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OFFICE OF THE INSURANCE OMBUDSMAN (GUJARAT)

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AHMEDABAD

SYNOPSES OF AWARDS 2008-09

3. LIFE=MISCELLANEOUS

Award dated 14-10-2008

Case No.25-06-088-09

Ms. Ramila H.Patel Vs. Birla Sun Life Insurance Co.Ltd.

The case is of non cancellation of policy and refund of premium from Respondent.

The complainant took flexi save plus plan under two policies but inadvertently wrote mode of premium as Annual instead of single premium. The amount was so large that she did not have any means to pay the premiums.

The moment she received Receipt but not policy, she applied for cancellation under "Free look period" within 15 days but about refund there was no response from the Respondent.

The Respondent pleaded that for cancellation they require policy or Indemnity Bond to which complainant was remitting.

The Forum ordered Respondent to pay the agreed sum and complainant has to submit the Indemnity Bond as per rules and case was disposed.

Award dated 27-10-2008

Case No.24-001-0151-09

Mr.Maheshkumar D.Pareek Vs. LIC of India

The Complainant had a policy which was serviced by Ahmedabad D.O and was subsequently transferred to Delhi on the mode of payment was monthly under Salary Saving Scheme. The last paid premium at Ahmedabad was January 1992. From February 1992 onwards the employer sent the monthly remittances to Delhi Branch who refused to accept the premium as they did not received the policy records from Ahmedad.

Meanwhile the policy was matured for paid up claim but was not settled by either of LIC branch at Ahmedabad and Delhi.

On hearing the Respondent showed readiness to settle the paid up claim treating last premium received on January 1992 with attached bonus and interest @ 8% for delayed period. The complainant insisted for including subsequent premium which were lying with employer.

On mediation the complainant agreed to accept paid up claim as offered by Respondent and to take refund of paid amount through salary from the employer after submitting policy and discharge form, thus case was disposed.

Award dated 05-11-2008

Case No.22-013-0105-09

Mr. Kuljit Pal Singh Vs. AVIVA Life Insurance Co.Ltd.

Life Long Linked Policy

Complainant purchased ULIP Linked plan for Sum Assured of Rs.2,52,000/ from AVIVA Life Insurance Co. Ltd. and premium mode of payment was monthly @ Rs.1000/- through ECS from complainant's bank account.

Respondent could not debited due premium according to option availed and advised the complainant through letter to reinstate the policy by paying accumulated premium of Rs.3,000/-which was not ready by the complainant.

Complainant demanded for refund of premium paid with 18 % interest.

On mediation of this forum, Respondent is agreed to pay Premium paid amount plus 8% interest against cancellation of policy. The complaint thus disposed.

CHANDIGARH

Miscellaneous

Chandigarh Ombudsman Centre
CASE NO. Aviva/245/Gurgaon/Panchkula/22/09
In the matter of Avneet Grewal Vs Aviva Life

Order Dated: 23.10.08

Facts : The complainant Ms. Avneet Grewal stated that she was mis-sold a policy bearing no. RSG-1484187 from Centurion Bank of Punjab. She was sold the policy on the

pretext that the amount invested could be withdrawn after one year from the date of purchase and alternately the premium payable annually would be Rs. 16000/- to Rs. 20000/- every year after the fist premium. However she had now received a notice to pay annual premium of Rs. 96000/-. She was finding it difficult to pay such a high premium every year and wanted the premium to be reduced. She stated that at no point of time it was told to her that it was an insurance policy nor any medical was conducted. After several follow-ups and visits, their officials failed to give her satisfactory reply.

Findings : The insurer clarified the position by stating that the policy had been issued as per the policy form filled by the complainant. The product is approved by IRDA and it does not have any clause for reduction of premium from 2nd year onwards. The policy was in a lapsed condition and could be revived as soon as the 2nd premium was received after completing the formalities as per terms and conditions of the policy.

Decision : Held that the contention of the insurer that the policy had been issued based on the proposal form filled up appeared justified. Therefore, it would be prudent if the complainant could continue the policy by paying the annual premium as mentioned in the policy document. . The complaint was dismissed.

Chandigarh Ombudsman Centre
CASE NO. HDFC/234/Mumbai/Mohali/22/09
In the matter of Dalbir Singh Vs HDFC Standard Life Insurance Co. Ltd.

Order dated : 03.11.08

Facts : The complainant, Sh. Dalbir Singh sated that he had purchased a policy bearing no. 10120932 by paying single premium of Rs. 6000/- on 23.11.04. When he received the policy he learnt that he had to pay the premiums on yearly basis. When he enquired, he was told that he would get the refund after one year. After completion of one year when he again enquired, he was told that he would get the amount after 3 years with

interest. Again on completion of three years, he was told to continue the policy in order to get the entire amount.

Findings : The insurer clarified the position by stating that this was an HDFC Saving Assurance Plan with annual premium of Rs. 6000/- for ten years with an assured amount of Rs. 49301/-. No premia were received in Nov-05, Nov-06 and Nov-07. Hence the policy was in a lapsed condition. The complainant was aware of the fact that it was an annual premium policy which is borne out through standing instructions given by the complainant to HDFC bank to deduct annual premium of Rs. 6000/- from his bank account and credit the same to HDFC Life Insurance Co. Ltd. He further stated that the amount was not deducted from the complainant's account as they were given to understand that there was not sufficient bank balance in the account of the complainant. In this regard a letter dated 28.11.05 was issued to the complainant regarding direct debit dishonor letter and thereafter lapsation letter was also sent on 19.12.05. However no documentary proof was available in support of his contentions. On a query whether matter was taken up with HDFC Bank/ complainant for non receipt of premium before giving lapsation notice, the insurer could not give a satisfactory reply.

Decision : Held that the contention of the insurer regarding lapsation notice etc is not based on documentary evidence. Hence giving the benefit of doubt to the complainant, the policy should be treated as void *ab-initio* since there appears to be lacuna in the sale of the policy. Since closing of policy at this late stage may not be feasible, refund of an amount of Rs. 6000/- which was the initial premium on *ex-gratia* basis would meet the end of justice. It was ordered that an amount of Rs. 6000/- should be paid by the insurer to the complainant on *ex-gratia* basis as per powers conferred under Rule 16(2) read with Rule (18)of RPG Rules 1998.

Miscellaneous

Chandigarh Ombudsman Centre

CASE NO. HDFC/276/Mumbai/Chandigarh/22/09
In the matter of Ramesh Goyal Vs HDFC Standard Life Insurance Co. Ltd.

Order dated : 16.12.08

FACTS : The complainant, Sh. Ramesh Goyal stated that he had purchased a policy bearing no. 11671839 on 24.03.2008 for a period of 20 years and S.A of Rs. 30.00 Lakhs. He had taken a housing loan of Rs. 34.00 lakhs from HDFC Ltd.and in order to protect the home loan he wanted to take an insurance cover. Accordingly he applied for HDFC Endowment Plus policy by paying a one time payment of Rs. 108000 in two half yearly installment. Thereafter he was required to pay a minimum sum of Rs.10,000/- for a period of two years. After lock in period of three years he would be eligible for partial as well as full withdrawal. After paying the amount he was told that the mortality charges would be deducted for the next 20 years. This was not his intention while applying for home loan insurance cover. He wanted that the amount of Rs. 108000 should be adjusted for giving him Home Protection Plan by canceling the existing Endowment policy and issuing a new Home protection Plan Policy.

