by him to the clinic and $387.12 being the cost of overseas insurance, totalling $25,981.12.

The definition of 'pre-existing condition' of the policy issued to the complainant clearly excluded diseases known to be in existence at inception of the policy. In terms of clause 8 of the policy, it covered Life Saving unforeseen emergency measures etc. for disease arising out of pre-existing condition. The cost of treatment for these emergency measures would be paid till the Insured becomes medially stable or is relief from acute pain. The probable cause was attributed to infection or flaring up of the pre-existing Crohn's disease. Moreover, the report given by the attending doctor on General Surgery Inpatient Consultation stated that the patient did not require any emergent or urgent surgery indicating lack of emergency to undergo the surgery at the time of discharge. Accordingly, expenses incurred subsequent to first period of hospitalization were not payable.

HEARING

At the time of hearing, the complainant submitted a letter dated 15.12.2006 from the Clinic clarifying that the problem of adenocarcinoma was a fresh and new one, which presented de novo with acute small – bowel obstruction that proved to be secondary to adenocarcinoma of the terminal ileum. The complainant alleged that the insurance company failed to pay $9,500 committed in the GOP resulting in short payment of $3,746 even in respect of the first hospitalization. He further stated that the insurance company was kept informed at every stage of his treatment and they never raised any objection. In fact, the insurance company attributed the delay in claim settlement towards non-submission of post-surgery bills, which would indicate that they were ready to settle the claim. However, eventually they refused to pay the balance amount.

The insurance company reiterated their stand in the self-contained note but expressed that the certificate of the Clinic was not available with them. They expressed their desire to review the claim based on complete medical documents. They also agreed to release the balance amount $3,746 as committed in the GOP, if not already paid.

DECISION

The insurance company should verify their records and release $3,746 to the Clinic within seven days and confirm the same to this office. As regards balance claim for the second phase of treatment, clause 8 of the policy would be relevant and the question of pre-existing disease will not arise if the second phase of operation was required to be conducted on an emergency basis and as an extension of the first phase of treatment. Since, the issue of Crohn's disease has found a mention in the Clinic records and the complainant himself admitted of its existence, it was felt that a further medical opinion from a neutral authority was required to be taken. In the circumstances, the insurance company were directed to refer the entire matter to a doctor specialist in the related field of surgery and who was acceptable to the complainant for further opinion specifically on the question of continuation of emergency situation. The complainant shall have opportunity to make further representation directly to such specialist doctor. Based on the doctor's opinion, the insurance company shall review the claim. The above entire exercise is to be

completed within one month from the date of receipt of consent letter from the complainant. If the complainant is still aggrieved by the Insurers' review decision, he shall have liberty to approach this forum once again for redressal.

Mumbai Ombudsman Centre
Case No. : GI-322 of 2005-2006
Shri R.N.Talcherkar
V/s
ICICI Lombard General Insurance Company Limited

Award Dated : 05.10.2006

Shri R.N.Talcherkar who was on a tour with his family and friends to Moscow and St.Petersburg had taken an Overseas Leisure Travel Insurance policy for the period 20.9.05 to 5.10.05 from ICICI Lombard General Insurance Company Ltd. On 28.09.2005, when he was sightseeing at Moscow he experienced chest pain in the morning and again in the evening for which he got admitted to American Clinic. After the treatment and other investigations, he was discharged on 29.9.2005 with an advice to visit a doctor on his arrival to India. After his return to India on 4.10.2005, when Shri Talcherkar preferred a claim to ICICI Lombard General Insurance Company Ltd., the Company repudiated the claim invoking pre-existing condition under exclusion clause (1) (3) of the policy. Aggrieved by the decision of the Company, Shri Talcherkar approached this Forum seeking intervention of the Insurance Ombudsman for settlement of his claim. His contention was that at the time of taking the policy, the Advisor of ICICI Lombard had assured him that the pre-existing diseases were covered as per clause 8 of the policy. The records have been perused and scrutiny of the claim reveals that Shri R.N.Talcherkar had Hypertension and IHD for quite some time and his By-pass surgery was also done about 10 years back. Obviously therefore, this disease which was pre-existing became a pointed exclusion in the policy. The issue is whether the limited coverage for an existing disease to be considered only when it is life threatening in an emergency situation as claimed by the Complainant would be sustainable or not in this case. Again precisely on that depends the admissibility of the claim. The Company pointed out that there was no criticality in his health status and that the treatment received at the hospital was more of evaluation of the health status than providing minimum medical relief to sustain the patient and help him in recovering with the emergency medical support. All the annotations and observations by the doctors at American Clinic indicated that they were comfortable after examining the patient and there was no untoward situation to call for an emergency life saving medical support which would have qualified for reimbursement as per the terms and conditions of the policy specially read in conjunction with condition 8 of the policy. Accordingly, the decision of the Company to reject the claim is sustainable.

