CHENNAI

DEATH

Complaint no-21.002.2213

Smt.R.Amudha vs SBI Life Insurance Co.

The complainant had mentioned that her husband was a member under the master policy of SBI Life Super Suraksha which was taken under SBI Deposit scheme. In this case the individual members do not make any proposal for insurance but it is the group policy holder ,vig, the bank which submits a single proposal to the company on behalf of all the individual members of the group. The policy will be in force for one year and the company may extend the validity of the policy at its option. The master policy is one year renewable group term assurance policy and the said policy lapsed due to nonpayment of renewal premium since October 2007.The renewal of the master policy is not automatic and the premium due under the policy has not been paid and the master policy got lapsed.

The LA died on 28.09.2008.The premium due under the policy on 17.10.2007 was recovered by SBI only on 2.01.2008 and the claim lodged by the complainant was rejected by the insurer stating that the policy was lapsed from 17.10.2007.According to the insurer since no cover was available as on the date of death the claim was repudiated.

Award no-IO(CHN)/L-017/2010-11 dt 8th Oct 2010

The contract of the Group insurance is between the State BANK OF India,Avdi Branch and SBI Life Insurance Co Ltd. All the deposit holders of the bank who fulfill the eligibility criteria of the scheme and who have signed the consent cum authorization letters and are paying the premium will be members of the scheme. The Mater policy was effective from 18.10.2004 and the premium due under the policy was payable every year in the month of Oct. The complainant's husband joined the scheme on 21.10.2005 and the annual premium due under the policy was debited to SB account of LA ON 21.10.2005,9.11.2006 and 2.01.2008 It is observed that on .01.2008 two instalments each Rs 675/-has been recovered from the SB a/c. The LA died on 28.09.2008 and the claim lodged by the complainant was rejected by the insurer stating that the policy was in a lapsed state since 17.10.2007 and hence nothing is payable. The complainant had argued that the premium payable under the policy was recovered on 2.1.2008 before the death of her husband on 28.09.2008.

It was also observed that SBI Avadi branch had informed the complainant that premium debited on 02.01.2008was beyond the grace period and it was refunded back on 01.02.2008.As

regards the other debit of 675/-made on 2.01.2008 it was raised by mistake and the same has been refunded to LA's account on14.05.2010.The representative of the insurer stated that the master policy was not renewed since the renewal premium due on 18.10.2007 was not remitted by the master policy holder. As the master policy was in a lapsed condition no cover was available to the members of the group.

From the records it is established that

(i) the master policy under which LA was member is in a lapsed condition from 18.10.2007 and the same is not subsequently renewed.

(ii)The death of LA has taken place on 28.09.2008 and on this date the policy was in a lapsed condition.

(iii)Recovery of premium from an individual member will not bring the policy to force as the master policy holder had not remitted the total premium for all the members under the scheme.

Since the master policy was not in force as on the date of death of the LA the repudiation of life cover by the insurer in the present case is justified.

The complaint is dismissed.

DEATH

Complaint no-21.02.2227

Smt.K.E.Dhanammal vs LIC Chennai

The complainant had stated that her husband had taken Jeevan Anand policy for a sum assured of rs1,00,000/-from 25.12.2004.and died on 30.06.2008 due to respiratory failure.The policy was allowed to lapse by non payment of premium due 12/2005 and was revived on 16.09.2006.The insurer had mentioned that LA was admitted on 02/07/2000 and was diagnosed acute exacubation of COPD as per discharge summary from the hospital. He was a known case of asthmatic and did not disclose this fact in the said personal statement at the time of proposal and revival. As he had withheld material information regarding health at the time of getting the policy revived, the claim was repudiated.

Award no-IO(CHN)L-018/2010-11 dt 8 th Oct 2010.

The complainant had submitted that her husband was suffering from Asthma since 2 to 3 years ,but said that he never used to inform them about going to Sundaram Hospital for treatment.The representative from the insurer submitted that their investigation revealed LA

was hospitalized on 2.07.2000 for breathing problem and again on 3.10.2000 was treated for same problem.The LA had not disclosed this fact in the personal statement of health at the time of proposal and revival and said repudiation was on the basis of pre revival illness not disclosed.The date of proposal is 31.03.2005 and date of personal statement of health is 29.08.2006.The LA has answered Qno2(a) and 2(b) as NO and has not answered the question 2(c)and 2(d)Further since the LA has not answered Q2(c)Insurer cannot say LA has given false answer to that question It is observed that LA had complaints of wheezing since morning and was treated for the same. The life assured by occupation was a gunny merchant and it is likely that they get affected by wheezing owing to dust to which they are exposed. The insurer has not produced any record between the period 3.10.200 to 25.06.2008 to establish that life assured was suffering from this problem continuously. The proposal for insurance was submitted on 31.03.2005, 4 years after the treatment taken by him for wheezing. More over the treatment taken by him was as an outpatient. Therefore the LA cannot be charged with suppressing this fact that too with a fraudulent intention. The policy has run for 3 years 6 months and 5 days and therefore it attracts the provision of sec45 of the insurance act.

Considering all the facts the action of the insurer in repudiating the claim is not justified and the insurer is directed to settle the full sum insured under the policy with other benefits as per the terms of the contract.

The complaint is allowed.

DEATH

Complaint no-21.08.2234.

Mr.V.Dhakshanamurthy vs LIC,Vellore.

The complainant had mentioned that his wife was working as an agent in LIC and she had taken a single premium "profit plus "policy for rs1,30,000/-SA with single premium of rs1,02,000/-.The date of commencement of the policy was 13/12/2007.According to the complainant she died on 16.06.2008 due to heart attack. The insurer had repudiated the claim stating that surrender value of the bid value rs76,000/-is only payable as death occurred due to suicide within one year of taking the policy. The insurer had argued that the policy has become null and void in terms of the policy contract and only surrender value of the bid value is payable as death claim.

Award no-IO(CHN)/L-019/2010-11 dt 8th Oct 2010.

The main issue in the complaint is the cause of death of the life assured .The complainant says that she died due to Heart attack where as the insurer has repudiated the

claim on the ground that LA committed suicide and since death has taken place within 1 year due to suicide the claim was denied and only the surrender value of the bid value is payable. The insurer has filed two affidavits (1)by Sr. Branch Manager stating that "from the enquiries made the life assured died on 16.06.2008by committing suicide(no case was registered at police station and hospital)(2)By Dev Officer stating that LA had died on 16.06.2008 due to committed suicide. The complainant had submitted declaration by Village Executive Officer, President Panchayat confirming that death was due to heart attack only and not due to suicide. A statement of deposition by local villagers was that the death was due to Heart attack and not suicide. From the above it is seen that the complainant was able to substantiate that his wife died due to Heart attack by producing various written declarations and the insurer was able to produce only letters given by their officials mentioning that death has taken place due to suicide. The LA herself was an LIC agent and she must be aware that if a person insuring his life commits suicide within 1 year of taking policy ,nothing is payable under the policy to the beneficiaries. Further she has taken the policy with the life cover for rs1,30,000/-under single premium mode for rs1,02,000/-.This indicates that policy was taken with the sole purpose as an investment for future needs, without any suicidal intention.

Considering all aspects the benefit of doubt as to the cause of death should be given to the complainant and hence the insurer is not justified in repudiating the claim. The insurer is directed to settle the sum insured under the policy

The complaint is allowed.

DEATH

Complaint no-21.08.2231

Smt.K.Gunasundari vs LIC Vellore.

The complainant, wife of the deceased LA had stated that her husband had taken Jeevan Anand policy for a sum assured of rs1,00,000/-on 25.12.2003 and he died on 25.01.2006 due to kidney disease. She mentioned that her husband was in good health and has not taken any leave due to sickness. He had consulted Doctor only in 2005 and taken treatment. He was admitted at JIPMER hospital before death. The insurer had denied the claim on account of the fact that the deceased had suffered from Diabetes Mellitus which was confirmed by blood test report taken by him in the year 2001 and the same was confirmed in the case sheets of the hospital at which he took treatment in 2005.LA had withheld this information regarding his health at the time of taking the policy and hence the claim was repudiated.

Award no-IO(CHN)L-020/2010-11 dt 08.10.2010.

The LA had taken Jeevan Anand policy for a sum insured of Rs 1lac and died on 25.01.2006due to kidney failure. As per claim form B the primary cause of death is shown as Renal failure, Carcinoma bladder with Bilateral Nephrosis. Duration of disease is shown as 1 year. The diseases which preceded /coexisted are shown as Diabetes Mellitus and Right Femoro Popleatel Deep VeinThrombosis.It is also mentioned that diabetes was first observed 4 years back. In claim form B1The Doctor from Jipmer Hospital states that life assured was earlier admitted to Apollo Hospital ,Chennai and "he was a known patient of diabetes mellitus since 4 years and old case of carcinoma bladder from Jan 2005"As per discharge summary of Apollo hospital LA underwent surgery on 12.02.2005 and was discharged on 12.03.2005.The LA was diagnosed for ca Bladder stage IV(TCC).History says patient had history of diabetes mellitus for 4 years on regular treatment.The investigating officer has also submitted a copy of the lab report dated 30.03.2001 issued by a laboratory had FBS reading of 243mg%and PPBS reading of 325mg%

During the hearing the complainant stated that her husband took treatment for cancer in 2005 and died due to cancer on 25.01.2006.She said her husband was not aware of his diabetes nor did he undergo any treatment for the same. From the hospital records and claim form B and B1 it is seen that death was due to carcinoma of bladder The LA was diagnosed for cancer during feb2005 which is post proposal date. The pre proposal illness suffered by LA as per the records was DM. Further as per leave records LA had taken only 8 days leave during 2001before proposal and this shows that LA was not seriously ill during the pre proposal period. Therefore it can be concluded that LA would not have had any fraudulent intention in not disclosing his diabetes condition in the proposal submitted by him. Considering all aspects the insurer is not fully justified in repudiating the claim and hence an Ex gratia amount of rs 50,000/- is awarded to be paid to the complainant.

The complaint is partly allowed on exgratia basis.

DEATH

Complaint no-21.08.2266

Sri.M.Gnanaraja vs LIC

The complainant, son of the diseased LA had stated that his mother had had taken a Bima Gold policy for a Sum Assured of rs40, 000/-from 14.03.2006 and she died on 31.10.2008 due to hypertension and chest pain. The claim was repudiated by the insurer on account of the fact that the deceased LA had withheld material information regarding her health at the time of effecting the assurance.LA had suffered from Diabetes Mellitus and hyper tension for which she took treatment in a hospital since Sep 2003.These facts were not disclosed in the proposal and hence the claim was repudiated.

Award no-IO(CHN)/L-021/2010-11 dt8th Oct 2010.

From the records it was observed that during her terminal illness the LA was admitted to Hospital from 28.10.2008 to 31.10.2008.The cause of death as per Medical certificate was acute Anterior wall Myocardial infarction with Cardiogenic shock. As per claim form B,B1 dated 28.11.2008 the primary cause of death is shown as Acute Anterior wall Myocardiac infarction due to Diabetes mellitus and Hypertension. As per records DLA is only a known case of Hypertension and on treatment. It was also submitted that the DLA was also taking treatment at ESI Hospital and as per the DR LA was a known case of Hypertension on long treatment. During the hearing the complainant stated that he was not aware of his mother suffering from DM and Hypertension. The claim forms B, B1, and B2certified by Dr. mention about HT and DM but are silent about the date when first observed. Further no details of treatment taken from 18 th Oct 2003 to 29 th Nov 2007 are made available to indicate that the LA was under continuous treatment. Therefore this cannot be treated as a reliable evidence to prove the pre proposal illness of the Lathered is nothing to point out that LA had fraudulent intention to cheat the insurer by suppressing facts of her ill health. Considering all facts the repudiation of the claim by the insurer is not justified and hence they are directed to settle the claim for full sum assured under the policy as per terms and conditions of the contract.

The complaint is allowed.

DEATH

Complaint no-21.07.2271.

Smt.J.Gold Sheeba vs LIC .

The complainant had mentioned that her husband had taken Bima Gold policy for a Sum Assured of Rs 2 lakhs from 28.03.2006.and the policy was revived on 24.09.2008.LA had died on 11.10.2008 due to brain fever. The insurer had denied the claim on account of the fact that LA had suffered from Meningo encephalitis,Toxicencephalopathy prior to the date of revival for which he took medical treatment in the hospital during revival. He did not disclose these facts in his personal statement at the time of reviving the policy and hence the claim was repudiated.

Award no-IO(CHN)/L-022/2020-11 dt 8th Oct 2010.

On a perusal of various records it is observed that her husband died on 11.10.2008 due to brain fever and while giving details relating to name and address of doctors consulted –

furnishes the date of consultation as 20.09.2008-11.09.2008(month wrongly mentioned as 09 instead of 10)As per claim form B the primary cause of death was Meningoenceohalitis with toxic encephalopathy and secondary cause was diabetes mellitus with DKA corrected /Tithe insurer submitted that LA died within 17 days of reviving the policy and the policy had been revived while LA was undergoing treatment in the hospital. The certificate of hospital treatment (form B1,B2)clearly indicates that life assured was admitted to the hospital from 20.09.2008 to 11.10.2008.as an inpatient. The revival of the policy has been effected on 24.09.2008 based on the personal statement of health dated 24.09.2008 and on this date he was in the hospital suffering from brain fever. This clearly shows that LA has given false answers to the questions in the revival form regarding his health and has suppressed material facts as he was suffering from a serious disease and was hospitalized and under treatment. Considering all the facts the repudiation of the claim by the insurer in the present case is justified.

The complaint is dismissed.

DEATH

Complaint no21.06.2273.

SmtV.Padmavathi vs LIC.

The complainant had mentioned that her husband had taken a Jeevan Saral policy for a sum assured of rs1.5 lakhs from 28.03.2005 and died on 15.05.2007 due to Heart Attack. The primary cause of death has been recorded as Systemic Hypertension chronic liver disease and secondary cause was congestive cardial failure cardiomyopathy with congestive cardiac failure. The insurer denied the claim on account of the fact that LA was suffering from Systemic Hypertension with chronic Liver disease for which he had taken treatment from the hospital LA had not disclosed these in the proposal form and as he had withheld material information regarding the health at the time of effecting the policy the claim was repudiated.

Award no-IO(CHN)L-023/2010-11 dt 21st Oct 2010

The life assured was admitted for terminal illness at BHEL Hospital on 15.5.2007 where he died on the same day. The primary cause of death was Systemic Hypertension with chronic liver disease secondary cause being congestive cardiac failure.cardiomyopathy. The Doctor has also certified in claim formB,B1that the LA was taking treatment in new hospital for hypertension since 2002.The treating DR has also issued a letter dt 15.12.2008 where he states that LA was suffering from Systemic hypertension since 2002and was on treatment as outpatient at BHEL Hospital. On 15.5.2007 he was brought to casualty and the clinical evaluation were suggestive of systemic hypertension,chronic liver disease and congestive cardiac failure. Inspite of treatment the patient died on 15.05.2007

During the hearing the complainant stated that her husband had 6 policies with LIC and was in good health. LIC had settled claim for all the 6 policies but repudiated the claim under this policy. When confronted as to why her husband had taken frequent leave she said that leave was taken to take their daughter for treatment at CMC Hospital for kidney problem. She also produced Hospital records to substantiate her contention. The fact that LA was suffering from chronic liver disease is mentioned only in Form B and not in Form B-1.In the Dr's letter dated 15.12.2008 also there is no mention of chronic liver disease. Barring a letter given by DR.V.Ramamurthy who has mentioned that LA was under treatment since 2002 for hypertension Insurer has not produced any other reliable evidence such as case sheets/medical diary of the diseased LA to prove their contention that DLA was under continuous treatment for Hypertension. The complainant could convincingly prove the reason for her husband availing frequent leave/absence from duty as it was for taking his daughter to hospital by showing the relevant hospital records. Considering all aspects the repudiation of claim by the insurer is not justified and hence the insurer is directed to settle the death claim as per the benefits allowed in the contract.

The complaint is allowed.

DEATH

Complaint no 21.08.2243

Smt.R.Gowri vs LIC.

The complainant had stated that her husband had taken a policy for rs50,000/-on 30.03.2007 and died on 20.07.2007.due to heart attack. He was having five more policies and the insurer has settled claims for all those policies. The claim for the policy taken in 2007 was denied on the ground that LA was under medical treatment during 2006 and was on medical leave for 32 days prior to the date of proposal. As he had withheld material information regarding his health at the time of effecting insurance the claim was repudiated.

Award no-IO(CHN)L-024/2010-11 dt 21st Oct 2010.

The complainant's husband had taken Bima Gold policy for a sum insured of rs 50,000/-from 28.03.2007 and died on 20.07.2007.The claim was repudiated by the insurer on the ground that he had taken sick leave on various dates as per their Employer letter and since he has not disclosed correct information reg. his health the claim was not considered. In claim form B signed by DYMedical officer of General Hospital it is mentioned that the primary cause was Acute MyocardiacInfarction,Secondary cause as Haematemsis,Septicemia,cirrhosis of liver,portal hypertension. The insurer has also filed a medical treatment book issued by the employer of LA where it was mentioned that LA had two wheeler accident on 28.07.2002 and as

per the investigations he was under alcoholic intoxication. He was admitted on 18.07.2007 and discharged on 20.07.2007 for complaints of bouts of Haematmesisand the diagnosis was cirrhosis of liver. During the hearing the complainant denied that her husband was alcoholic and the accident took place when a truck from opposite direction hit his vehicle while he was taking a U-turn. From the proposal form it is observed that LA has not disclosed his accident and his sick leave particulars which were submitted by the insurer by collecting from the employer. But the insurer was not able to produce any other records to establish that LA was actually ill during that time. The secondary cause mentioned by the Doctor would not have developed within 3 months and LA must be suffering from the disorders of liver even before the date of proposal. Considering all aspects and to ensure equity the insurer is directed to pay 50% of the sum insured as Exgratia as full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.013.2247

T.R.Venkataraman vs AVIVA LIC.

The complainant H/O of Mrs.V.Seethalakshmi stated that his wife had taken a policy with the above insurance co in July 2006.and she died on 14.12.2009 due to lung cancer with lung secondaries. The complainant had argued that it is not correct on the part of the insurance company to say that as per medical discharge summary issued by Vijaya health centre ,the diseased life assured was diagnosed cysts right breast in 2002 in health checkup at Apollo hospital ,mass progressively increasing in size. The report only says multiple cysts in left breast. The biopsy was done in 2007 after taking the insurance policy which proved to be cancerous. Therefore according to the insured the question of nondisclosure does not arise before 2007.The insurer denied the claim on account of the fact that as per medical discharge summary issued by Vijaya health centre the deceased LA was diagnosed cysts right breast in 2002 when she went for health checkup at Apollo hospital and this was not disclosed in the proposal form. Since this amounts to non disclosure of material facts the claim was repudiated.

Award no-IO(CHN)L-025/2010-11 dt 25 th Oct 2010.

The LA had taken a lifelong unit linked fund policy for a sum insured of rs 2.25 lacs.LA died on 14.12.2009 and the claim was repudiated by the insurer for nondisclosure of material facts contending that LA had not disclosed that she was diagnosed for cyst right breast in 2002.LA was admitted to VS Hospital at the time of terminal illness where she reportedly died on 14.12.2009.The primary cause of death was carcinoma of breast, secondary cause being lung secondaries. The history states that she was an old case of carcinoma right breast

diagnosed in April 2007.The personal history records "known DM since 1 year,NOH/Oht/ihd,surgical History-H/O having undergone right upper lobectomy in childhood for TB. She had undergone Radio therapy AND chemotherapy on various dates and had been advised to report for 3 rd cycle of chemotherapy on 23.01.2009 before which she expired. The discharge summary from Vijaya Hospital states that h/o right breast cyst diagnosed first in 2002.Mammogram report from Apollo hospital shows multiple cysts in both breasts.

During the hearing the complainant argued that his wife was not having any complaint of HT or DM and she died of carcinoma of right breast on 14.12.2009.He contended that his wife was diagnosed of cancer only in 2007 and she had undergone various tests under wellness women clinic in 2003 and 2004 which did not reveal cancer. The LA had answered negative in the proposal DT 29.07.2006 to the question –whether she had undergone any medical/surgical investigations for any form of cancer, tumour or growth. She has also answered NO to question "have you ever suffered from cancer,tumour,cyst,lump,or disorder of skin or lymph glands or other malignancy. Before the date of proposal LA had undergone number of tests in the Apollo hospital during 2002 and 2004 where it was diagnosed as multiple cysts in both the breasts. This was further referred in the discharge summary dated 20.04.2007 of Vijaya Hospital that LA had history of multiple cysts right breast was diagnosed in 2002.Though the question in the main proposal does not specifically mention cyst, the question in the medical report to be answered before medical examiner specifically mentions cyst. The LA has not disclosed the information of cyst while answering relevant questions. Considering all the above facts the repudiation of the claim by the insurer is justified. However the policy has run for 3 years and the policy in question is a unit linked policy where in the investment risk in investment portfolio is borne by the policy holder. The insurer has no justification to forfeit the fund value under the policy and hence they are directed to pay the fund value under the policy as on the date of intimation of death of LA. **The complaint is partly allowed.**

DEATH

Complaint no-21.009.2262

Smt.V.Sivakumari vs Bajaj Alliance Lic Ltd

The complainant had stated that her husband had taken Unit Gain plus policy on 08.07.2006 for a sum assured of rs5,00,000/- from 08.07.2006.with a yearly premium of rs25,000/-The LA died on 25.05.2009 .The policy was lapsed due to nonpayment of premium and was again revived on 08.04.2009 and LA died within 1month and 17 days of revival. The claim was denied by the insurer stating that the LA was diagnosed of carcinoma cheek treated with Radiotherapy and Chemotherapy on 31.03.2009 and these were not disclosed in the declaration of good health submitted for revival on 08.04.2009.

Award no-IO(CHN)L-026/2010-11 DT 25 TH OCT 2010.

The insurer has submitted various documents to substantiate that LA was having pre revival illness:-Hospital treatment report dated 9.9.2009 which says that primary cause of death was aspiration pneumonitis /septicemia/ca check. The duration of illness is 12 months. Nature of pre existing illness is shown as 12 months.LA underwent Radiotherapy and Chemotherapy

From the discharge summary of Krishna Hospital it is observed that deceased LA was admitted to the hospital on 7.04.2009 and discharged on 10.04.2009 and was diagnosed for advanced Cancer check and was treated for the same. It was also observed that LA had earlier consulted Cancer Institute on various dates .On 28.03.2008 LA underwent US Abdomen/Pelvis and the impression was Hepatomegaly with fatty changes. Biopsy report dated 4.4.2008 reveals the impression as Ca.gingivum,punch Biopsy done-suggestive of squamous cell carcinoma-Gr IIN4-Intermediate

The policy which was in a lapsed condition was revived on 8.04.2009 on the basis of declaration form and the LA had answered NO to all questions relating to his existing illness if any. It was also observed that on the date of revival LA was taking treatment in a hospital for Cancer cheek. The LA was very much aware of his condition of health and therefore it can be said that the replies given to question in the declaration form for the revival amounts to clear concealment of facts coupled with fraudulent intention. Hence the insurer is justified in repudiating the claim by declaring the revival of the policy as null and void. However the action of the insurer in forfeiting the fund value under the policy is not correct since the investment risk in the investment portfolio is borne by the policy holder. Hence they are directed to pay the fund value of rs 98,745 to the complainant in full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.009.2272

Smt.M.Kalarani vs Bajaj Alliance Lic Ltd

The complainant had mentioned that her husband had taken Capital unit gain size one policy with the above insurance co for a sum insured of rs1,00,000/-commencing from 07.09.2007.The LA had died on 18.04.2009 due to Heart Attack. She stated that her claim was denied by the insurer on the ground that her husband was suffering from Type II diabetes Mellitus. She said that her similar policy with SBI and LIC were honoured. The insurer had

stated that they have denied the claim due the fact that LA was under treatment for Diabetes mellitus type II for more than 10 years. These facts were known to the LA prior to making the proposal for insurance and the same was deliberately concealed in the proposal. As this was material nondisclosure the claim was repudiated.

Award no-IO(CHN)L-029/2010-11 dt 12 th Nov 2010.

The LA was a govt servant and reported to have died due to Myocardial infarction on 18.04.2009.On a perusal of various records it was observed that their family Dr has mentioned that LA was first examined by him in the year 1999and that the name of the disease/illness was DM .For the date diagnosis- the doctor states prior to coming to me for consultation –10 years ago. Under the column- Nature of treatment he states that Diet+Insulin Injection. The insurer has based their decision in repudiating the claim on the basis of their investigator report and the certificate issued by the family doctor. How ever there was no proof to establish that the Doctor who has given the certificate was the family Doctor. further the insurer could not produce any other evidence such as case sheets or Medical diary or test reports of the LA to establish that LA was under continuous treatment for DM type II. Taking all the factors into account the insurer has not convincingly established that LA had suppressed material facts in the proposal submitted by him for Insurance. Therefore the insurer is not justified in repudiating the claim. The insurer is directed to settle the sum assured under the policy (less partial withdrawal if any) as per clause 6(2) of the policy conditions.

The complaint is allowed.

DEATH

Complaint no-21.009.2277.

Smt.J.Micheal Marry vs Bajaj Alliance LIC Ltd

The complainant had mentioned that her husband had taken New Unit Gain plus SP for a sum assured of rs1,25,000/-commencing from 24.07.2009 on a single premium of rs 25,000/-The term of the policy is for a period of 10 years. She said that her husband had served in the Army for more than 20 years and retired from the service in Sep 2008.On 21.08.2009 he fell down and taken to the hospital for treatment and after a day in ICU he died. The insurer denied the claim on account of the fact that the deceased LA had history of Thrombosis Portal venous Recanalysed in 2006.These facts known to the LA were not disclosed in the proposal and the policy duration was only 28 days. As this was a material non disclosure they have repudiated the claim.

Award no-IO(CHN)L-030/2010-11 dt 15 th Nov 2010.

During the hearing the complainant submitted that her husband retired from Army and had no health problems. The insurer had submitted discharge summary issued by Hospital and as per this LA was admitted on 17.04.2009 for complaint of chest pain from 16.04.2009 and discharged on 18.04.2009. The history recorded states that LA is Ac/Oof rt side chest pain from 16.04.2009(treated in 2006 –received Acitrom) Ct scan taken on 20.08.2009 revealed Left Cerebellar Infarct. In the medical attendant's certificate issued by Kaveri Medical Centre it was stated that LA consulted them for chest pain on 16.04.2009 was admitted to the hospital on 17.04.2009,nature of complaint being chest pain aggravated during deep breathing. He was discharged on 18.04.2009.The insurer stated that LA had Thrombosis portal venous recanalysed as per Medical records during 2006.He had answered no to questions pertaining to health in the proposal and he had not disclosed his illness. On disclosure of material fact is clearly established. Therefore the repudiation of claim by the insurer is justified. However the fund value of rs26,758/- payable under the policy should be paid to the complainant in full and final settlement of the claim.

The complaint is partially allowed.

DEATH

Complaint no-21.010.2278

Smt.R.Gunavathi vs Reliance Lic Ltd

The complainant had mentioned that her husband had taken two policies with the above insurance co for a sum insured of rs50,000/-and rs4,00,000/-The policy for rs 50,000/- commencing from 17.03.2009 is Super Investor Assure Plan and the policy with sum assured of rs4,00,000/-commencing from 15.06.2009 is Return of Premium for a period of 15 years.LA died on 06.11.2009 due to heart attack. The legal notice sent by the insured has mentioned that LA had no previous medical history of BP, heart ailment or chronic bronchitis and he died of heart attack only. The insurer denied the claim on account of the fact that the diseased LA was suffering from DM and chronic bronchitis for one year and was on continuous treatment. This was reported in the investigation and medical reports. This is a clear case of suppression of material facts and hence the claim was denied.

Award no-IO(CHN)L-031/2010-11 dt 3rd Dec 2010

It has been observed in Claim Form B dated 16.11.2009 the Doctor has certified that LA died on the way to the hospital and the LA was diagnosed for Acute Myocardial Infarction. The same doctor has mentioned that LA complained of illness one year back i.e.

5.11.2008 and the cause of illness was Diabetes and Bronchitis,history was reported by the patient himself and he was treated as outpatient. A certificate issued by another Doctor also mentioned that LA was treated by him in his nursing home for past 1 year for Diabetes with P.V.D with Bronchitis. The insurer submitted that the first policy for sum insured of rs50,000/- was taken on 17 th March 2009 and second policy on 15.06.2009 for a sum assured of rs 4lakhs.Their investigation revealed that LA was suffering from DM ,PVD and chronic bronchitis even before proposing for the policy. The following points need consideration;

LA was not married and has insured for a high sum of rs4.5 lakhs though he is not gainfully employed. The need for insurance was not established.

The nomination under the policy is made in the name of step-sister, though the mother and immediate sister are alive.

The nominee's husband was an agent who introduced the policy.

The claimant admitted that DR.R.Sekar treated the LA in his last illness and the investigating agency states the claimant confirmed that LA was diabetic and under treatment though they denied he was alcoholic.

Considering all aspects the fact that LA was suffering from DM,P.V.D and Bronchitis even before proposing the policy was established and hence the repudiation of claim by the insurer is justified. The insurer is directed to refund the fund value of rs 10,970.65 under the policy.

The complaint is dismissed.

DEATH

Complaint no-21.08.2329

Smt.S.Rose vs LIC.

The complainant, wife of the deceased stated that her husband working in NLC had taken 7 policies on different dates under SSS and he died on 09.01.2007 due to cardio respiratory arrest. She said that her husband is not in the habit of smoking or drinking and had not taken any continuous treatment in a hospital. She mentioned that she has paid rs1lakh towards premium for all the policies.LIC had not considered claim in respect of any policy stating that LA had suffered from seizure disorder before he proposed for the first policy. The LA had taken treatment in a hospital which was not disclosed in his proposals and further he has also not disclosed previous policy particulars in the proposals as well as the details of policies surrendered by him. In view of all the above the insurer had denied the claim to the insured.

Award no-IO(CHN)L-032/2010-11 DT 3RD DEC 2010.

On a perusal of various documents it was observed that the insurer has based his decision to repudiate the claim on the claim enquiry report, Claim formB, and b1Discharge summary from NLC Hospital .The internal investigation report states that LA was a known case of seizure disorders for 10 years duration.

Claim form B-Medical Attendant's certificate states the cause of death as Cardio Respiratory Arrest ;he was suffering from illness for four months; symptoms of involuntary movement first observed in Oct 2006.No history of other diseases or illness is provided.

Claim form B-1gives history of seizure disorder as first observed in Sep 2006.

Discharge summary of NLC Hospital for the period 8.10.2006 to 10.10.2006 –LA was in the hospital from 8.10.2006 to 10.10.2006 and was diagnosed for seizure disorder /lacerated wound

Discharge summary of NLC Hospital with case sheets for the period 7.01.2007 to09.01.2007.He was diagnosed for seizure disorder, strokes, viral fever, and cardio respiratory arrest. In case sheet dated 8.01.2007 it is stated that patient is known case of seizure disorder 10 years duration.

The LA who was diagnosed for chronic epilepsy was referred to Apollo Hospital on 11.10.2006 and underwent MRI Scan Brain on 15.10.2006.

It was also observed that LA had disclosed the previous policies numbering around 5 in the proposals submitted by him.

DEATH

Complaint no-21.012.2346

Smt .Anusuya Sridhar vs Met life India ins co ltd

The LA had taken Met Easy policy for an annual premium of rs95,000/-commencing from 26.10.2007.The insured had died on 05.03.2009 due to Myo cardial infarction and the claim was rejected due to the fact that LA was suffering from severe diabetic which was not disclosed in the proposal form. The insured had represented that the insurer is not justified in rejecting the claim on the basis of information filled up by the insurance advisor. The insurer had stated that the insured was hospitalized at Venkateswara hospitals where he was reported dead. In the case history it has been recorded as "H/Odiabetes Mellitus type1 from childhood for 33 years on insulin. The medical records reveal significant past treatment at MV Hospital for Diabetes on various occasions during 1992, 2001, 2003.Therefore it has been established that the

LA was suffering from diabetic under prolonged treatment and the claim was denied due to nondisclosure in the proposal form.

Award no-IO(CHN)L-033/2010-11 DT 3RD DEC 2010.

From a perusal of various records it was observed that the insured was admitted in a hospital for terminal illness on 05.03.2009 and expired on the same day. The cause of death was probable acute Myocardial infarction and associated problem coexisted was Diabetes Mellitus Type-1from childhood for 33 years on insulin. The claimant has also mentioned that the diseased LA was under treatment for DM for the last 5 years at Ganga Nursing Home. The treating Doctor has certified that LA was his patient for the last 25 years .

It was observed that the proposal for insurance was submitted on 19.10.2007 and the LA has answered NO to all questions though he was suffering from DM Type-1 prior to proposal. Case summary from Venkateswara Hospital reveals the deceased had history of DM Type 1from childhood for 33 years on Insulin. During the hearing the complainant had also admitted that he was a Diabetic for more than 30 years and was taking regular treatment. Considering all aspects it is clearly revealed that LA had suppressed material facts about his health at the time of taking the policy and he was in full knowledge of his Diabetic condition from childhood. Hence the decision of the insurer in repudiating the claim is fully justified.

The complaint is dismissed.

DEATH

Complaint no21.03.2317.