FINDINGS : The insurer clarified the position by stating that the Unit Linked Endowment Plan Policy was given to the complainant as per the proposal form filled by him. He had paid the half yearly premium due in Aug-08 amounting to Rs. 54,000. This clearly shows that he was interested in continuing the policy. Since the request for cancellation had not been received within the free-look period no cancellation of the policy was possible at this belated stage.

DECISION : After hearing both the parties and going through the records carefully, I am of the opinion that there appears to be a communication gap between the complainant and the insurer. The need of the complainant appears to be for protection of home loan whereas he had been given HDFC Unit Linked Endowment Plus Policy. In order to meet

the requirement of both the parties a via media could be to assess the fund value of the policy under per NAV as on 16.12.08 and adjust the amount in giving a new policy which should be specifically suited to cover the Home Loan Protection Plan Policy. For this the complainant should apply to the insurer accordingly and fill up a specific proposal form in this regard. The insurer should take into account and issue a fresh policy accordingly as per usual terms and conditions and levying of charges.

Chandigarh Ombudsman Centre

CASE NO. LIC/261/Rohtak/Tohana & Hansi/22/09
In the matter of Manju Kansal VS LIC of India

Order dated : 06.01.09

FACTS : The complainant, Smt. Manju Kansal stated that she had purchased two policies bearing Nos. 172803485 for sum assured Rs. 5.00 Lakhs and 172068182 for sum assured Rs. 25,000/-. She met with an accident on 27.03.05 due to which her backbone was injured and operated on 29.03.05 in Basant Kunj Hospital Delhi. Now, she is totally paralysed in the lower half as such she has a 100% permanent disability as per the doctor's certificate issued by CMO Fatehabad on 07.06.06. She has submitted all the papers in connection with disability claim payment but she has not received any response from the insurer.

FINDINGS : The insurer clarified the position by stating that In the case of one policy for Rs. 25,000 Rs. 200 per month was being paid. In the case of the other policy, only waiver of premium upto Rs. 20,000 was allowed and no cash payment was to be made as per terms and conditions of the policy. On a query whether she was given benefit of premium waiver, the complainant's representative, her husband, replied in the negative and said that he was paying Rs. 25,000 every year.

DECISION : Held that the contention of the insurer that no disability benefit amount is payable is justified. However, he is advised to issue instruction for premium waiver.

They are also advised to refund Rs. 60,000/- being excess premium received in 2005,2006,2007 alongwith interest @ 8% w.e.f 15.07.06 till the date of payment. Another hearing was held wherein the insurer stated that as per T & C of the policy premium waiver is permitted only on Rs. 20,000/- sum assured. Accordingly, no premium waiver is possible in respect of policy no. 172068182 for Rs. 5.00 lakhs. In respect of policy no. 17280345, for sum assured of Rs. 25,000, premium waiver upto sum assured of Rs. 20,000 is allowed. The premium for Rs. 25,000 sum assured is Rs. 200. Hence on a prorate basis, the premium for Rs. 20,000 will be slightly lower. The same amount will be waived off. Held that the contention of the insurer is in order. The insurer is advised to waive off the premium for sum assured of Rs. 20,000 accordingly on a prorate basis.

MEDICLAIM(LIFE)
Chandigarh Ombudsman Centre
CASE NO. Bajaj Allianz/307/Pune/Chandigarh/21/09
In the matter of Kamlesh Kumari Vs Bajaj Allianz

Order dated :23.12.08

FACTS : The complainant, Ms. Kamlesh Kumari stated that she had purchased a policy bearing no. 0024868747. She had submitted the proposal form on 10.08.06 and policy was issued on 21.09.06 after completing all the necessary medical tests by the company. Premium due 21.09.07 was paid on 28.09.07 and premium due Jan-08 was paid on 04.09.08. When she applied for a hospital cash claim for the period 24.09.07 to 01.10.07, the claim was rejected on the grounds that the policy was in lapsed condition as on date of hospitalization i.e 24.09.07. As per the company premium due 10.08.07 was not paid within grace period of one month and was paid only on 28.09.07. She stated that all the premiums were paid in time.

She stated that no intimation was received by her regarding the due date of premium as the policy bond was not received by her. According to her understanding, the effective date of the commencement of the policy was 21.09.06 and the next premium due was

on 21.09.07 which she had paid on 28.09.07 which was within the grace period of 30 days.

FINDINGS : The insurer clarified the position by stating that this was a Term Care policy with hospitalization benefit. The first premium was received on 10.08.06 along with the proposal form. Accordingly the next premium was due on 10.08.07 and the grace period of one month was over on 10.09.07. The policy was therefore in a lapsed condition on the date of hospitalization on 24.09.07. The policy was revived on 28.09.07 after the receipt of the premium due. On a query whether any declaration of good health form was signed and completed by the complainant at the time of paying the premium on 28.09.07, the insurer replied in the negative. On a query whether the premium due intimation was given to the complainant the insurer replied that it should have been in the policy bond. On a query, whether the policy bond was available the complainant replied that the policy bond was not received by her till date.

DECISION : The policy was declared as lapsed by the insurer without proper intimation to the complainant and without going through the procedural formalities for revival of a lapsed policy. Also taking into account the fact that the complainant had not, according to her version, received the policy bond, the benefit of doubt should go to the complainant. The policy should be treated as being inforce without any break. In view of the above the repudiation of the hospitalization claim is not in order. The claim is payable. It was ordered that the admissible amount of claim should be paid by the insurer to the complainant

Chandigarh Ombudsman Centre

CASE NO. Kotak Mahindra/369/Mumbai/Ludhiana/22/09
In the matter of Avtar Singh Vs Kotak Mahindra

Order dated : 10.02.09

FACTS : The complainant, Sh. Avtar Singh stated that he was allured by the company's executive in purchasing a Kota Safe Investment Plan (ULIP). He was assured that he

would get a life cover of Rs. 30.00 Lakhs by investing Rs. 3,00,000/- p.a, which was to be paid for a minimum period of 3 years. Accordingly he gave a cheque for Rs. 3.00 lakhs in March-07. After repeated follow-ups he got the policy in Sep-07 with issue date 11.09.07 i.e after a lapse of six months of his funds being utilized by the company. When he received an SMS to pay his next premium due in Sep-08, he went through the policy document and was shocked to notice that the plan given was Kotak Retirement Income Plan bearing no. 00719686 without any risk cover. The proposal form was also not signed by him. Moreover the maturity amount was taxable. He felt cheated and gave a written complaint to the insurer on 16.09.08. He was assured that the amount would be refunded with interest. After several follow-ups he did not get any satisfactory reply.

FINDINGS : The insurer clarified the position by stating that a proposal was received for coverage for Rs. 30,00,000. This was not underwritten as the complainant had a medical problem. He changed the proposal to coverage for Rs. 15.00 lakhs which was again rejected. He then applied for ULIP without insurance cover by investing Rs. 3.00 lakhs which were already with the insurer. This policy was issued to him.