Mumbai Ombudsman Centre
Case No. : GI-549 of 2006-07
Smt. Sucharitha L. Narasimhan
V/s.
United India Insurance Co. Ltd.

Award Dated : 30.03.2007

In the matter of the above complaint, the brief facts are as under :

Smt. Sucharitha L. Narasimhan took an Overseas Mediclaim Policy bearing no. 020461/46/05/80071 from United India Insurance Co. Ltd. for the period 8/5/2005 to 3/11/2005 during her visit to USA in May 2005. The policy was issued under Plan B I with exclusions for Diabetes and Heart & Circulatory disorders based on the declarations in the proposal form.

During her stay there, she developed a sudden sharp pain in her right hand radiating to her shoulder, chest, and jaw. She presented herself for treatment at Delnor Community Hospital, Geneva, USA on 26/6/2005 as an emergency case. She was diagnosed to have “Radiculopathy (R) Shoulder”. She preferred a claim with Coris- Miami International which was not settled by them. She represented her case for review with M/s. Heritage Health Services P. Ltd. (Indian Representative of the Coris) along with a certificate from Dr. M. Vishwanathan , DM (CARD) MD (MED),FISE. M/s. Heritage Health Services after careful scrutiny of the representation and medical documents, informed the Insured the reasons for repudiation of the claim

Analysis of the case reveals that the Insured, Smt. Narasimhan took the policy while she was visiting USA in May 2005. She was hospitalized at Delnor Hospital for Radiculopathy Rt. Shoulder and lodged a claim with the Insurer’s claim settling agent in USA – Coris Miami International. They repudiated the claim as available medical records indicated that the Insured was suffering from pain in right hand shoulder, jaw and chest since last 4 months. i.e. much before the commencement of the policy and hence pre-existing. They also observed that the Hospital’s papers noted past medical history of Triple Bypass in Feb. 2004, NIDDM, HTN and “Frozen Shoulder” and previous surgeries of Triple Bypass and Hysterectomy. Accordingly, they invoked pre-existing exclusion and held it was not payable. The matter was also re-examined by the Company and they obtained an opinion from Dr. Ismail Bandookwala, MD, DGO who opined that “as per the Emergency Room Triage assessement report of the Hospital dated 26/6/2005, she now had pain in the right shoulder, jaw and chest off and on for the past 4 months i.e. since Feb. 2005. She was diagnosed to have cervical radiculopathy after ruling out any acute cardiac problem after investigations. She was thus prescribed medicines for her problems including heart disease and diabetes mellitus.” He concluded that “the Insured had the symptoms although not of sufficient severity earlier much before the proposal date. The problem was therefore, definitely pre-existing. She has also been treated for the excluded heart disease and diabetes mellitus and she has claimed for the same. The Insurance Company is justified in repudiating the claim.”

In the light of the above analysis based on documents made available to this Forum, the rejection of the claim by United India is sustainable as it is noted that she was under treatment for frozen shoulder which is “ a chronic painful stiffness of the shoulder joint which may be due to injury, a stroke or myocardial infarction or may gradually develop for no apparent reason.” (Quoted from Oxford Medical Dictionary). Also the same was not disclosed in the proposal form. The present ailment of radiculopathy is inflammation of the root of a nerve of or relating to the neck is related to the past ailment of frozen shoulder for the fact that she developed sudden pain in the right hand radiating to the shoulder, chest and jaws.