Smt.T.Kalyani vs LIC Coimbatore

The LA had taken Money Plus Policy from LIC for a sum assured of rs1,00,000/- commencing from 17.03.2007.The insured died on 16.11.2008 due to sudden heart attack. The insured had stated that the agent has given false statements since he obtained only signature from the Lathe claim was repudiated by the insurer on account of the fact that the LA was suffering from DM and Hyper tension for the last 16 years and these facts were not disclosed in the proposal form at the time of taking the policy. The insurer had therefore repudiated the risk portion of the claim and settled the fund value for rs10,094/-

Award no-IO(CHN)L-034/2010-11 DT 3RD DEC 2010

The complainant's husband had taken a Money Plus policy for a sum insured of rs1,00,000/-commencing from 17.03.2007 and he died on 16.11.2008. The claim was rejected due to suppression of his DM and HT which he is suffering for the last 16 years in the proposal. The investigating officer had submitted that LA had treatment for DM from 2002.He had regular check up till 2007.In the claim form B, the Doctor has certified the primary cause as Myocardial Infarction and secondary cause cardiac arrest and other disease preceded or coexisted with that immediately caused to death is Hyper tension and DM. The insurer has also submitted Ecocardiogram report and copy of regular reading chart BP and sugar from 16.03.2002 to 17.12.2007.diagnosed as Diabetic in March 2002.From the records submitted it is clear that diseased LA was under regular check up from 16.03.2002 to 17.12.2007.; copy of case sheets from 16.03.2001 to 17.12.2007 show that LA was a known case DM and hyper tension ;The ECG report dated 16.07.2001 reveals diastolic dysfunction grade-1.Considering all aspects there is a clear case of suppression of material facts while proposing for the policy and LA was in full knowledge of the facts of his pre proposal illness. Therefore the insurer is fully justified in repudiating the claim.

The complaint is dismissed.

DEATH

Complaint no21.004.2337

Smt Deejan Begum vs ICICI prudential LIC ltd.

The LA had taken Life time super for a period of 10 years with a yearly premium of rs50,000/-from 30.10.2007.The LA died on 16.09.2008 due to myocardial infarction with renal failure. The insurer denied the claim on account of the fact that LA was a known case of hyper tension since 2003 and was on treatment for the same. Further the insurer had mentioned that LA was hospitalized twice in 2005 for coronary artery disease with left ventricular failure and chronic renal failure. In August 2005 LA underwent Ultrasonography of the abdomen and all these diseases were not disclosed in the proposal form. In view of suppression of material facts regarding the illness the insurer had denied the claim.

Award no-IO(CHN)L-035/2010-11 DT 3RD DEC 2010

The LA had taken Life Time Super Unit Linked Policy from the above insurer for a sum insured of rs 2,50,000/-commencing from 30.10.2007 and he died on 16.09.2008 .As per the documents submitted by the insurer the case sheet and discharge summary issued by Shenbaga Hospital revealed that LA was treated as inpatient from 18.08.2005 to 26.08.2005 diagnosed as coronary artery disease with left ventricular failure,chronic renal failure and Hypertension and also treated for the period from 05.09.2005 to 16.09.2005.It was observed that

the proposal was signed on 29.10.2007 and the LA has answered NO to all questions which seeks information on health condition of the insured though it is proved that he was hospitalized and undergone various tests for illness. Copy of patient records and discharge summary shows that he was admitted on 18.08.2005 and discharged on 26.08.2005 diagnosed as Caronary Artery Disease with Left Ventricular Failure, Chronic Renal Failure and Hypertension. Again he was admitted from 5.09.2005 to 16.09.2005 for the same illness. From the above it is clear that diseased LA was regular inpatient in Hospital and non disclosure of his health condition in the proposal amounts to suppression of material facts. Considering all aspects the decision of the insurer in repudiating the claim is fully justified. However the fund value under the policy amounting to rs11,439/- as on the intimation of death has to be paid to the complainant.

The complaint is partly allowed.

DEATH

Complaint no-21.009.2382

Mrs .P Kalavathi vs Bajat Alliance LIC Ltd

The complainant had mentioned that her husband had taken New Unit Gain policy with annual premium of rs 10,000/- for a sum assured of rs 3,00,000/- from 28.03.2007 from Bajaj Allianze LIC Ltd. The LA died in a Road accident on 09.03.2009 and the complainant had submitted all required documents to the insurer. The claim was denied by the insurer on account of the fact that LA was hospitalized in 2007 for compensated chronic liver disease ,portal hypertension ,diabetes mellitus. These facts known to the LA were not disclosed in the proposal form dated 12.03.2007.The insured had also mentioned that New India and LIC had settled the claim.

Award no-IO(CHN)L-037/2010-11 dt5 th Jan 2011.

The LA met with a road accident and was admitted in the hospital on 04.03.2009 consequent on injuries suffered by him in the accident. The death summary states that "Mr.Prabakaran ,a known case of DM/SHT/Alcoholic liver disease operated for sub acute intestinal obstruction was brought to the hospital with history of Road Traffic Accident on 02.03.2009.The insurer has also filed 3 three different discharge summaries from the PSG Hospital which relates to hospitalisation of the life assured during Feb/March2007.The discharge summary of 7 th Feb 2007 to 13 th Feb 2007 indicated compensated chronic liver disease,Ethanol related cirrhosis of liver,Portal Hyper tension,Recurrent sub acute Intestinal Obstruction. The history the patient underwent laparotomy 10 years ago elsewhere. He is a known Hypertension for past 10 years, Known DM for diabetic for past two years on irregular

medication. Discharge summary from 28.02.2007 to 02.03.2007 indicated that LA was hospitalized for the second time when he was diagnosed additionally for portal vein Thrombosis, DM/HT.

The complainant has submitted copy of FIR which mentioned the cause of death as "The deceased would appear to have died of head injury sustained by him. During the course of hearing the complainant had argued that LA had died due to accident and not due to DM/Thin this case it is clearly established that there is suppression of material facts and whether this suppression has been fraudulently made to benefit out of insurance. It has been proved in this case that the deceased LA was suffering from serious illness and he had full knowledge of his ailment and that being the case of non disclosure amounts to violation of Principle of Utmost good faith .Considering all facts the Insurer's decision to repudiate the claim is fully justified but since this being Unit Linked policy the insurer has to pay the Fund Value on the date of intimation of death which amounts to rs4,831/-.

The complaint is partly allowed.

DEATH

Complaint no-21.05.2388.

Smt.S.Mani vs LIC Salem

The complainant, wife of the diseased LA in her appeal had mentioned that her husband had taken two policies for a sum assured of rs1lakh and 2 lakhs from LIC, with date of commencement from 29.03.2006 and 24.03.2006.He expired on 21.10.2008 due to heart attack. LIC had settled claim for one policy i.e.; for the sum assured of rs 2lakhs was settled on 31.03.2009.The claim for one policy for rs1lac was repudiated due to nondisclosure of the previous policy taken on 24.03.3006.According to the insurer Medical examination was required to be done before accepting the proposal for rs1lac if the insured had disclosed his previous policy for a sum assured of rs2lacs.Hence the insurer had denied the claim on account of suppression of previous policy particulars.

Award no-IO(CHN)L-038/2010-11 dt03/01/2011.

It was observed that LA had taken two policies with date of commencement on 24.03.2006 for rs 2lakhs and 29.03.2006 for rs 1 lac and in the proposal for the policy taken on 29.03 06 he has not disclosed the previous policy particulars even though he was having full knowledge of the earlier policy details. Further the two proposals have been submitted through different Agents under different Development officers. Had it been introduced through the same agent the agent would have brought it to the notice of the insurance company. The

insurer's representative informed that since the second policy was taken within such a short time after the first one, the data relating to the first proposal would not have been updated in the records of the insurer for them to verify the position. The insurer had further submitted that if the LA had disclosed the previous policy particulars they would have called for medical reports before accepting the proposal since the maximum sum insured under non medical for ages up to 40 was 2 lakhs only. Therefore since the suppression of age in this case affected the underwriting decision this fact has to be treated as a material fact and not disclosing the same amounts to fraudulent intention on the part of the Lactating all the factors into account the decision of the insurer in repudiating the claim is fully justified.

The complaint is dismissed.

DEATH

Complaint no-21.013.2404

Mr.C.Sivam vs AVIVA Life Insurance Co Ltd.

The complainant had mentioned that his wife had taken Sachin century plus policy for a sum assured of rs3,00,000/-on a yearly premium of rs15,000/- from the above insurance co.The complainant had stated that his wife died suddenly on 16.12.2009 due to Heart Attack. The insurer had denied the claim on account of the fact that the diseased was a known case of DM from last two years and taken treatment for the same. This fact in respect of pre proposal illness was not disclosed in the proposal form. Hence the claim was repudiated due to non disclosure of material facts.

Award no-IO(CHN)L-039/2010-11dt5 th Jan 2011.

The claim in respect of the deceased LA was denied by the insurer on the ground of suppression of health in the proposal form. The insurer has relied on various documents for taking their decision. As per the Medical attendant's certificate dt 17.01.2010 LA died on 16.12.2009 due to cardiac arrest, the primary cause being IHD. The duration of illness is mentioned as 25 days and symptoms are chest pain and breathlessness. History of type II dm is referred and its date when first observed is shown as 2 years back. Another Doctor has also issued a certificate dt 20.01.2010 stating that LA had undergone Hysterectomy 2-1/2 years back and she was detected to have HT and DM at that time. In the diabetic questionnaire it is confirmed that diabetes was diagnosed in 2005.The insurer has also submitted Lab reports to prove that LA was suffering from pre proposal illness. During the hearing the complainant admitted that his wife had diabetes and HT and her DM was under control. From all the records it is clearly established that LA was suffering from DM and HT since 2005.Before taking the policy The LA had taken policy with SBI Life also with DOC21.10.2009 and this fact has not

been disclosed while answering Q no-5 in the proposal. She has also answered NO to questions relating to her existing illness. Considering all the above aspects the repudiation of the claim by the insurer is fully justified. Further since the insurer has already settled the Fund value the complainant shall not be eligible for any other benefits.

The complaint is dismissed.

DEATH

Complaint no-21.08.2418.

Smt.R.Indira vs LIC,Vellore DO

The complainant had stated that her husband had taken 2 policies from LIC from 20.03.2004.He died on 24.07.2006due to Cerebro Vascular Accident.The claim in respect of one policy was settled and she has not received the claim for the other policy. The insurer denied the claim on account of the fact that the DLA had suffered from Cerebro vascular accident ,DM and HT for which he took treatment in hospitals. He did not disclose these facts in the proposal. As he had withheld material information at the time of taking the proposal the claim was repudiated. The insured had stated that her husband was working in the collectorate and had not taken any medical leave since 5 years.

Award no-IO(CHN)L-040/2010-11 dt10th Jan 2011.

The complainant had mentioned that her husband complained of severe headache on 23.06.2006 and was not able to speak or move his limbs and fell unconscious. He was given treatment in two local hospitals and subsequently referred to Pondichery Institute of Medical sciences where he was admitted from 6.07.2006 to 24.07.2006 and died on 24.07.2006.In the history it is mentioned that he was a known case DM 3 years taking regular medicine ,known SHTon irregular medicine. The records of Krishna hospital report the diagnosis as Type II DM and HTN/CVA. The past history of illness is not recorded. In claim form B the Medical Attendant has certified that the patient had DM-9 years,HTN-3 years. The leave records submitted by the insurer shows that LA has taken leave for 90 days from May 2008 to Aug 2008.During the hearing the complainant argued that her husband was not taking any medicine for DM. The death summary issued by the Hospital states that the patient was a known case DM 3 years taking regular treatment and known SHT on irregular treatment. Hence it has been established that LA was suffering from DM and HT before then date of proposal but the insurer could not prove that he has taken treatment in hospital. Insurer also could not substantiate the fraudulent intention on the part of the LA in suppressing the facts of his suffering from DM and SHT. There is inordinate delay on the part of the insurer in repudiating the claim. Taking all the factors into account, to ensure justice to both the parties the Insurer is directed to pay a sum of rs 40,000/-as Exgratia amount in lieu of full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.04.2397

Mrs.S.Subbulakshmi vs LIC Madurai

The complainant, sister of the LA had mentioned that her brother had taken an endowment policy on 13.10.2004 from LIC and the policy was revived on 4.09.2006.He died on 12.07.2008 due to neck cancer.According to the insured the illness was sudden development. The insurer denied the claim on account of the fact that LA was not maintaining good health and was suffering from neck cancer and took treatment in a hospital since 24.08.2006 which was prior to the date of revival. These were not disclosed in the Health report submitted before revival by the insured. Since illness prior to revival has been established by hospital records the claim was repudiated for suppression of material facts regarding pre revival illness.

Award no-IO(CHN)L-041 dt10 th Jan 2011.

The complainant had preferred a claim under the policy for the death of her brother on 12.07.2008 and the claim was denied due to non disclosure of his illness in the pre revival form.LA was taking treatment for Neck Cancer in a hospital since 24.08.2006 which is prior to the date of revival i.e. 04.09.2006.The investigating officer has reported that LA was suffering from neck cancer identified on 19.08.2006 and was taking treatment since then. The Laboratory report dt 21.08.2006 from Doctor's diagnostic centre reveals impression as "possibilities "are (i0metastatic poorly differentiated carcinoma;(ii)non Hodgkin's Lymphoma-High grade and was advised for biopsy. As per claim form B as certified by the DR the primary cause of death was neck cancer –carcinoma neck. The medical certificate dt 23.01.2004 issued by Doctor certifies that LA was suffering from Peptic disease. the discharge summary dt 14.11.2008 certifies that LA was admitted on 14.11.2006 and was discharged on 05.01.2007 and he had treatment from 24.08.2006 to 12.07.2008.during the hearing the complainant admitted that her brother was detected of neck cancer in 2006 and had also availed medical leave.LA was a Veterinary Doctor and it can be presumed that he had full knowledge of the disease he was suffering and knowingly he has suppressed the information at the time of revival. Considering all the facts the repudiation of the claim by the insurer is fully justified.

The complaint is dismissed.

DEATH

Complaint no-21.013.2427.

Ms.S.Ananthai vs AVIVA Life Ins Co Ltd

The complainant had stated that her son had taken Life saver plus unit linked policy from the above insurer for a sum insured of rs1,50,000/-with an annual premium of rs15,000/-with date of commencement from 28.02.2008..He was admitted as inpatient in a Govt hospital and due to sudden health problem he died on 28.10.2009.He paid premium for two years for a total amount of rs30,000/-The insurer had denied the claim and settled only fund value for rs 20,911/- The insurer denied the claim on account of the fact that the deceased LA was a known case of Bronchitis Asthma since childhood and he had not disclosed the same in the proposal at the time of taking the policy.LA died due to Brain Dysfunction and respiratory failure and in medical terms the Asthma which is lung disease and brain dysfunction are one of the major causes for respiratory failure. Hence the claim was repudiated due to nondisclosure of material facts by the LA in the proposal.

Award no-IO(CHN)/L-042/2010-11 dt10thJan 2011

The death claim of the LA was denied by the insurer on the ground that he has not disclosed his illness in the proposal form. In support of their contention they have submitted Discharge summary along with case sheets which clearly states that the cause of death of LA was mentioned as subarachnoid Haemorrahage,Brain stem disfunction and respiratory failure and he expired on 28.10.2009.The history of illness states patient 26 years old male a known wheezer from childhood used to have frequent exacerbation for which he used to have injections and stereoids. The insurer has paid fund value under the policy amounting to rs20,911/-.During the hearing the complainant had mentioned that her son never had any health problem. The records from the Govt hospital clearly state that life assured had Asthmatic problem since childhood. The nature of the disease is such that LA would be having continuous knowledge of the same. As the above information was not disclosed in the proposal it amounts to clear suppression of material fact .Taking all factors into account the decision of the insurer in repudiating the claim is fully justified.

The complaint is dismissed.

DEATH

Complaint no-21.005.2415.

Ms.R.Vidya vs HDFC Std Life Ins Co Ltd

The complainant ,daughter of deceased LA stated in her complaint that her mother had taken unit linked young star plus policy with the above insurance co for 15 years with a yearly premium of rs30,000/-.LA had expired on 23.05.2010 and the complainant had stated that she has received only rs4,484.53 towards settlement of the claim. The insurer had mentioned that the policy was lapsed due to nonpayment of second year premium due on 18.03.2009.The deceased LA had paid only rs10,000/- as against rs30,000/-and this amount was returned to the LA since the signature did not match in the PHS form. The full premium was not paid and no approval was also given for reduction in premium. Hence no benefits are payable under the policy and hence settled the amount for Fund value.

Award no-IO(CHN)L-043/2010-11 dt 10 th Jan 2011

The LA had submitted a proposal dated 29.01.2008 for taking Unit linked young star plus plan covering sum insured of rs 1,50,000/-with an annual premium of rs30,000/-.The frequency of premium payment was mentioned as yearly. the insurer has mentioned that the policy has lapsed for nonpayment of premium due 18.03.2009.They received a sum of rs10,000/- only on 20.01.10 .The policy continued to be in lapsed condition only and in the mean time LA died on 23.05.2010.The insurer's representative contended that since full premium due was not paid, the policy could not be revived. The complainant had stated that the agent had told them orally that premium payable was rs30,000/-,rs10,000/-,10,000/- respectively for I year, II year and IIIyear are all oral and there are no records to establish this. The policy under question was lapsed and could not be revived as full instalment premium of rs30,000/-had not been paid. The policy being a Unit linked policy; the insurer has repaid the Fund Value under the policy amounting to 4,484.53. Considering all aspects the repudiation of claim by the insurer in this case is in order. As the fund value has already been paid, no further relief is considered under the policy.

The complaint is dismissed.

DEATH

Complaint no-21.03.2490.

Smt.S.Subbulakshmi vs LIC.

The complainant had stated that her husband had taken and endowment policy for rs1,00,000/-from 28.07.98 for a term of 15 years with a quarterly premium of rs1,780/-On 24.11.98 he complained of chest pain and was taken to a hospital .He died on 24 11 98 due to cardio respiratory arrest. The claim papers were submitted to LIC in Feb 99 and LIC denied the claim due to nondisclosure of material facts by the DLA at the time of taking the policy.

She had approached the Honble High Court Chennai by way of writ petition in WP no 11162 of 2006 seeking a direction to disburse the SA on the life of her husband with interest. The court had directed the petitioner to approach ombudsman for her claim. The insurer had mentioned that LA was suffering from chronic kidney disease and had undergone dialysis. This fact was confirmed as per medical slip and medical certificate received from the hospital.LA had undergone first dialysis on 17.08.98 and last dialysis on 20.11.98.Hence the claim was repudiated due to suppression of material facts.

Award no-IO(CHN)L-044/2010-11 dt 27th Jan 2011.

The complainant's husband had taken a policy for a sum insured of rs 1lac from 28.07.2008 and died on 24.11.2008.The claim was denied by the insurer on the ground that the LA had suppressed his illness while taking the policy. As per claim form B the medical attendant had certified the cause of death as cardio respiratory failure pulmonary hypertension and Pulmonary Tuberculosis. He could not give as to how long LA was suffering from the disease and he has also mentioned other disease preceded or coexisted as Chronic Renal failure and LA had undergone dialysis on 17.08.1998.The claim form B1 also certifies the diagnosis as chronic renal failure,PT,Pulmonary HTN and cardiac respiratory failure. The investigating officer has mentioned in his report that as per the information he has gathered from the neighbours of the deceased LA was a chronic Kidney patient.

During the hearing the complainant submitted that her husband did not suffer from any disease other than the problem of his legs. It was also mentioned that LA was truck driver and frequently suffered from pain and swelling in legs for the last 6-7 years.LA has answered NO to questions 11(a),11(d),11(e) of the proposal though he was suffering from swelling in the legs and was taking treatment. Considering all facts the suppression of material facts is clearly established and the decision of the insurer in repudiating the claim is fully justified.

The complaint is dismissed.

DEATH

Complaint no-21.01.2479

MrM.Chinnamani vs LIC.

The complainant, father of the diseased LA stated that his daughter had taken two policies under salary saving scheme.LA was suffering from tooth ache and had also undergone Piles operation. According to the complainant due to unhealthy food habits she again had health related issues and died on 01.12.2008 by hanging herself. The claim was denied by the insurer on the ground that the diseased LA committed suicide within one year of taking the

policy. The suicide clause is operative and hence the policy has become null and void and nothing is payable as per the terms of the contract.

Award no-IO(CHN)L-045/2010-11 dt7th Jan 2011.

During the hearing the complainant admitted that his daughter died due to suicide since she had family problems and requested to treat the death as accident death. The insurer has submitted required documents and on perusal of various documents to prove that LA committed suicide. FIR no 269/2008 dated 01.02.2008 stated that LA and her husband were having problems and divorce case was pending in the court. Her mother had noticed LA committed suicide by hanging from the ceiling fan .The panchayathers have also observed that LA had committed suicide. As per post mortem certificate no 1258/08 dated 02.12.2008 opined that deceased would appear to have died of Asphyxia due to hanging. The LA was a police constable and was living separately and divorce case was pending in the court. Police report-FIR, PIR and PMR established the cause of death as suicide. Clause 6 of the policy states that the policy shall be void if the LA commits suicide at any time on or after the date or which the risk under the policy has commenced but before the expiry of one year from the date of this policy the claim will not be entertained. This policy commenced from 03.03.2008 and the suicide occurred on 01.12.2008 i.e. within one year from the date of policy. In view of the foregoing the decision of the insurer in repudiating the claim was justified.

The complaint is dismissed.

DEATH

Complaint no-21.01.2481.

Smt.D.Vasantha kumari vsLIC.

The complainant wife of the deceased LA stated that her husband had taken LIC policy for a sum insured of rs1,00,000/-from 25.03.2002 with an annual premium of rs6,734/-.The policy was revived on 07.07.2008 by paying two instalments premium and he died on 09.09.2008.The claim was denied by the insurer on the ground that LA was diagnosed for Acute Myeloid Leukemia in 20.07.2007 for which he has taken treatment. He did not disclose these details at the time of revival on 07.07.2008.As he had withheld correct information regarding his health at the time of revival the policy is declared as null and void. The insurer had mentioned that they can entertain the claim for vested bonus which was secured by the policy on the date of lapse.

Award no-IO(CHN)L-046 dt7thJan 2011

The claim form B and B1 submitted by the insurer and duly certified by the Doctor states that LA was admitted on 04.09.2008 and died in the hospital on 09.09.2008 Cause

of death was Acute Myeloid Leukemia, first observed in Aug 2007.The insured has also taken treatment at Cancer Institute Adyar on various dates. As per the death summary issued by Sri Ram Chandra Medical Centre patient is a known case of acute Myeloid Leukemia, post bone marrow transplant. Date of admission 01.09.2008 and date of death 09.09.2008.As per the certificate issued by Cancer Institute dated 11.12.2007 LA was admitted in Aug 2007 with diagnosis of Acute Myeloid Leukemia. Before revival of the policy on 07.07.2008 LA had given a Health declaration in which he has stated that he was not suffering from any disease and had not undergone any treatment with the Doctor during the period before revival and revived the policy on 07.07.2008.This clearly shows that LA has suppressed the material facts about his illness at the time of revival of policy. Hence the decision of the insurer in repudiating the claim is fully justified and they are advised to settle the vested bonus of rs 23,900/-which has accrued in the policy as on date of lapse.

The complaint is dismissed.

DEATH

Complaint no-21.01.2478.

Smt.S.Jeeva vs LIC.

The complainant Smt.S.Jeeva wife of LA stated that her husband had taken two policies from LIC for a sum insured of rs50,000/- with date of commencement as 28.04.2008 and 30.05.2008 respectively. He died on 04.02.2009 due to jaundice and the claim was denied by the insurer on the ground that LA had not disclosed the pre proposal illness at the time of taking the policy. The insurer denied the claim on account of the fact that the deceased LA was a chronic alcoholic and had history of jaundice in Jan 2008.LA had not disclosed these facts in the proposal and since material information regarding health was withheld the claim was denied.

Award no-IO(CHN)L-049/2010-11 dt 28th Feb2011.

The insurer has submitted various documents to substantiate their stand of repudiation. As per Form B,B1and B2issued by a Doctor I n a Govt. hospital the primary and secondary cause of death of deceased LA was DCLD/PHT/UGI and bleed HBV related. Previous history of deceased LA as per case sheets of Govt General Hospital, Chennai states that he was a chronic alcoholic for 10 years and had history of jaundice in Jan 2008.In the proposal for a specific question 11(d) ailments relating to liver the answer is given as NO. The complainant also admitted that her husband used to take alcohol and LA has answered NO to questions on using Alcohol-6(h). Thus suppression of material fact is clearly established but taking into account the fact that LA was an illiterate there is a likelihood of his signing the proposal without understanding the contents. Considering all aspects an exgratia amount of

rs3,000/- is awarded under policy no 715207862 and Bid value of rs6,893/-under policy no 715208424 in full and final settlement of the claim.

The complaint is partly allowed on Exgratia basis.

DEATH

Complaint no-21.08.2550.

Mr.A.Alagesan vs LIC.

The complainant husband of the deceased LA stated that his wife had taken an insurance policy with LIC on 30.07.2007 for a sum insured of rs50,000/- with half yearly premium of rs2,500/-She died on 07.06.2009.She had undergone heart surgery in 1999.The insured had denied the claim on account of the fact that the LA had undergone Mitral Valve replacement in the year 1999for which she took treatment in a hospital. She did not disclose this fact in the proposal and as she had withheld material information from the insurer regarding her health at the time of taking the insurance policy the claim was repudiated. The complainant had stated that this fact was not knowingly suppressed and since they are living in a remote village they are not aware of insurance contract.

Award no-IO(CHN)L-050/2010-11 dt28thFeb 2011.

The insurer has submitted various documents to justify their stand in repudiating the claim. As per B,B1 from Jipmer Hospital the cause of death was RHD-MS,MR(postMVR) and MVR done in 1999.The case sheet reveals that Past history of Rheumatic fever at 5 years ,Baloon Mitral Valvotomy in 1997.Admitted on 02.10.1999 to 27.11.2009 underwent Mitral Valve Replacement on 17.11.1999.Subsequently further follow up and treatment done on 10.12.1999,25.01.2000,28.03.2000 and 16.01.2001.During the hearing the complainant admitted that his wife was operated for valve problem in the year 1999.It is evident from all the above records that LA had made deliberate misstatements and withheld material information from the Insurer regarding her health at the time of effecting the insurance. Taking all the factors into account the repudiation of the claim by the insurer is fully justified. The insurer is advised to settle the Bid value of rs8, 227.69.

The complaint is dismissed.

DEATH

Complaint no21.04.2540.

Mrs.B.Dhanalakshmi vs LIC,Madurai

The complainant, wife of deceased LA stated that her husband had taken New Bima Gold Policy for rs50,000/-on 08.03.2007.He died on 8.11.2008 due to heart attack. The insured denied the claim on account of the fact that the deceased LA was not keeping good health and suffered from diabetes mellitus and as per Jawahar hospital treatment summary the LA was a known case of DM for 15 years on regular treatment since 25.09.2003 with insulin and known case of PT and had ATT twice. He had not disclosed the above in the proposal and since he had withheld correct information regarding his health from the insurer at the time of effecting the insurance, the claim was repudiated.

Award no-IO(CHN)L-051/2010-11 dt28thMarch 2011.

The complainant's husband had taken Policy for a sum insured of rs50,000/- from 08.03.2007 and died on 08.11.2008 due to severe heart attack. The insurer had submitted Form B-1 certificate of hospital treatment stating LA was under his care since 25.09.2003, the LA had diabetes since 1993 and bronchitis and was referred to Jawahar hospital on 6.11.2008 for cholecystitis, cirrohisis of lever with ascites. In claim form B-Medical Attendant's certificate issued by the Dr Primary cause of death was perforation peridontis, chronic liver disease and secondary cause was old PT and DM. During the hearing the complainant admitted that her husband was suffering from diabetes for past 10 years on Insulin. The fact that the insured was suffering from diabetes mellitus and was under treatment taking insulin much before submitting his proposal has been proved beyond doubt and this information he has clearly suppressed in the proposal submitted by him while answering Q. 11(e).His answers to Qn11(a) and 11(i)are false. Further the facts suppressed are material to underwriting the risk and they have been knowingly suppressed. Considering all the facts, the repudiation of the claim by the insurer is fully justified.

The complaint is dismissed.

DEATH

Complaint no-21.003.2570.

Mrs.C.M.Emelda vs TATA AIG LIC Ltd

The complainant stated that her husband had purchased a product Invest Assure II from the above insurance co for a sum insured of rs4,30,000/-from 9.6.2008,paying an annual premium of rs20,000/-.He died on 14.10.2009 due to cardiac arrest. The insurer denied the claim on account of the fact that the insured was suffering from Diabetes Mellitus since 5 years prior to his application for insurance as per the investigation report. In the history sheet of the admission record of J.K.Hospital in section past history it is stated that known DM for 5 years and the above fact is also supported by an interview given by DR.N.Jayaselvan from

J.K.Hospital it is stated "Diabetic 5 years" which implies that the insured was a diabetic since 5 years. Since the insured has not disclosed this material fact at the time taking the policy the company has repudiated the claim.

Award no-IO(CHN)/L-052/2010-11 dt28thMarch 2011.

In support of their contention the insurer has submitted a questionnaire duly certified by the treating Doctor where he has stated that LA was treated by him from 4.01.2009 to 8.10.2009, that the LA was admitted on 3.10.2009 and was diagnosed for DM, HTN and Ischemic Heart disease and he died in the hospital on 14.10.2009.He has also mentioned that he suffered from DM for 5 years. Similarly in the past history of J.Khospital is recorded that patient is a known case of DM 5 years. Again LA was admitted from 8.10.2009 to 13.10.2009 at NIMS Heart Foundation and in the history it is stated that LA is known to have Type II Diabetes Mellitus with Nephropathy and Hypertension. During the hearing the complainant submitted that she had submitted the same records to LIC and they have settled the claim and reiterated that her husband visited hospital for the first time only on 04.01.2009 and was diagnosed for DM only in June 2009.The insurer had argued that from all the hospital records it is established that LA was suffering from DM since 5 years and pre proposal illness is established. Considering all the facts the repudiation of the claim by the insurer is fully justified and since the insurer has also settled the fund value amounting of rs17, 045.66 no other relief is allowed to the complainant.

The complaint is dismissed.

DEATH

Complaint no-21.07.2571.

Smt.A.Pushkala vsLIC Tveli

The complainant had stated that her husband had taken a NEW BIMA gold Policy with the above insurer for a sum insured of rs 50,000/-from 15.12.2006.The LA had died on 15.05.2009 due to Blood Cancer. The claim was rejected by the insurer on the ground that LA was suffering from Acute Lymphatic Leukaemia prior to the date of revival i.e. 5.08.2008 for which he took treatment in a hospital. These facts were not disclosed in the personal statement at the time of revival. The complainant had admitted the discrepancy in the proposal and it happened due to their ignorance. The insurer had argued that LA had made deliberate misstatement and withheld material information regarding his health from the insurer at the time of getting the policy revived. Illness prior to revival is established by hospital records and they have therefore repudiated the claim for suppression material facts regarding pre revival illness and treatment.

Award no-IO(CHN)L-053/2010-11 dt28th March 2011.

The complainant had stated that her husband complained of body pain 10 months before his death and was hospitalized for treatment and died on 15.05.2009 due to cancer. In the claim formB-1 duly certified by the Dr., it is mentioned that LA first consulted him on 07.07.2008 and he was suffering from acute from Acute Lymphatic leukemia. In the form B1 and B2 it was mentioned that LA was hospitalized from 4.07.2008 to 07.07.2008 and was diagnosed as a case of Acute Lymphatic leukemia. The discharge summary of the hospital also confirms that LA was hospitalized from 4.07.2008 to 07.07.2008 with H/O Myalgia, fever on and off for 3 days, the insured was treated for Acute Lymphatic leukemia.Before his death LA was admitted from 30.04.2009 to 02.05.2009 for leukemia, which was diagnosed earlier. The Dr from the Regional Cancer Centre TVM has issued a certificate of Hospital treatment in FormB-1 where she confirms LA was hospitalized from 25.08.2008 to 15.09.2008 for ALL He was earlier admitted on 07.07.2008 for fever on and off for 2 months.

The policy was revived on 05.05.2008 by remitting 3 Qly premiums on the basis of personal statement regarding health dated 05.08.2008 submitted by Lathe LA has answered NO to all questions relating to his existing illness. It is proved beyond doubt that LA was suffering from history of Mylagia-25 days and fever on/off with 3 days before 04.07.2008when he was admitted in Hospital and was diagnosed for acute lymphatic leukemia. This is prior to 5.08.2008 when the policy was revived based on the personal statement of health. Hence taking all the factors the repudiation of the claim by the insurer is fully justified.

It is to be noted that pre proposal illness was not established, but only pre revival illness was established. Further the complainant is economically very poor and deserves sympathetic consideration on humanitarian grounds. Keeping this in mind the insurer is directed to settle the claim on Exgratia basis by paying rs5,000/-in full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.02.2585.

Smt.S.Kasturi vs LIC,Chennai

The complainant ,wife of the deceased LA stated in her complaint that her husband had taken two policies with the above insurer for a sum insured of rs1lakh each from 24.10.2007 and 26.03.2009 and he died on 24.12.2009.due to difficulty in breathing and lung infection at Vijaya Hospital. The death summary was issued based on the version given by the

relatives about her husband's health. The claim forms and other papers were submitted to LIC and afterwards the complainant noticed that the year was wrongly mentioned as 2000 instead of 2009.According to the insured when he was having slight pain in OCT 2009 he had taken treatment at a nearby hospital .In view of the above discrepancy she got another revised discharge summary from the hospital. The insurer had stated that as per the discharge summary there was history Coronary Artery disease in the year 2000 and jaundice.Pre insurance illness is clearly evident as per discharge summary produced and also immediate cause of death was coronary syndrome which has nexus with the previous illness. Hence they have rejected the claim.