DECISION : After hearing both the parties and going through the records carefully, I am of the opinion that the case has not been dealt with in a professional manner. The complainant was not informed about the reason for non-underwriting and funds were transferred in another policy without his request consent. The letter allegedly written by him does not appear to be genuine. Therefore, refund of the premium amount of Rs. 3.00 lakhs by cancellation of the policy would in my opinion meet the ends of justice. It is hereby ordered that an amount of Rs. 3,00,000 should be refunded by the insurer to the complainant.

Chandigarh Ombudsman Centre
CASE NO. LIC/384/Chandigarh/Ropar/22/09
In the matter of Parvin K Aggarwal Vs LIC of India

Order dated : 25.02.09

FACT : This complaint has been filed by Sh. Parvin K. Aggarwal on 26.11.2008. Brief facts of the case are that his policy bearing no. 160226509 under Pension Plan matured for payment on 28.03.06. But the company paid him Rs. 5,16,298/- on 03.10.2007 that too after vigorous follow up & repeated requests. He had requested the insurer to pay him the interest for the delayed payment. Instead the insurer informed vide letter dated 29.10.08 that they had paid him in excess and hence some amount was recoverable from him. Hence he sought intervention of this forum in getting the matter redressed at the earliest.

FINDING : The insurer clarified the position by stating that the policy had vested and hence the lump sum amount was not payable. The case was referred to the Zonal office for settlement of pensionary benefit. However the same was treated as non-vested policy and an amount of Rs. 516298 was paid on 03.10.07 as against Rs. 438026 which was payable on 28.03.06. Thus an amount of Rs. 78272 has been paid excess. Even if penal interest @8% from 28.02.06 to 03.10.07 is calculated even then an amount of Rs. 25222 has been paid in excess. This amount is recoverable from the complainant.

DECISION : After hearing both the parties and going through the records carefully, I am of the opinion that after the vesting date of the policy the pension alone was payable and not the surrender value. Since the surrender value has been paid, the complainant is advised to accept the action taken by the insurer and in the interest of justice and fair play refund an amount of Rs. 25222 to the insurer. The insurer is advised to intimate the details of Rs. 516298 to the complainant.

Chandigarh Ombudsman Centre

CASE NO. ICICI/409/Mumbai/Chandigarh/21/09
In the matter of Smt. Rashmi Pal Vs ICICI Prudential Life Insurance Co. Ltd.

Order dated : 25.02.09

FACTS : This complaint has been filed by Smt. Rashmi Pal on 12.12.2008. Brief facts of the case are that she was allured in purchasing a Mediclaim Policy bearing no. 06117880 by paying a premium of Rs. 8750/- on 29.06.07. After approximately four months on 12.10.07 the company issued her the policy. On 02.03.08 she was admitted in Alchemist Hospital, Panchkula for getting her uterus removed. She had incurred an expenditure of Rs. 46,058. She filed a claim on 18.03.08 but the same was rejected vide letter dated 14.04.08 due to exclusion of the disease i.e Uterus, Fibroid from the policy. At the time of taking the policy she had disclosed her health condition and treatment to the executive but he had assured her that in case of any problem including Uterus & Fibroid, it will be covered. The executive had mislead her. She wanted the claim to be paid or the premium refunded.

FINDINGS : The insurer clarified the position by stating that this was a hospital care policy. Treatment of Uterine Fibroids is permanently excluded under this policy. Hence the claim was repudiated under the exclusion clause of the Hospital Care Policy. On a query, whether the policy was issued to the complainant before the treatment in Alchemist hospital, the insurer replied in the affirmative.

DECIION : After hearing both the parties and going through the records carefully, I am of the opinion that the contention for the insurer that the claim is not payable due to exclusion clause of the policy is justified as the terms and conditions of the policy were made known to the complainant before the treatment taken. The repudiation of the claim is in order. No further action is called for. The complaint is dismissed.

Chandigarh Ombudsman Centre

CASE NO. Aviva/476/Gurgaon/Khanna/22/09
In the matter of Vishal Kumar Angrish Vs Aviva Life Insurance Co.Ltd.

Order dated : 16.03.09

FACTS : The complainant, Sh. Vishal Kumar Angrish stated that he had purchased a policy bearing no. LSP 1577535 on 14.06.2007. He paid Rs. 50,000/- and was told that he could reduce the premium from the next year. When the next premium fell due he went to pay Rs. 15,000/- in Centurion Bank Of Punjab, but the person refused to take the amount saying that a request application was required to be submitted before one month from the due date. He stated that the application was given on 04.06.08. He said he paid Rs. 15,000/- in cash to the Manager, CBOP who said that the same will be deposited at Indus Ind Bank, Khanna as their contract with the insurer was over. Now after almost seven months he has been informed that his application for reduction of premium has been rejected as it was not given before one month of the due date and was advised to pay Rs. 50,000. He felt cheated as the terms and conditions were not explained to him. Feeling aggrieved he has approached this forum in getting the refund of total amount of Rs. 65,000/- paid or in reduction of premium.

FINDINGS : The insurer clarified the position by stating that the complainant was dealing with Centurion Bank of Punjab who were their corporate agents. The Corporate agency of Centurion Bank of Punjab has since been terminated and hence there was a communication gap between the complainant and the insurer. No request for reduction of the premium was received by them. However as a special case they had decided to allow the reduction of premium on the basis of declaration of good health by the complainant since the policy was in a lapsed condition at present.

DECISION : The offer of the insurer to revive the policy and reduce the premium to Rs. 15,000 annually is appreciable. The complainant is advised to deposit Rs. 15,000/- by cheque /draft to the insurer by 10.04.09 in respect of the premium due on 14.06.08. No late fee or interest should be charged by the insurer. To enable the complainant to mobilise the resources, the next premium due on 14.06.09 should be allowed to be paid by 14.09.09 without late fee and the risk should be covered by treating the policy as

being in force upto 14.09.09. If the premium is not deposited by 14.09.09, the policy would lapse again.

MEDICLAIM(LIFE)

Chandigarh Ombudsman Centre

CASE NO. LIC/511/Karnal/Yamuna Nagar/24/09
In the matter of Brij Lal Bhola Vs LIC of India

Order dated : 30.03.09

FACTS : The complainant, Sh. Brij Lal Bhola stated that his son Sh. Vijay Kumar and his daughter- in-law Smt. Kamlesh had purchased a policy bearing no. 176004476 under Health Plus Plan. Smt. Kamlesh had to undergo an operation in Gaba Hospital at Yamuna Nagar and was discharged on 20.10.2008. The complainant has submitted all the medical claim papers in the branch office on 25.10.2008 but has not received any response from the insurer so far.

FINDINGS : The insurer clarified the position by stating that the claim papers were received late after the grace period of 15 days of the Discharge from the hospital. Time was required to condone this delay which has since been done. Moreover the policy commenced on 31.03.08 and the date of admission in the hospital was 16.10.08 to 20.10.08. Since it was within the first 180 days of the commencement of the policy, the case was recommended for repudiation by the TPA to the insurer. On a query as to whether the claim papers were submitted late, the complainant stated that the papers were submitted on 25.10.08, 5 days after the date of discharge.

DECISION : After hearing both the parties and going through the records carefully, I find that the complainant had submitted the papers on 25.10.08 which was 5 days after the date of discharge. Hence there was no need to condone the delay. As far as treatment within 180 days is concerned, the date of admission being 16.10.08. it is after the expiry of 180 days. Hence repudiation of the claim on that ground is not in order. The claim is payable. It is hereby ordered that the admissible amount of claim should be paid by the

insurer to the complainant by 20.04.09 alongwith interest @ 8% pa w.e.f from 01.12.08 till the date of payment.

CHENNAI

OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO(CHN) 22.01.2301/2008-09

Smt.S.Natchiar

Vs

Life Insurance Corporation of India

AWARD No: IO (CHN) L-024/2008-09 dated 22.10.2008.

The complainant had submitted a proposal for Insurance on own life for sum assured Rs.3 lakhs under Jeevan Anand Plan for a term of 16 years on 28.12.05. The Insurer after calling for Medical reports and other special reports offered the said plan for a reduced sum assured of Rs. 2 lakhs with health extra at Rs.7.50 per thousand sum assured. On receipt of the consent the insurer had issued the policy for sum assured of Rs. 2 lakhs with effect from 10.01.2006 on an yearly premium of Rs.18729 (inclusive of extra premium). The Insurer also refunded a balance of Rs.6564/- remitted by the proponent in excess. Subsequently the complainant was informed by the Insurer vide their letter dated 20.12.06 that the premium under the policy was erroneous calculated by the system and that the system had quoted Rs.7.41 per thousand sum assured instead of Rs.19.76 per thousand sum assured as health extra. The Insurer said they came to know about this only during the audit and the correct premium payable under the policy works out to Rs.21199/- and the Insurer called for the difference of premium of Rs.2470/-

The complainant was not ready to accept the enhancement of the premium and she requested the Insurer to refund the premium paid with interest and cancel the policy. The insurer replied that the policy cannot be surrendered as the same

has not run for three years and the premium paid cannot be refunded. They also suggested that if the insured is not willing to pay the higher premium, the Insured can opt for reduction in Sum assured under the policy to Rs.175000/- for which the premium would be Rs.18549/-. The Insurer had informed the policyholder vide letter dated 11.01.08 that she is advised to pay the difference of premium of Rs.4940/- towards premium due January'06 and January'07 immediately lest the policy would lapse and premiums already paid cannot be refunded as it was not a deposit or a Saving Scheme. Aggrieved by this complainant had approached the court.

During the hearing the complainant contended that the policy under question was taken for the purpose of Income Tax benefit and they had given consent for reduction in sum assured to Rs. 2 lakhs with health extra at Rs.7.50 per thousand assured. More than a year after the issue of the policy the Insurer is demanding extra premium at Rs.19.76 per thousand sum assured and had they known this they would not have taken the policy at all.

The Insurer contended that the proposal was accepted with health extra of Rs.19.76 per thousand sum assured and their branch was duly intimated to this effect. Due to programming error the system wrongly quoted Rs.7.41 as against Rs.19.76 as health extra it was not checked at that stage. They argued that no party to a contract can take advantage of clerical error by other party.

The Ombudsman advised to complainant to agree for reduction in sum assured to Rs.175000/- the premium for which works out Rs.18549 less by Rs.180/- being paid under the policy now. The complainant was advised to continue the present policy as there are chances of a fresh policy not being offered to the Insured even if she desires to take one as she is sub-standard life. The Ombudsman also observed that the human error compounded in the technological error in the present case had caused lot of mental agony to the insured and the grievance of the Life assured had not been dealt with a servicing approach.

Taking all aspects into consideration the Ombudsman recommended to the Insurer to revive the policy in question for reduced sum assured of Rs.175000/- on an yearly premium of Rs.18549/- (inclusive of Cl . VI health extra) as offered earlier subject to receipt of satisfactory declaration of Good Health from the Insured along with arrears of premium within 15 days of fresh revival quotation in this regard. To compensate for the mental agony of the Insured the

Ombudsman recommended that the Interest on Premium **due January'08 be waived in full as a Special Case.**

OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO (CHN) 21.08.2430/2008-09

Dr.V.Elangovan

Vs

Life Insurance Corporation of India

AWARD No. IO (CHN) L-043/2008-09 dated 06.02.09

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Dr.V.Elangovan had taken an Asha Deep Policy in **September'93** for sum assured Rs.85000/-. He underwent Cardio Pulmonary Bye-pass surgery on **02.03.98**. He preferred his claim for the benefits under Asha Deep Plan on **18.04.07**.

The insurer while stating that the **claim was time barred claim** agreed to examine the claim without prejudice to the corporation and issued claim forms. Subsequently the insurer rejected the claim on 18.02.08 stating that the insured had suppressed the material fact of his suffering from **Asthma for 10 years at the time of giving the proposal.** However, the insurer offered to continue the policy as an ordinary Endowment policy on continuation of premium payment. Challenging this decision of the Insurer the complainant approached the forum.

The complainant said that he had taken the Asha Deep Policy in September 93 and was paying the premium regularly. He had undergone Bye-pass surgery in 1998 and as he was ignorant of the policy benefits he continued to pay the premium and subsequently when he came to know about the benefits under the plan he preferred the claim in April'07.

The Asha Deep Plan referred above provides for on the happening of anyone of the contingencies viz. CABG mentioned in Para-11(b) of conditions and privileges – immediate payment of 50% of sum assured, payment of balance of 50% of Sum assured with Bonus on Maturity or Death if earlier, payment of 10% of Sum assured every year and waiver of future premiums.

Condition 11(c) of the policy under question provides that claim for benefits under the plan shall be made within 120 days from the date of happening of the contingencies mentioned under Para 11(b). Since the complainant preferred the claim after a lapse of 9 years the Insurer is well within his rights when he stated that the **claim is time barred and nothing is payable**. The plea of the Insured that he was ignorant of the provisions of the policy and the agent who had sold the policy had not guided him in this regard was not acceptable as the Insured is a well educated person, more so a **qualified doctor on the panel of LIC who is expected to know special features of this plan as he was expected to medically examine proponents seeking insurance under this plan**.

The Insurer was able to establish that the Insured was suffering from Bronchial Asthma prior to the date of the proposal. The discharge summary from the Apollo hospital where the Insured underwent bye-pass surgery clearly mentioned that the Insured had Bronchial asthma of 10 years duration for which he was under self-treatment. The Insured had claimed the Mediclaim benefits from the New India Assurance Company immediately after the operation but had failed to prefer his claim with LIC. Inspite of the non-disclosure of material facts in the proposal which was established which can be a good ground for rescission of the contract, the Insurer has come forwarded to continue the policy as an ordinary Endowment policy subject to payment of future premiums.

Considering the above facts the Ombudsman said that the decision of the Insurer was justifiable and dismissed the Complaint.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO (CHN) 21.01.2512/2008-09

Shri R.Gopalakrishnan

Vs

Life Insurance corporation of India

AWARD No. IO (CHN) L-051/2008-09 dated 26.02.09

The brother of the complainant had taken a New Janaraksha Policy for a sum assured of Rs.25000/- commencing from 28.03.02 from LIC of India. The Life assured died on 07.08.07 due to reported accidental fall within 3 years 4 months of reviving the policy which was earlier lapsed.