Award no-IO(CHN)L-054/2010-11 dt28thMarch 2011.

The complainant's husband had taken two Jeevan Anand policies for rs1lac each from 2410.2007 and 26.03.2009 and he died on 24.12.2009 due to cardiac arrest. The insurer had mentioned that LA had history of coronary artery disease in the year 2000which he has not disclosed in the proposal. The complainant had submitted claim forms A,C and B,B1dated 12.10.2010 completed by the DR and as per this the primary cause of death was acute coronary syndrome and secondary cause were acute anterior wall MI,Acute Pulmonary Edema,Cardiogenic Shock and old inferior wall Menthe Doctor certified that the insured was a known case of coronary artery disease 2000.In claim form B1 also the DR has certified the LA as a known CAD –2000.the complainant submitted that her husband had slight chest pain in Oct 2009 and the year 2000 has been wrongly noted instead of 2009.This information was wrongly conveyed by her relatives and submitted another set of claim forms and revised discharge summary.

On comparison of both set of documents the following were observed. As per claim form B dt 12.01.2010 answer to q4(a),(b)is Acute coronary syndrome, Acute anterior Wall MI, Acute Pulmonary Edema, Cardiogenic Shock; Answer to q4(d)-severe chest pain, breathing difficulty ,profuse sweating;Qno6-Known case of CAD-2000.

Answers to above questions in Claim form B dt 20.03.2010 issued by the same DR-Q4(a),(b)-acutePE, Cardiogenicshock, breathlessness, old inferior wall MI ,severe chest pain;Q4(d)Profuse sweating andQ6-Known CAD-2009.

In the minutes of the hearing duly corrected by the complainant it is stated as "later on 23.12.2009,he went to Sarala Hospital for chest pain, he was asked to provide his earlier treatment details (i)prescription cum Diagnosis Memo dated 23.10.2009 issued by Regina Nursing Home refers to complaints of chest pain and the medicines prescribed. (ii) Complainant submitted that LA was taken the hospital on 23.12.2009 but submitted discharge summary showing the date of admission as 23.10.2009.The diagnosis reads –Acute Coronary Syndrome/going for LVF,CAD/old InfMI. By the side of old InfMI, it is mentioned in a bracket

(2009) which raises the questions about veracity as the handwriting differs. if the LA had chest pain for the first time in Oct 2009, the hospital authorities would not have mentioned it as a case of old Inf MI. This implies that LA had past history of MI. Taking all the factors into account the repudiation of the claim by the insurer is fully justified.

The complaint is dismissed.

DEATH

Complaint no21.02.2588

Mr.P.Koteeswaran vs LIC,Chennai.

The deceased LA had taken Money Plus policy for a sum insured of rs 1 lakh from 28.03.2007 and he died on 06.11.2008 due to cardiac arrest. The claim submitted by the complainant was denied by the insurer on account of the fact that the deceased LA was known case of DM,Hypertension and had undergone renal transplant in 1991 and was admitted in the hospital with the history of breathlessness of 2 days duration. There was history of renal transplant in 1991.Pre insurance illness is clearly established as per the discharge summary and suppression of material facts regarding health was clearly evident and hence the claim was repudiated. The complainant had represented that there was no malafide intention to suppress the facts and requested for favourable consideration of the claim.

Award no-IO(CHN)L-055/2010-11 dt28th March 2011.

The complainant had mentioned that LA was admitted in a hospital for terminal illness and died on 06.11.2008.In the claim form B the primary cause of death is shown as cardiac arrest and Pulmonary edema. It has also been mentioned that the patient had undergone Renal transplant in 1991(Transplant rejection),Hyperkalemia,Portal hypertension with Ascitis. The death summary of the hospital also states that the deceased life assured was a known case of DM,hypertension and renal transplant in 1991.During th ehearing the complainant admitted that the insured had underwent Kidney transplant and for 16 years thereafter he had no health problem. He admitted that the insured was a diabetic for 7 years and hypertensive for 6-7 years .The LA must be having full knowledge of the above diseases and the surgery undergone as it is a major surgery. Though the proposal was submitted after a long time in 2007, 16 years after the surgery, the insured is bound to disclose this fact and also the facts that he was diabetic and hypertensive as they affect the underwriting decision of the insurer. As suppression of material facts coupled with fraudulent intention is clearly established, the repudiation of the claim by the insurer is fully justified. As the policy is Unit linked policy the insurer is directed to settle the Fund value of rs14,334/-.in full and final settlement of the claim.

DEATH

Complaint no-21.016.2591.

Smt.J.K.Jeyalakshmi vs Shriram Life Insurance Co Ltd

The deceased LA had taken a policy with the above insurer for a sum insured of rs2,25,000/-from 02.11.2007for a period of 15 years with an annual premium of rs30,000/-. He died on 01.11.2008 due to sudden Heart failure and the complainant, sister of LA had lodged a claim. She has represented that the proposal form was not filled by her brother and he has only affixed his signature. The proposal form was filled by the agent. She said that there was no deliberate nondisclosure of material facts directly by the proposer or any misstatement directly by him. The insurer had denied the claim on account of the fact that the deceased LA had suffered severe heart problems and availed sick leave prior to taking VRS. The DLA had heart attack 2 years back and from then was on medication. Medical certificate from the hospital shows that DLA was admitted into the hospital on13.02.2007 with the complaint of Myocardial infarction and discharged against medical advice on 19.02.2007.As LA had suppressed material facts which were vital for assessing the risk the claim was repudiated.

Award no-IO(CHN)L-056/2010-11dt 28thMarch 2011.

The complainant had mentioned that his brother was suffering from BP for last two years and also suffering from Heart problem for last 2 years.DLA was admitted with complaints of Myocardial infarction on 13.02.2007and discharged against medical advice on 19.02.2007 as per Hospital letter dated 20.08.2009.He availed Medical leave for viral hepatitis from 03.05.2005 to 20.05.2005fro 18 days, from 09.09.2005 to 20.09.2005 for 12 days for fever and from 21.09.2005 to 10.10.2005 for hepatitis. The proposal is dated 29.10.2007 and the LA has not disclosed his hospitalisation on 13.02.2007.Considering all the facts the suppression of material facts has been clearly established and hence the decision of the insurer in repudiating the claim is fully justified. The insurer is directed to settle the bid value of rs42,855.06 which was available as on the date of intimation of death.

The complaint is partly allowed.

DEATH

Complaint no-21.009.2509.

Smt.A.Gnana Devasitham vsBajaj Alliance LIC Ltd

The complainant, wife of the deceased LA stated that her husband had taken an insurance policy called New Family Gain for a term of 15 years for a sum insured of

rs1,80,000/-from 23.02.2008 and with an annual premium of rs12,000/-.He died on 31.12.2009 due to ill health and the claim lodged by the complainant was repudiated on the ground that LA had not disclosed his illness at the time of taking the policy. The insurer had stated that the deceased LA was under consultation /treatment for pulmonary tuberculosis since June 2006 and these facts known to deceased LA were not disclosed in the proposal form. Hence the claim was repudiated due to non disclosure of material facts.

Award no-IO(CHN)L-057/2010-11 dt28 th March 2011.

The claim under the policy was repudiated on the ground that the DLA was under consultation /treatment for pulmonary Tuberculosis since June 2006 and these facts the proposer has not disclosed in the proposal dated 31.01.2008.As per medical certificate the cause of death reported as acute myocardial infarction, old pulmonary tuberculosis, Left ventricle failure cardio respiratory arrest. First consulted in the year 2006 and treated for pulmonary tuberculosis from 2006 middle. During the course of hearing the complainant admitted that her husband suffered from Tuberculosis 5 years ago and was cured. The insurer's representative submitted that he suppressed the fact that he was under consultation/treatment for pulmonary TB since 2006.Qn no 14(c) of the proposal ask for any disease of the respiratory system such as tuberculosis, Asthma, etc; The LA has answered negative though he was diagnosed and treated for tuberculosis. Considering all the factors the decision of the insurer in repudiating the claim is fully justified. However since the policy is Unit Linked Policy the fund value of rs 20,411 as confirmed by the insurer is to be paid to the complainant in full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.01.2620

Smt.P.Poongavanam vs LIC,Chennai.

The complainant had stated that her husband had taken a policy from LIC for a sum insured of rs1lac from 28.10.2007 under salary saving scheme. He died on 21.11.2009 due to heart attack and Pneumonia sepsis and the claim was rejected on the ground non disclosure of illness in the proposal form. The complainant said that she is not aware of any illness of her husband since 5 years and requested for sympathetic consideration. The insurer had mentioned that LA was suffering from Coronary obstructive pulmonary disease and was taking treatment. He was suffering from COPD w.e.f.5.09.2003.as outpatient which is 4 years prior to the date of commencement. He did not disclose these facts in his proposal. In view of withholding material information regarding his health the claim was repudiated.

Award no-IO(CHN)L-059/2010-11 dt 28th March 2011

During the hearing the complainant had submitted that they were not aware of Insured's illness as he always went alone to see that Doctor. They came to know about his illness only in 2009.He took leave frequently in the last year of his service. She further said that LAS got a permanent job only in 2007 and he was medically found fit as per the Medical certificate. The insurer's representative submitted that the LA died within 2 years 23 days of taking the policy and that LA was taking OP treatment since 05.09.2003 for chronic pulmonary disease. As per claim form B-Medical Attendant's certificate issued by the hospital the primary cause of death was Sepsis and secondary cause was lung Pneumonia with COPD. The DR states that LA had COPD for 6 years. In the hospital treatment (in form B-1) issued by the Dr. a mention is made of COP for 6 years and the LA had visited the Institute on 15.12.2005, 21.12.2005, and 7.08.2009 as outpatient. The Supdt of Govt Hospital in his letter dated 8.06.2010 addressed to LIC states that LA visited their hospital as outpatient. There is no mention as to for what illness the LA was treated from 5.09.2003 onwards when LA visited as outpatient. For pre proposal illness the only evidence made available is Doctor's noting in claim form B. Even the physical fitness certificate in Nov 2005 states he had no illness except that he was under weight. The insurer has not been able to establish the preproposal illness with concrete evidence. If the version of the Dr who issued claim form B and visits of LA to Govt Hospital of Thoracic Medicine are to be considered it is likely that LA had some pre proposal illness. Again it is difficult to prove that LA had fraudulent intention in suppressing facts of his illness while submitting the proposal. Taking all the factors into account, to ensure justice is not denied to either of the parties an ex gratia amount of Rs50,000/-being 50% of the sum insured is to be paid to the complainant by the insurer as full and final settlement of the claim.

The complaint is partly allowed on ex -gratia basis.

DEATH

Complaint no-21.007.2621.

Mr.Rajkumar Mohanraj vs Max Newyork lic Ltd.

The complainant, husband of the LA had mentioned that his wife had taken policy with the above insurance co for a sum insured of rs 7lakhs from 30.11.2006 with a yearly premium of rs 45,685/-.The LA died on 13.10.2009 and the claim lodged by the complainant was denied on the ground of nondisclosure of her health in the proposal form. The insurer stated that LA was suffering from SLE since 2002 and was under treatment which is prior to signing the proposal form as confirmed by the hospital records. Hence the insurer had repudiated the claim for reasons of material medical non disclosure of SLE by deceased life

insured. The complainant had stated that LIC has settled the claim and she was an absolutely normal person when the policy was taken. He further said that the policy was taken mainly for tax saving and investment purpose.

Award no-IO(CHN)L-060/2010-11dt 28th March 2011.

The claim lodged by the complainant was rejected by the insurer on the ground that LA had not disclosed her existing illness of SLE which she was suffering since 2002.It is also reported that LA was suffering from DM since 2 years. As per claim form C-Attending physician's statement who has treated LA for terminal illness certifies the immediate cause of death as Bilateral Hemispherical Infarcts with coning. The deceased was reported to be under medical care for SLE since 2002on treatment.The above Doctor has also answered to a question stating that LA was having past ailment of DM for 2 years and SLE since 2002.The deceased LA has answered in relation Qn3 and 7 pertaining to being diagnosed or suffering from any ailment in the neagative. the complainant submitted that he got married with the LA in the year Aug 2006 and at that time his wife was healthy; She was employed in WIPRO as Soft ware Engineer for the past 5 years, she was found fit in the pre-recruitment Medical Examination. Only when she was admitted to the Apollo Hospital he came to know that she had SLE in 2002 and was under medication for 3 years. From the records submitted by the complainant in respect of earlier hospitalisation in 2002 LA was diagnosed for Sleuths fact LA has not disclosed while answering Qno5 in the proposal form and this amounts to suppression of material facts. The repudiation of the claim has been made after 3 years, 4 months and 20 days from the date of issue of policy and the LA died after 2 years 10 months and 13 days from the date of commencement of the policy. As per the provision of the Insurance Act the insurer has to establish the fraudulent intention on the part of the insured in taking the policy. As regards non disclosure it is clearly established and the complainant himself has provided the documents to establish the same. According to the complainant his wife was healthy and the policy was taken for tax saving only. Though she was diagnosed for SLE in 2002 she had proposed for the policy only after 4 years, that too for a limited pay Endowment plan under which she has to pay heavy premium. The circumstances of the case lead one to assume that it is a case of non disclosure of facts without any ulterior motive. The insurer also could not establish fraudulent intention on the part of the insured while suppressing the facts.

Considering all these facts and to ensure Equity in the case an exgratia amount of rs70,000/-is to be paid by the insurer to the insured as full and final settlement of the claim.

The complaint is partly allowed.

DEATH

Complaint no-21.07.2614.

Mrs.C.Santhakumari vs LIC Tveli

The complainant had stated that her husband Mr.R.Ponnayan had taken a policy for rs1lac from 28.10.1996.and he died in a road accident at Saudi Arabia on 8.10.2002.The insurer had settled only the basic sum insured plus bonus and she was claiming for accidental benefit also under the policy. She has submitted records given to her by Director of Riyadh traffic, Ministry of health, Ministry of accident report and Indian Embassy report clearly revealed that her husband died of accident. She said that in spite of submitting all records the insurer rejected the claim stating it is time barred and there is no concrete evidence to prove the cause of death due to accident.

Award no-IO(CHN)L-061/2010-11 dt30TH March 2011.

The complainant's husband Mr.R.Ponnayan had taken a policy from 28.10.1996 for rs 1 lac by submitting a copy of his passport showing his date of birth as 15.06.1964.His wife Mrs. .C.Santhakumari was the nominee. She had lodged a claim for the death of her husband due to accident on 08.10.2002 in Saudi Arabia and has submitted all relevant documents.LIC had settled the basic sum insured plus bonus under the policy on 08.01.2004 and did not settle the double accident benefit under the policy.LIC had repudiated the accident benefit claim vide letter dated 30.12.2008 quoting non submission of concrete evidences to prove the cause of death due to accident. The insured had submitted following documents and a closure look of these documents show the following;

Death certificate issued by General Director of Civil Affairs of Kingdom of Saudi Arabia – One Mr. Arul Raj Charles Nationality Indian DOB-19.09.1965 died on 8.10.2002 in a traffic accident.

Report of death from Medical dept, Riyadh Traffic-Undertaken medical checkup of the body of Mr. Arul Raj–cause being Traffic Accident and ultimately caused his death on 8.10.2002.

Letter dated 27.10.2002 issued by Embassy of India-Informed Mrs. Santhakumari about the death of her husband Charles Arulraj in a Traffic Accident on 8.10.2002.The y have also mentioned that her husband has embraced Islam before death and changed his name to Abdul Rahman.

Medical report issued by Supervisor of the dead bodies-Mr. Arul Raj died on 8.10.2002.

The complainant had also submitted copies of Passport;

(a)Passport no-341171-Name-Ramachandran Ponnaiyan

Place of birth-Parthivapuram

Date of birth-15.06.1964;Wife-Santha

(b)Passport no-E-0393315-Name:Charles Arul Raj

Place of birth:Arasumoodu

Date of Birth:19.09.1965.Wife;Gracy

A study of all the above clearly indicate that one Mr. Arulraj Charles having Passport no393315 died in a traffic Accident on 08.10.2002.These records do not say Mr. .R.Ponnayan died.

To establish the identity of the DLA Insurer has relied on two affidavits.

(i)Affidavit by the Mrs .Santhakumari w/o late R.Ponnaiyan@Arulraj stating that her husband first went abroad in the name of Ponnaiyan and second time went in the name of Arulraj S/o Charles and that both the names indicate the same person.

(ii)Affidavit by the President of Puthukkadai Selection Grade Town Panchayat stating that the deceased is locally known as Ponnaiyan had another name called Arulraj and in Riyadh to continue in employment embraced Islam and changed name to Abdur Rahman.

Based on the above affidavits the insurer has satisfied himself about the death of the LA and has settled the basic sum assured even though there are lot of discrepancies in both the passports. The insurer has satisfied himself on this count that the LA under the policy and the person deceased as per death certificate are one and the same person and has settled the claim for the basic sum assured under the policy.

The accident benefit claim which is an additional benefit under the policy was denied by the insurer on the ground of non submission of concrete evidence to prove cause of death due to accident. The complainant has submitted all documents as mentioned above which clearly established the cause of death as due to accident. But still Insurer has delayed considerably and denied the accident benefit claim stating that documents have not been submitted.

Taking all factors into account the insurer is not justified in rejecting the accident benefit and they are advised to settle the claim for Accident Benefit immediately.

The complaint is allowed.

DEATH

Complaint no-21.04.2617.

Mrs.A.Jayamary vs LIC Madurai

The complainant had stated that her husband had taken Jeevan Anand policy from LIC for a sum insured of rs1 lac from 13.03.2009 and he died on 08.06.2009 due to Kidney failure. The complainant had mentioned that he used to take tablet only for head ache and was not having any bad habits. She is not aware of his illness .The insurer denied the claim on account of the fact that the DLA was not maintaining good health and suffered from hypertension. As per discharge summary of the hospital, LA was a known case of HT for one and half year's duration on drug-uncontrolled fluctuating between 170/100-200/130 which is prior to the date of proposal. As he had held withheld correct information from the insurer regarding his health at the time of effecting the assurance the claim was repudiated.

Award no-IO(CHN)L-062/2010-11 dt 30th March 2011.

It has been observed from the Medical Attendant's certificate (claim form B) the cause of death was chronlc Kidney failure with hypertension with left hemiparesis. There is no mention as to since when the LA was suffering from this disease and there is no mention of illness which preceded /coexisted .The treating Dr in his letter dated 22.02.2010 addressed to the insurer mentioned that he had the history of Hypertension for the past 11/2 years, not on regular drugs and developed left sided weakness on 6.05.2009.He was diagnosed for Hypertension and chronic renal failure. He was discharged on 30.05.2009.In the case sheets also it was mentioned as a known case of HT-1 ½ years duration on drugs-uncontrolled. Earlier he was also admitted at Apollo hospital from 6.05.2009 to 14.05.2009.As per the discharge summary final diagnosis was Acute Ischemic Stroke…..Hypertension, Renal failure-now detected. The history of patient says patient had history of Hypertension-2 years.

During the hearing the complainant maintained that her husband did not take any treatment prior to May 2009 and he came to know about his kidney failure only after visiting Apollo Hospital. The insurer has argued that LA had given false answers to Q11 (a) to (e), h to j and suppression of material facts has been established. Whether LA was aware of his uncontrolled HT and its serious effect is a matter of debate. As contended by the complainant it is also likely that he may be consuming tablets for Head ache without knowing that he is suffering from hypertension .Considering all these facts the insurer is advised to pay an ex gratia amount of rs25,000/-to the complainant in full and final settlement of the claim.

The complaint is partly allowed on Exgratia basis.

DELHI

Case No.LI/284/ING Vysya/09

In the matter of Shri Mahavir Singh

Vs

ING Vysya Life Insurance Company Limited

AWARD dated 01.10.2010 – repudiation of death claim

1. This is a complaint filed by Shri Mahavir Singh (herein after referred to as the complainant) against the decision of the ING Vysya Life Insurance Company Limited (herein after referred to as respondent insurance company) repudiating the death claim.

2. The complainant submitted that his son late Shri Jitender Singh had taken a life insurance policy from ING Vysya Life Insurance Company Limited. The insurance policy was taken through agent on 11.01.2007. The premium was payable quarterly of Rs.2770/- and the sum assured was Rs.1,20,000/-. The agent was paid premium before the insured's death. Later on, while his son was going to village, his son met with a fatal accident and expired. He further informed that the company had reinstated the policy of his son on non-medical ground. Had his son paid premium on 28.08.2009, the policy would not have lapsed. The company's agent did not deposit the premium. He had only one son who died in the accident. Now there is no one to support him. He requested that the death claim be got settled.

3. Detailed written reply was submitted on behalf of the company which is placed on record. It has been submitted therein that due to non-receipt of renewal premium due on 11.07.2009, the policy went into lapsed state. The premium was not paid even after lapse of grace period. A sum of Rs.2815/- was received on 14.09.2009 towards revival of the lapsed policy. On receipt of renewal premium, the policy was revived on 29.09.2009. However on 08.10.2009, the company had received death intimation cum claim form dated 01.10.2009 from the complainant. The company found that the policy was revived after the death of the life assured. The company had repudiated the claim and has given reasons for repudiation. It was submitted that the premium was paid to the agent Shri Vijender Singh by the deceased life assured is only an afterthought and conception of the complainant. The complainant before lodging the complaint to this Forum had never approached the company. The company had informed the complainant that it was unable to honour the claim because the policy was lapsed at the time of death of the life assured. The complainant had paid premium on 14.10.2009 by concealing the fact the life assured had died on 01.09.2009. By making payment of premium after death showed that there was malafied intention on the part of the complainant. The company stated that the policy was revived fraudulently after the death of the life assured. The sum and substance of the argument of the insurance company is that the claim has been repudiated

due to the fact that the policy was lapsed before the death of the life assured and the same was fraudulently revived after the death of the life assured.

4. I have considered the submissions of the complainant very carefully and have also perused the written replies which are placed on record on behalf of the company. After due consideration of the matter, I hold that the company was justified in repudiating the claim because policy was lapsed before the death of the life assured. It is the duty of the life assured to make payment of premium. The plea of the complainant that amount was given to the agent before him for depositing the same with the insurer and the agent had not deposited the same is not acceptable because the amount given to the agent had not gone to the company's account before the death of the life assured. There was no point in depositing the same after the death of the life assured. The company was also not immediately informed about the death of the life assured. In fact, efforts were made to revive the policy even after the death of the life assured. The death claim is payable only after fulfillment of terms and conditions of the policy and when the policy is lapsed before the death of the life assured, the insurance company is not under obligation to fulfill its liability of making payment of sum assured. **Therefore, in my considered view, the insurer was justified in repudiating the claim under the fact and circumstances of the case. The same is not required to be interfered with. However, the insurer is directed to refund the premium amount received by it on 14.09.2009 after the death of the life assured. The complaint filed by the complainant is dismissed.**

5. Copies of the Award to both the parties.

Case No.LI/09/HDFC/10

In the matter of Smt. Komal Chandel

Vs

HDFC Standard Life Insurance Company Limited

AWARD dated 26.10.2010 - Repudiation of death claim

1. This is a complaint filed by Smt. Komal Chandel (herein after referred to as the complainant) against HDFC Standard Life Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of death claim.

2. The complainant submitted that she had saving bank account with HDFC Bank, New Delhi. She along with her husband Late Shri Sanjiv Chandel used to visit the branch for operations in the above mentioned bank. One fine morning, an official at the branch office called her and persuaded her husband to take HDFC Standard Life Insurance policy. She stated that her husband had already undergone brain operation (for brain tumor). She told the representative of the insurer that since her husband had already

under gone brain surgery, he could not take the insurance policy. But the official who approached (Mr. Anuj Nair) told them that despite this fact, policy can be taken. That is to say, that despite informing correctly about the brain operation, he was persuaded to take the policy. She further stated that though her husband late Shri Sanjiv Chandel wanted to fill up the proposal form himself but he was persuaded not to do the same as the same would be filled by the person who approached them for taking the policy. Accordingly, policy was issued to late Shri Sanjiv Chandel and a premium of Rs.25000/- was paid. The policy was taken without any medical checkup and verification.

In the meanwhile, her husband fell ill and was advised brain surgery again due to recurrence of brain tumor. He underwent the required surgery first in July, 2006 then in March, 2008 and last in December, 2008 and unfortunately expired on 12.04.2009. She had paid second and 3rd instalment of premium of Rs.25000/- respectively on due dates. In all a total sum of Rs.75000/- was paid by way of premiums. She stated that the scar on the forehead was visible for having operated for brain tumor but the same was ignored by the representative of the company while giving the policy. She stated that nothing was concealed by the deceased life assured while taking the policy. As a matter of fact, the deceased life assured was made to sign only the proposal form where he is required to put his signatures and remaining details were filled in by bank official. Therefore, deceased life assured was not aware as to how the entries were filled in the proposal form. The complainant further stated as under:

"You are requested to please very kindly intervene in the matter and order HDFC Bank not to make fool of people like us only for meeting their targets and to make good the payment for the cover amount under the insurance policy issued by them in Sept.'06 under reference."

The complainant also expressed her anger in the following words which are as under:
"Sir, under above mentioned circumstances, you are requested to take up the matter with HDFC bank, why they had cheated us? Why they had issued insurance policy? Why they continued accepting annual premium for the policy? If they had any objection to it, they should have asked my (late) husband for medical checkup from Bank's doctor/ any other doctor at the panel of the bank, to know about his health condition. Sir, there was no medical checkup done/no verification from family doctor for the said policy No.10714821 before/after issuance of insurance policy."

3. Written submissions were placed on record on behalf of the company. It had quoted Clause 19 of the policy documents which reads as under:

"19. Incorrect information and non-disclosure-

(i) Your policy is based on the application and declaration which you have made to us and other information provided by you/on your behalf. However, if any of the information provided is complete or incorrect, notwithstanding any other provisions under the policy, we reserve the right to vary the benefits, which may be payable and, further, if there has

been non-disclosure of a material fact then we may treat your policy as void from commencement."

It further stated that deceased life assured had submitted the proposal on 13.09.2006 for purchase of HDFC Unit Linked Young Star Plan. The proposal was accepted on the basis of information provided by the deceased life assured and policy was issued to him with risk commencement date 19.09.2006. A letter dated 03.05.2009 was received by the company on 05.05.2009 whereby the complainant informed the company about the death of the life assured on 12.04.2009. She further requested for settlement of the death claim relating to the policy on the deceased life assured. The company further stated that claim has been rightly repudiated for incorrect information and non-disclosure. Proviso 19 of the policy documents clearly stipulates that any material non-disclosure will result as void from commencement.

4. I have very carefully considered the submissions of the complainant and have also perused the written reply placed on record on behalf of the company. After due consideration of the matter, I hold that the company was justified in repudiating the claim because true facts relating to the health of the deceased life assured have not been disclosed. There has been material suppression regarding health of the life assured while filling the proposal form. Deceased life assured was not hale and hearty when policy was taken. As a matter of fact, he was operated for brain tumor before taking the policy but this fact was not disclosed in proposal while taking the policy. There is no reason with me not to accept the version of the complainant that while taking the policy, it was clearly conveyed that deceased life assured was operated for brain tumor and that the deceased life assured only signed the proposal form and had not filled other entries in the proposal form which were filled by the official of the bank who persuaded him to take the policy despite the adverse information about the health of the deceased life assured. However, facts remain that the deceased life assured was operated for brain tumor before taking policy and this fact was not disclosed in the proposal form. Once the proposal is signed, policy holder binds himself irrespective of the fact that the entries therein are filled in by some other person. Therefore, I cannot accept the version of the complainant that despite correct information about the health of the deceased life assured conveyed to the person who persuaded him to take the policy, the policy holder was not responsible for furnishing incorrect information. **The claim is not payable and the company was justified in repudiating the claim. No interference is required on this count. However, having due regard to the nature of the policy, the complainant is entitled to the fund value as on the date of death and having due regard to the fact that three premiums have been paid amounting to Rs.75000/- in all, the company is under obligation to make the payment of fund value as on the date of death of the policy holder. It is awarded accordingly.**

5. 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.

6. Copies of the Award to both the parties.

Case No.LI-DL-II/13/10
In the matter of Shri Manohar Singh
Vs
Life Insurance Corporation of India

AWARD dated 24.11.2010 - Repudiation of death claim

1. This is a complaint filed by Shri Manohar Singh (herein after referred to as the complainant) against the decision of LIC of India (herein after referred to as respondent Insurance Company) regarding repudiation of death claim of his late son Mr. Rohan Singh.

2. Complainant submitted that LIC of India was not justified in repudiating the death claim of his late son Shri Rohan Singh. The deceased life assured had not withheld any material information regarding his health, at the time of affecting the insurance policy. He submitted that the observation of Doctor that his son was a known case of IV drug abuser is baseless. He submitted that such observation had been deliberately added to mislead the attention from medical negligence. He submitted that no such word "A known IV Drug abuser is used in case summary issued on 17.05.2006 issued by Dr. Suman Banerjee of same hospital. It was the duty of LIC to conduct thorough medical examination through a competent doctor before commencing the policy. It has been requested by him to this forum that the said repudiation order in view of the representations made by him deserves to be set aside. During the course of hearing, the complainant stated that his son was not a known case of drug abuser. He died of appendices due to negligence of the operating doctor. He had cited number of decisions in support of his argument that the death claim was repudiated with wrong reasons. His son was an employee in a Hotel Industry. He was hale and hearty and due to pain in the abdomen he was admitted in the hospital whereat he was operated for the appendices and died. It is submitted by him that LIC had not proved the allegation it had leveled for while repudiating the claim that his son had suppressed material information regarding his health while submitting proposal for taking policy.

3. During the course of hearing the representative of the Insurance Company stated that the deceased life assured was known case of IV drug abuser and the doctor had stated this clearly. Therefore the claim was rightly repudiated by the LIC of India. He also referred to the proposal form submitted while taking the policy wherein the deceased life assured answered negatively to question no. 11 (a) to (i). It has been submitted that deceased life assured was known case of IV drug abuser for long time before he proposed for the policy. He did not disclose this fact in his proposal form though he had personal knowledge of the same. Instead he gave false answers therein. It has been stated that he had made incorrect statements and withheld correct information from LIC regarding his health at the time of affecting the assurance. It has been stated by the representative that since decease life assured had withheld material information regarding his health while taking the policy, the Insurance Company was justified in repudiating the claim. During the course of hearing the representative of the Insurance Company was specifically required to substantiate and provide evidence to the effect that the deceased life assured was using drug and taking treatment prior to taking policy. He was provided a week's time to produce such evidence because doctor's observation did not specify the duration of use

of drug by the deceased life assured. But the representative of the LIC of India did not furnish any evidence to this day. The Insurance Company had placed reliance only on the observation of the treating doctor who wrote that deceased life assured was a known case of IV drug abuser.

4. I have very carefully considered the submissions of the complainant and also carefully gone through the letter dated 29.04.20058 of the LIC of India and also considered the verbal submissions made by the representative of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the death claim because the allegation against the deceased life assured that he had with held material information regarding health at the time of submission of the proposal while taking policy is not provided by any supporting evidence. As a matter of fact no evidence whatsoever could be placed on record by the insurer that deceased life assured was suffering from any kind of disease what to speak of drug abuse prior to taking policy. It had not placed on record any evidence that he had taken any treatment, anywhere for any disease prior to the submission of the proposal for affecting the insurance policy. The death claim was repudiated merely on the basis of the discharge summary wherein doctor stated that deceased life assured was a known case of IV drug abuser without specifying the duration of abuse and placing on record any evidence in support of such observation and also to specify the duration of his being a case of IV drug abuser. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of death claim along with penal interest @ 8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No.LI-Kotak/73/10
In the matter of Shri Mandeep Singh
Vs
Kotak Mahindra Old Mutual Life Insurance Company Limited

AWARD dated 18.01.2011 - Non-payment of death claim

1. This is a complaint filed by Shri Mandeep Singh (herein after referred to as the complainant) against the decision of Kotak Mahindra Old Mutual Life Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for non-payment of death claim of her late father Shri Man Mohan Singh.

2. Complainant stated that his family met with a tragic road accident on 26.04.2009 near Deoli (NH-11), while coming back from Jaipur to Kota. The vehicle was totally damaged and his father Shri Man Mohan Singh, his mother Smt. Parminder Kaur and his elder Brother Shri Divjot Singh died on the spot. While the family was struggling to negotiate the turbulent period, his uncle Inder Mohan Singh visited the Kota office of the Insurance Company during middle of May 2009 to enquire about the procedure for settling the claim. It was informed by the Insurance Company that since policy is lapsed claim cannot be entertained. Account statement

was not given. Though the staff of the Insurance Company was not cooperative yet the claim was preferred vide letter dated 24.06.2009. The Insurance Company vide their letter dated 20.07.2009 repudiated the claim stating that the policy was in lapsed mode. At the same time it was pointed out by the company vide para 4 of their said letter dated 20.07.2009 quoting "Premium under the said policy were paid only till 28.09.2008, accordingly the half yearly premium, that fell due under the said policy after the said date was outstanding and remained unpaid till date". During the course of hearing it was submitted by the complainant that the Insurance Company repudiated the claim on the ground that policy was lapsed when the deceased life assured died, but the Insurance Company had accepted the premium on 06.11.2008.