The Insurer settled the death claim for basic sum assured along with bonus. However, the complainant demanded an additional amount equal to the sum assured as Accident benefit under the policy. The Insurer denied payment of Accident benefit stating the death was not due accident.

The First Information report filed by the complainant before the police authorities mentioned the cause of death due to accidental fall. The postmortem report conducted in the case revealed that there were no external injuries except blood discharge from anus. The report stated the deceased would appear to have died due to intra cerebral hemorrhage and abdominal bleeding due to CVA and Hyper Tension. As per Police Inquest report deceased was reported to have gone to toilet where he had slipped and fell. The police final report attributed the cause of death due to accidental fall.

It was observed that while taking the policy in March'02 the proponent had declared his age as 38 years furnishing his date of birth as 15.01.64 as per which his age at death should have been around 43 years. As against this the age of the deceased at the time of death was reported as 51 years as per Postmortem report and Death certificate. Insurer obtained the Standard age proof of the life assured – Secondary school leaving certificate which declared the date of birth as 30.01.57. Thereby it was evident that the Insured had suppressed his real age while submitting the proposal which would have made him un-insurable under the Non-medical scheme of the Insurer for the above clause. However, the Insurer had not taken this plea to reject the claim and instead had settled the Basic Sum Assured along with Bonus.

The Accident Benefit as per policy condition is payable if the life assured shall sustain any bodily injury resulting solely and directly from the accident caused by outward , violent, and visible means. In the present case there were no external injuries to suggest the accident was caused by outward, violent and visible means. The death appeared to be due to intra cerebral hemorrhage and abdominal bleeding due to CVA and Hypertension. **Considering the above facts the complaint was dismissed**.

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DELHI **Miscellaneous**

CASE No. LI- ING Vysya /77/08

In the matter of Dr. Nirmal Singh

Vs

ING Vysya Life Insurance Company Limited

ORDER dated 12.11.2008

Dr. Niramal Singh had lodged a complaint with the office of Insurance Ombudsman, Chandigarh on 08.09.2008 and the complaint was transferred to this Forum on 12.09.2008. Dr. Nirmal Singh had mentioned in his complaint that he issued cheque no. 854818 and 854819 dated 14.02.2006 for Rs.75000/- each, aggregating to Rs.150000/- with the intention/direction that he intend to invest the amount in the name of his wife and son in one time investment "One Life" fund and get the benefit of growth at a later stage to cope up with the growing needs of his family. His wife and his son got the Insurance policy document on 31.03.2006 which mentions lot of charges and payment of yearly premium payable upto 31.03.2016 and 15.03.2050 respectively which has never been their intention to go in for Insurance Policies to increase their financial liability with annual premium of Rs.150000/- for such a long period. There was no indication of type of plan as mentioned in the policy e.g. Freedom Future perfect. The Sales Manager Shri Vikash Saini, who introduced the proposal of such Insurance investment has thus mis- represented the facts, misguided the insured to enter into annual commitments by making them liable for continued payment of heavy premium to a long period in addition to bearing of heavy varied charges. The Sales Manager on his own bifurcated the amount of Rs.150000/- paid through cheques as Rs.100000/- + Rs.50000/-. Even the fact mentioned in the policy would indicate that the sales manager filled the proposals forms at his own will whatever he could find favourable for him/company. It is evident from the facts under heading details of coverage in case of Smt. Uma Devi as under:-

"Item No. 2"	Sum assured Rs.100000/-
"Item No. 3"	Premium Rs.150000/- beside of item
(Item No. 24)	Income from other sources as sum of Rs.25000/-

It is clear and evident that even the form was not properly scrutinized to understand as to how an old lady of 63 years would pay premium of Rs.100000/- (income being Rs.25000/- only) up to 31.03.2016. Thus the Sales Manager who is representative of the esteemed Insurance Company has misrepresented, misguided the facts to Insured who has been compelled to bear the burden of an insurance policy to make annual payment of premium for a long period and failing which allowed the policy to lapse to the benefit of the Company. He also stated that the insured normally does not understand the implications of difficult terms and conditions of the policy and time limit of acceptance/ disagreed of such conditions. Keeping in view the reputation of the Company as also guidelines given by the agent of the company they accepted the documents without reading the terms and conditions of the policy. This is a well known fact that insured hardly understands the items mentioned in the form and sign the form at the end enabling the able agent to fill the form as may be desired by him on the basis of information gathered on the spot as also at his own will to achieve the target allotted to him. This shows that nobody from the company as a responsible officer has scrutinized these forms carefully. He has thus made the request to cancel the policy and invest the money to a complete growth fund which have minimum charges (Load) to be borne by them (as already requested earlier "One Life" One Time Policy) alternatively the amount of Rs.150000/- may please be refunded together with the interest for that period or any other benefits accrued to date.

At the time of hearing Dr. Nirmal Singh at the outset raised certain issues regarding forging of his signatures as well as of his wife Smt. Uma Devi. He also stated that certain papers were not signed by him or his wife, were placed in the file of Insurance Company to make their case strong against them. The attention of Dr. Nirmal Singh was drawn to the fact that the charges now being leveled by him attract certain provisions of Indian Penal Code on which, this is Forum is not competent to decide. The Forum advised Dr. Nirmal Singh that if he wishes to withdraw his complaint from this Forum, he may do so and approach the appropriate Forum. Dr. Nirmal Singh expressed his intention of withdrawing and requested that he may be allowed to withdraw his complaint and request was acceded to.

The complaint is disposed of finally as withdrawn.

Miscellaneous

CASE No. LI- Kotak Life /76/08

In the matter of Shri S.K. Banerjee

Vs

Kotak Mahindra Old Mutual Life Insurance Limited

Award dated 12.11.2008

Shri S.K. Banerjee had lodged a complaint with this Forum on 05.09.2008 that he proposed Kotak Smart Advantage Plan from Kotak Life Insurance Co. Ltd. for self and also in the name of his wife Smt. Bharati Banerjee. Due to the urgent need of money he requested the Insurance Company to cancel the proposals and refund the same as soon as possible. He received two cheques no. 46964 and 46996 dated 12.07.2008 for Rs.50000/- and 49999/- respectively on 19.07.2008 and it was credited to his account on 01.08.2008. He has requested the Forum to intervene in the matter and ask the Insurance Company to fulfill the loss incurred by him:

1. The amount of Rs.99999/- was kept by Kotak Life Insurance office for two months i.e. from 01.06.2008 to 01.08.2008, and he has been put to loss of interest for two months on this amount. Therefore, he requested the Forum to ask the Insurance Company to pay the interest of two months @ 18% p.a.
2. The amount of Rs.450/- debited to his account as cheque clearing charges as the cheque issued by the Insurance Company was not payable at par.
3. He has incurred Rs.500/- towards postage, E-mail, Typing, consultation etc. He requested to get the refund of the same.
4. He has been mentally harassed by Kotak Life Insurance Co. Ltd. He has, therefore, requested the Forum to ask the Insurance Company to pay him Rs.5000/- towards mental torture.

Therefore the total loss claimed by him comes to Rs.9550/-.

At the time of hearing Shri Rahul Jain appearing on behalf of the Insurance Company informed the Forum that the proposals submitted by Shri Banerjee could not be completed for want of requirements. Moreover, a reasonable time was taken in making refund of the amount.

The Forum informed Shri S.K. Banerjee that it is not competent to pass any award towards mental torture and expenses towards postage, typing consultation etc., and if he wishes to withdraw his complaint from this Forum he may do so.

Shri S.K. Banerjee informed the Forum that he is ready to accept the decision of this Forum and requested the Forum that amount of Rs.450/- was debited to his account as cheque clearing charges which should be paid to him alongwith interest @18% for two months from 1.6.2008 to 01.08.2008 i.e. the time period the amount was kept by the Insurance Company.

After hearing both the parties and on careful perusal of the documents submitted, I pass an Award that Shri S.K. Banerjee be paid interest @ 8% from 01.06.2008 to 01.08.2008 on Rs.99999/-, alongwith Rs.450/- debited to his account as cheque clearing charges.

Miscellaneous

CASE No.LI-HDFC/48/08

In the matter of Smt. Vijay Laxmi

Vs

HDFC Standard Life Insurance Company Limited.

Recommendation dated 31.10.2008

Smt. Vijay Laxmi had lodged a complaint with this Forum on 03.07.2008 that she had taken a policy no. 10083201 from HDFC Standard Life Insurance Co. Ltd. Ever since they received the first bonus statement (covering period- 01.04.2004 to 31.03.2005) in the month of August 2005, they have lost peace of mind as it indicated “Death Benefit” as Rs.120000/-, when they had already paid Rs.240000/- (September 2004 to August 2005- 12 X 20000) her husband is

a 70 years old and a pensioner and they do not have any other source of income. Her husband is a diabetic and she is heart patient. She has requested the Forum to take necessary action in this regard.

HDFC Standard Life Insurance Co. Ltd. has informed the Forum vide their letter dated nil that the policy document under the head "schedule of Benefits" provides the basic benefit, wherein the benefits at the time of death and maturity are clearly provided for. The HDFC Saving Assurance Plan is a with profits savings policy, which offers the following features:-

- Regular premium payment throughout the term of the policy, which enables a customer to save systematically for specific goals.
- There is no maximum premium under this policy, which enables the customer to choose. At the outset, an appropriate sum to save as, as per his/her convenience.
- The policy receives simple reversionary bonuses.

At maturity the policy pays out the basic sum assured plus reversionary bonuses declared during the policy term. Interim or terminal bonus may also be payable at the time of claim.

The Benefits on Death- "During the first year from the date of commencement or the date of reinstatement of policy, whichever is later, the death benefit is 80% of premium received.

After the first year, for regular premium paying policies the amount payable on death is lesser of

- The total of premium paid to date plus interest at 6% per annum, on each premium from the premium due date to the date of death; or
- The basic sum assured plus reversionary bonuses declared till date.

The **Reversionary bonus** attached to any policy is guaranteed payable only on maturity or on earlier death claim. This guarantee is not applicable if the policyholder surrenders the policy at any time during the policy term.

The Surrender Benefit: The policy can be surrendered provided the policy has completed the first three years of the policy term. After which there will be a guaranteed Surrender Value of 50% of premium paid subsequent to the first year in respect of the basic benefit, excluding all additional premiums.

After 3 years regular premium has been paid, if the investment conditions allow, then they may pay a significantly higher discretionary surrender value over the minimum guaranteed surrender value.

The bonuses are not used to calculate asset share. Bonuses are paid on the sum assured, not the premiums paid and are guaranteed to be paid at maturity, not on surrender.

In the illustration/ brochure provided to the insured at the time of sale of product, they state that, "This contract is designed for long term savings and is not designed for short term investment. Should you need to surrender your policy in the short term, any surrender benefits may be less than the premiums you have paid."

They further mentioned that all the features of the policy were explained to the complainant. The complainant after understanding all the features of the policy signed the policy documents. As a procedure after explaining all the features of the policy the customer is to sign the customer declaration wherein it is clearly stated "I declare that I have understood the questions in this application and that all the information given by me/on my behalf in this application is true and I have not withheld any material fact within my knowledge. The complainant has signed the same on 02.09.2004. The policy documents when dispatched to the customer are accompanied by a letter wherein it is very clearly mentioned that "In case you are not agreeable to any of the provisions stated in the policy and the details in the proposal form, you have the option of returning the policy to us stating the reasons stated thereof, within 15 days from the date of the receipt of the policy. The complainant in her/his own letters dated 19.05.2007 and 02.08.2007 very clearly mentions that he has not read the terms and conditions.

The complainant has before this Forum has also admitted of taking the policy through a person who was his friend and associate for number of years. As the complainant has applied for the policy on 02.09.2004 and the policy commenced on 17.09.2004 when the first bonus statement for the year 01.04.2004 to 31.03.2005 was made the complainant had deposited only seven premiums. The schedule of benefits as mentioned in the policy documents clearly describes the amount/quantum of death benefit. That due to non-payment of premium on time the complainant had to apply for revival of the policy. The complainant had not paid the premium from the period 17.10.2004. Only after the receipt of premium till 17.01.2005 the policy was revived. Due to non-payment of premium, the policy has gone into paid-up status from

17.09.2007. The complainant letter dated 12.04.2007 and .05.2007, were duly replied vide their letter dated 17.05.2007 and 07.06.2007. The complainant has stated concern towards premium reduction from Rs.20000/- **per month** to Rs.20017/- **per annum** as requested vide letter dated September 15, 2005. The extracts from the reply are reproduced herein below:-

"……The premium paid by complaint you in 1st year is Rs.240000/- (Rs.20000 x 12 months) wherein we have covered your life with Sum assured of Rs.1870892/- for that particular year. We would like to mention that we have declared a bonus of Rs.35469/- for the aforesaid policy during its 1st year on the sum assured. The bonus declared will be attached to your maturity amount on its maturity.

	1st year	2nd year
Premium Amount	Rs.20000/-	Rs.20017/-
Frequency	Monthly	Annually
Sum Assured	Rs.1870892/-	Rs.223843/-
Bonus Declared	Rs.35469/-	Rs.7275/-

Further, we would like to mention that the revised Sum Assured of Rs.223843/- and revised premium of Rs.20017/- per year has been calculated taking into account the fact that you have paid excess premiums in the 1st year. The yearly premiums to be paid for the Sum assured of Rs.223843/-, would be higher than the Rs.20017/- that is required to pay. We would like to refer to page no. 4 in your letter where you have asked to reduce the bonus of 1st year, we would like to mention that as we have reduced the premium from 2nd year of the policy any changes or amendments is not possible for 1st year. It is clear that the higher premium paid be you has resulted in a higher revised Sum Assured and a higher vested bonus. Hence no refund of premium is payable." While replying to complainant's letter date 02.08.2007 mentioning his concern regarding the aforesaid policy, vide letter dated 07.06.2007, it was reiterated that the premium paid by complainant in 1st year is Rs.240000/- (Rs.20000/- x 12 months) the complainant life was covered with Sum assured of Rs.1870892/- for that particular year. That the bonus of Rs.35469/- was declared for the aforesaid policy during its 1st year on the Sum Assured. This bonus declared will be attached to the insured maturity amount on its maturity.