The due date for making payment of premium was September and March. It is the submission of the complainant that since deposit was accepted on 06.11.2008 by the Insurance Company it goes to show that on the date of payment the policy was not lapsed that is to say premium was due for September 2008 was accounted for and since the next premium was due in the month of march 2009, there was a grace period admissible for making the payment of premium and the accident took place on 26.04.2009. the policy was not lapsed because the premium which was due in the month of March 2009 could have been paid up to 28.04.2009 and the life assured expired on 26.04.2009 and the Insurance Company is not justified in stating that since policy was lapsed on the death of the deceased life assured the claim is not payable. Normally payment of premium is not accepted if there is any outstanding premium, or there is any communication from the Insurance Company to the policy holder with regard to any outstanding payment of premium. As a matter of fact during the course of hearing the representative of the Insurance Company could not place on record any evidence of communication to the policy holder with regard to any deposit of payment or any other requirement.

3. Insurance Company had filed detailed written submissions which are placed on records wherein it has been stated that the policy was issued on 07.10.2006 in Kotal Capital Multiplier Plan with half yearly premium of Rs.6407/- for a term of 15 years. The date of commencement of policy is 28.09.2006 and the first renewal premium was due on 28.03.2007. it was further stated that the policy holder paid first premium on 12.04.2007 which was due on 28.03.2007 and subsequent half yearly payment due on 28.09.2007 and 28.03.2008 were paid by the policy holder on 06.11.2008, vide receipt dated 06.11.2008. It is pertinent to mention that renewal premium due on 28.09.2008 had not been paid by the policy holder despite sending the lapse notice dated 15.12.2008 by the Company. Since the policy holder did not make the payment for premium due on 28.09.2008, the policy turned into lapsed mode. The complainant informed the Insurance Company about the death of the insured on 26.04.2009, the claim was repudiated by the Insurance Company as the policy was not in force on the date of the death of the insured. It was in lapsed mode and there can be no valid claim under the policy contract and the same has been communicated to the complainant by the Insurance Company vide letter dated 20.07.2009.

4. I have considered the submissions of the complainant. I have also perused the detailed written submissions furnished by the Insurance Company. After due consideration of the matter I hold that the Insurance Company was not justified in stating that claim is not admissible as the policy was under the lapsed state on the date of the death of the deceased life assured because the Insurance Company had accepted the payment on 06.11.2008 without generating any requirement of outstanding payment on that date. The Insurance Company had accepted the

payment of 06.11.2008 as if there is no outstanding payment of any premium on that particular date due before 06.11.2008. While paying the premium on 06.11.2008 the policy holder was under bonafide belief that he had paid all premiums due and his policy is in force because no amount of premium can be accepted to allow the lapse policy to remain in the lapsed condition. Admittedly deceased life assured expired in accident on 26.04.2009 and there was still time for making payment of the premium which became due in the month of March 2009. Therefore, it could not be said that claim is not payable. Technically policy cannot be termed as lapsed on the date of death of the deceased life assured. Therefore, the claim is admissible and Award is passed, with a direction to the Insurance Company, to make the payment of the same to the nominee of the policy subject to deduction of any outstanding premium.

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

6. Copies of the Award to both the parties.

Case No.LI-Max/136/10
In the matter of Ms. Maya Devi
Vs
Max New York Life Insurance Company Limited

AWARD dated 18.01.2011 - Repudiation of Death Claim

1. This is a complaint filed by Ms. Maya Devi (herein after referred to as the complainant) against the decision of Max New York Life Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Death Claim.

2. Complainant stated that she is a wife of deceased Late Shri Raj Kr. Singh who had taken insurance policy on his life from the Insurance Company bearing no. 311021653. He had also taken another policy bearing no. 468158704. This policy was taken in the month of March 2008. Earlier policy was taken on 11.06.2007. The deceased life assured was admitted in the hospital on 20.03.2009 due to certain illness and expired on 21.03.2009 in this hospital. She had submitted the claim with requisite documents but death claim was repudiated by the Insurance Company stating therein that deceased life assured was suffering from disease and had given cheque for Rs.18651/- whereas claim was for Rs.387840/- (50000/- + Rs 337840/-),. She has dependent children to whom she had to bring up and she had requested that the claim be got settled at an early dated as she is poor and death claim would help her. It was stated during the course of hearing that the deceased life assured was doing the work of welding and something had entered in his eyes and for that he had to go to the Gurunanak Eye Hospital as OPD patient. Before any surgery to be undertaken, he was advised by the doctor to undergo certain tests. It was somewhere in 2004 that is much prior to taking the policy whether such test were conducted or not, what was the outcome is not on record. However, he was given some diet chart, whether he had taken diet according to chart is also not known. The complainant stated that these tests were conducted before eye surgery but he was not suffering from diabetes and he had never

taken any treatment for that disease. As regards treatment taken in Guru Teg Bahadur Hospital, Shahdara, he was an OPD patient for a day as he felt pain in left part of the abdomen.

The complainant that is the wife of the deceased life assured stated that her husband was not suffering from diabetes and he had never taken any treatment for such disease.

3. The Insurance Company repudiated the claim vide its letter dated 25.12.2009, it has been stated that the proposal was received in the Branch office on 07.03.2008 and the policies were issued on 30.04.2008 and on 16.06.2007 respectively. The deceased life assured Late Shri Raj Kr. Singh had given a declaration that he had made complete, true and accurate disclosure of all the facts and circumstances. He had answered the questions in negative. As per item No. 3 which goes as under:

Item 3- Are you now or have you ever been diagnosed with Diabetes- NO.

However as per medical treatment records dated 09.07.2004 issued by Loknayak Hospital, Shri Raj K. Singh was suffering from Diabetes prior to signing the proposal form. Therefore, the medical disclosure as he was required to make in the proposal form was not made correctly. Had he disclosed the correct facts about the medical treatment he would have not been issued the policy. The claim was repudiated on the ground of the reasons that material medical non-disclosure of Hypertension. The Insurance Company also filed detailed written submissions which are placed on record wherein it had stated that the Insurance Company had received the death claim information that deceased life assured passed away on 21.03.2009. In pursuance of the claim, investigation was conducted by the Insurance Company through an agency named Scrut Scan Consultants Pvt. Ltd. The investigation agency during its investigations discovered certain medical records pertaining to the deceased life assured issued by Loknayak Hospital as early as on 09.07.2004 and medical records from Guru Teg Bahadur Hospital, Shahdara dated 22.02.2002 disclosing the fact the deceased life assured was suffering from Diabetes prior to signing the proposal form. The same has been reported in the investigation report by the Insurance Company along with the relevant documents pertaining to medical history of the deceased life assured. Since the Deceased Life Assured had made material non-disclosure in the proposal form, the Insurance Company had repudiated the death claim under both the policies. Since deceased life assured had given false declaration in the proposal, the Deceased life assured was a known case of Diabetes for the past 5 years, the Insurance Company had refunded, the account value of the policies i.e. Rs.18,651.19/- vide cheque bearing no. 721205 drawn on Axis Bank against the policy no. 468158704. During the course of hearing the Insurance Company was required to produce the facts to the effect that deceased life assured was taking any treatment with regard to Diabetes prior to taking the policy. The Insurance Company did not produce any evidence that deceased life assured was being treated for diabetes prior the policy was taken.

4. I have very carefully considered the submissions of the complainant. I have also perused the detailed written submissions as placed on record on behalf of the Insurance Company, the death claim repudiation letter, and also investigation report, submitted by the Insurance Company, a part of its arguments that deceased life assured was suffering from Diabetes and had suppressed the material facts regarding his health. I have also considered the verbal arguments made in their respective support during the course of hearing. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the death claims because the Insurance Company had failed to provide any evidence that the deceased life assured was a diabetic patient

before taking the policy. It had not given any evidence, what so ever, to the effect that the deceased life assured was taking any Diabetic treatment at the time of taking the policy. As regards the submissions of the Insurance Company that deceased life assured was advised Diabetic Diet Chart and was instructed to undergo various tests before surgery at Guru Nanak Eye Centre, the same was advisory in nature and before undertaking any eye surgery, it might be the medical requirement to ensure that the patient was not a diabetic. He was an OPD patient there. Similarly deceased life assured was an Outdoor patient for a day in Guru Teg Bahadur Hospital also when he had felt pain in left abdomen. There are no medical evidence brought on record by the Company that the deceased life assured was suffering from Diabetes before taking the policy. Thus no conclusive evidence brought on record by the Insurance Company that the deceased life assured was Diabetic patient before taking the policy. Therefore in my considered view allegation of the Insurance Company that deceased life assured suppressed material facts relating to his health at the time of taking the policy was not correct, it remained unsubstantiated. I therefore held that Insurance Company was not justified in repudiating the death claims, I found the claims payable. I therefore, direct the Insurance Company to make the payment of death claims to the nominee as per rules at the earliest.

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

6. Copies of the Award to both the parties.

Case No.LI-JD/435/10
In the matter of Smt. Bhagwati
Vs
Life Insurance Corporation of India

AWARD dated 13.01.2011 - Repudiation of Death Claim

1. This is a complaint filed by Smt. Bhagwati (herein after referred to as the complainant) against the decision of LIC of India, D.O-Jodhpur (herein after referred to as respondent Insurance Company) for repudiation of Death Claim.

2. Complainant stated that death claim was wrongly repudiated by the Insurance Company. She stated that her husband who was insured and he did not conceal any information relating to his health while taking the policy. He was not suffering from any serious disease before 5 years of taking the policy. He did not get any treatment for any disease neither he was admitted in the hospital. He was quite hale and hearty before a week of his death. He was a Photographer. She stated that she is not satisfied with the investigation as done by the Insurance Company while repudiating the claim. She has a large family to support. She requested this forum to get the claim settled. It was stated further that the Insurance Company had wrongly relied on the date mentioned upon the prescription wrongly by Dr. Sanjay B. Modi as 10.09.2006 as a matter of fact the correct date on prescription given by the Dr. Sanjay B. Modi was 10.06.2009. the same doctor certified on 18.10.2010 which is placed on record that he had wrongly mentioned the date

as 10.09.2006 as against the correct date of 10.06.2009 but the Insurance Company had not changed its stand even despite the fact that doctor certified that he had seen him on 10.06.2009 and not on 10.09.2006.

3. Insurance Company repudiated the claim vide its letter dated 29.03.2010 and also informed the complainant, wherein it has been stated that the claim has been repudiated on account of suppression of material information. The deceased life assured had submitted the proposal dated 31.12.2008 wherein he answered question 11 (a), (b) & (e) in negative. The Insurance Company further found that deceased life assured was suffering from ARF illness for 2 years prior to taking the policy.

The deceased life assured had not disclosed facts correctly while taking the policy. The gist of the repudiation letter was that the death claim was not payable on account of material suppression relating to health while taking the policy. The representative of the Insurance Company stated that the claim was further reviewed by Zonal Claim Review Committee and it also agreed with the decision taken by the Insurance Company earlier for repudiation of the claim. The Insurance Company had gone by the prescription of Dr. Sanjay B. Modi dated 10.09.2006 in support of this it is observed that deceased life assured was suffering from disease for 2 years prior to date of taking the policy.

4. I have very carefully considered the submissions of the complainant. I have also perused the repudiation letter and also investigation report and considered verbal submissions of the representative of the Insurance Company made during the course of hearing. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because the Insurance Company could not produce any evidence on record that the deceased life assured was suffering from any disease for which he was taking treatment prior to 2 years of taking the policy. It appears that the Insurance Company had wrongly gone on the basis of wrongly mentioned date on prescription given by Dr. Sanjay B. Modi to the deceased life assured. It appears that the treating doctor had wrongly mentioned the date on prescription as 10.09.2006. The doctor had certified that he wrongly mentioned the date on the prescription as against the correct date of 10.06.2009. The subsequent treatments were also after the date of 10.06.2009. The deceased life assured had taken treatment regularly from 10.06.2009 till he died i.e. to say there is no evidence on record whatsoever to the effect that deceased life assured was taking treatment for any disease prior to taking the insurance policy. Accordingly, the Insurance Company was not justified in repudiating the claim by stating that deceased life assured had suppressed material information relating to health and that he was suffering from ARF prior to 2 years of taking this policy. In my considered view the claim is payable and accordingly Award is passed with the direction to the Insurance Company to make the payment of Death claim to the complainant.

5. 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.

6. Copies of the Award to both the parties.

Case No.LI/JD/126

In the matter of Smt. Sundari Devi Vidhani

Vs

Life Insurance Corporation of India

AWARD dated 03.01.2011 – Death claim

1. This is a complaint filed by Smt. Sundari Devi Vidhani (hereinafter referred to as the complainant) against the decision of Life Insurance Corporation of India (hereinafter referred to as respondent insurance company) for not deciding the issue in view of the order passed by Honourable District & Session Judge, Jodhpur dated 19.08.2003 with regard to death claims on the life of her husband.

2. The decision in this case referred above was given by my predecessor on 12.09.2000 wherein it has been inter-alia held, **"In view of all this, I pass the award upholding the repudiation action of LIC, Jodhpur under both the policies. The repudiation action is totally justified and sustainable in law. In view of the same, the case does not call for any ex-gratia payments by LIC of India under any of these policies. Copies to both the parties."**

This Award was challenged by Smt. Sundari Devi Vidhani wife of deceased life assured late Shri Nanak Ram Vidhani R/O, C-37, Umed Club Road, Rai Ka Bag, Jodhpur under section 34 of Arbitration and Reconciliation Act-1996, before District and Session Judge, Jodhpur (Rajasthan) in the Civil Case No.1-A/2001/Award wherein LIC, Jodhpur and Insurance Ombudsman, Delhi & Rajasthan were made respondents.

The Honourable District & Session Judge vide his Order dated 19.08.2003, had set aside award given by Insurance Ombudsman, Delhi & Rajasthan dated 12.09.2000 with the direction that a fresh decision be taken after reconsidering the contents of the affidavit filed by Dr.J.S.Ujawal and other relevant facts after giving proper hearing to the parties to the dispute and pass order accordingly.

3. In view of the decision of Honourable District & Session Judge dated 19.08.2003 in this case, the case was heard at Jodhpur on 24.12.2010 whereat the complainant was represented by her son Shri Pradeep Vidhani and LIC of India was represented by Shri G.N.Nawal, Manager(Claims). It was stated that the matter was pending for quite some time. The family of the deceased life assured is facing difficulties and decision is to be taken at an early date. I have also perused the complaint filed by Smt. Sundari Devi Vidhani wife of deceased life assured which was received in my office on 30.08.2010

wherein it has been stated that LIC of India had not so far paid the death claims in respect of policies No.182158496 and 182349782 taken by her late husband on his life. She stated that the District Court, Jodhpur had rendered the decision in this case in 2003 and a copy of such decision was made available to this office but despite the fact that considerable time had elapsed since passing judgement in this case by District and Session Judge, Jodhpur, LIC of India had not settled the claim nor it had given any other reaction though the number of letters were written to LIC of India in this regard to expedite disposal of death claims. She had stated and requested that LIC of India be instructed to settle the claim and pay the claim at an early date. Though as per records of this office, this case was fixed for hearing on 15.12.2003. It was brought to my notice that the matter is still pending and decision is to be taken as per the judgement of Honourable District and Session Judge.

4. It was pleaded on behalf of LIC of India that since its decision was upheld by the Insurance Ombudsman by passing award dated 12.09.2000 and no decision was taken by Insurance Ombudsman, Delhi & Rajasthan in view of the judgement of Honourable District and Session Judge, Jodhpur dated 19.08.2003, LIC of India could not have decided this issue.

5. I have very carefully perused the decision of the Honourable District and Session Judge, Jodhpur. I have also perused the decision dated 12.09.2000 of my predecessor and also perused the entire records relating to this case. After careful consideration, I consider it appropriate to respectfully disagree with the decision taken by my predecessor while giving Award in this case on 12.09.2000, firstly because there appears no justification to intervene with the decision of LIC of India to grant ex-gratia payments to the complainant in respect of both the policies because that was not the point at issue before the Insurance Ombudsman so far as LIC of India was concerned.

6. In the facts and circumstances of the case, LIC of India instead of paying full death claims considered it appropriate to pay ex-gratia payments of Rs.37500/- in respect of both the policies separately. Secondly, I find that there was no corroborative evidence on record to establish that the deceased life assured was suffering from Diabetes Mallitus-II for the last 7-8 years before the date of death and taking treatment for such disease. Thirdly because the contents of the affidavit submitted by Dr.J.S.Ujawal were accepted as gospel truth without requiring substantiating the contents and without providing reasonable opportunity to the party against which decision was taken on the basis of affidavit. The equity and justice demanded that such opportunity should have been given to the complainant also, at the same time; it was desirable to direct the party which submitted affidavit to substantiate the stand taken therein.

7. I have perused the investigation report as got conducted by LIC of India before repudiating the claim by two different officers and I find nothing adverse against the deceased life assured for justifying the repudiation of death claims. The cutting on bed head ticket appears to be genuine without any malafied intention because the medical

attendant's certificate submitted by Dr.Kothari as well as the hospital treatment certificate received from the same hospital mentions the duration of illness as 5 to 6 days only and not 7 to 8 years. It appears that the observations of Dr.Dinesh Kothari that he is a family doctor of the deceased life assured for the last 8 to 10 years was taken if he was treating the deceased life assured for such period for the same disease. Moreover no independent evidence was brought on record by LIC of India that the deceased life assured was being treated for the disease known as diabetes mellitus-II for 7 to 8 years before the deceased life assured expired. No evidence has been brought on record that the deceased life assured had suppressed any material information relating to his health. Accordingly, in my considered view, the decision taken by LIC of India while repudiating the claims was not in order and that needs to be revoked.

8. Accordingly, Award is passed with the direction to LIC of India to make payment in respect of death claims under both the policies subject to realization of any loan including interest still outstanding and pending premiums if any under the policy as on the date of death. It is further directed that LIC of India to make payment of penal interest also @ 8% from the date of repudiation, that is, from 29.12.1999 to the date of actual payment.

9. 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.

10. Copies of the Award to both the parties.

Case No.LI/191/Bajaj/10

In the matter of Smt. Sangita Roopchandani

Vs

Bajaj Allianz Life Insurance Company Limited

AWARD dated 12.01.2011 - Repudiation of death claim

1. This is a complaint filed by Smt. Sangita Roopchandani (hereinafter referred to as the complainant) against the Bajaj Allianz Life Insurance Company Limited (hereinafter referred to as respondent insurance company) in respect of repudiation of death claim.

2. The complainant stated that the claim was filed under policy No.33814275 on the death of late Shri Ramesh Chandra Roopchandani but the claim was rejected by Claims Review Committee vide its letter dated 09.03.2009. Several attempts were made to get the claim settled but the claim was not paid. He requested this forum to consider and instruct the company to make the payment of death claim. It has been submitted further that late Shri Ramesh Chandra Roopchandani had taken a policy No.33814275 on 28.12.2006 under Bajaj Allianz Capital Unit Gain. The policy became effective from 28.12.2006 and the

deceased life assured was insured for Rs.2.50 lakhs. The premium was Rs.50000/- annually and the same was paid for two years. It has been submitted by her that her husband did not conceal any fact to the company. Her husband was also insured by LIC of India from where a sum of Rs.3,90,400/-was received as claim but present insurer had repudiated the claim.

3. The insurance company vide letter dated 26.09.2008 had repudiated the claim and stated that it had covered the risk for the said policy on the basis of the facts mentioned in the proposal form. However, on receipt of the death intimation on the above said policy, investigations were done and medical records received which confirmed that the patient had a history of Diabetic Mellitus and Hypertension since 5 years. Such facts were only known to deceased life assured and were not disclosed in the proposal form dated 20.12.2006. The company got the claim reviewed and the Claims Review Committee also declined to intervene in the decision of the company to repudiate the claim.

4. I have considered the submissions of the complainant and have also perused the written submissions as placed on record on behalf of the company. I have also perused the repudiation letter and the decision of the claims review committee and have also considered the verbal arguments as made by the representative of the company during the date of hearing. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because death claim is payable. The company had not brought on record any evidence to the effect that the deceased life assured was suffering from Diabetic Mellitus and hypertension before taking the policy. Too much reliance was placed on the discharge summary of the hospital. The insurance company had not brought on record any reliable evidence whatsoever to the effect that the deceased life assured was being treated for such diseases before taking the policy. The policy has run almost for two years. Two premiums @ Rs.50000/- were received by the company. In my considered view, death claim is payable. Since the company had not placed any reliable evidence to the effect that deceased life assured was suffering from Diabetic Mellitus and hypertension before taking the policy, death claim is payable. **Accordingly, Award is passed with the direction to the insurance company to make the payment of death claim to the nominee under the policy.**

5. 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.

6. Copies of the Award to both the parties.

Case No.LI/22/Metlife/10

In the matter of Shri Sunny Sadh

Vs

Met Life India Insurance Company Limited

AWARD dated 14.01.2011 - Repudiation of death claim

1. This is a complaint filed by Shri Sunny Sadh (herein after referred to as the complainant) against the decision of Met Life India Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of death claim.

2. The complainant stated that his mother bought policy bearing No.00578174 from Met Life Insurance Company Limited with a sum assured of Rs.1.50 lakh. Two premiums of Rs.30000/- each were paid by her on time. She expired on 15.08.2009. The claim was filed with the company and the same was repudiated by the company. It is submitted by him that it is breach of faith by insurance company. The decision of the company declining the claim is totally unfair and questionable. He requested this forum to intervene in the matter.

3. The company vide its letter dated 25.11.2009 to the complainant stated that the request to reconsider the decision to repudiate the claim was received by the company. It further informed that the appeal was reviewed by the competent authority which independently examined all the facts and circumstances of the case and documents on record. It was observed that Mrs.Roopkala Sadh was suffering from Hypertension since 8 to 10 years as per medical records received from Max Super Specialist Hospital which was prior to taking the insurance policy. However, this material fact was not disclosed by Mrs. Roopkala Sadh in her application for the above said policy. After due consideration, the competent authority had decided to uphold the decision to repudiate the claim in the matter. During the course of hearing, it was stated by the complainant that she was hale and hearty but the representative of the company stated that she was suffering from Hypertension for the last 8 to 10 years prior to taking the policy.

4. I have considered the submissions of the complainant and also perused the submissions as placed on record on behalf of the company. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim because the company had not brought on record any evidence to the effect that the deceased life assured was under treatment of any kind of disease prior to taking the policy. Merely because the doctor casually remarked in the case history, the otherwise payable claim cannot be declined. It has been brought to my notice that under similar circumstances, LIC of India had paid the death claim whereas the Met Life India Insurance Company Limited had repudiated the claim. In my considered view, claim is payable. **Accordingly Award is passed with the direction to the insurance company to make payment of death claim relating to policy No. 00578174.**

5. 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.

6. Copies of the Award to both the parties.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/001/059/L/10-11/GHY

Mr. Shyamal Rajbongshi

- Vs -

L.I.C. of India, Pathsala B.O. under Bongaigaon Division

Date of Order : 19.10.2010

Mrs. Rajo Bala Roy procured the policy bearing No. 488568933 from the L.I.C. of India, Pathsala Branch under Bongaigaon Division covering the risk with effect from 15.03.2005 for a Sum Assured of Rs.50,000/-. The Insured died on 27.12.2007 while the policy was in force. The claim lodged by the Complainant, being the nominee under the policy, was repudiated by the Insurer and it is alleged that such repudiation action was improper and justified. Feeling aggrieved, this complaint was lodged.

The Insurer has contended in their repudiation letter that the Deceased Life Assured had concealed her sufferings from Hypertension in her declaration made at the time of revival of the policy. Due to such non-disclosure of actual health condition, the claim was repudiated.

The copy of the repudiation letter however shows that the above policy was allowed to be lapsed by non-payment of premiums but on 24.12.2007, the policy was revived on the strength of a personal statement regarding health made by the Deceased Life Assured on 22.12.2007 wherein she had suppressed about her sufferings from various ailments. The Insurer has referred to question No. 2 (a) (ii) to (iv) wherein false declaration was made as regards sufferings from diseases. The repudiation letter shows that the Insurer has alleged about suffering from Hypertension by the Insured for last two months prior to submission of the said declaration on 22.12.2007 and it was stated that the Insured was under treatment of Dr. A. Ramchiary at Barbari MPHC as OPD patient from 28.10.2007. During hearing, the Complainant has also stated that his mother died due the High Blood Pressure on 27.12.2007 in his house when Dr. A. Ramchiary treated her. Such suffering from Hypertension was there prior to few months before her death as admitted by the Complainant. The representative of the Insurer has stated that the Insured was under treatment of Dr. A. Ramchiary in the Barbari MPHC on and from 28.10.2007 for Hypertension, Chest pain etc. and in proof of that he has produced a copy of the prescription. The representative has also produced a copy of the certificate issued in form No. 3784 (Revised) Claim Form 'B' submitted by the Complainant along with his claim which was procured from Dr. A. Ramchiary, who was the attending physician of the Deceased even at the time of her death. The Claim form 'B' clearly shows that (from the answer furnished against question No. 4 (c)) the Deceased was under his treatment prior to two months of her death. She died due to Hypertension and she was treated for that prior to two months of her death. The another certificate which was also issued by Dr. A. Ramchiary wherein it was clearly stated that the Insured Rajo Bala Roy was under his treatment since 28.10.2007. All the above proves that Rajo Bala Roy was suffering from Hypertension and was treated for that by Dr. A. Ramchiary prior to submission of the declaration in the Revival Form. Treating the Insured Rajo Bala Roy by Dr. A. Ramchiary for Hypertension (High Blood Pressure) prior to few months of her death has also not been disputed by the Complainant. The declaration made in Revival Form however proves that she did not disclose about such sufferings rather made false answers while replying to question No. 2 (a) (ii) particularly relating to her sufferings from High Blood Pressure, while praying for revival of the policy. All these were done with intention and thereby failed to maintained "Utmost Good Faith". Thus, repudiation of the claim, due to such suppression of fact, cannot be said to be improper and irregular and hence I find no material to proceed ahead and interfere with the decision of the Insurer. The complaint is accordingly treated as closed finding no scope to interfere with the decision of the Insurer.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/004/067/L/10-11/GHY

Mrs. Shobha Shah

- Vs -

ICICI Prudential Life Insurance Co. Ltd.

Policy No. 08202692

Award dated : 19.10.2010

Mr. Shriram Prasad Shah, husband of the Complainant, was the insured under the above "Life Stage RP Insurance Policy" procured from the above Insurer for a Sum Assured of Rs.1,25,000/- with the date of commencement on 15.03.2008. While the policy was in force, the Insured died on 01.08.2009. The claim lodged by the Complainant, being the nominee under the policy, has however been repudiated by the Insurer. It is alleged that the Insurer has repudiated the claim without any justified ground and feeling aggrieved, this complaint was lodged.

The Insurer has contended in their note that the Life Assured was suffering from Hypertension, Ischemic Heart Disease, Effort Angina and underwent Electrocardiogram which revealed Ventricular troubles who was being treated for such diseases since February, 2008. It is also stated that the medical records of Tata Tea Limited (Referral Hospital & Research Centre) Chabua wherein he was treated proves that the L/A was a known case of Hypertension, Ischemic Heart Disease, Effort Angina since February, 2008. It is alleged that all such sufferings were suppressed by the L/A in the proposal form and by furnishing false information, the policy was procured. The Insurer has accordingly repudiated the claim due to suppression of material facts about the actual health condition of the L/A.

The Medical Attendant's / Hospital Certificate (Format AI – Death Claim) furnished in connection with the death claim before the Insurer shows that the L/A was a known case of HTN, IHB and he was suffering from such diseases since 01.02.2008 and treated in the R.H.R.C., Chabua and died due to the above diseases on 01.08.2009. The statement of the Doctor of Referral Hospiral and Research Centre, Chabua made in answer to question No. 3 of the said from also proves that since 01.02.2008, the L/A was treated in the Hospital for his sufferings from Hypertension and IHD. During hearing, the Complainant has stated that her husband died due to heart attack within an hour from such attack and prior to that he was not treated for any ailments excepting influenza. The representative of the Insurer has however produced a copy of the prescription issued by the Tata Tea Limited (Referral Hospital and Research Centre) Chabua which proves that the Insured Sriram Prasad Shah was treated in the said Hospital for ailments like Hypertension, angina and he was advised to have ECG and other laboratory tests. His blood pressure was recorded to be 170/100 on 01.02.2008 which clearly supports and corroborates the contention of the Doctor, who issued the certificate. The above two documents clearly establishes the fact that the Insured was suffering from Hypertension and Heart ailments since 01.02.2008. According to the representative, the Insured did not disclose about his sufferings from the said diseases in his proposal form which was submitted before the Insurer on 10.03.2008. It is seen from the answer furnished against health questions mentioned in column No. 23 wherein the Insured had answered all the queries in the negative. Particularly, while

answering to question No. 23 (h) (ii) when he was asked to answer about sufferings from blood pressure, the Insured answered in the negative which appears to be material as he was under treatment for HTN at that time. Although the Insured was treated for his sufferings from Hypertension on 01.02.2008 but such fact was suppressed and furnished false information while answering to query relating to his health in question No. 23 of Proposal form. This appears to be nothing but a clear and intentional suppression of material fact as regards his health condition. The contract of insurance is based on "Utmost Good Faith" and in the instant case, the Insured appears to have failed to maintain "Good Faith" and furnished false information suppressing material facts in order to have illegal gains under the policy. The claim was repudiated for such suppression of material facts and the decision of the Insurer was communicated to the Complainant vide letter dated 22.12.2009 and I find no irregularity in the settlement process.

In view of the above facts and circumstances, I find no ground to interfere with the decision of the Insurer and hence the complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/002/087/L/10-11/GHY

Mrs. Dipali Borgohain

\- Vs -

SBI Life Insurance Co. Ltd.

Date of Order : 12.03.2011

This complaint is filed against the above Insurance Company for total repudiation of the claim under policy no. 86000056808 and the same has been admitted under Rules 12 (1) (b) of the R.P.G. Rules, 1998.

The complainant has stated that her husband / Deceased Life Assured was in sound health at the time of taking the policy, hence the death claim should be paid in full.

The Insurer has furnished medical records dtd.16.05.2008. The radiology report dtd.16.05.2008 and other reports from Guwahati Medical College and Hospital, all dated May, 2008 to prove that the policyholder concealed the medical history in the proposal form and thus doctrine of utmost good faith was breached.

During hearing, the Complainant explained the grounds of complaint and stated that her husband was in perfect health and did not suffer from any disease as alleged by the insurer. Her claim is totally genuine and it has been repudiated arbitrarily and in an unjustified manner by the Insurer.

The representative of the insurance company has stated that the LA had applied for the policy under Swadhan Group Insurance Scheme for a sum assured of Rs.3.00 lakhs, after completion of formalities including as declaration of good health showing that he fulfilled all the eligibility criteria. The declaration given by him confirmed that he was in sound heath and did not suffer from any illness like diabetes, hypertension, etc., prior to the date of the policy and during the last three years he had not been hospitalized for any ailment. The policy is therefore issued with DOC as 01.06.2008. The DLA died on 06/10/2008. The duration of the policy was just four months and since it was an early claim necessary investigations were made by the insurer to verify the genuineness of the claim. Their investigations have revealed that the DLA was suffering from Acute Chronic Pancreatitis, Hepatosplenomegaly with bilateral effusion and Diabetes Mellitus prior to the date of commencement of the policy. In support of their contentions, the insurer has filed copies of his medical reports from OPD of Janata Bhawan, Dispur dtd.16.05.2008, an ultrasonography report of Guwahati Medical College dtd.16.05.2008 which revealed that he was suffering from chronic pancreatitis and hepatosplenomegaly. Further, copy of the discharge summary of Guwahati Medical College is filed showing that on 16/05/2008 the DLA was admitted in the Medical College Hospital and discharged on 29/05/208 and he was diagnosed for acute chronic pancreatitis. His random glucose level was 359 on 19/05/2008 which clearly shows very high level of blood sugar. Insurer has further stated that DLA was on leave from 16.05.2008 to 30.06.2008 as per Employer's Certificate. Since all these records pertain to the period prior to the commencement of the policy, clearly establishes that he had suppressed material fact in the proposal form, as a result of which, the policy has become null and void and nothing is payable to the complainant.

We have heard the submission of both the parties and carefully perused the document and other evidences filed before this forum. There is no dispute about the fact that the DLA was suffering from acute pancreatitis and high blood sugar prior to the date of policy. It is also not disputed that he did not disclose any of these ailments in the declaration of good health given along with the proposal form. As per the claimant's statement and the death certificate issued by the Guwahati Medical College and Hospital it is clear that the DLA died due to acute chronic pancreatitis, hepatosplenomegaly with bilateral effusion and diabetes mellitus. The complainant also did not counter the allegation of the insurer during the course of hearing. She did not give any additional argument in her defense. We, are therefore, of the opinion that insurer has produced irrefutable and convincing documentary evidence to prove that DLA was suffering from complicated ailment resulting from diabetes and pancreatitis and he was under obligation to disclose the same in the proposal form. It is well settled law that the contract of insurance is based on the principles of utmost good faith and any violation of the principle may disentitle the claim of the LA. The LA is under solemn obligation to make true and fair disclosure of material facts, failing which the policy terms are vitiated and it becomes null and void. In this case suppression of material facts has been established by the insurer. Therefore, the decision of the insurer is correct and valid and the same is upheld. The petition is dismissed without any relief to the complainant.

HYDERABAD

COMPLAINT No. L-21-001-536-2010-11

Smt. Pushpa Sanghvi

Vs

LIC Of India, **622478812 S**himoga Division

AWARD NO.I.O.(HYD)L-046/2010-11

Sri S. Viswanadham, who was working as Asst. Lineman in AP Transco, had taken seven policies in all. The first policy was taken in 1985 for a sum of Rs.10,000 and subsequently from the year 2000 onwards six policies were taken. He died on 26.1.06 due to cardio respiratory arrest. The Insurer admitted death claim in full under the four policies as they were non-early claims. In respect of the last 3 policies, 50 % of the basic SA was paid as recommended by the Zonal Claims Committee.

The complainant submitted that the insurer rejected her appeal for payment of full claim stating that her late husband had made incorrect statements in the proposal. The premiums were paid for 3 years under two policies and for 14 months under one policy. She contended that after two years of policy commencement, repudiation of claim was not valid. She further submitted that she had to look after 3 minor daughters and that her husband had taken the policies for their daughters' marriages.

The insurer submitted that the death claim was repudiated under three policies on grounds of non-disclosure of material facts relating to the habits of the insured at the time of taking the policies. The insurer possessed indisputable evidence to show that the DLA was addicted to alcohol. They further submitted that the claims under 4 other policies were settled in full as they had completed more than 3 years. The insurer further stated that the DLA was admitted in Yasodha Hospital on 13.1.06 with complaints of generalised weakness and tremors of whole body with swelling of abdomen and legs. He died on 26.1.2006 while undergoing treatment in the hospital. The cause of death was cardio- respiratory arrest due to CRF, chronic liver disease, cerebella degeneration and hypertension. As per the hospital records, the DLA was an alcoholic with frequent falls for 20 years. The insurer stated that it was established beyond doubt that the DLA suppressed material information relating to personal habits and the personal habits had close nexus with the cause of death, i.e. cirrhosis of liver and CRF. The insurer also stated that while applying for policy No. 682019586, the DLA deliberately omitted to mention the policies obtained in January and July 2003, i.e. policies bearing Nos. 682018769 & 682018376 for Rs. 2.50 lakhs in order to avoid special reports. The insurer submitted that had the DLA disclosed all the facts relating to his habits and the policies that he had, they would have called for further information/reports and the decision to accept the proposals would

have been on different terms. The insurer also stated that for Policy No. 682018769 & 682018376 there were gaps in the premium for March and April 2004 as the DLA was absconding from duties and his absence was treated as *dies non* by the employer. Therefore, the claim under these policies had to be on *ex gratia* basis only. The insurer submitted that when the complainant appealed for reconsideration, the Zonal Claims Review Committee recommended for payment of 50% of the basic SA under all the three policies as ex gratia in full and final settlement which was accepted by her. The insurer, therefore, stated that the complaint was baseless and requested dismissal of the same.

Pursuant to the notice issued by this office, both the parties attended hearing on 13.9.2010.

The grounds for repudiation of death claim under three policies were that:

a) the DLA had suppressed material information relating to his habits.
b) particulars of two policies obtained in 2003 were not mentioned in the proposal dated 31.08.04 submitted for policy No. 682019586.
c)

The DLA had replied in the negative to question relating to habits in all the proposals as under :

Q. No.	Personal History	Answer given
11 (h)	Do you use or have ever used (i) alcohol drinks (ii) narcotics (iii) or any other drugs (iv) tobacco in any form ?	NO

As per the records of Yashoda Hospital where the DLA was treated for terminal Illness, he was a chronic alcoholic since 20 years and was in the habit of taking zarda. This shows that the DLA suppressed material facts about his habits. Had he disclosed his drinking habit, the consideration of the proposals would have been on different terms. The DLA omitted to mention two policy nos. obtained in 2003 in the proposal dated 31.8.04. Had the DLA disclosed all the previous policy particulars, the insurer would have called for special reports as required. The insurer was, therefore, denied the opportunity to correctly assess the risk.

In respect of Policy No. 682018376 & 682018769 premiums for 3/04 & 4/04 were not deducted as per the employer certificate since the employee's absence was treated as *dies non*. Since the policies were in lapsed condition, any claim had to be considered on ex gratia basis only.

The evidence produced by the insurer clearly established the fact that the DLA suppressed material facts relating to his habits and particulars of the policies obtained in 2003. There is enough evidence to demonstrate that his death was hastened by his personal habits.

In view of the above, the insurer was justified in repudiation of the claims. However, the complainant's appeal for reconsideration to ZO, CRC was considered by the committee and recommended for payment of 50% of SA as ex-gratia. The insurers have obtained an "ex-gratia discharge form" which states as under:

"Received from LIFE INSURANCE CORPORATION OF INDIA a sum of Rs…….. (Rupees) as an Exgratia payment made to me, without admitting any liability by the said Corporation, in full and final settlement, satisfaction and discharge of all my rights and claims of any kind whatsoever against the said Corporation in respect of Policy No. …….. Dated …… on the life of Sri/Smt. …….. (deceased)".

The offer by the insurer for payment of the claims on ex gratia payment, without admitting any liability by them, in full and final settlement has been accepted by the complainant. The contract, therefore, stood discharged by preference. The complainant has not stated that her consent was obtained by fraud/coercion/undue influence.

In view of the foregoing, it was held that the complainant cannot make any further claim from the insurer after accepting the ex gratia claim in full and final settlement of all the claims by executing the discharge voucher willingly and voluntarily without any protest or objection. Even on merits, the complaint cannot succeed.

In the result, the complaint is dismissed.

COMPLAINT No. L-21-011-0498-2010-11

Smt. V. Sridevi, 00733350

Vs

ING Vysya Life Ins. Co. Ltd.,

AWARD NO. I.O. (HYD) L-055/2010-11

Shri V. Srinivas Reddy was covered under Policy No. 00733350 issued by ING Vysya Life Insurance Company for Sum Assured of Rs. 2,55,000/- from 28.6.2007. The policy lapsed due to non-payment of renewal premium which was due on 28.6.08. The life assured had applied for renewal of the policy vide application dated 19.11.08. The policy holder expired on 14.6.2009. When the nominee under the policy claimed the policy money, the insurer stated that the policy did not acquire any paid up value as on the date of death of the life assured and paid only the fund value and the deposit paid for revival along with interest on the same to the nominee.

The complainant stated that in spite of paying the requisite amount while submitting revival application dated 19.11.2008, the policy was not revived by the insurer.

The Insurer stated that for want of necessary requirements from the deceased life assured, the policy could not be revived during the life time of the life assured.

In response to the notice of hearing issued, both the parties attended on 28.10.2010.

O R D E R

It is noticed that the Life assured had paid an amount of Rs. 15,130/- along with application dated 19.11.2008 for revival, which was received by the insurer on 25.11.2008. In view of the discrepancy observed in the signature of the life assured, the insurer vide letter dated 27.11.2008 called for a fresh application for revival, along with his specimen signatures in the prescribed format. The application for revival along with specimen signatures of life assured was received by the insurer on 20.2.2009. The insurer vide letter dated 27.2.2009 advised the life assured to undergo medical examination and submit medical examiner's report which was a pre-requisite for considering revival under the policy. The life assured died on 14.6.2009. Since he failed to submit the medical requirements during his life time, the policy could not be revived. As a result, the policy remained in lapsed state. The insurer was, therefore, not liable to admit the claim under the policy.

The information on record shows that there was no omission on the part of the insurer and it was only for want of requirements from the life assured that the revival was kept pending at their end.

It is stipulated in the policy conditions that if payment of regular premium is discontinued before completion of three years from the policy commencement date, the insurance cover shall cease with immediate effect.

As on the date of death of the life assured, the policy was in lapsed status and it had not acquired any paid-up value. The insurer paid the fund value of Rs.7,024/- as also the amount paid by the Life assured towards revival together with interest, i.e. Rs.15,130/- to the complainant. These payments made by the insurer to the complainant are in accordance with the terms and conditions of the policy.

In view of the above, It was held that the insurer rightly repudiated the claim under the policy.

In the result, the complaint is dismissed without any relief.

COMPLAINT No. L-21-007-0557-2010-11

Shri. Peddiraju Kondeti

Vs

Max New York Life Insurance Co

AWARD NO. I.O. (HYD) L-064/2010-11

Shri. Thathaiah Kondeti was covered under two policies bearing numbers 706222732 & 387178676 issued by Max New York Life Insurance company for total sum of Rs. 3 Lacs. He effected nomination in favour of his brother's son Shri. Peddiraju Kondeti, under the policies. The life assured died after six and half months from the date of commencement of the policies. Cause of death of the life assured was heart attack. Claim under the two policies was repudiated by the insurer on the ground of misrepresentation of age of the life assured in the relevant proposals. However, in respect of Policy No. 706222734 unit value of Rs. 19394.39 was refunded to the complainant.

The complainant stated that cause of death of the life assured was heart attack. He contended that without any valid reason claim under the two policies was repudiated by the insurer.

The insurer contended that claim under the two policies was rejected as it was revealed during their claim investigation that the life assured understated his age in the relevant proposals.

Pursuant to the notice issued by this office, both the parties attended hearing on 8.12.2010

ORDER

It was observed that age of the life assured was admitted on the basis of Voter's Card as 63 years with Date of Birth as 30.10.1946. The insurer repudiated the claim under the two policies on the basis of ration card of the deceased life assured, which revealed that he was found to be over 72 years as on the date of commencement of the policies. At the proposal stage, age was admitted on the basis of non-standard age proof and the insurer

relied on ration card, which is non-standard age proof, for repudiation of claim under the policies. The proposal listed the following documents in support of date of birth :

Passport, Voter ID Card, Driving Licence, Municipality Birth Certificate

School/ College certificate, Others

The life assured tick marked Voter ID card in support of his date of birth. He must have had other evidences also which the insurer traced out after receipt of the claims but he submitted proof which was specifically listed in the proposal. He was illiterate and so the complainant stated that he could not be aware that his date of birth was recorded differently in different documents and that, even if was aware, he could not be accused of falsehood in stating his age because he gave a document listed in the proposal in support of declaration of age.

It is noticed that the insurer obtained the following non-standard age proofs of the deceased life assured which are at variance as stated below :

Age Proof	**Age on DOC of policies**
Rajiv Arogya Sree Health Ins.Card	72 Years

Ration Card	73 Years
Pension Book	83 Years
Landless Agricultural labourers Pension Certificate	67 Years

The various age proofs of the deceased life assured obtained by the insurer are non-standard age proofs. It is evident that life assured derived benefit under various Government Schemes claiming himself to be older than the age as per Voter ID card. Therefore, it is difficult to believe that he did not know that his age was recorded differently in different records. Yet, he cannot be accused of falsehood because he tick marked a listed proof of age. The fact that he passed away soon after taking the policies, however, is suggestive of understating his age in the Voter's ID, which was accepted while taking the policies.

It is also noted that the DLA was a landless agricultural labourer whereas in the proposals he had stated that he was an agriculturist with annual income of Rs.80,000. That he drew pension as agricultural labourer supports the insurer's claim that the DLA made false declarations in the proposal in regard to his occupation as also income.

The foregoing shows that the deceased life assured gave Voter ID card in support of age proof while the insurer relied upon many other records to say that the age admitted was wrong and understated. The insurer's contention is that had the DLA admitted his age as per the other records, the policies would not have been issued. The only reason as to why the DLA cannot be accused of falsehood is that there is no yardstick by which it is possible to decide the correct age of the DLA as on the date of the proposal. Any of the records could be wrong or right.

In view of the foregoing, I hold that the action of the insurer in repudiating the claim under the two policies on the basis of alternative non-standard age proof is untenable. Nevertheless, the DLA appears to have made a wrong declaration in relation to another material fact, namely, occupation and income. Although the insurer did not rely upon this reason for repudiation, the insurer's representative urged this also to be taken into consideration while deciding the complaint.

Considering the totality of the facts and the circumstances of the case, namely, that the DLA derived benefit of pension from the Government which he would not have been entitled to if his age was reckoned by the Voter's ID and that he mis-declared his occupation and income, I hold that the complaint cannot succeed in toto. However, in view of the fact that the DLA gave age proof as per the listed proofs in the proposal and the insurer repudiated the claims on the basis of age proof, I consider that this is a fit case for grant of ex-gratia.

On the basis of the foregoing, the insurer directed to pay ex-gratia of Rs.25,000 (only Rs. Twenty five thousand) each against the policies to the nominee. Needless to say that the unit value already paid against one policy is liable to be deducted from the payment to be now made in accordance with this decision.

In the result, the claim under the two policies is allowed for Rs. 50,000 minus fund value already paid.

COMPLAINT No. L-21-007-0557-2010-11

Shri. Rayani Ramanjaneyulu

Vs

Max New York Life Insurance Co.

AWARD NO. I.O. (HYD) L-065/2010-11

Smt. Madhura Lalasa obtained three policies for total sum assured of Rs. 9 Lacs from Max New York Life insurance company on her life. She obtained policy bearing No. 749326294 on her life for SA Rs. 4,00,000 from Max New York Life Insurance Co. She died in Road traffic accident. The claim under the policy was rejected by the insurer on the ground of non-disclosure of the previous policy particulars by the life assured at the time of effecting insurance with them

The complainant stated that the car in which he and his wife were travelling was hit by a lorry on 20.11.2009 and his wife died in the accident on the same day. He contended that despite submitting all documentary evidences and necessary requirements, the claim under the policy was repudiated by the insurer.

The Insurer contended that claim under the policy was rightly repudiated on grounds of suppression of previous insurance policies

Pursuant to the notice issued by this office, both the parties attended the hearing on 09.12.2010.

O R D E R

It is seen that the insurer informed the complainant that the claim under the policy issued on the life of his late wife was repudiated due to non-disclosure of previous policies in the proposal which constituted the basis for issue of the policy under consideration.

The impugned policy was Unit Linked policy for SA Rs.4,00,000. The premium was Rs. 25,000 biannually. The insured person furnished a proposal which formed the basis for policy No. 749326294 issued by the insurer. It is not disputed that the insured person did not furnish the details of the previous insurance policies taken by her from other insurers in the proposal form relating to this policy.

The question is whether while filling up the proposal the failure of the insured person to furnish the details of other policies that she had taken from other insurers would entitle the insurer to repudiate the liability under the policy.

The insurer's representative contended that the policy would not have been issued if they were aware of the other policies that the prospect had since by then she was over insured. The policy of the insured is to allow insurance to a person as a multiple of the annual income of the prospect. The declared annual income of the prospect in the proposal was Rs.8 lakhs. Thus, the cover would have been under Rs.1 crore. The prospect had already exceeded this limit. The insurer, therefore, held that suppression of the previous policies prompted the insurer to issue this policy erroneously.

It is noticed that the prospect knew only Telugu language. The proposal form is in English. It is obvious that she did not understand the contents if the form. There, however, is a vernacular declaration to the effect

that someone read out the contents of the form and explained them to the proposer. If the insurer knew the English language, the proposer could have no excuse at all. If, however, the proposer did not know the language of the document, the quality of translation would be important. If the person who explained the document did not understand the contents himself, as would often be the case with the insurance agents, the proposer would still not know what she agreed to. In the case on hand, the question is excess insurance. The proposer did not declare her previous policies. The internal guidelines of the insurer provided that a person should be allowed cover as a multiple of the annual income. The insured person would not have known this. If she was aware that her failure to declare her other policies would have had the effect of repudiation of the policy, it is inconceivable that she would still have bought the policy. The risk of such a nature did not enure her any again. She would be the loser without any doubt. Taking such a risk would be senseless. Thus, she would have been better off without the policy. In spite of this, if the prospect bought the policy, as had happened in the case on hand, the proposer cannot be presumed that she was aware of the consequence. Nevertheless, the insured person stand to lose since the insurer has protection in the form of vernacular declaration in the proposal form signed by one R. Srinivas.

Examination of the proposal (which resulted into policy No.749326294) Shows that in case the life assured / proposer or signs in vernacular language, the declaration has to state the language in which the proposal was explained to the proposer. The name of the language (which must be Telugu in this case) has not been filled in. Thus although the vernacular declaration contains the signature of one R.Srinivas, who explained the contents of the proposal, probably was not conversant with the English language. Thus the insurer did not notice the deficiency. Thus, technically, the proposal is incomplete.

There is little doubt that the proposal form omitted the previous policies of the proposer with other insurers. The consequence of the omission was that the insurer allowed excess insurance cover to the prospect. The insured person would still have been given the benefit of the doubt on the ground that the proposal was in English. But the aggregate value of insurance until the date of proposal was far in excess of the amount for which the proposer could have been insured.

The policy has a rider of accident death benefit of Rs. 4 lakhs. While the basic sum assured was dependant on the aggregate insurance as on the date of the policy, accident death benefit was not dependant on the aggregate insurance. Yet, death benefit also cannot be allowed since it was a rider benefit. If the main ingredient of basic sum assured itself cannot be allowed, logically, the death benefit, which is a rider to the basic sum, cannot be allowed.

In view of the foregoing, it was held that the insurer rightly repudiated the claim under the policy.

Notwithstanding the foregoing, the insurer is directed to pay the fund value to the nominee.

In the result, the complaint is partly allowed.

COMPLAINT No. L-21-007-0592-2010-11

Shri. A.Laxmana Ranga Rao

Vs

Max New York Life Insurance Company

AWARD NO. I.O. (HYD) L-068/2010-11

Smt Akula Lakshmi was covered under Policy No. 744505470 with effect from 06.01.2010 for a sum of Rs. 4,00,000 issued by Max New York Life Insurance Company. The Life assured died of chest pain on 24.3.2010 after a brief period of 2 months 18 days from the DOC of the policy. The Life assured died on 6.10.2009 of heart attack. The insurer repudiated the claim on grounds of non-disclosure of material facts. However, account value of Rs.24858.34 were paid to the complainant. The decision of the insurer was not acceptable to the complainant. Therefore, he sought our intervention for consideration of claim under the policy.

The complainant submitted that cause of death of his mother was chest pain. He alleged that after submitting claim requirements, the insurer obtained a fictitious medial certificate in the name of his mother from Dr. D.D.Naidu, Anakapalle, wherein it was wrongly stated that his mother had consulted with a complaint of peripheral neuritis. He contended that claim under the policy was erroneously repudiated by the insurer on the basis of the Medical certificate and appealed to render justice to him.

The Insurer stated that due to non-disclosure of history of the illness by the life assured in the proposal form, claim under the policy was repudiated on the ground of suppression of material facts.

Pursuant to the notice given by this office, both the parties attended the hearing on 04.11.2011

O R D E R

As per the proposal, the occupation of the deceased life assured was agriculture and her income was Rs.1,00,000 per anum whereas at the time of hearing the complainant informed that during the life time the DLA earned daily income of about Rs.200 to Rs.300 through dairy farming and she did not possess any agriculture land in her name. It is evident that the answer given by the LA in the relevant proposal were not honest. That the life assured opted for life insurance on her life for the first time at the advanced age of 58 years itself is suprising. It is also rather odd to note that the life assured's husband who is the main bread winner of the family did not take any insurance on his life.The complainant stated that his mother had Rs. 20,000 with her to which he added his own money and paid the premium for the policy. The complainant is married and has his own family and he claimed to have an insurance policy paying a small premium whereas annual premium payable under his mother's policy Rs.40000.

The life assured died within a year brief period, i.e. 2 months and 18 days, from DOC of the policy. The complainant stated that his mother died of chest pain all of a sudden while the insurer claims that the life assured had been ailing even prior to the DOC of the policy.

The insurer relied on the medical certificates of Dr.D.D.Naidu obtained along with the claim investigation report which revealed that the life assured had consult him for Peripheral Neuritis four month ago which fell prior to the date of proposal. The complainant stated that this doctor was never consult by his mother.Mere assertion of Dr.D.D.Naidu without supporting evidence such as prescription papers or case file or some report of contemporaneous evidence would not help the case of the insurer. The claim investigation report states state that the LA was bedridden with paralysis for 6 months prior to her death. If the LA was afflicted with paralysis, the agent and the medical examiner would have noticed her ailment at the proposal stage itself since paralysis could not have been concealed. Another piece of evidence that the insurer relied upon was the

note dated 26.6.2010 of Sarpanch of Tummapala Gram Panchayat. It is stated that the life assured suffered from paralysis for quite some time. This note is ambivalent.

Notwithstanding the foregoing, it is difficult to believe that the life assured reached terminal stage of illness within 2 months 18 days from the dte of taking the policy without any illness. It is clear that the life assured apparently underwent medical examination. The said examination ought it have revealed the illness that afflicted the life assured. The life assured did not have any agriculture land. Yet, the proposal mentioned agriculture as her occupation. The income of the proposer was minuscule. Yet, the insurer failed to take cognizance of moral hazard that existed on the life of the proposed at the proposal stage and she was provided insurance. When the claim was made, the insurer depend on inquiries which have no evidentiary value.

In sum, the proposal was wrong in regard to some material facts. The life assured died soon after DOC of the policy. Therefore, the insurer had valid reason for repudiation if the claim. But the insurer repudiated the claim on the strength of the inquiry report and said report has no evidentiary value.

In view of the above, although the insurer repudiated the claim on grounds which cannot be completely justified, this is a case where it would be unjust if the claim is fully allowed. Therefore, It was considered this is to be a fit case for grant of ex gratia and the the insurer directed to grant ex gratia of Rs. 75,000 (Seventy five thousand)only to the complainant. This would be in addition to the sum of Rs 24,858, being the fund value, already paid to the complainant under policy to the complainant.

In the result, the complaint is partly allowed for Rs 75,000 as ex gratia

COMPLAINT No. L-21-001-247-10-11

Smt.G. Vimala

Vs

Life Insurance Corporation of India, **673792620, 673792285**

AWARD NO. I.O. (HYD) L-047/2010-11

Sri G. Madan Mohan was covered under two policies bearing Nos. 673792285 and 673792620 with risk dates 28.12.2003 and 28.2.2005 for a sum of Rs. 30,000 and Rs.One lakh respectively. The policies lapsed without acquiring any value. They were revived on the strength of personal statement of health. The LA died on 27.8.2008 of Heart Attack. When claimed for policy monies, the insurer declared the revival of policy void and repudiated the claim on grounds of non disclosure of material facts relating to health prior to the date of issue of the policies.

The complainant submitted that her husband died of heart attack suddenly on 27.8.08. He was working as Panchayat Secretary and he had taken insurance policies from Vinukonda Banch Office. She further submitted that when she applied for policy monies LIC, Vinukonda Branch did not settle the claim. She stated that the insurer wrongly rejected the claims.

The insurer submitted that the policies lapsed owing to non payment of the premiums. Neither policy acquired any value. However, they were revived for full sum assured on the strength of personal statement of health as under:

Policy No.	Dt. of risk	Dt. of lapse	Dt. of revival
673792620	2.8.2005	28.9.2005	17.6.2008
673792285	28.12.2003	28.4.2005	21.7.2008

Since the LA died within a few months after effecting revival of the policies, the insurer caused investigation and found that DLA suffered from Pulmonary Tuberculosis during the period 20.4.03 to 17.8.03 for which he had taken treatment from a doctor and had also availed sick leave for the said period. The illness suffered was prior to the date of both the proposals. The insurer contended that the insured deliberately suppressed his medical history while submitting the proposals. Further, in the personal statement of health submitted for revival of the policies also the illness was suppressed. Revival of the policies was therefore declared as void and all money paid towards revival of the policies stood forfeited.

Pursuant to the notice issued by this office, both the parties attended the hearing on 21.10.2010 at Vijayawada

ORDER

The insurer repudiated the claim under the two policies due to non-disclosure of material facts, which had a bearing on the risk relating to the life insurance contracts under the two policies. The claims under both the policies were rejected on the ground that the deceased life assured made deliberate mis-statements and withheld material information regarding his health and the treatment at the time of getting the policies revived. Revival, therefore, was declared void and money paid towards revival of the policies and subsequent thereto stood forfeited. Prior to revival, the policies were in lapsed condition without acquiring any value and hence nothing was payable to the claimant.

Policy No. 6736762620 was revived on 17.06.2008 and Policy No. 673792285 was revived on 21.07.2008. The deceased life assured answered the relevant questions in the personal statement of health as under:

Points No. 2(a) & 4 of Personal Statement of Health are as follows:

2. Since the date of your Proposal for the above mentioned policy

a) Have you ever suffered from any illness / disease requiring treatment for a week or more : **"NO"**

4. Are you at present in sound health ? "**GOOD"**

As per the evidence submitted by the insurer, the illness suffered / treatment taken is prior to the date of submission of the proposals. The Life Assured got another opportunity to disclose his past medical history at the time of revival. Here again, the LA made incorrect declaration.

The evidences relied on by the insurer are :

i) Medical cum fitness certificate dated 17.08.03 issued by Dr. Vali Ahmed of Neha Nursing Home stating that the Life Assured was treated by him for Pulmonary Tuberculosis from 20.04.2003 to 17.08.2003.

ii) Employer's leave record which confirmed that the Life Assured availed leave on sick grounds from 20.4.2003 to 17.8.2003 for Pulmonary T.B.

iii) Certificate dated 05.03.2009 issued by Dr. Sk. Vali Ahmed confirming that the deceased life assured was treated by him for Pulmonary T.B. as out patient for 20.04.2003 to 17.08.2003.

The evidences submitted clearly establish that the Life Assured was suffering from Pulmonary Tuberculosis prior to the date of revival of the policy. Treatment for the said disease was taken during the period 20.04.2003 to 17.08.2003 from Neha Nursing Home, Vijayawada. The history of the said ailment is prior to the date of submission of both the proposals. The deceased life assured availed leave on sick grounds for the said period as per the copy of his letter obtained from his employer, Mandal Praja Parishad, Bollepalli Mandal. Therefore, in terms of the declaration contained in the proposals / personal statement of health, the claim has been repudiated for suppression of material facts relating to health prior to the date of the proposals.

The insurer has indisputable documentary evidence to show that the life assured suffered from ill health prior to the date of submission of proposals, which he deliberately suppressed. It was held that the insurer correctly repudiated the claims on the ground of non-disclosure of material facts.

In the result, the complaint is dismissed without any relief.

COMPLAINT No. L-21-007-411-10-11

Smt.B. Kavya Latha, 414928408

Vs

Max New York Life Insurance Co.Ltd.

AWARD NO. I.O. (HYD) L-048/2010-11

Sri Boyina Venkateshwara Rao was covered under Life Maker Investment Plan policy bearing No. 414928408 for a sum of Rs. 1,68,768/- with risk date 23.6.2006. The LA died on 9.4.09. The insurer repudiated the death claim preferred by Smt. B. Uma Maheswari (wife) for reasons of material medical non-disclosure. The insurer refunded the account value of Rs. 34,121.17 on 19.8.09. Aggrieved, Smt. B. Uma Maheswari lodged a complaint with us on 8.2.10. In view of the death of Smt. B. Uma Maheswari, a fresh complaint was lodged by the DLA's daughter on 22.7.2010.

The complainant submitted that the DLA was a diabetic for 15 years before his unfortunate death on 9.4.09. He disclosed the facts to the insurer's executive and also attended medical

examination before the insurer's medical officer. She stated that her father had no intention to suppress the facts to the insurer. She further stated that the LIC settled the claims for policies held with the LIC. She also contended that as per section 45 of the Insurance Act, 1938 the insurer cannot question the policy on the grounds of misstatement in the proposal after expiry of two years

The Insurer submitted that on 19.6.06 the DLA submitted a proposal for "Life Maker Unit Linked Insurance Plan" giving all relevant details and information for an assured sum of Rs. 1,68,768 and paid premium of Rs. 15,000/-. Based on the information furnished and the medical report dated 16.6.06, the proposal was accepted and policy bearing No. 414928408 was issued on 23.6.06. The insurer further submitted that the intimation of the L.A's death on 9.4.09 was received only on 26.7.09.

As per the death summary issued by the Manipal Super Specialty Hospital, the DLA was suffering from diabetes for the past 15 years. Therefore, it was evident that medical disclosure required in the proposal form was not made by the DLA. Had he disclosed the facts at the proposal stage the captioned policy would not have been issued as proposed. The claim, therefore, was repudiated for reasons of material non-disclosure of diabetes for the past 15 years by DLA. The Account Value of Rs. 34,121.17 had been sent to the claimant.

Pursuant to the notice issued by this office, both the parties attended the hearing on 21.10.2010 at Vijayawada.

O R D E R

The insurer repudiated the claim on the ground that the medical disclosure as required in the proposal form was not made by the life assured. The insurer relied on the death summary dated 9.4.2009 issued by Manipal Super Specialty Hospital, where the deceased life assured underwent treatment for terminal illness. The other evidence relied on is "Form C" filled in by the attending physician and submitted by the claimant. In reply to Query No. 7, the doctor replied as under:

Q.No. 7 : Did the deceased suffer from any other ailment other than the ailment that eventually lead to death ?

Reply : Yes: NIDDM * 15 Years

The aforesaid documents clearly established that the life assured was suffering from diabetes for the past 15 years and he did not disclose the same in that proposal form.

In her letter dated 4.2.2010, the original complainant (wife of the deceased life assured) stated that her husband was a diabetic patient for 15 years and that he had declared the same to the insurer's executive who visited them at the time of effecting insurance. She further stated that her husband attended medical examination prescribed by the company and that the doctor should have found out that he was diabetic.

Perusal of the proposal form shows that the relevant questions were answered by the deceased life assured as under:

I. Proposal Form :

D : Medical & Life style details of the life to be insured :

(3) Are you now or have you ever been diagnosed with any of the following conditions? If yes, please provide details or attach relevant questionnaire.

	CONDITIONS	**REPLY**
iii)	Diabetes	No

In fairness, the complainants admitted, both in the complaint as also during the hearing, that the deceased life assured was suffering from diabetes for the past 15 years as mentioned in the hospital records. However, their main argument is that the DLA never suppressed his medical condition and that the doctor who examined him ought to have noted that the insured was a diabetic.

The aforesaid contention is not valid. Had the insured answered Q.No.(3) (iii) in the proposal form in the affirmative, the medical examiner would have sought further information and other pathological tests as required by the Insurer would have been conducted and a proper decision whether to accept the proposal or not, and if so, on what terms, could have been decided by the Insurer. The relevant questions recorded by the medical examiner in his medical report, after ascertaining the answers to the questions from the insured, are as below:

4 (b) Diabetes, thyroid or any other endocrine disorder ? **"NO"**

7. Are you currently taking medication ? **"NO"**

The complainant's contention that section 45 of the Insurance Act prevents the insurer from questioning the policy on the grounds of misstatement in the proposal after expiry of two years is not valid since the same section carves out some exceptions. The exceptions to this stipulated under sec.45 *ibid* are as under:

> *"…unless the insurer shows that such statement was on a material matter, or suppressed facts which it is material to disclose, and that the policyholder knew at the time of making it that the statement was false or that he suppressed facts which it was material to disclose."*

There is no doubt that the insured was covered under the aforesaid exceptions.

In the light of the aforesaid, it is evident that life assured obtained the insurance policy on his life by suppressing the material fact relating to his health. The contract of life insurance is one of utmost good faith. In this case, the life assured had transgressed this principle. In the circumstances, the insurer cannot be faulted for repudiating the claim. Accordingly, It was held that the insurer rightly rejected the claim.

In the result, the complaint is dismissed without any relief.

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COMPLAINT No. L-21-009-478-10-11

Smt.S. Savithri

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD NO. I.O. (HYD) L-049/2010-11

Sri S. Udaya Bhaskara Rao was covered under Policy No. 0112702-95 for Rs.1,20,000. The LA died on 6.10.2009 of heart attack. The insurer repudiated the claim on grounds of non-disclosure of material facts.

The complainant submitted that the death claim under the policy of her late husband was rejected on the ground that he had taken treatment in a hospital in January 2007. She stated that her husband was fully cured of the disease and he never consulted any doctor or took medicines after that. She further submitted that there was no intention to suppress the facts.

The Insurer submitted that the claim under the policy was repudiated for reasons of non-disclosure of material facts relating to the health of the insured prior to the date of proposal. The DLA was hospitalised and he had undergone investigations and treatment for tuberculosis and pleural effusion in January 2007. These facts were known to the DLA and he did not disclose the same in the proposal dated 24.10.08.

As per the discharge summary and medical reports of ASRA of Medical Sciences Hospitals, the LA underwent investigation for pleural fluid for proteins and was treated in the hospital from 20.1.2007 to 23.1.2007, which he did not disclose in the proposal dated 24.10.2008. Had he declared the facts at the time of proposal, the insurer might have insisted on further tests and, depending on the results, the insurer might have declined the case.

Pursuant to the notice issued by this office, both the parties attended the hearing.

O R D E R

The insurer repudiated the claim for non-disclosure of material facts. The claim for policy monies arose 10 months and 19 days after risk had commenced. The insurer relied on the following documents for repudiation of the claim

1) ASRA Medical Sciences Hospital OP Card No. 70119237 dated 19.1.07 which showed the diagnosis as “Pleural Effusion Cell” and past history is recorded as a known case of TB.

2) Discharge summary of ASRA Medical Sciences hospital dated 23.1.07 which shows that the DLA underwent treatment from 20.1.07 to 23.1.07 for the problem diagnosed on 19.1.07. The hospital records show that the DLA underwent several investigations before the final diagnosis.

In contrast to the aforesaid evidence, in the proposal form dated 24.10.2008 submitted for insurance, the relevant questions were answered in the negative. They are:

Q. No. 14: Have you ever been treated or currently under treatment for any of the following complaints.

(c) Any disease and disorders of respiratory system such as but not limited to blood in sputum, tuberculosis, asthma, infected respiratory disease or any respiratory system disease including frequent nose bleeding fever and dyspnoea NO

(l) In the last 5 years have you ever had or been advised to have or are likely within the next 30 days to undergo medical examination or any investigations such as but not limited to blood test, urine test, x-ray, ECG or biopsy, CT scan or test by any other special instrument?
NO

(m) Injured, sick, operated, given a medical consultation, given a medical advice on health, care in any hospital? NO

If the answer to any of the above questions in 14 is YES, details are to be provided.