It was further clarified that request to reduce the bonus of 1st year is not possible. With reference to the complainant letter dated 26.09.2007, requesting to adjust the 1st years

premium towards the future premium, in its reply dated 18.10.2008 correspondence dated 07.06.2007 and 15.09.2007, were referred and relied upon and it was reiterated that request cannot be accepted. They further mentioned that on receipt of complainant letter received on 09.04.2008 stating various apprehensions regarding the Savings Assurance Policies (SAP). Telephonic conversation between Ms. Malini Mukhopadhaya- Grievance Redressal Officer and Shri Rajesh P, complainant son was arranged on 18.04.2008. Further detailed investigation with Shri Pradeep Kumar Das, Branch Manager, HDFC Bank was carried out wherein it was confirmed that all features of the Savings Assurance Plan had been explained to the complainant at the time of taking this policy. The Grievance Officer informed about the said investigation and conversation to the complainant vide its letter dated 29.05.2008 wherein it was reiterated that "to refer to our letter dated 15.09.2007 and 07.06.2007, wherein all the concerns of the complainant was clarified. Hence, our earlier decision as conveyed remains unchanged. The complainant letter dated 16.06.2008, requesting clarifications on the benefits associated with the aforesaid Savings Assurance Plan was duly replied back vide letter dated 30.07.2008, wherein point-wise clarification was given. Wherein the complainant has requested for surrender value for the aforesaid policy (Surrender quote amount Rs.122772/- dispatched at your correspondence address on 25.07.2008 is valid till 13.08.2008) and also for clarification on surrender value of aforesaid policy, it was also explained that on maturity the amount complainant will receive would consist of:

1. Sum Assured (Rs.149192/-) plus
2. The reversionary bonuses attached to the policy plus
3. Interim bonus and Terminal Bonus at the time of maturity, if applicable.

In the event of premiums not being paid towards the policy after 3 or more years of regular premiums have been paid the policy will become paid-up. The sum assured for the main benefit will be reduced and the reversionary bonuses attached at the date the policy is made paid-up will remain attached. Thereafter paid-up policy will become non-participating i.e. no further bonuses will attached". They further mentioned that if the customer did not agree with the charges, he had the option to return clause, wherein he could have returned the policy and the free look-in period, which was entitled to him. They mentioned that under the circumstances, it is submitted that the complaint is devoid of any substance and is without merit and it is prayed that the complaint may be dismiss.

At the time of hearing the complainant confirmed that on receipt of the policy bond it was kept as it is without going through the terms and conditions of the policy which he felt that it was a mistake on her part, otherwise she would have availed the free look period and sought refund of the amount deposited. The Insurance Company was asked to explain the basis for arriving at the reduction of Sum Assured, the Company has explained vide their letter dated 18.10.2008 that the premium payment frequency is altered from monthly to annually. When the premium is reduced the level of sum assured is also bound to reduce. The extent of reduction in sum assured post reduction in premium is determined by several factors as such as

a. Age of the insured
b. Remaining terms of the plan
c. Premium payment frequency
d. Operations and maintenance expenses on inception and during the tenure of the plan,
e. Actual returns on investment and expected return on investment in future.

The method is not a straight forward, factor based method. Revised sum assured is calculated by taking into account the present value of future premium expected from the policyholder and present value of expected payouts to the policy holder in the form of claim/maturity benefits and also the existing bonuses. The value of previous premiums (which are at higher level) is also adjusted while calculating the revised sum assured. Total annualized premium was reduced from Rs.240000/- (20000/- x 12) to Rs.20017/- (total reduction is about 92% from the original level).

After hearing both the parties and on careful perusal of the documents submitted, the Insurance Company has decided according to the terms and conditions of the policy. However, keeping in view the advanced age of the policyholder as well as that of the nominee, it is recommended that the Insurance Company may as a special case consider the spreading of the amount of premium received as on date for the rest of the term of the policy, treating the policy as fully paid up and in force without asking any further premiums and may regularize the policy as requested by the complainant.

Surrender Value

In the matter of Ms. Neerja Kant

Vs

Life Insurance Corporation of India.

AWARD dated 30.10.2008

Ms. Neerja Kant had lodged a complaint with this Forum on 12.08.2008 against LIC of India, Divisional Office-II, that there was a delay in settlement of Surrender Value by 219 days and she has demanded interest @ 36% on the delayed payment. She has requested the Forum to take necessary action in this regard.

LIC of India vide their letter dated 22.09.2008 have enclosed the detailed reply and surrender value quotations as on 08.10.2007 and 08.05.2008. On going through the reply it is conveyed that the policy was lying in the lapse condition as on 05.10.2007 beyond the stage of revival i.e. policy can be revived within 5 years from the date of first unpaid premium which in this case is 28.03.2002 i.e. 5 years 6 months and 7 days. They further mentioned that they have received the surrender application along with policy bond on 06.10.2007. It is further conveyed that since at the time of taking the policy by the proposer, Life Assured was a minor, her signatures on the application form did not tally with their records. Due to this on 10.11.2007 a letter was sent to the policy holder alongwith signatures attestation form to be submitted for processing the case. That on not hearing from the Customer, they once again searched the file, and could lay their hands on signatures in DGH Form dated 13.11.2001, which was attested by Development Officer. They further mentioned that on basis of these signatures, case was processed on 06.05.2008. However, the payment made to the policyholder was based on revised quotation dated 06.05.2008 (As per rules of LIC) i.e. Rs.7157/- instead of surrender quotations dated 08.10.2007 i.e. Rs.7129/-. They further stated that in connection with the above, it is observed that there is a difference of Rs.28/- between two calculations, while paying the S.V. to the policy holder, hence the penal interest does not become payable.

After hearing both the parties and on the basis of the documents submitted, the contention of LIC of India does not sound good as the difference in both the surrender values is Rs.28/- only. It is expected that LIC should have considered the payment of surrender value with

interest @ 8% from 07.11.2007 till the time of payment on Rs.7129/-. I, therefore, pass an award accordingly as with a careful and thorough check up of the file; LIC of India could have processed the papers on the date of submitting itself without calling for any signature attestation.

Disability Benefit

CASE No.LI-JP/92/08

In the matter of Shri Makna Ram

Vs

Life Insurance Corporation of India.

AWARD dated 17.11.2008

Shri Makna Ram had lodged a complaint with this Forum on 12.09.2007 against Life Insurance Corporation of India, Divisional Office-Jodhpur, that he had taken a policy no. 100236713 on 28.10.1994 under table term 93-25 for a sum assured of Rs.20000/-. He informed that on 11.11.1998 he met with an accident and became completely disabled because both of his lower limbs stop working and since 1998 he is on bed. Inspite of taking all the treatment there is no improvement. As per the terms and conditions of the policy he should have received disability benefit which he could not get. At the instance of the agent, he completed all the formalities and his policy was surrendered and because of negligence on the part of the office or the agent he was deprived of the disability benefit. He requested the Forum that his complaint should be taken up with the Insurance Company and the benefits available to him as per the policy be paid to him.