From the aforesaid, it is evident that the DLA was under hospitalization/treatment/medical investigation for TB and plural effusion in January 2007, which was prior to the date of proposal. This material fact known to the LA was not disclosed in the proposal form. Had the LA disclosed the facts at the time of proposal, the insurer's decision to underwrite the risk would have been different. The LA knowingly had given wrong answers to the queries relating his health prior to the date of proposal.

As it is established from the medical records that the DLA had misguided the insurer by providing false information, the insurer was well within its right in repudiating the claim under the policy.

In the result, the complaint is dismissed without any relief.

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COMPLAINT No. L-21-017-373-10-11

Smt. Saraswathi Sirapu, 00285106

Vs

Future Generali India Life Insc.Co.Ltd

AWARD NO. I.O. (HYD) L-050/2010-11

Sri Chinna Rao Sirapu obtained an endowment assurance policy with profit for Rs. One lakh by submitting a proposal dated 19.11.2009. The proposal was accepted and policy No. 00285106 was issued on 21.11.09. The LA died on 23.12.09 of fever, vomiting and motions. Smt. Saraswathi Sirapu, W/o Late Sri. Chinna Rao claimed for policy monies. The insurer rejected the claim on grounds of non-disclosure of material facts relating to health.

The complainant submitted that her husband took a policy for Rs.2 lakhs vide application dated 19.11.2009 and paid premium of Rs.3,006. He was hale and hearty before taking the policy and was not suffering from any disorder. He died unexpectedly on 23.12.009 due to high fever and motions. She claimed that repudiation of the claim by the insurer was unlawful. She contended that the insurer should be called upon to pay the insurance amount of Rs. 2 lakhs along with damages of Rs.50,000.

The Insurer submitted that based on the information furnished and declarations made by the proposer in his application dated 19.11.2009 the proposal was accepted and policy was issued on 21.11.2009. The LA died on 23.12.09. The cause of death was mentioned by the claimant as fever, vomiting and motions. The matter was investigated and it was found that LA was suffering from Liver problems prior to the date of proposal. And that the DLA suppressed material information relating to his health. He had hidden the fact that a few days before applying for the insurance policy he was admitted to the hospital and he was diagnosed as afflicted by cirrhosis and Ascites+. The insurer stated that the claim for policy monies was repudiated in view of non-disclosure of material facts by the LA. Had the company known the medical history of the life assured, no policy would have been issued to him.

Pursuant to the notice issued by this office, both the parties attended the hearing on 21.10.2010 at Vijayawada.

ORDER

The policy holder died one month and two days after the issue of the policy. The claim for death benefits was rejected on the ground that the deceased life assured was a known case of alcoholic liver

disease and was under treatment for Cirrhosis, Ascities, Jaundice, Fever and had low hemoglobin rate even prior to the date of his application for insurance.

The insurer produced copies of the following documents to show that the life assured suffered for ill health prior to the date of proposal i.e., 19.11.2009:

1. Prescription dated 1.09.09 issued by Seeta Gastro & Liver Super speciality Hospital, Rajahmundry which reveals that the life assured was suffering for abdominal distention, swelling in feet & MGI Bleed (since 4 months). The life assured was treated by Dr. Sreeramulu Vietla.
2. Prescription of Swetha Hospital, Rajahmundry, which reveals that the life assured was diagnosed as k/c/o alcoholic liver disease and on examination found to be Ascetics Positive.
3. Aarogya Mitra Registration Form dated 4.11.09 issued under Rajiv Arogyasri community Health Insurance scheme, which reveals that the life assured was referred to Apollo Hospitals, Kakinada on 4.11.09 for treatment. He was diagnosed with abdominal distention, mild fever and H/o. Jaundice positive.

In spite of the forgoing illness, the life assured replied in the negative, to the relevant queries in the proposal related to health details in Q.No. 8.2 as below:

Q.No.8.2 (A) : Are you suffering from or have you ever suffered from or sought advice or treatment or have been advised to undergo investigation or treatment for :

i) Ulcer, Colitis, Gall Stones, Chronic Diarrhea, Piles, Fistula, Hepatitis A/B/C, Jaundice, Cirrhosis, or other Liver or Pancreas or Digestive Disorders ? –No

ii) Chest pain, Palpitation, Rheumatic Fever, Stroke, Heart Attach, Heart Murmur, Shortness of Breath or other Heart Disorders ? – No

vii) Anemia, Bleeding, hemophilia, thalassemia or Blood Disorders ? – No

8.2 (B) : Apart from the medical conditions mentioned above, have you in last five years :

i) Suffered from any ailment/injury requiring treatment for more than a week ? -- No

ii) Undergone or are currently undergoing or advised to undergo any form of medical treatment, investigation or test ? –No

iii) consulted any doctor or other health practitioner except for common cold/influenza lasting less than 7 days ? - No

8.2 (E) : Do you have any health symptoms or complaints for which a physician / homeopath / ayurvedic / alternative medical advisor has been consulted or treatment received e.g., persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.? –No

The Insurer therefore has irrefutable documentary evidence to show that the life assured suffered from ill health prior to the date of proposal and suppressed material information deliberately. The life assured obtained the Policy on 21.11.09 and he died of fever, vomiting and motions on 23.12.09. The policy had run for just one month. The evidences produced by the insurer clearly establish that life assured suppressed material facts about his state of health deliberately while obtaining the policy. Life Insurance contracts are contracts of utmost good faith and, in this case, the life assured had breached this principle by concealing the facts about his health prior to the date of the proposal.

In view of the above, It was held that the insurer has rightly repudiated the claim.

In the result, the complaint is dismissed without any relief.

KOCHI

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-172/2010-11

Sony Salikumar

Vs

LIC of India

AWARD DATED 13.08.2010

The complaint is as to repudiation of death claim on the ground of suppression of material fact. The widow of the deceased life assured, who is also the claimant under the policy represented that her husband had undergone a surgery in 2001, after which his usual health condition was normal. He had no neuro problem after the said surgery, which is also supported by the medical examiner's report. He was under medication for 4 months after the surgery. In November 2008, he was readmitted to the hospital as he felt some difficulty in writing. He was diagnosed to have tumor which eventually led to his demise. The policy in question commenced on 13.12.2007 and demise was on 11.05.2009, i.e., within 2 years from the date of commencement of the policy. The claim has been denied by the insurer on the ground of pre-proposal illness which has been established by the insurer with documents such as hospitalization records, non-disclosure of facts in the proposal form and Certificate by the treating doctor.

The insurer is, therefore, justified in repudiating the claim and the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-001-086/2010-11

K.Marseena

Vs

LIC of India

AWARD DATED 09.11.2010

The complainant's deceased husband was covered under a Group Insurance Policy issued by LIC of India to Pondy State Co-operative Housing Federation Ltd. at the time of availing housing loan in July 2005. The beneficiary [deceased] passed away on 14.09.2007 while he was employed in Dubai due to heart problem. Subsequently, a claim was raised by his wife was repudiated by the insurer on the ground that there was suppression of material facts with regard to his health conditions.

At the time of personal hearing, the insurer's representative submitted that though initially the claim was repudiated by them, on humanitarian grounds, LIC has decided to settle the same. A cheque for Rs.2,23,605/- in favour of the Housing Society has been already been on 27.10.2010 towards the outstanding loan amount.

The nominee, who was also present at the time of hearing, was apprised of this fact. The counsel who accompanied her requested for waiver of the interest accumulated on the EMI after the demise of the beneficiary as the EMI stands unpaid till date. The Ombudsman suggested that this Forum cannot give a direction on this issue. However, the nominee can take it up with the Housing Society as the lumpsum amount has been received by them in advance against the amount that they would have got in instalments during the repayment of loan by way of EMI.

As the insurer has settled the claim thereby redressing the grievance of the complainant, the complaint stands **CLOSED**.

DEATH**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-219/2010-11

Sherly

Vs

LIC of India

AWARD DATED 22.12.2010

The complaint is against repudiation of death claim. The deceased life assured had taken a policy commencing on 13.10.2008. Unfortunately, he passed away on 16.10.2008 due to cardiac failure. Death claim raised was repudiated on the ground of pre-proposal illness. The complainant contended that her brother had never fallen sick prior to the date of proposal. He did have occasional allergic cold and cough for which he had taken treatment, but was never hospitalized. The cause of death has no relation to the treatment taken for cold and cough.

The insurer contended that the medical records available proved pre-proposal illness. He was under continuous treatment for bronchial asthma and this fact was suppressed by the insured in the proposal form. The policy is vitiated by suppression of material fact. The insurer is, therefore, not liable to settle the death claim.

The insurer had produced photocopies of certain OP tickets issued to the insured. The said OP tickets were referred to one Dr.Babu Chacko, who opined that the medicines prescribed were steroids and related medicines for bronchial asthma. But the OP tickets do not reveal that the insured was diagnosed for bronchial asthma. The insurer could not prove that the deceased life assured was hospitalized at any point of time for treatment of asthma. The answers to queries in the proposal with regard to his personal health are as if he was in absolutely good state of health.

The cause of death as per the PMR is cardiac arrest. The insurer has no case that the deceased had any ailment earlier relating to heart. So there is consistent and reliable evidence that the death of the insured is due to cardiac arrest. As he died during the currency of the policy, the nominee is rightly entitled to the claim money.

In the result, an award is passed directing the insurer to pay to the nominee [complainant], the sum assured after making all allowable deductions with 9% interest from the date of claim petition till this day.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-212/2010-11

P.Shajan

Vs

LIC of India

AWARD DATED 22.12.2010

The deceased wife of the complainant had taken a Unit Linked policy. He was offered only the fund value of the units but the claim for the sum assured was repudiated on the ground that there was suppression of material fact while proposing for insurance.

On a verification of medical records, the following facts are revealed. The deceased insured had undergone surgery for removal of intra oral growth one year prior to taking the policy. But this fact was not mentioned in the proposal form. The subsequent development which necessitated surgery in the next year also related to oral cavity swelling and growth. It is at this juncture, the omission on the part of the insured to mention her prior ailments and consequent surgery assume more importance. Had these facts been disclosed, the underwriting would have been different or even the proposal would have been declined. That opportunity was denied to the insurer. The facts and circumstances clearly show that the omission on the part of the insured to mention the ailment which was pre-existing and also to mention the surgery she had undergone prior to the date of proposal was intentional and such suppression of material fact would only vitiate the policy. The complaint is DISMISSED.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-228/2010-11

Limna

Vs

LIC of India

AWARD DATED 28.12.2010

Death claim was repudiated by the insurer on the ground of manipulation in the date of death. The insurer submitted that the investigation made by them revealed that the life assured had actually

died on 05.09.2008 and as on that date, the policy was in lapsed condition. Two premiums were remitted on 06.09.2008. The date of death has been manipulated in the records submitted before the authorities giving date of death as 08.09.2008. The available records have been suppressed or destroyed so as to appear that the date of death is 08.09.2008. The complainant had produced copy of the death certificate issued by the Registrar of Births and Deaths and Secretary of Grama Panchayat. The insurer had not produced a concrete evidence to support their stand. It is held that the death certificate has been issued by a statutory authority under the provisions of a statute and in the absence of any contra evidence, it has to be presumed for all purposes that the contents of the certificate issued by the Secretary of the Grama Panchayat are true and genuine. Hence an award is passed directing the insurer to pay Rs.8,68,130/- to the complainant, who is the nominee under the policy.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/24-001-214/2010-11

Ponnamma

Vs

LIC of India

AWARD DATED 29.12.2010

The complaint was filed against repudiation of death claim under a life policy. The insurer repudiated the claim on the ground that there was suppression of material fact while proposing for insurance.

The documents and medical evidences revealed that the deceased insured was having hypertension for 3 years prior to taking the policy. It was also noted that the insured was a smoker and alcoholic and earlier afflicted with tuberculosis. But these facts were not mentioned in the proposal form. Had the insured disclosed these facts, the proposal would not have been accepted or the underwriting would have been different even if the proposal was accepted. Since the suppression of pre-existing illness was very material, the same had influenced the underwriting and hence the contract was vitiated. The repudiation of claim by the insurer is proper and sustainable. The complaint is **DISMISSED**.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-203/2010-11

C.K.Geetha

Vs

LIC of India

AWARD DATED 28.12.2010

The deceased life assured had 3 policies under salary savings scheme. The complainant, the nominee under the policy, submitted that the insurer had not offered the full benefit under the policies on the ground that the policies were in lapsed condition at the time of the death of the insured. She stated that the policyholder was never informed by the insurer that the policies were in lapsed condition. Deductions were made from the salary of the policyholder and remitted. The repudiation of claim for full benefits under the policies was irregular and improper.

The insurer submitted that there was continuous default of payment of premium for 15 months and as such, the policies were lapsed on the date of death. When the defaulted premium in a lump was received, the same was returned to the party directing to make the remittance along with the requirements for the revival of the policies. But it was returned undelivered with endorsement 'party expired'. Since on the date of death of the life assured, the policies were lapsed, the complainant was entitled to only the benefits offered by the insurer.

On examining the records made available, there was nothing to show that the complainant was entitled to more benefits than she was offered by the insurer. There was nothing to find fault with the insurer. Hence the complaint is **DISMISSED**.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-365/2010-11

P.Thimothy

Vs

LIC of India

AWARD DATED 05.01.2011

Death claim was repudiated by the insurer on the ground that there was suppression of material fact.

The complainant submitted that his wife, the deceased life assured, was never hospitalized before taking the policy. As she was having allergic cough, she was taking medicine occasionally. Nothing material was suppressed by the insured in the proposal form and hence, repudiation of death claim is without any justifiable reason.

The insurer submitted that the deceased life assured was a known asthma patient as per the medical records and also she had undergone surgical procedures before the proposal form was filled up. This suppression of pre-proposal illness has materially affected the underwriting and also has influenced the decision in issuing the policy. The insurer further submitted that the suppression of material fact has vitiated the policy and, therefore, there was no valid contract of insurance. The repudiation of claim is legal and proper.

The medical records produced revealed that she had been prescribed medicines normally taken by an asthmatic patient. The discharge summary from the hospital also revealed that she was a known asthmatic since 3 years on treatment prior to the taking of the policy. On going through the records, it is seen that the earlier treatment taken by the insured was just 6 months prior to the inception of the policy. Hence the complainant and the deceased life assured, being highly educated and well employed, cannot contend that they were not aware of the answers to be given to the questionnaire in the proposal form relating to the health conditions of the insured. On account of non-disclosure, the insurer had been prevented from taking a proper and just decision on the acceptance of the proposal. As the contract of insurance is vitiated, the repudiation of claim is just and proper. In the result, the complaint is DISMISSED.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/24-001-387/2010-11

A.M.Radha

Vs

LIC of India

AWARD DATED 06.01.2011

The complaint is against repudiation of claim. The deceased husband of the complainant had taken policy under Marriage Endowment/Education Annuity Plan [with profits]. He died in 2003. The complainant is the appointee of the nominee who is a minor. The respondent-insurer had not provided the claim amount under the policy. The respondent-insurer contended that the life assured died before the date of maturity of the policy. Payment of future premium was waived. The claim can be entertained only after the maturity of the policy as per Clause 11 of the policy conditions.

The policy and the policy conditions are perused. Clause 7 of the policy conditions deals with surrender of the policy by the life assured. Though the respondent-insurer had relied on Clause 11 of the policy conditions, such a clause is absent in the policy conditions. The other policy conditions do not expressly prohibit claiming of benefits under the policy by the nominee on the death of the life assured before the policy matures. In the endorsement made on the policy, there is no mention that on the death of the life assured, the benefits under the policy will be provided only on the maturity of the policy. So the contention taken up by the respondent-insurer to withhold the benefits under the policy cannot be sustained.

An award is passed directing the respondent-insurer to pay to the nominee/appointee the sum assured with profits. No cost.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-009-374/2010-11

Shinta Liz Sunny

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 12.01.2011

The complainant was filed against repudiation of death claim under a unit linked policy. The claim was repudiated on the ground that there was non-disclosure of material facts at the time of submitting the proposal.

The complainant, who is the nominee, submitted that there was no deliberate attempt on the part of the insured to conceal any material fact. The insured had only mild ailments for which she had taken medicines occasionally. If at all there was any suppression, the same was not intentional. Hence she is entitled to the benefits under the policy.

On a perusal of medical records, it is revealed that the deceased insured was suffering from ailments of severe nature at least from 1994 onwards. Even at the time of proposal in 2009, she was suffering from different ailments of severe nature. Had she disclosed her ailments, the underwriting would have been different or even the proposal would not have been accepted at all. Hence the complainant cannot contend that the non-disclosure of a previous ailment in the proposal is not material or without any knowledge or intention. Also it cannot be said that the deceased was not aware of the ailment she was suffering from at the time of submission of the proposal form. Since there was non-disclosure of material facts, the contract of insurance is vitiated and the complainant is not eligible for the death benefit under the policy. But the insurer cannot deny the fund value of the units. Hence an award is passed directing the insurer to pay the fund value of the units with 9% interest from the date of complaint till payment is made.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-389/2010-11

Jessy George

Vs

LIC of India

AWARD DATED 13.01.2011

The complaint was registered against repudiation of death claim under a life policy on the ground that there was suppression of material fact. The complainant, sister of the deceased life assures, submitted that there was no suppression of material fact as there was no malafide intention on the part of the life assured to get undue benefit from the insurer. All the columns in the proposal form were filled up by the agent and the life assured only signed the proposal form. As there was no ill-motive in not furnishing the details regarding his previous health condition, the repudiation of the claim is unwarranted.

The insurer submitted that had the life assured disclosed all the relevant and material facts regarding his health condition, the underwriting would have been different. The suppression of material fact has denied the insurer opportunity to take into consideration all the relevant factors while considering the feasibility of issuing or non-issuing the policy. Therefore, the policy is vitiated and the complainant, the nominee, is not entitled to any death benefit. She is eligible for the fund value only.

On examination of various documents and evidences, it was proved that there was material suppression of fact regarding pre-proposal illness. To substantiate their contention, the insurer had produced medical records which showed that years before taking the policy, he had undergone treatment for chronic kidney disease. The questions in the proposal form relating to ailments of liver, stomach, heart, lungs, kidney, brain, etc. were answered negatively. The ailment was of serious nature and he was undergoing continuous treatment. The non-mentioning of the pre-proposal illness had denied opportunity to the insurer to decide as to whether to accept the risk or not. It has adversely affected fixation of premium also. On a consideration of the entire facts, evidence and circumstances, it can be seen that the suppression of pre-proposal illness is very material and the same had vitiated the policy. Hence it is clear that the complainant is not entitled to any further benefit under the policy. The complaint is **DISMISSED**.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-295/2010-11

K.Baby Lathika

Vs

LIC of India

AWARD DATED 19.01.2011

The complaint was filed against repudiation of death claim under a policy. The claim was repudiated by the respondent-insurer on the ground of non-disclosure of material facts regarding the health of the life assured at the time of submitting the proposal.

Various documents were produced for verification. Copies of medical documents revealed that the deceased life assured was suffering from chronic liver disease and hospitalized for treatment on several occasions before the policy was taken. But these facts were not disclosed in the proposal form. Had these facts been disclosed, the underwriting would have been different. As there was suppression of material facts, the contract is vitiated. Hence the repudiation of the claim is perfectly justifiable. The complaint is **DISMISSED**.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-009-394/2010-11

Alphonsa Thankappan

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 25.01.2011

The complaint was against repudiation of death claim. The complainant submitted that her deceased husband had taken a policy on his life and he had paid 2 premiums of Rs.15,000/- each. During the currency of the policy, her husband died. But the claim was repudiated by the insurer on the ground that the insured had not disclosed, in the proposal, the details of the illness he had suffered prior to the date of proposal. She submitted that the alleged suppression of illness was not willful and hence she was entitled to get all benefits under the policy.

The insurer submitted that the deceased was very much aware of his heart ailments for which he had earlier undergone treatment. The suppression regarding pre-proposal illness was very material and the same had affected the underwriting procedure. The policy is vitiated and hence the complainant is not entitled to any claim under the policy.

On examination of various documents and records produced by both the parties, the following facts are revealed. The life assured died within 1 year 8 months and 4 days from the commencement of the policy. The certificate issued by the hospital revealed that the deceased was treated there for CAD and he was subjected to angioplasty on 19.03.1999. But these facts were not mentioned in the proposal form. Not only that, the questions in the proposal form relating to cardio vascular disorders were answered negatively. From this, it is clear that there was suppression of pre-proposal illness and the suppression was material since it affected the underwriting decision of the insurer. Hence the policy is vitiated and the complainant is not entitled to the death benefits under the policy. But the policy was issued under ULIP scheme. Though the claimant is not entitled to the death benefits, she cannot be deprived of the benefits of any amount in investment. As per the statement submitted by the insurer, the net investment after deduction of charges available as on the date of death intimation is Rs.21,011/-. The complainant, who is the nominee under the policy, is entitled to receive that amount. In the result, an award is passed as follows:

1. **Repudiation of claim for death benefit is sustainable and, therefore, that portion of the repudiation is upheld.**
2. **Repudiation of that portion of claim demanding payment of money in investment is not sustainable. Hence the insurer is directed to pay Rs.21,011/-, being the amount in investment, to the complainant.**

R.Jayachandran

Vs

Metlife India Insurance Co.Ltd.

AWARD DATED 27.01.2011

The complainant is filed against repudiation of death claim under a unit linked policy. The claim was repudiated on the ground that there was material suppression of pre-proposal illness. The complainant submitted that the deceased never thought that a mild attack of cirrhosis of liver was very much relevant to be declared in the proposal form. There was no willful suppression of a material fact.

The death summary and other medical evidences produced revealed that the deceased was a known case of cirrhosis of liver with portal hypertension and chronic pancreatitis. She had been under treatment for the said diseases earlier to the submission of proposal form. But these facts were not mentioned in the proposal form. The non-disclosure of pre-proposal illness vitiated the policy and as such, the complainant cannot claim any death benefit. The policy being unit linked, the fund value had already been given to the complainant, which is not disputed. The complaint is **DISMISSED**.

DEATH**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-009-463/2010-11

Annamma Mathew

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 28.01.2011

The complaint was filed against repudiation of death claim under unit linked policy. The claim was repudiated on the ground that there was suppression of material facts. The deceased life assured was having ethnol related chronic liver disease, liver cirrhosis, etc. for which he was hospitalized. But these facts were not disclosed at the time of filing the proposal. As the policy was vitiated, the claim was repudiated.

On verification of the documents and evidence produced, it was revealed that the deceased life assured was hospitalized 6 months prior to the submission of proposal, for ailments mentioned above. But these facts were not disclosed in the proposal form. Since there is suppression of material fact relating to pre-proposal illness, the policy is

vitiated. Since the policy is a unit linked plan, the complainant is entitled to the fund value of the units. Hence an award is passed upholding the repudiation of death claim and directing the insurer to pay Rs.49,593/- to the complainant towards fund of the units.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-457/2010-11

Prabha G.Nair

Vs

LIC of India

AWARD DATED 10.02.2011

The death claim on the life of the deceased husband of the complaint was repudiated by the insurer on the ground of suppression of material fact. The insurer submitted that prior to proposing for insurance, the deceased life assured had taken treatment for jaundice. He was diabetic and hypertensive for the past 5 years. The deceased had not revealed these facts in the proposal form. Due to suppression of material fact, the policy is vitiated and hence the claim is not payable. Hospital records were produced for verification. The hospital records revealed that the deceased was a diabetic and hypertensive for years before taking the policy. At the time of admission in the hospital, he was having fever and jaundice. On verification of the proposal form, it is revealed that all these facts were suppressed. Had he disclosed the actual state of health, the underwriting would have been different. The suppression of pre-proposal illness had adversely affected the very basis of underwriting and influenced the decision of the insurer in accepting the proposal. Since the contract is vitiated due to suppression of pre-proposal illness, the nominee is not entitled to claim any death benefit under the policy. The complaint is **DISMISSED**.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-005-498/2010-11

K.G.Rema Devi

Vs

HDFC Standard Life Insurance Co.Ltd.

AWARD DATED 25.02.2011

The complaint is against repudiation of death claim. Deceased Shri Sadasivan Nair had taken policy under unit linked endowment plan for a term of 10 years. He died on 31.08.2009. The claim seeking death benefits was repudiated on the ground of non-disclosure of pre-existing ailments. The respondent-insurer appeared and contended that the life assured did not disclose pre-existing ailments in the proposal form. Therefore, the claim was repudiated. Both sides were heard.

As per records, commencement of the policy is on 28.06.2007. The life assured died on 31.08.2009 due to multi organ failure. The medical records available would reveal that the life assured had surgery in 1989 and he was under treatment for CAD and Parkinsonism at least from February 2007. The life assured had withheld the same in the proposal form. The proposal was underwritten on the bonafide belief that the facts disclosed relating to the health condition, were true and genuine. On account of suppression of material facts, the policy is vitiated. The complainant is not entitled to claim any death benefits. The policy being unit liked, the respondent-insurer is directed to pay the unit value of Rs.58,648/- to the complainant. No cost.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-489/2010-11

Geetha S.

Vs

LIC of India

AWARD DATED 25.02.2011

This complaint is against repudiation of death claim. Shri Sivakumar, deceased husband of the complainant had taken policy under Jeevan Saral Plan for a term of 10 years. On his death, when claim was submitted by the nominee-wife, the same was repudiated stating that revival of lapsed policy was made based on a declaration of good health [DGH] wherein there was suppression of material facts relating to his health status. The respondent-insurer contended that in the DGH dated 17.01.2007, the declarant had suppressed the fact that he was afflicted with carcinoma and was undergoing treatment. The policy was vitiated.

Heard both sides. Though the complainant would contend that the policy never lapsed and the deceased was entrusting premiums regularly with the agent, that contention could not be substantiated by the complainant. Medical evidence produced would reveal that the deceased underwent surgery in connection with *carcinoma ileocaecal region* on 30.08.2006. There is also evidence that he was admitted at RCC on 15.04.2008 and treated there for the same ailment till

23.04.2008. Even then, the life assured had stated in the DGH that he was keeping good health. So the evidence is that, in the DGH, he had not disclosed his actual health status. If the contention of the complainant, that no application for revival was made, is accepted, then the policy was in a lapsed condition at the time of the death of the life assured. Therefore, on either count, the complainant cannot claim death benefits under the policy. At the same time, the complainant is entitled to paid-up value quantified at Rs.8,379/-.

In the result, repudiation of the death claim is sustained. The respondent-insurer is directed to pay Rs.8,379/- being the paid-up value. No cost.

DEATH OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-005-390/2010-11

Veena Suresh

Vs

HDFC Standard Life Insurance Co.Ltd.

AWARD DATED 24.02.2011

The deceased life assured had taken a unit linked policy. Only the 1st half yearly premium was paid. The 2nd premium was due on 05.09.2009, but the life assured died on 05.11.2009, leaving the 2nd premium unpaid. The claim was rejected by the insurer stating that the policy had lapsed on account of non-payment of 2nd premium. The complainant submitted that her deceased husband was working abroad and he was not intimated of the due date for payment of 2nd premium. He died before the expiry of the revival period. Had he been alive, he would have paid the defaulted premium and revived the policy.

As per policy conditions, the complainant is not entitled to death benefit under the policy, as death occurred while the policy was in a lapsed condition. Out of the first instalment of premium, an amount of Rs.27,877.26 was invested in units and the same had grown to Rs.56,000/- as on the date of lapsation. As per policy conditions that amount must also go to the insurer. The deceased was lucratively employed in Africa. Had he been alive, there was every chance for payment of premium regularly. Based on the policy conditions and schedule of charges, the insurer cannot be allowed to take undue advantage or make undue gain out of precarious situation the complainant is put to. Equity, good conscience and the principle of natural justice compel this forum to look into the provisions of RPG Rules 1998, which provides for ex-gratia payment wherein it is stated that if the Ombudsman deems fit, he may award an ex-gratia payment. On a consideration of the entire facts, evidence and circumstances available in this complaint, this forum is satisfied that this is a fit case where Rule 18 of the RPG Rules 1998 is to be invoked in favour of the complainant. Ex-gratia is not being made out of any legal obligation but out of genuine grace. Hence the insurer is directed to pay Rs.56,000/- being the unit fund value available on the investment made utilizing the first premium paid by the life assured as on the date of lapsation.

DEATH **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/21-001-490/2010-11

Rajeswari Selvarajan

Vs

LIC of India

AWARD DATED 23.02.2011

The complaint was filed against repudiation of death claim by the insurer. The claim was repudiation on the ground that the policy was obtained fraudulently by manipulating the date of medical examination. The deceased life assured, who was employed in Kuwait, reached India only on 04.12.2008, but the medical report and proposal form were dated 03.12.2008. Copies of the proposal form, agent's confidential report and medical report were produced for verification. All the documents were dated 03.12.2008. Medical Examiner's Diary in original was also produced. The diary revealed that 4 persons were examined on the same day i.e., 03.12.2008 and the deceased life assured was examined as the 2nd case of the day. Hence there is no change for entering a wrong date in all the 4 certificates issued by the doctor. The argument of the complainant that the deceased life assured was actually examined by the doctor on 06.12.2008 cannot be believed since it is revealed from the office seal of the insurer that the proposal along with all the requirements were received in the office on 05.12.2008. Moreover, the nationality query form submitted was also dated 03.12.2008. The unusual consistency shown in repeating the same mistake in all the papers prepared and submitted for taking the policy definitely indicate fraudulent action on the part of the life assured as well as the agent. On account of the fraud played on the insurer, the entire contract of insurance is vitiated and based on such a contract, the complainant cannot claim any benefit. The complaint is **DISMISSED**.

DEATH**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/LI/24-007-479/2010-11

Leela Gopi

Vs

Max New York Life Insurance Co.Ltd.

AWARD DATED 25.02.2011

This complaint is against repudiation of death claim. Son of the complainant had taken policy for Rs.10,00,000/- sum assured. He died on 08.06.2009. The complainant, who is the nominee under the policy, submitted a death claim. The respondent-insurer did not honour the claim. The respondent-insurer contended that due to non-payment of premium, the policy had lapsed. At the time of death of the life assured, the policy was in a lapsed condition and, therefore, the complainant is not entitled to any benefit. Both sides were heard.

Son of the complainant had taken Level Term to Age 60 Plan policy. Policy was issued on 04.03.2008 with effective coverage from 29.02.2008. The next annual premium was due on 28.02.2009. Inspite of sending of renewal premium notice and renewal premium reminder notice, the life assured did not make payment of the 2nd premium. Policy lapse intimation was also sent by the insurer on 30.03.2009. The life assured died on 08.06.2009. The policy was not revived before the death of the life assured. As the death was when the policy was not live, the nominee under the policy is not entitled to any of the benefits under the policy. The claim was rightly repudiated.

The complaint is **DISMISSED**. No cost.

KOLKATA

OFFICE OF THE INSURANCE OMBUDSMAN,

KOLKATA

AWARD IN THE MATTER OF

Complaint No.	:	197/24/001/L/05/2010-11
Nature of Complaint	:	Non-payment of female critical illness claim
Category under RPG Rules 1998.	:	12 (1) (e)
Policy No.	:	534028013
Name & Address of complainant	:	Shri Ajay Kumar Singh, Vill. Chittaur, P.O. Jai Jore, Via. Andar, District: Siwan Bihar – 841 231.
Name & Address of	:	Life Insurance Corporation of India,

the insurer		Muzaffarpur D.O., Jeevan Prakash, Umashankar Prasad Marg, Muzaffarpur – 842 002.
Date of Hearing	:	12.11.2010

Hearing :-

Both the parties were called for hearing on 12/11/2010. The complainant was not present. The representative of the Insurance company attended and informed this forum that the claim is pending due to non-receipt of the claim forms. He stated that the claim was earlier lodged for critical illness benefit, but it was not in the prescribed claim form and as a result the same could not be settled. In the meantime, the LA died and the claimant was asked to submit a non-early death claim form along with death certificate, claim form 'A' &'C', but the same are still awaited.

Decision :

We have heard the submissions of the Insurance company. Since the claimant was not present, we could not hear his views. However, it is seen that the claim is still pending for non-submission of the claim forms. We, therefore, direct the insurance company to contact the claimant at the earliest and obtain the requisite forms and settle the claim within 15 days from the receipt of this order. The claim is accordingly allowed.

(MANIKA DATTA)
INSURANCE OMBUDSMAN

OFFICE OF THE INSURANCE OMBUDSMAN,

KOLKATA

RECOMMENDATION IN THE MATTER OF

Complaint No	:	239/24/001/L/05/2010-11
Nature of Complaint	:	Non-payment of death claim
Category under RPG	:	12 (1) (e)

Rules 1998.

Policy No.	:	451343406
Name & Address of complainant	:	Smt. Manisha Hembram (Soren), Rly. Qtr. No.76/B, Type -1, Kashmir Colony, P.O. New Jalpaiguri, District: Jalpaiguri.
Name & Address of the Insurer	:	Life Insurance Corporation of India, Jalpaiguri Divisional Office, Jeevan Prakash, P.O. Jalpaiguri – 735 101, District: Jalpaiguri.
Date of Hearing	:	12.11.2010

Hearing :-

Both the parties were called for hearing on 12/11/2010. The complainant was absent. The representative of the Insurance company attended but did not file SCN and verbally informed us that the claim is pending for want of certain papers relating to the medical leave of the DLA which are yet to be submitted by the claimant.

Decision :

We have heard the submissions made by the representative of the Insurance company and gone through the submissions of the complainant. From the correspondences she has made with insurer, we find that she has already submitted her claim form with other relevant documents on 19/02/2009. She has also filed the police final report in September, 2009, but even after submitting all the papers, the insurer is further asking to submit the copy of leave applications along with medical certificates of her husband from his employer. She has pleaded that she is a widow lady and not in a position to collect any document from the former employer of her deceased husband and she has also submitted that her claim has been pending for almost two years even though she had submitted all the relevant documents. As per the status report of the policy, it is seen that the LA had paid premium for five years and three months. So it is a case of non-early claim and protection u/s 45 of the Insurance Act is available. The complainant has submitted all necessary papers for settlement of the claim and has expressed her inability to obtain the copy of leave applications along with the medical certificates from the former employer of her husband. The onus of collecting information, which may be required by the

insurer to settle the claim lies on them and two years time is reasonably good enough to take a final decision in this case. This clearly shows a casual approach of the insurer as procuring the documentary evidence is their responsibility.

We therefore, direct the insurer to procure any further evidence, which they may require for settlement of this claim and take a final decision in this case within 15 days from the date of the receipt of this order. The complaint is accordingly allowed.

(MANIKA DATTA)
INSURANCE OMBUDSMAN

OFFICE OF THE INSURANCE OMBUDSMAN,

29, N.S. ROAD, KOLKATA

ORDER IN THE MATTER OF

Complaint No.	:	1049/21/012/L/03/2009-10
Nature of Complaint	:	Repudiation of Death Claim
Category under RPG Rules 1998	:	12 (1) (b)
Policy Nos.	:	437943500
Complainant	:	Smt. Sujata Dhara W/O Late Nilmani Dhara Saishakti Tower, Jessal Park

Bhayander(East), 6th floor,

Flat No.603, Mumbai – 400 066.

Insurer : Life Insurance Corporation of India,

Singur Branch/Howrah D.O.

Rallis Building, 16, Hare Street,

Kolkata – 700 001.

Date of Hearing : 17.02.2011

Hearing

Both the parties were called for a hearing on 17/02/2011. The complainant attended along with her sister and submitted before this forum that her husband had purchased this policy few months before his death but at that time he was absolutely healthy and had no ailments. He died within one hour after suffering chest pain. Moreover, non-mentioning of the previous policy particulars in the proposal form was not intentional.

The representative of the insurance company on the other hand supported the decision of the insurer to repudiate the claim on the ground of non-disclosure of the previous policies at the time of proposing the policy under consideration. If he had mentioned the fact that he had taken two more policies then the sum under consideration (SUC) would be Rs.3.5 lakhs and it would require special medical reports e.g. ECG, BST (FBS+PPBS), LIPIDOGRAM, ELISA for HIV, Haemogram & RUA. Assessment of life risk of the DLA could not be done for intentional non-disclosure of previous two policies. But taking into consideration the sum proposed under proposal no 22393, policy no. 437943500 under-writing decision was OR + AB and accordingly no special medical report was called. The LA died within 8 months and 5 days of taking the

policy. Although the claim was very early in nature, but no other investigation regarding pre-existing disease etc. was made by the insurer.

Decision

We have heard both the parties and perused the materials available on record. It is seen that the date of commencement of the policy is 28/03/2007. The LA expired on 02/12/2007 and the claim forms for all the three policies were submitted by the nominee (wife). The claim under two policies 437009867 & 434032661 (early claim) has been settled and payment has been received by the nominee. Objection regarding suppression of material facts has been raised only at the time of processing the third policy no.437943500. The LA did not mention the particulars of the previous two policies in the proposal form and according to the insurer if he had disclosed the two policies, special medical reports were required. This could have changed their underwriting decision. However, we find that although the claim was very early in nature, but no other investigation regarding pre-existing disease etc. was made by the insurer and the representative admitted that no other negative point regarding the DLA has come to their knowledge.

We have further noted that the insurer had already paid two claims (one early) and they did not conduct any investigation because they did not have any suspicion of any pre-existing disease. Since the LA was not known to have a history of any disease and nothing adverse has come to the knowledge of the insurer, then the medical examination would not have made much difference to their underwriting decision. Therefore, in our opinion only non-disclosure of two policies should not be taken as the sole factor fact for deciding the claim under the third policy. This will disentitle the claim of the widow who is saddled with the responsibility of two minor daughters and in our opinion it will be a very harsh decision.

In view of the above, we are of the considered opinion that the total repudiation of the claim, although technically correct, is not fair and justified in the circumstances mentioned above. Considering the acute financial hardship faced by the widow and the two minor children after the untimely and sudden death of the head of the family and considering that no pre-existing disease has been suspected either by the doctor or by the insurer, we set aside the decision of the insurer and grant an ex-gratia payment of Rs. 50,000/- equal to the first premium paid under the policy no.437943500. The refund of the premium, purely on humanitarian and compassionate ground will meet the end of justice in this case. We therefore, direct the Insurer to admit the claim and refund the premium on ex-gratia basis within 15 days from the date of receipt of this order along with consent letter. The petition is partly allowed.

(MANIKA DATTA)

INSURANCE OMBUDSMAN

LUCKNOW

DEATH CLAIM(28.3.2011)

Award No.IOB/LKO/96/001/10-11

Complaint No.L-639/21/001/10-11

Smt. Gaina Devi

V/s

Life Insurance Corporation of India

Smt. Gaina Devi filed a complaint against the decision of LIC of India, D.O. Agra under policy no.264665907 on the life of her husband late Narain Das Lalwani on the grounds of pre-existing of liver disease which was not disclosed in the personal statement of health in the proposal for insurance dated 28.12.2008. According to the respondents this non-disclosure was material for under writing decision.

In support of their decision the respondents have relied upon the following documents :-

1. Treatment sheet of Pushpanjali Hospital & Research Centre, Agra.
2. Opinion of Divisional Medical Referee Shri Rajeev Mangal
3. Discharge summary of ASOPA Hospital and Research Centre Agra.

On the basis of above documents it was concluded that the life assured had suffered from the liver disease before the date of proposal and this fact was also in the knowledge of the life assured. The complainant also did not deny the fact that the life assured had suffered from the chronic Liver Disease but informed that the life assured was an insurance minded person and took several policies on regular basis. The policy in question was a single premium policy taken solely for investment purpose. The policy is an investment instrument and the risk element under the policy is very less. However as per the CRM circular dated 28.08.2010 an ex-gratia payment of 25% of single premium is admissible excluding extra premium. Accordingly, the forum directs the respondent to refund 85% of the premium as defined above to the claimant towards full and final payment under the policy.

DEATH CLAIM(28.3.2011) **COMPLAINT NO. : L-478/21/001/10-11**

AWARD NO. IOB/LKO/155/001/10-11

Shri AJAI MOHAN CHAKRABORTI V/S LIC of India

FACTS : On 01.10.2007, one Smt Bandana Chakraborti took out policy no.284944170 under plan & terms 188/10 for ` 50,000/- which was accepted at OR & AB. Unfortunately the L.A. died on 28.04.2008 due to sudden pain. Claim was preferred by the complainant nominee, husband of the deceased L.A. The claim was repudiated by the Sr. Divisional Manager, LIC of India, Varanasi Division vide their letter dated 19.05.2009 on the ground that prior to proposing for insurance the L.A. was sick and she did not disclose this fact at the time of proposal. Respondent company argued that had the fact been disclosed at the time of proposing insurance, the policy would not have completed.

FINDINGS : In order to substantiate the claim of the respondent that the L.A. had suppressed her past medical history. It was very important for the forum to peruse the proposal form and at the proposal form the life assured had clearly mentioned that she is not suffering from any disease nor she had taken any treatment from any hospital from last five years. The complainant had stated that no misstatement was made in the Proposal form.

DECISION : It was observed by the forum, that the complainant had made deliberate misstatement at the time of proposal and hence violated the principle of utmost good faith. The Forum did not interfere with the decision of the SDM, Varanasi

MUMBAI **MUMBAI INSURANCE OMBUDSMAN CENTRE**

Complaint No. LI – 1096 (2009-2010)
Award No. IO/MUM/A/ 280 /2010 – 2011

Complainant : Smt. Sunita K. Suruse
V/s
Respondent : Life Insurance Corporation of India, Mumbai Divisional Office II

AWARD DATED 6.10.2010.

Shri Ganesh Kisan Suruse had taken Life Insurance Policies from Life Insurance Corporation of India, Mumbai Divisional Office II. Shri Ganesh Kisan Suruse expired on 27.03.2009 due to Pulmonary Tuberculosis. The claims were preferred under the above policies by his sister Ms. Sunita K. Suruse, the nominee under the policies. LIC repudiated the claim stating that the DLA made deliberate mis-statement and withheld material information from them regarding his health at the time of Revival of his policies for the full sum assured on the strength of a Personal Statement regarding health and that they had evidence and reasons to believe that he had been suffering from Pulmonary Tuberculosis since 2002 and that he was on treatment on OPD basis since 7 years. and therefore they treated the revival of the Policy as Null & Void.

In the Medical Attendant's Certificate (Claim Form B) and Certificate of Hospital Treatment (Claim Form B-1) dated 18.06.2009, signed by Dr. C.R. Desai, he states that the Shri Ganesh Kisan Suruse was admitted to The Group of T.B. Hospitals (GTB), Sewri, Mumbai on 26.03.2009. It is stated that he was transferred from ESIS Hospital, Vashi on 25.03.2009. The Diagnosis stated was "Pulmonary Tuberculosis". To the question - How long had he been suffering from this disease? – the answer stated was "7 years" and since 7 years he was taking treatment on OPD basis. The history was reported by the patient himself. He expired on 27.03.2009. The Certificate of Treatment / Consultation, signed by Dr. S.L. Jain, states that Shri Ganesh K. Suruse had consulted him two year back and Dr. Jain had treated him for MDR TB. According to papers of ESIS Hospital, Vashi, Shri Ganesh Suruse was admitted to hospital on 02.08.2008 and the provisional diagnosis given was " k/c/o PTB MDR. The case papers mention "Patient had PTB 2 years back had later on ART for 6 months". There is a mention in the case papers dated 25.03.2009 to the RMO "Kindly arrange for an ambulance for this pt. of PTB with MDR to be transferred to Sewri TB hospital on 26.03.2009".

A letter dated 14.09.2009 was issued by the Medical Superintendent of Municipal Corporation of Greater Mumbai, Group of T.B. Hospitals, Sewri, Mumbai, in reply to the enquiry made by LIC regarding the hospitalization of Shri Ganesh K. Suruse. In the said letter he states the following:

1. Patient came to this hospital for 1st time on 26.03.2009.
2. Patient was transferred from ESIS hospital, Vashi.
3. While recording the history of patient by Ward Doctor, Patient told him he was suffering from PTB since 2002.

4. Either you will get the date from ESIS Hospital, Vashi, New Mumbai or from patient's relatives.

These documents clearly prove that the deceased life assured Shri Ganesh Kisan Suruse was having Pulmonary Tuberculosis since 2002 and he was taking treatment for the same. He suppressed this material information regarding his health while submitting the Personal Statement for revival of his policies. He was duty bound to disclose all the information about his health correctly. The claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI – 206 (2010 – 2011)
Award No. IO/MUM/A/ 336 /2010 – 2011

Complainant : Smt. Alka Jayesh Shah
V/s
Respondent : Life Insurance Corporation of India, Mumbai Divisional Office II

Award dated 9.11.2010.

Shri Jayesh Bhupatbhai Shah had taken Money Plus Unit Linked Life Insurance Policy from LIC of India with yearly premium of Rs.20,000/- for term of 10 years. The DOC was from 14.8.2007.

Shri Jayesh Bhupatbhai Shah expired on 19.04. 2009 due to Heart Attack The claim was preferred under the above policy by his wife Smt. Alka Jayesh Shah. LIC repudiated the claim on the ground that Shri Jayesh Bhupatbhai Shah made deliberate mis-statement and withheld material information from them regarding his health at the time of proposal for the above policy. LIC, stated that they had evidence that he was operated for Hiatus Hernia with Splenectomy in July 2006 and he had also undergone appendectomy in 1994 He did not, however disclose these facts in his Proposal.

As per the discharge summary of Hurkisondas Hospital, the deceased life assured was admitted to the hospital on 24.07.2006 to 11.08.2006. The diagnosis arrived at was "Hiatus Hernia Nissens Fundoplicate with Spleenectomy with closure of Esophageal Hiatus which was done on 26.07.2006 – c/o acidity since 1 year and recently diagnosed DM". The deceased life assured was admitted to Ashirwad Heart Hopital on 28.03.2009 with severe chest pain. In the case papers of the said hospital there is a mention of H/o Splenectomy done in 2006, Hiatus Hernia operated in 2006.

The deceased life assured was admitted to Jupiter Hospital on 18.04.2009 with complaints "recently detected IHD – SVD admitted for PTCA. H/o ASMI on 28.03.2009 – was admitted on 28.03.2009 at Ashirwad Hospital and thromboiysed with Elaxim then shifted to S.R. Mehta for CAG. CAG done on 02.04.2009 – 3/0 – SVD Patient admitted for PTCA to LAD. The Past History is mentioned as " Hiatus Hernia Sx 2006. Appendectomy 15 years". He expired at Jupiter hospital on 19.04.2009 due to Acute Myocardial Infraction post Angioplasty.

The above documents clearly prove that the deceased life assured Shri Jayesh Bhupatbhai Shah was operated for Hiatus Hernia and Spleenectomy on 26.07.2006. He proposed for insurance on 14.08.2007 and he suppressed this material information regarding his health while submitting the proposal form to LIC. The policy was a non-medical policy and it was his bound duty to disclose this material fact in the proposal form. Only the Bid Value is payable.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No. LI – 288 (2010 – 2011)

Award No. IO/MUM/A/ 337 /2010 - 2011

Complainant : Bhojraj N. Hajare

V/s

Respondent : Max New York Life Insurance Company Ltd.

Award Dated 9th day of November, 2010.

Smt. Manda Bhojraj Hajare had proposed for a Life Insurance Policy from Max New York Life Insurance Company Ltd. and Policy No.438634420 was issued to her. The duration of death from date of commencement of policy was 2 yrs and 11 months. The SA was for Rs.3,61,447/-.

Smt. Manda Bhojraj Hajare expired on 11.04.2007 due to Acute Leukaemia. The claim was. repudiated by the company on account of the deceased having withheld material information regarding her health in the proposal form. Max New York Life Insurance Company Ltd. stated that the deceased life assured was a known case of Syringomyelia with Syringobulbia in August 2003 and operated for Foramen Magnum Decompression with removal of Arch of atlas with excision of constricting dural band with duraplasty on 18.09.2003. Post operation she was on neurological treatment and physiotherapy which is prior to signing the proposal form. She did not, however, disclose these facts in her proposal for insurance. The Insurer stated that had these facts been disclosed as required in the proposal form, the policy would not have been issued as proposed.

During the hearing Shri Bhojraj Hajare admitted the fact that his wife Smt. Manda Hajare had suffered from Syringomyelia with Syringobulbia in August 2003. She was operated for Foramen Magnum Decompression with removal of arch of atlas with excision of constricting dural band with duraplasty on 18.09.2003 and post operation she was on neurological treatment and physiotherapy. By way of evidence, the company has submitted copy of the Discharge Summary issued by Jaslok Hospital dated 24.10.2003, the consultation notes issued by Dr. Manoj Gunale dated 31.01.2004, 16.02.2004, 22.04.2009 and 08.07.2009 and the Discharge Summary issued by Sushrut Hospital dated 02.02.2010 prove beyond doubt that Smt. Manda Hajare suffered from Singomyelia with Syringobulbia from August 2003. The company stated that there is no dispute about the cause of death of Smt. Manda Hajare. The dispute is the non disclosure of her previous ailments in the proposal for assurance.

As the statutory period of two years had clearly expired when Max New York Life Insurance Company Ltd. repudiated the claim, Section 45 of the Insurance Act, 1938 applies in the present case and policy cannot be called in question only on the ground of misstatement.

The Company has provided evidence to prove that Smt. Manda Hajare had suffered from Syringomyelia with Syringobulbia in August 2003. She was operated for Foramen Magnum Decompression with removal of arch of atlas with excision of constricting dural band with duraplasty on 18.09.2003 and post operation she was on neurological treatment and physiotherapy. The deceased life assured had not disclosed this fact which was important to the Insurer for underwriting the risk. It was known to her that she was a case of Syringomyelia with synngobulbia, but this fact was not disclosed in the proposal form. The claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No. LI – 523 – 2010 - 2011

Award No. IO/MUM/A/ 335 / 2010 – 2011

Complainant : Smt. Raksha Kumarswamy Mudliyar

V/sRespondent : Bajaj Allianz Life Insurance Company Ltd., Mumbai

Award dated 9.11.2010.

Shri Kumaraswami Shunmugum Rajen had taken a Bajaj Allianz Centrury Plus Main Benefit Policy from Bajaj Allianz Life Insurance Company Ltd.. The SA was Rs.2.5 lakhs with yearly premium Rs.50,000/- for a term of 10 yrs. Shri Kumaraswami Shunmugum Rajen expired on 09.02.2010 due to Cardio Respiratory Arrest. The claim was preferred by his wife Smt. Raksha K. Mudliyar, however, the Company repudiated the claim. The Company stated that on the basis of various investigations and the various medical certificates confirm that the deceased life assured had history of diabetes mellitus, high blood pressure and occasional alcoholic since 10 years and he had not disclosed these facts in the proposal form.

The policy has run for 1 year 3 months and 17 days and thus resulted in an early claim. As per the written note from the complainant Smt. Raksha Muddliyar, the wife of the deceased life assured, she stated that her husband was healthy and regular in his duties. However in August 2009 for the first time he complained of pain in penis and he was admitted to Ashirwad hospital, Ulhasnagar from 28.08.2009 to 05.09.2009. He was referred to Bombay Hospital where he was admitted five times from 25.09.2009 to 21.10.2009, 26.10.2009 to 03.11.2009, 27.11.2009 to 07.12.2009, 28.12.2009 to 30.12.2009 and from 14.01.2010 to 03.02.2010. He was shifted to Sushrut hospital from 03.02.2010 and he expired on 09.02.2010.

As per the medical records from Ashirwad hospital, the deceased life assured was admitted with complaint of swelling on penis and history of DM since last 2 years. He was referred to Bombay Hospital for further treatment.

As per the medical records from Bombay Hospital, the deceased life assured was admitted with penis lesion since 10 months, jaundice since 10 days and a known case of Diabetes on medicine. He was diagnosed of Carcinoma of Penis (3rd stage) with cholestatic jaundice. He underwent operation of penis in the hospital and started with chemotherapy. As per the case papers the hospital, he was k/c/o uncontrolled diabetes mellitus and hypertension since last 10 years. Occasional alcoholic since last 10 years and had family history of diabetes mellitus.

As per the hospital papers of Sushrut hospital he was admitted on 03.02.2010 with complaint of left leg swelling with loss of appetite and nausea. He was under treatment till 09.02.2010 and declared dead due to cardio respiratory arrest with advanced carcinoma of penis with diabetes mellitus.

As per the Certificate of Hospital Treatment dated 22.04.2010 of Bombay Hospital, it is stated that Shri Kumarswami Shunmugum Rajen was admitted to the hospital on 25.09.2009 and discharged on 03.02.2010. The nature of the complaint is stated as "swelling of Penis – 1 – 2 months" the exact history reported by the patient at the time of admission was stated as "c/o carcinoma of Penis with Nodal Mets" and he was under the treatment of Dr. Deshpande of Ashirwad Hospital. The diagnosis arrived at the hospital of "Carcinoma Penis with Nodal Met".

As per the Medical Attendant Certificate dated 16.04.2010, signed by Dr. S.H. Advani of Shushrut Hospital & Research Centre, Chembur, he states that Shri Kumarswami Shanmugum Rajen expired on 09.02.2010 at the hospital. The primary cause of death was "Cardio Respiratory Arrest" and the secondary cause of death was "Advanced Ca Penis" and the duration of the ailment given was "6 months". The history reported was "Pt. was k/c/o Ca Penis (post operative) and had loss of appetite, swelling in groin, severe pain. To the question "Any other pre-existing / co-existing / past medical history" the answer given was "Diabetes" and Diabetes since 4-5 years".

From the evidence on record it is proved beyond doubt that the insured suppressed his health status at the time of proposal which was material for proper assessment of the risk by the Insurer. The basic claim was denied and the company was asked to refund of policy fund value to the claimant as at the time of intimation of death.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No. LI – 541 (2010 – 2011)

Award No. IO/MUM/A/ 390 /2010-2011

Complainant : Smt. Narmada Kalidas Tekale

V/s

Respondent : Life Insurance Corporation of India, Mumbai Divisional Office II

AWARD DATED 7.12.2010.

Shri Kalidas Damodar Tekale had taken Endowment policy from LIC of India for SA Rs.1.00 lac with quarterly premium of Rs.1917/- for a term of 20 yrs. The DOC was from 28.11.2003. The policy lapsed on 28.2.2006 and the same was revived on 31.7.2007. He expired on 5.2.2008 i.e. within6 months from date of revival of policy. the claim was rejected by LIC stating that they have indisputable evidence to prove that the LA had suffered from Diabetes Mellitus Type II, hypertriglycerides and Ischaemic heart disease since 2005 for which he took medical treatment in a hospital.. They stated that he did not, however, disclose these facts in the said Personal Statement of Good Health for the above policy at the time of revival of his policy

LIC has submitted the following documents as evidence to prove non-disclosure of material facts at the time of reviving his policy.

1. Letter from Dr. Rahul R. Tambe dated 27.08.2009. Dr. Tambe has stated in the said letter that Shri Kalidas D. Tekale was first seen by him in 2005 and subsequently on 10.11.2006 and that he was suffering from type II Diabetes Mellitus with IHD with hyper triglycerides.
2. The Certificate of Treatment and Consultation from Dr. Rahul R. Tambe states that the last date of consultation was on 10.11.2006 for IHD with type II DM with triglycerides. and he was suffering from the same since 2-3 years.
3. The Case History sheets of Arpan Nursing Home shows the Date of admission as 17.07.2005 and date of discharge as 22.07.2005. The diagnosis mentioned is TIA with DM with HT.
4. The OPD paper of Dr. Rahul R. Table dated 20.10.2006 states that Shri Kalidas D. Tekale was under his treatment from 09.10.2006 to 14.10.2006 on emergency basis with MI with Type II DM.
5. The Discharge Summary of Arpan Hospital shows the date of admission as 09.10.2006 and date of discharge as 14.10.2006 with diagnosis as Acute Inferior Wall MI with Type II DM with triglycerides..

The above documents clearly prove that the deceased life assured had consulted medical men and was undergoing treatment for his various ailments since 2005 had not disclosed his ailments at the time of reviving his policy on 31.07.2007. All the above hospitalizations and treatments were before the revival of the policy. Had he disclosed the correct information at the revival stage, LIC would have called for relevant medical reports and taken appropriate underwriting decision or even refused to revive the policy. The claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI-1015 (2010 -2011)
Award No. IO/MUM/A/ 430 /2010 – 2011

Complainant : Shri Bhavarlal Babulal Jain
V/s
Respondent : Max New York Life Insurance Company Ltd., Mumbai

AWARD DATED 4.1.2011.

Shri Amitkumar Bhavarlal Jain had taken policies from Max New York Life Insurance Company Ltd. The details of the policies under dispute are as under:-

Policy No.	268652336	268652344
Sum Assured Accident Benefit Rider	Rs.5.00 lacs Rs.5.00 lacs	Rs.5.00 lacs Rs.5.00 lacs
Product Name	Endowment to Age 60 on Participating Insurance	Endowment to Age 60 on Participating Insurance
Term of Policy with Riders	Upto 19.11.2041 36 years	Upto 19.11.2041 36 years
Date of Birth	20.11.1981	20.11.1981
Date of Proposal	20.11.2005	20.11.2005
Date of Commencement	19.11.2005	19.11.2005
Premium Amount	Rs.12,671.40	Rs.13,499/-
Mode of Payment	Annually	Annually
Date of Lapse	19.11.2008	19.11.2008
Date of Revival	25.05.2009	25.05.2009
Date of Death	17.09.2009	17.09.2009
Duration from Date of Revival	3 months 22 days	3 months 22 days

Shri Amitkumar Bhavarlal Jain had committed suicide and expired on 17.09.2009. His father Shri Bhavarlal Babulal Jain submitted the claims under the policies to the Company. HDFC Standard Life Insurance Company Ltd. sent a settlement letter dated 31.12.2009. In the said letter, the company drew the attention of the complainant to the suicide exclusion clause of the policy contract and as per which if the life insured commits suicide sane or insane within

one year from the later of effective date of coverage or the date of reinstatement of the policy, then the policy coverage shall come to an end simultaneously with the occurrence of such event and the liability of the company shall be limited to refund of the premiums received without interest, less any expenses incurred by the company. The company therefore refunded the premiums under the above policies vide cheques dated 31.12.2009 drawn on AXIS Bank. However, Shri Bhavarlal Jain was not happy with the decision of the Company and therefore he wrote to them again on 20.01.2010 for the full payment of his claims. The Company replied to his letter on 05.03.2010 stating that as the life assured had committed suicide within one year from the date of reinstatement of the policies, under such circumstances, the liability of the company shall be limited to refund of premiums received without interest, less any expenses incurred by the Company.

Shri Amitkumar Bhavarlal Jain had committed suicide and expired on 17.09.2009. His father Shri Bhavarlal Babulal Jain submitted the claims under the policies to the Company which the company refused quoting the suicide exclusion clause which reads as :

"Notwithstanding anything to the contrary stated herein, if the Life Insured

Commits suicide, whether sane or not at the time, within one year from the later of:

The Effective Date of Coverage or

a) The Date of Policy, or
b) The date of any reinstatement,

Then the policy coverage shall come to an end simultaneously with the occurrence of such event, and the liability of the Company shall be limited to refund of the premiums received, without interest, less any expenses incurred to the Company"

The Company stated that the policies lapsed due to nonpayment of premiums due 19.11.2008. The renewal premiums were paid on 19.05.2009 and the policies were reinstated on 25.05.2009. The life assured committed suicide and expired on 17.09.2009 i.e. within 3 months and 22 days of the reinstatement of the policies and as the policy contract was treated afresh, and as such, since the policy had not completed one full year after reinstatement, they refunded the premiums after deducting the expenses incurred by the Company.

The death of Shri Amitkumar Bhavarlal Jain had occurred within one year of reinstatement of the policies and suicide stands established as the cause of death as per records submitted. The claim for policy moneys is not, therefore, sustainable as per policy conditions. The Company is to refund the premiums paid under the policies, less any expenses incurred by the company, if not already paid, as per the terms and conditions of the Policies. In

view of the above, there is no justified reason to intervene with the decision of the Insurance Company.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI - 765 of 2010-2011
Award No. IO/MUM/A/ 436 /2010 - 2011
Complainant: Smt. Geeta Mahendra Rashinkar
V/s
Respondent: LIC of India, Thane Divisional Office.

AWARD DATED 10.1.2011.

Shri Mahendra R. Rashinkar had taken a policy from LIC of India, Thane Divisional Office for SA Rs.1.00 lakhs with quarterly premium of Rs.1811/- for a term of 16 years. The DOC was from 15.1.2008. Unfortunately Shri Mahendra R. Rashinkar expired on 11.09.2009 due to cancer i.e. within 1 year 7 months and 27 days from the date of commencement of the policy resulting in an early claim. His wife Smt. Geeta Rashinkar submitted a claim to LIC of India but the claim was repudiated for non-disclosure of leg fracture prior to date of proposal for which he had consulted medical practioner and had taken treatment from hospital and further he did not attend office for 31 days in March/April 2005. He however did not disclose these facts in his proposal statement.

As per the Medical Attendant's Certificate - Claim Form B, signed by Dr. Bomen Dhoblar from Sushrusha Hospital, he states that Shri Mahindra R. Rashinkar expired on 11.09.2009 and the primary cause of death was Non Hodgkin's Lymphoma (NHL), a type of cancer . He states in the said certificate that the symptoms were high grade fever and general weakness and the symptom were first observed in January 2009. He also states that no other disease co-existed with the previous illness. The Histopathology Report from Tata Memorial Hospital dated 28.03.2009 states that the impression of the Cervical Lymph node is "Non Hodgkin's Lymphoma with infarction and necrosis making typing difficult. However I Favour – Anaplastic large null cell type of lymphoma based on morphology of viable cells". The Immunohistochemistry results show "These large cells are positive for CD30. They are negative for CD20, CD3, ALKI, EMA, CK & LCA".

LIC has no dispute about the cause of death of the life assured. They have admitted that his death was due to cancer and the same was detected in March 2009. The main dispute is about the non-disclosure of left leg fracture in March/April 2005 and when the deceased life assured had also availed of 24 days leave in the month of March and 7 days leave

in the month of April and reason for leave taken was "Fracture / Plastered" Shri Mahendra R. Rashinkar, the deceased life assured was working with the Company M/s Bhagvati Steel Industries. His employer has provided the leave record of Shri Mahendra R. Rashinkar for the years from January 2005 to December 2007 i.e. 3 years leave records before the commencement of his policy. During the year 2005, apart from the leave which he had availed for fracture, from May 2005 to December, 2005, he has availed 6 days leave. During the period January 2006 to December 2006 he has availed 13 days leave during the year and 14 days during the period January 2007 to December 2007 on various occasions. The leave record does not show any long leave taken by the deceased life assured during these years. This proves that the fracture of the deceased life assured had healed and he was attending to his duties. It is evident that a person who sustains a leg fracture will not be able to walk due to the bandage and plaster and it is obvious that he had availed of 31 days during this period.

Shri Mahendra R. Rashinkar had proposed for the policy on 15/01/2008 and was issued the above policy with date of commencement as 15/01/2008. However, in the proposal form he failed to mention about his fracture. From the said records it is also seen that his wife Smt. Geeta Rashinkar was the agent for the said policy and it was her bound duty to mention the incident of fracture in the proposal form.

From the above documents it could be ascertained that the deceased life assured had expired due to cancer. However, from the hospital records and Histopathology report of Tata Memorial Hospital produced by the complainant, it is evident that the onset of cancer was from March 2009 i.e. only after the commencement of the policy. The repudiation of the claim by the Insurer was on the ground that the deceased Life Assured suppressed the fact that he had a left leg fracture, for which he availed of 31 days leave during March / April, 2005 and except for this the insurer has not produced any other documents as evidence that the LA's fracture had not healed and that he was taking treatment for the same prior to the proposal of the policy. LIC of India has failed to provide any evidence by way of any other medical reports, orthopedic reports, consultation papers or medical prescription of a doctor or medical bills prior to issuance of the policy.

The Forum observes that the Insurer has repudiated the claim on the grounds of suppression of material facts regarding non-disclosure of fracture of left leg in 2005 prior to the date of the proposal. The basis of such repudiation is the leave record of the deceased life assured where he availed of 31 days leave due to fracture / plaster. However he expired due to cancer which developed from March 2009.

Taking into consideration all the facts of the case, and looking to the fact that the deceased life assured had a fracture of left leg in 2005 and he expired due to cancer on 11.09.2009 which he came to know only in March 2009, and looking to the fact that there is no nexus between a leg fracture and cancer, an exgratia payment of Rs.50,000/- was awarded.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 790 (2010 – 2011)

Award No. IO/MUM/A/ 437 /2010-2011

Complainant : Smt. Sheela Michael Gonsalves

V/s

Respondent : Bajaj Allianz Life Insurance Company Ltd., Mumbai

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AWARD DATED 10.1.2011.

Shri Michael Sabestian Gonsalves had taken a New Unit Gain Main Policy from Bajaj Allianz Life Insurance Company Ltd. The SA was Rs.6.25 lacs with an annual premium of Rs.25,000/-. The DOC was 4.3.2010. Shri Michael Sabestian Gonsalves expired on 31.03.2010 due to Cardiac Arrest i.e. within 27 days from the commencement of the policy.. The claim was preferred by his wife, Smt. Sheela Michael Gonsalves. Bajaj Allianz Life Insurance Company Ltd. repudiated the claim due to non disclosure of material facts. They stated that in his proposal form dated 19.02.2010 he had not disclosed history of hospitalization/treatment for convulsion with seizure disorder with acid peptic disease with anxiety since 28.05.2008. In the said Proposal Form dated 19.02.2010 the life assured in reply to Q.No.14 (1.) which reads as "In the last 5 years have you ever had or been advised to have or are likely within the next 30 days to undergo medical examination or any investigation such as but not limited to Blood test, Urine Test, X-ray, ECG or Bioscopy CT Scan or test by any other special instrument" He had answered "No". Bajaj Allianz Life Insurance Company Ltd. therefore, repudiated the claim on the grounds on non-disclosure of material facts of his illness prior to his proposal for assurance

Smt. Sheela Michael Gonsalves, wife of the Deceased Life Assured and Smt. Mary Remedios, elder sister of the complainant appeared and deposed before the Ombudsman. Smt. Sheela Michael Gonsalves stated that Bajaj Allianz Life Insurance Company Ltd. refused to settle the claim. Smt. Mary Remedios stated that since her sister could not speak English, she would depose on behalf of her sister. Smt. Mary Remedios stated that her brother-in-law Shri Michael Gonsalves was issued the policy after he was examined by the company's doctor and then only he was issued the policy. She wanted to know how the company could issue the policy if her brother-in-law had some health problem. The company states that he had history of hospitalization/treatment for convulsion and therefore refused the claim. However, Smt. Sheela Gonsalves admitted that in 2008 her husband was admitted to the hospital for 3-4

days for convulsion and seizure but after that he was alright. She stated that her husband was fit and healthy at the time of taking the policy.

Bajaj Allianz Life Insurance Company Ltd. was represented by Shri G. Ramchandra Raju, State Operations Manager. He submitted that policy has run only for 27 days after date of commencement of the policy when the death claim materialized. He also clarified that the policy was under non-medical and no medical examination was done. As it was a very early claim, investigations were carried out by the Company. He stated that as per the medical certificate issued by Om Hospital, the life assured died due to cardiac arrest, acute myocardial infarction and hypertension. As per the certificate dated 28.05.2008 issued by Dr. Prasheel A. Patil, the LA was diagnosed convulsion with seizure disorder with APOD with anxiety. Had these facts were known the company would have called for the treatment papers and accordingly called for certain medical reports and accordingly the underwriting decision would have been different. The company would have either rated or declined the case. The Company was right in repudiating the claim for non-disclosure of material facts. He defended the decision of the Company.

During the hearing it came to the notice of the Ombudsman that Smt. Mary Remedios was the Lead Generator of this policy and she has signed the proposal form. In spite of being asked in the beginning whether she was an agent, she told that she was not. To a pointed question from the Ombudsman she agreed that she was the lead generator under the policy and her LG code is 10L0205204. Hence the Ombudsman held that she has misled the proceedings of the Hearing, and since she has a vested interest in the case, the case could not be heard by him. He dismissed the case and asked the complainant to approach any other Forum as she deems fit.

However, the Insurance Company's decision of forfeiting the full premium may be technically correct in view of the declaration signed by the proposer but neither it is neither fair nor reasonable. The Insurer is entitled to recover all the charges and cost incurred while procuring the policy, managing the fund, and mortality charges but it will be unfair not to refund the fund value as the policy has a component of investment in addition to risk cover Bajaj Allianz Life Insurance Company Ltd...was directed to pay the Policy Fund Value under the Policy on ex-gratia basis.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI – 792 (2010 – 2011)
Award No. IO/MUM/A/ 478 /2010 – 2011
Complainant : Smt. Savita Sudhir Sonawane
V/s
Respondent : Tata AIG Life Insurance Company Ltd., Mumbai

AWARD DATED 1.2.2011.

Shri Sudhir Suryakant Sonawane had taken "Mahalife Gold" Plan policies for his daughter Khushi Sudhir Sonawane and his son Rishi Sudhir Sonawane from Tata AIG Life Insurance Company Ltd. Shri Sudhir Suryakant Sonawane had opted for Payor Benefit Rider under both the policies as per which if in any unfortunate event of death or total and permanent disability of Payor, the future premiums would be waived off and the base policy would continue. The details of the policies are given below:

Mahalife Gold Policies of :	**Khushi Sudhir Sonawane**	**Rishi Sudhir Sonawane**
Policy Nos.	C139046317	C142346868
Sum Assured	Rs.1,70,000/-	Rs.1,70,000/-
Premium Amount Mode of Payment	Rs.15,979/- Annual	Rs.16,429/- Annual
Premium Paying Term	15 years	15 years
Policy Term / Maturity Date	93 years / 18/01/2103	95 years / 04/01/2105
Date of Birth	22/09/2002	26.09.2004
Date of Proposal	30/12/2009	30/12/2009
Date of Commencement	18/01/2010	04/01/2010
Date of Death of Payor (Shri Sudhir S. Sonawane)	30/04/2010	30/04/2010
Duration from Date of commencement	3 months 12 days	3 months 26 days

Unfortunately, Shri Sudhdir Suryakant Sonawane expired on 30/04/2010 due to Cardio Respiratory Arrest. As the duration between the issue of the policies and the date of death of Payor was approximately 3 months, the company conducted investigations that showed that the Shri Sudhir S. Sonawane had not disclosed his health problems in the application form and therefore repudiated the claim for non disclosure of material facts.

The repudiation of the claim. was due to non-disclosure of past medical history and suppression of material facts by the deceased life assured in the proposal for assurance. The company submitted the medical documents of Shri Sudhir S. Sonawane. The proposal of the above policies were dated 30.12.2009 and the medical records were prior to the proposal date. The company has produced by way of evidence the following reports.

1. Report dated 25.09.2009 of the Sonagraphy of Abdomen from Darshan X-ray and Sonagraphy Clinic. The impression stated in the report was "Mild hepatomegaly with fatty infiltration. No focal lesion is seen. P.S. Tenderness was noted in epigastrium and RHC, over the stomach and gastric antrum, is likely to indicate possibility of gastritis/antral gastritis. Kindly evaluate further clinically".
2. The Liver Function Test Report dated 18.12.2009 from Advance Diagnostic Centre shows the S.G.O.T, S.G.P.T. and ALK Phosphate levels very high.
3. The Bio Chemistry Report dated 25.11.2009 from Advance Diagnostic Centre shows the G.G.O.T., T-BILIRUBIN AND D- BILIRUBIN levels very high.

Based on the above medical reports which were prior to the proposal of the posicy, it is confirmed that Shri Sudhir S. Sonawane was suffering from Hepatomegaly with fatty infiltration of liver prior to application for insurance. The claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI – 735 (2010 – 2011)
Award No. IO/MUM/A/ 477 /2010 – 2011
Complainant : Smt. Anita Anand
V/s
Respondent : Tata AIG Life Insurance Company Ltd., Mumbai

AWARD DATED 1.2.2011.

Shri Yogesh Hansraj Anand had taken Tata AIG Life Invest Assure Flexi Plan policy with SA Rs.3.00 lacs. The premium amount payable was Rs.60,000/- annually for a policy paying term of 3 years. The policy term was 5 years. The DOC was 20.11.2009.
Shri Yogesh Hansraj Anand expired on 20/04/2010 due to Cardio Pulmonary Arrest. The claim was preferred under the above policy by his wife Smt. Anita Anand. Tata AIG Life Insurance Company Ltd. repudiated the claim on the ground that Shri Yogesh Hansraj Anand made deliberate mis-statement and withheld material information from them regarding his health at the time of proposal for the above policy.

Tata AIG Life Insurance Company Ltd., however, stated that the aforesaid answers were false as their investigations have established that the life assured was suffering from Diabetes Mellitus and Hypertension and was on regular treatment since prior to the application for insurance. Hence they repudiated the claim on grounds of non disclosure of material facts. The Company sent a cheque for Rs.51,590.29 being the bid value under the policy.

As per the medical records of Bhabha Atomic Research Centre where the deceased life assured was taking regular treatment on OPD basis from 2005 onwards, it is stated that Shri Yogesh Anand was having Hypertension since 20 years and Diabetes Mellitus since 9 years. The policy was taken in November 2009. The complainant, Smt. Anita Anand has also admitted in her complaint 18.10.2010 to this Forum that her husband was a known case of Hypertension and Diabetes Mellitus. During the hearing on 12.01.2011 at this Forum, the complainant admitted that her husband was having Hypertension and Diabetes Mellitus and was on regular treatment. Despite this known fact, the deceased life assured had not mentioned his ailments in the proposal for assurance. The claim was denied.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 063 (2010-2011)

Award No. IO/MUM/A/ 487/2010-2011

Complainant : Smt. Gayatri Srinivas Garje

V/s

Respondent : HDFC Standard Life Insurance Company Ltd., Aurangabad.

AWARD DATED 07.02.2011.

Shri Yashpal Baburao Terakar had taken an HDFC Unit Linked Young Star Suvidha Plan Policy from HDFC Standard Life Insurance Company Ltd. with SA Rs.2.5 lac with yearly premium of Rs.50,000/- for a term of 15 years. The DOC was 31.8.2008. The policy lapsed on 17.9.2009 and was revived on 24.10.2009. He expired on 13/12/2009 due to Cancer of the mouth. He expired within 50 days of revival of the policy. The claim was preferred by his daughter Smt. Gayatri Shrinivas Garje to HDFC Standard Life Insurance Company Ltd.. The Company repudiated the claim quoting the exclusion clause 3(i) (b) of the policy terms and conditions of the policy document. The company along with the repudiation letter sent a cheque for an amount of Rs.61,289.83 towards the fund value under the policy.

Clause 3(i) (b) of the policy terms and conditions which read as follows

> **"In case of non accidental death, risk cover will commence from the 91st day after the date of commencement or the 91st day after the date of issue or the 91st day after the date of revival of the policy, whichever is later".**

The policy lapsed due to non-payment of 2nd renewal premium due 31.08.2009. The renewal premium was paid and the policy was revived on 24/10/2009. However, the life assured expired on 13/12/2009 i.e. within 50 days of revival of policy. According to the above terms and conditions of the policy document, the death benefit is not payable and only the fund value is payable. The company accordingly has sent a cheque for Rs.61,289.83 towards fund value to the claimant. The claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI – 484 (2010 – 2011)
Award No. IO/MUM/A/ 492 /2010 – 2011
Complainant : Smt. Geeta Ganesh Patil
V/s
Respondent : LIC of India, Mumbai Divisional Office, MDO II

AWARD DATED 8.2.2011.

Shri Ganesh Sitaram Patil had taken a life insurance policy from LIC of India for SA Rs.1.00 lacs for a term of 20 years with premium amount of Rs.441/- payable monthly. The DOC was 4.3.2007. Shri Ganesh Sitaram Patil expired on 20/05/2008 due to alcoholic liver cirrhosis. His wife Smt. Geeta Ganesh Patil preferred the claim. LIC of India repudiated the claim stating that the deceased life assured had withheld correct information regarding his health at the time of effecting the assurance.

LIC of India, stated that the DLA was a known case of chronic alcoholic and he was suffering from nutritional anemia secondary to chronic alcoholism. He was also diagnosed for Mitral Valve Prolapse in 1993 and he was suffering from generalized tonic convulsion from 2006. He did not disclose these facts in his proposal form.

The deceased life assured was working with BARC, Tarapur as a Helper. By way of evidence, LIC has provided the Medical Summary dated 11/05/2009 signed by Dr. Sweta Agrawal, MO/C and Dr. S.K. Jain, Medical Superintendent of Tarapur Atomic Power Station Hospital (TAPS). The case history records of TAPS Hospital of Shri Ganesh Sitaram Patil is stated below:

- The patient was a known case of chronic alcoholism. He was repeatedly admitted at TAPS Hospital due to lack of appetite, generalize weakness, tremors in all limbs, alcoholic gastritis and hematemesis secondary to alcoholism.
- He was sent to BARC Hospital Mumbai for psychiatric consultation and treatment.
- He underwent EMG test at Jaslok Hospital Mumbai on 20/12/1993 to rule out alcoholic peripheral neuropathy and it was suggestive the evidences of sensory neuropathy in both lower limbs.
- Patient was diagnosed for suffering from MVP (Mitral Valve Prolapse) in 1993 and was advised 2 D ECHO but the patient did not go for it.
- Patient was also suffering from nutritional anemia secondary to chronic alcoholism.
- Patient was referred to BARC Hospital, Mumbai, for alceration and indurations at left border of the tongue. The tongue biopsy was don and showed chronic inflammatory fungal hyphae.
- Patient complained of GTC (generalized tonic convulsion) from 2006 and was started with antiepileptic drugs, which patient was not taking regularly.
- Patient was on Tab Eptoin (100 mg)1 TDS, Tab LIV 52, Tab. Librium (10 mg) 1 TDS, Tab Serenace (1.5 mg) BD, Tab. Folvite (5 mg) BD.

As per the Medical Attendant's Certificate - Claim Form B and Certificate of Hospital Treatment of TAPS Hospital, on 27/04/2008 Shri Ganesh S. Patil was brought dead to TAPS Hospital and the cause of death was given as Alcoholic Liver Cirrhosis. It is mentioned that he was a chronic alcoholic and 20 years back he was first observed for alcoholism.

Based on the above facts, it is clearly established that he has committed a breach of contract and hence LIC of India cannot be faulted for repudiating the claim made by Smt. Geeta Ganesh Patil

MUMBAI INSURANCE OMBUDSMAN CENTRE
Complaint No. LI – 707 (2010 – 2011)
Award No. IO/MUM/A/ 531 /2010 – 2011

Complainant : Smt. Rekha Lakhan Indrekar
V/s
Respondent : Max New York Life Insurance Company Ltd., Nasik

AWARD DATED 03.03.2011

Smt. Rekha Lakhan Indrekar, the wife of the deceased life assured Shri Lakhan Vishnu Indrekar, stated that her husband expired on 10/03/2009 due to Jaundice. According to the death claim application form submitted to the Company, it states that her husband expired due to Jaundice and the duration of the disease was from 07/03/2009 to 09/03/2009 and that Dr. S.R.Sharma was the doctor

treating her husband. She has also made a mention in the application form that Dr. Madhukar S. Acharya was their family doctor. However during the hearing she stated that the allegation of the insurance company that her husband was an alcoholic is wrong and that he did not have any family doctor and she did not know how Dr. Acharya had given a certificate that her husband was an alcoholic.

An examination of the various documents submitted by both the parties to the dispute and the oral deposition reveals the following:

- Shri Lakhan Vishnu Indrekar, who died on 10/03/2009 was given a whole life cover policy for a sum insured of Rs.5.00 lakhs along with level term insurance cover of Rs.3.00 lakhs and personal accident benefit cover of Rs.3.00 lakhs, with date of commencement as 08/05/2008.
- The policy is for a term of 29 years.
- The occupation of the life assured as per the proposal is "Grocery Shop" with an annual income of Rs.1.25 lakhs
- The proposal does not indicate the existence of any other insurance policy with any other insurer.
- The life assured has signed the application form in vernacular language and the proposal form does not clearly indicate the identity of the person who has explained to the Life Assured all the questions in the proposal to ensure that all answers have been truthfully recorded.
- The proposal and policy reveals that the permanent address of the Life Assured is House No.118-1-16, Mangaohala Pada Bazar Galli, Kalivada, Nasik 422215.
- But the death of the life assured has taken place on 10/03/2009 at Kasbe Vani, Taluka Dindori, Nasik District.
- Though the proposal does not indicate the existence of any previous insurance, it is found that the deceased life assured has taken Policy No.08855579 with ICICI Prudential Life Insurance Company Ltd. through proposal dated 12/05/2008 and the claim under the policy for Rs.4,13,852/- has been settled by the said insurer on 20/04/2010.
- It is pertinent to note that the deceased life assured has proposed for a basic insurance cover of Rs.5.00 lakhs on 08/05/2008 with Max New York Life Insurance Company Ltd. and within a span of another 4 days has proposed for a cover of Rs.4.00 lakhs on 12/05/2008 with ICICI Prudential Life Insurance Company Ltd., taking the total insurance cover to Rs.9.00 lakhs.
- It is also seen that the deceased life assured Shri Indrekar has not mentioned about the proposal for insurance submitted to Max New York Life Insurance Company Ltd. on 08/05/2008, in the proposal dated 12/05/2008 submitted to ICICI Prudential Life Insurance Company Ltd..

In my assessment, the denial of the liability under the policy has been done by the insurer on the basis of suppression of material facts by the deceased life assured at the time of taking the insurance. The death has happened within a period of 10 months and 2 days from the date of commencement of risk and hence Sec.45 of the Insurance Act 1938 is in favour of the Insurance Company, since the liability has arisen within 2 years from the date of commencement of risk.

I am of the view that arbitration in this case, in beyond the purview of this Forum for the following reasons:

- The deceased life assured has taken a fairly large insurance cover of Rs.9.00 lakhs in a short span of 4 days from two different insurance companies and he has not disclosed the details of previous insurance policy in the proposal submitted to Max New York Life Insurance Company Ltd. which is the subject matter of the complaint.
- The insurance company has denied the claim on the basis of a Doctor's certificate who has stated that the deceased life assured was suffering from alcoholic related disease for last 2 years.
- But the insurance company has not given any material evidence, other than the doctor's certificate, to prove that the deceased life assured was in fact an alcoholic and died due to alcoholic related disease.
- At the same time, the complainant has not also been able to prove to the satisfaction of the Forum that the deceased life assured was not consuming alcohol and the death is only due to jaundice. In fact the full detail of treatment of jaundice which is said to be the cause of death has not been submitted to the Forum.

Considering all the above facts, I came to the conclusion that there are certain basic inherent inadequacies in the whole case which in my opinion, needs a deeper examination. The Forum having limitations in the sense that under RPG Rules 1998, the proceedings of this Forum are summary in nature. Hence, I am constrained to dismiss the case at this Forum with a direction to the complainant Smt. Rekha Lakhan Indrekar to approach some other appropriate Forum like a Consumer Court as she deems fit for getting redressal of her grievance.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No. LI – 830 (2010-2011)

Award No. IO/MUM/A/ 554 /2010-2011

Complainant : Smt. Vrushali Vilas Pokale

V/s

Respondent : SBI Life Insurance Company Ltd., Goa.

AWARD DATED 18.3.2011

Shri Vilas Anand Pokale had taken SBI Life Horizon II insurance policy from SBI Life Insurance Company Ltd. for SA Rs.1.87 lacs for a term of 15 years with a yearly premium of Rs.25,000/-. The DOC was from 26.12.2006. The policy lapsed on 26.12.2008 and was revived on 6.3.2010. Shri Vilas Anand Pokale expired on 06/03/2010 due to Brain Stroke within 1 day of revival of policy. His wife Smt. Vrushali Vilas Pokale preferred the claim to the Company. SBI Life Insurance Company Ltd. repudiated the claim stating that the deceased life assured had withheld material information regarding his health at the time of revival of his policy.

SBI Life Insurance Company Ltd. has repudiated the death claim under the policy on the grounds of non disclosure of material facts. The deceased life assured was diagnosed for Right Temporal Glioblastoma in December 2008 and was under treatment for the same. The Insurer has

provided medical documents/reports by way of evidence to prove that the deceased life assured had not disclosed his various ailments in the Declaration of Good Health dated 04/03/2010 which was submitted to the Company is listed below:

1. The MRI Brain report of K.L.E. Belgaum Imaging & Diagnostics Pvt. Ltd. dated 14/11/2008 reveals that the deceased life assured Shri Vilas Anand Pokale had impression of "conglomerate tuberculomas in right parietal region".
2. The follow up MRI Brain report of K.L.E. Belgaum Imaging & Diagnostics Pvt. Ltd. dated 03/12/2008 reveals that there was a slight increase in the size of the irregular peripherally enhancing lesions.
3. The C.T. Scan report of K.L.E. Belgaum Imaging & Diagnostics Pvt. Ltd. dated 10/12/2008 reveals that the DLA was operated for right glioma (brain tumour).
4. The Histopathology report of NIMHANS dated 16/12/2008 had impression of Glioblastoma – WHO grade IV, right temperoparietal lesion.
5. The summary sheet dated 18/12/2008 of KLES, Dr. Prabhakar Kore Hospital & Medical Research Centre, Belgaum, shows that the DLA was diagnosed for Right Temporal Glioblastoma. It states that Shri Vilas Anand Pokale was admitted on 06/12/2008 and was discharged on 18/12/2008. It is also evident from the summary sheet that he had undergone right temporal craniotomy and decompression on 09/12/2008.
6. The CT Brain report dated 23/12/2008 reveals that the DLA had impression of SOL in the right parietal lobe-Astrocytoma (Astrocytoma is a kind of brain tumour).
7. The summary sheet dated 24/12/2008 of KLES, Dr. Prabhakar Kore Hospital & Medical Research Centre, Belgaum, shows that the DLA was admitted there on 23/12/2008 and discharged on 24/12/2008. He was diagnosed or recurrent glioma and has undergone surgery on 09/12/2008.
8. The MRI Brain report of Tata Memorial Hospital dated 26/12/2008 had impression of large residual tumour in the right parietal lobe. It is also noted in the report that this was a case of GBN post operative status.
9. As per the C.T. Scan report of Tata Memorial Hospital dated 30/12/2008, it was clear that there was evidence of residual disease.
10. The treatment plan report dated 26/02/2009 reveals that the DLA was under treatment.
11. The MRI brain report of Tata Memorial Hospital dated 07/05/2009 reveals that the DLA was still having brain tumour.
12. From the Discharge Summary of Tata Memorial Hospital it is clear that the DLA was admitted in the Radiation Oncology Department on 04/02/2010 and was discharged on 07/02/2010. It is clear from the discharge summary that the DLA was having residual disease. The Radiation Therapy prescription of Tata Memorial Hospital reveals that the DLA was advised to undergo radiation and from the radiation oncologist's notes it is clear that he was undergoing radiation therapy.
13. From the Medical Attendant's Certificate dated 05/04/2010, it is clear that the DLA had expired on 06/03/2010 due to Brain Stroke.
14. In the certificate given by Dr. Sandipkumar S. Yadav, he has certified that the most probable cause of death of the Shri Vilas Anand Pokale was multi organ failure due to Carcinoma brain.

On the basis of the above facts the claim was denied.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No. LI – 734 (2010 – 2011)

Award No. IO/MUM/A/ 577 /2010 -2011

Complainant : Smt. Laxmi Babu Salian

V/s

Respondent : LIC of India, Udupi Divisional Office.

AWARD DATED 28.3.2011

Shri Dinesh Babu Salian, the deceased life assured had taken two Bima Gold policies from LIC of India, one policy bearing No.882703963 from Mumbai Divisional office vide proposal dated 27/03/2006 for sum assured Rs.2.00 lakhs and by way of age proof he submitted his school leaving certificate where the age mentioned was 09/10/1973. The second policy bearing No.624813414 was taken from Udupi Divisional Office vide proposal dated 30/03/2006 for sum assured Rs.2.50 lakhs and by way of age proof he submitted his voters card where his age was mentioned as 01/01/1978. Thus both these policies have been taken with a gap of 3 days. However the age mentioned in both these policies were different. Shri Dinesh Babu Salian expired on 14/10/2007 due to Renal Failure and the claims were preferred by his mother Smt. Laxmi Babu Salian to the respective offices of LIC of India. Mumbai Divisional Office settled the full claim of Rs.2.00 lakhs under Policy No. 882703963. However, Udupi Divisional Office repudiated the claim on grounds of non-disclosure of hypertension, his previous proposal dated 27/03/2006 taken from Mumbai Divisional Office and understating his age by 4 years than his actual age. Smt. Laxmi Salian represented her case to the Claims Review Committee and after review of her case, considered to settle the claim for Rs.1,25,000/- on ex-gratia basis.

The Hospital records go to prove that the deceased life assured had expired due to Renal Failure where the symptoms are mentioned as suffering from 20 days. However, from the hospital records produced, it is not evident about the date of onset of hypertension. In the Discharge summary of the hospital the onset of hypertension is mentioned as 1 year. However, in the case papers of the said hospital it is mentioned as 1½ years.

If we consider the Policy No.882703963 taken by the deceased life assured from Mumbai Division II of LIC of India, we find that this policy has commenced on 27/03/2006. It is seen that he was medically examined by a panel doctor of LIC whose limit is Rs.10 lakhs. It is also seen that no special reports were called for in this case and the proposal 27/03/2006 does not also confirm any adverse revelations about his health and habits. The risk is accepted by LIC at normal rates. The approval for settlement of the claim has been given by the Zonal Claims Review Committee of Western Zonal Office of LIC and the claim was settled in full on 30/05/2009. In this case also, the claim has arisen within a period of 1 year and 6 months LIC Mumbai D.O. II must have conducted the necessary investigations and must have repudiated the claim at the first stage. On the appeal by the claimant, the claim was admitted.

Regarding Policy No.624813414 taken from Udupi Divisional Office of LIC. The main ground of repudiation are the facts of ill health mentioned in the hospital papers, the non disclosure of Policy No.882703963 taken from Mumbai Division II and understatement of age by submitting a voters' ID card instead of school certificate. I considered all the above 3 grounds of repudiation and I observe as below:-

- Other than the hospital papers which mention the history of hypertension, reformed alcoholic and smoker, LIC has not been able to produce any evidence of actual medical treatment taken by the deceased life assured.
- The fact that there is a variation in date of birth i.e. in the policy taken with Mumbai Division II, the DOB is given as 09/10/1973 with age as 32 years and in the policy taken with Udupi D.O. the DOB is stated as 01/01/1978 with age as 28 years, leads to an understatement of age by 4 years. Though this difference is significant, it will be very material if from underwriting perspective the difference in age makes it necessary to call for additional medical reports which are necessary to consider the risk. In this case it is seen that since the DLA's age was taken as 32 years in Mumbai, he had been medically examined by LIC's medical examiner on 25/03/2006 for the sum assured of Rs.2.00 lakhs. In the case of Udupi D.O. based on the age stated as 28 years, LIC had given an insurance cover of Rs.2.5 lakhs and LIC mentions that for considering this risk a person aged 32 years, only a medical report is sufficient. Accordingly, the mis-statement of date of birth leading to understatement of age does not make any serious underwriting implication.

- Finally, the question of not mentioning the policy No.882703963 taken in Mumbai D.O.II in the proposal submitted to LIC, Udupi, which is the subject matter of this complaint. Again the question here is, if the deceased life assured had stated the existence of the suppressed policy, whether any additional medical reports would have been called for and LIC's stand in this respect that even for Rs.4.5 lakhs, the medical report is sufficient. Hence I am of the view that the suppression of the previous policy is not making any material impact in this case.

Here the question of understatement of age and suppression of previous insurance is clearly established in this case. At the same time, in respect of suppression of medical history, other than the hospital reports, no other concrete evidence is produced.

Taking into account all the above aspects into consideration, LIC of India was directed to pay the balance amount of Rs.1.25 lakhs with bonus if any, under Policy No. 624813414 after deducting the appropriate difference of premium taking the correct date of birth as 09/10/1973 as given in the School Certificate of the deceased life assured.

MUMBAI INSURANCE OMBUDSMAN CEMTRE
Complaint No. LI – 422 (2010-2011)
Award No. IO/MUM/A/ 590 /2010 - 2011
Complainant: Smt. Tabassum Sheikh
V/s

Respondent: Future Generali (I) Life Insurance Co. Ltd., Nagpur

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AWARD DATED 29.3.2011.

Shri Sheikh Irfan Hussain had taken a Future Assure with Profit Endowment Assurance Plan Policy from Future Generali India Life Insurance Co. Ltd. The SA was Rs.1.00 lac for a term of 18 years. The DOC was from 20.2.2009. Shri Sheikh Irfan Hussain expired on 21/02/2010 due to Chronic Alcoholic with Cirrhosis of Liver with PHT with Ascites with massive haematemesis with shock. His wife Tabassum Sheikh submitted a claim which was rejected by the Company on grounds of non-disclosure of material facts.

The leave records for the years 2006 to 2009 obtained from Akashwani, Nagpur, where Shri Sheikh Irfan Hussain, the deceased life assured was working as a Helper reveal that he was very often on extra ordinary leave (leave not available to his credit) for long periods of time. Some particulars of leave availed by him for long durations before the date of proposal i.e. 16.2.2009 are given below:

17.1.2006 to 25.1.2006	**-**	**9 days**	**– leave not available to his credit**
26.1.2006 to 6.4.2006	**-**	**71 days**	**- leave not available to his credit**
22.10.2006 to 17.12.2006	**-**	**57 days**	**- leave not available to his credit**
17.1.2007 to 1.2.2007	**-**	**16 days**	**- half pay**
1.5.2007 to 9.5.2007	**-**	**9 days**	**- leave not available to his credit**
12.2.2007 to 2.3.2007	**-**	**19 days**	**- leave not available to his credit**
1.5.2007 to 9..5.2007	**-**	**9 days**	**- leave not available to his credit**
31.5.2007 to 22.7.2007	**-**	**53 days**	**- leave not available to his credit**
16.6.2008 to 13.7.2008	**-**	**28 days**	**- On medical grounds**

The Company declined the claim on the grounds of non-disclosure of material facts prior to proposal. The Company has provided by way of evidence a certificate dated 20.08.2008 (i.e. prior to date of proposal) from Dr. Harish Tirpude of Mayo General Hospital, Nagpur, that states "This is to certify that Shri Sheikh Irfan Hussain, age 41 years was suffering from infective hepatitis and was under my treatment since 30/07/2008 to 20/08/2008". He was fit to join his duties from 21.8.2008". However, from the above periods of leave it is observed that the deceased life assured was not on leave during this period, but

however, he might have been taking treatment from Dr. Harish Tirpude and attending his duties.

The company has repudiated the claim on the grounds of this evidence that the deceased life assured was taking treatment from Dr. Harish Tirpude for infective hepatitis. Shri Irfan Sheikh was admitted to Mure Memorial Hospital, Nagpur from 8.10.2009 to 12.10.2009 and was diagnosed as chronic alcoholic liver disease, hepatitis, choledocholithiasis and Megaloblastic anemia. This also proves that Shri Irfan Sheikh was not a social drinker as he had disclosed in the proposal form that he takes 2-3 pegs of whisky in a month but a heavy drinker to reach the stage of chronic alcoholic liver disease within 8 months of taking the policy. The company states that had he disclosed his fact, the underwriting decision of the company would have been different. It should also be mentioned that according to the leave particulars given by his employer, the leave availed by the deceased life assured was for very long periods at a given point of time and that to when he had no leave to his credit. During the deposition of Smt. Tabussum Sheikh at Nagpur, she had admitted that her husband had taken treatment from Dr. Harish Tirpude. She also admitted that in the past her husband had suffered from jaundice. However, he had not disclosed these facts in the proposal dated 16.2.2009 for insurance.

From all the above documents it could be ascertained that the deceased life assured had expired due to chronic liver disease and hepatitis. The basis of such repudiation is the medical certificate of Dr. Harish Tirpude dated 20.08.2008 where he treated the life assured for infective hepatitis from 30.7.2008 to 20.8.2008 which the deceased life assured had not disclosed. The claims was declined.

MUMBAI INSURANCE OMBUDSMAN CENTRE

Complaint No.LI-764 (2010-2011)

Award No.IO/MUM/A/ 591 /2010 - 2011

Complainant : Shri Dharamchand Shivchand Nimani

V/s.

Respondent : HDFC Standard Life Insurance Company Ltd., Pune

AWARD DATED 29.3.2011.

Shri Dharamchand Shivchand Nimani**,** had taken a Unit Linked Endowment Plan (Life & Health Option) policy from HDFC Standard Life Insurance Company Ltd. The Critical illness benefit was for Rs.2.00 lacs and life cover of Rs.2.00 lakhs The premium was Rs.10,000/- payable yearly. The DOC was from 9.5.2006

Shri Dharamchand Shivchand Nimani on 21.05.2010 informed the Company that he was having blockage in veins. Angiography was done on 19.04.2010 and he underwent CABG (Coronary Artery Bypass Surgery). He submitted his claim form and the medical documents under critical illness to the Company. The company approached the life assured's family doctor and obtained various medical documents when it was brought to light that the life assured had a history of HTN since 1998 and Inferior MI in March 2001. According to the Company they stated that under Section D – Personal and family history of the life to be assured under Point 6 of the proposal form, to the question "Have you ever suffered from any of the following conditions? "High Blood Pressure and Heart Disease" – he had answered in the negative. The information on Hypertension and Myocardial Infarction was not disclosed in the Application dated 09.05.2006. They stated that had this information been provided to the Company at the time of applying for the insurance policy, they would have not allowed any Critical Illness Cover. The Company repudiated the claim.

Now let me examine the grounds on which the Insurance Company has denied the critical illness cover. When Shri Nimani submitted his claims for Critical Illness Cover, he has submitted the relevant information in the following manner:-

Suffering from high BP	since 2001
Date of 1st consultation	January 2010
Investigation done ECG	20 times
Cardiac Enzyme Test	In 2001
ECG	In 2001
CTMT/Thallium Sean	4 times

He has given copies of the test reports done at Unique Diagnostic Centre of Dr. Yatin G. Joag. The first report dated 3/4/98 reveals that Shri Nimani had a history of HTN and atypical chest pain and was screened for evidence of CAD on Bruce Protocol. The report indicates that he exercised for 12 minutes and 33 seconds and the Doctor reports that he was hypertensive BP responsive and TST is negative for inducible myocardial ischemia. Shri Nimani has also produced two more reports dated 26/03/01, 6/6/02 from the same medical examiner Dr.Y.G.Joag, where both of them indicate as "Normal BP response and TST is negative for inducible myocardial ischemia." Only the report dated 13/04/10 clearly states that "Shri Nimani has Hypertensive BP response and his TST is positive for inducible myocardial ischemia."

An examination of all the above, reveals that Shri Nimani has indeed a history of hypertension and he was regularly taking medical checkups with his family Physician Dr. Joag.

In the case of Shri Nimani, who is aged about 53 years , the incidence of Hypertension was definitely there. Hypertension and Diabetes etc have become very common and they have become life style ailments and people by and large take recourse to medications and change of life style keep and them under control. But such persons when they apply for Life Insurance or health insurance cover are duty bound to reveal all facts. In the case of Shri Nimani he has failed to do so and hence has committed breach of trust. The claim was denied.

However, the policy taken by Shri Nimani with HDFC Std Life Insurance Company is a Unit Linked Plan and in such a policy the bulk of premium goes towards investment in funds chosen by the Life Assured and under such investment the risk is fully borne by the individual concerned, the insurance company bears only life risk and investment risk is borne by the individual. Hence HDFC Life Insurance Company cannot deny and deprive the policyholder all the monies when they took a decision to deny the Critical Illness Cover and cancel the policy. HDFC Standard Life Insurance Company Ltd. Was directed to pay the Policy Fund Value less the applicable charges as per the IRDA rules as on the date of intimation of claim for Critical Illness cover.