At the time of hearing, the representative of the complainant informed the Forum that Shri Makna Ram is an illiterate fellow and was not aware of all the benefits available to him under the policy which was in force as on the date of accident. Had the agent or the Branch Office conveyed him the benefits available to him, he would not have asked for Surrender Value

of the policy. The Insurance Company also confirmed but for the delay in conveying the accident his disability benefit is payable.

After hearing both the parties and on examination of the documents submitted, I feel that as the policy of Shri Makna Ram was in force for full Sum Assured as on the date of accident and because of his continued disability he becomes entitled of all the benefits i.e. the disability benefit and the Survival Benefit falling due as per schedule of the policy. I, therefore, pass an Award that his case be reconsidered and all the benefits available to him be paid from the date of his accident upto the maturity of the policy. The Insurance Company should also refund all his premium paid by him after his disability appropriating the amount of surrender value of Rs.3280/- along with interest @ 10.5% on the balance amount and the Insurance Company should give further disability benefit as per clause 10.2 of the policy.

GUWAHATI

Disability Benefit

CASE No.LI-JP/92/08

In the matter of Shri Makna Ram

Vs

Life Insurance Corporation of India.

AWARD dated 17.11.2008

Shri Makna Ram had lodged a complaint with this Forum on 12.09.2007 against Life Insurance Corporation of India, Divisional Office-Jodhpur, that he had taken a policy no. 100236713 on 28.10.1994 under table term 93-25 for a sum assured of Rs.20000/-. He informed that on 11.11.1998 he met with an accident and became completely disabled because both of his lower limbs stop working and since 1998 he is on bed. Inspite of taking all the treatment there is no improvement. As per the terms and conditions of the policy he should have received disability benefit which he could not get. At the instance of the agent, he completed all the formalities and his policy was surrendered and because of negligence on the part of the office or the agent he was deprived of the disability benefit. He requested the Forum

that his complaint should be taken up with the Insurance Company and the benefits available to him as per the policy be paid to him.

At the time of hearing, the representative of the complainant informed the Forum that Shri Makna Ram is an illiterate fellow and was not aware of all the benefits available to him under the policy which was in force as on the date of accident. Had the agent or the Branch Office conveyed him the benefits available to him, he would not have asked for Surrender Value of the policy. The Insurance Company also confirmed but for the delay in conveying the accident his disability benefit is payable.

After hearing both the parties and on examination of the documents submitted, I feel that as the policy of Shri Makna Ram was in force for full Sum Assured as on the date of accident and because of his continued disability he becomes entitled of all the benefits i.e. the disability benefit and the Survival Benefit falling due as per schedule of the policy. I, therefore, pass an Award that his case be reconsidered and all the benefits available to him be paid from the date of his accident upto the maturity of the policy. The Insurance Company should also refund all his premium paid by him after his disability appropriating the amount of surrender value of Rs.3280/- along with interest @ 10.5% on the balance amount and the Insurance Company should give further disability benefit as per clause 10.2 of the policy.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 22/001/164/L/08-09/GHY

Mr. Bimal Chandra Sarkar

- Vs -

L.I.C. of India, G.B.O.- I

Under Guwahati D.O.

Award dated : 24.02.2009

Mr. Bimal Chandra Sarkar has procured the policy bearing No. 483216202 with the date of commencement on 28.08.2004. According to him, he has been paying

premiums in cash regularly and the last premium was due on August, 2008, but when he went to pay the said premium, the concerned Cash Counter Officials, refused to accept the said premium on the plea that his earlier premium for August, 2004 remained unpaid. He then approached the Higher Officials and at their advice, he had to pay the lapsed premium in cash on 11.10.2008 on condition of refunding the said premium to him subsequently. Since the said amount was not refunded, feeling aggrieved, the Insured approached this Authority with this complaint for redressal.

During the course of hearing, the Complainant has stated that he had paid the premium amount due on 28.08.2004 in cash to his Agent while submitting the proposal. His statement also shows that he came to know about dishonouring of the cheque for the amount due on 28.08.2004 only when he went to pay the premium due August, 2008 and because of that gap was recorded. As per advice of the Insurer, he had to deposit the gap premium due on 28.08.2004 again for regularization of his policy. He had to pay the premium due on 28.08.2004 twice for no fault of his own. The representative of the Insurer, although stated that the premium due on 28.08.2004 was paid by cheque which was dishonoured but it is an admitted fact that this information was given to the policyholder only when he went to deposit the premium due on August, 2008 and the Insurer accepted all the premiums due after 28.08.2004 till August, 2008. The Insurer has also not been able to prove that the payment of premium due on 28.08.2004 was paid either by cheque or in cash and who paid the same. The policyholder was kept at dark about the gap premium due on 28.08.2004 till the time when he went to pay the premium due on August, 2008. The disputed premium due on 28.08.2004 was the first premium and the receipt produced by the Complainant goes to show that it was deposited on 31.08.2004 but there is nothing to disclose whether it was paid by cheque. The Complainant is found to be not at fault and he should not be penalized too compelling him to pay the premium twice. It is felt that the Insurer shall have to take proper action for refunding the amount involved in the premium due on 28.08.2004 which was realized twice from the Complainant. This exercise should be completed within fifteen days from the date of receipt of consent letter from the Complainant.

-Vs-

L.I.C. of India, GBO – III, under Guwahati D.O.

Award dated = 12.11.2008

Smt. Rashmi Dutta took a "Health Plus" policy bearing No. 484691954 with the date of commencement on 05.03.2008 for an annual premium of Rs.12,000/-. Subsequently, she availed the ECS facility for payment of annual premium in future. Surprisingly, she could learn that in the month of April, 2008 an amount of Rs.12,000/- was deducted from her Bank Account and another "Health Plus" policy bearing No.484691907 was issued in her name for which she never submitted any proposal. On receipt of the policy, she requested the Insurer for cancelling the said policy and refunding the amount so deducted from her account wrongly but the Insurer has taken steps to cancel the policy without refunding the premium. Being aggrieved the Complainant approached this forum for redressal.

In the "Self Contained Note", the GBO – III of the LICI has admitted the fault of wrong recovery of Rs.12,000/- from the Bank Account of Smt. Rashmi Dutta which was done through ECS by the Divisional Office and the amount is also accounted for by the Branch. They requested the Manager (Health Insurance) to arrange refund of the wrong recovery immediately.

In response to a notice for hearing, the Complainant attended but nobody represented the Insurance Company. During the hearing, the Complainant stated that she never submitted any proposal, except for Policy No.484691954 (Health Plus), for issuing any policy with ECS mode of payment of premium. She contended that an amount of Rs.12,000/- was deducted by the Insurer from her account in the month of April, 2008 and the annual premium of the above policy will fall due in the month of March, 2009 next.

The letter written to the Manager (Health Insurance), GDO dated 28.08.2008 by the GBO – III makes the position clear, wherein the GBO – III stated as follows :-

"But despite of Policy No.484691907 being cancelled, due to program error, ECS invoice was sent to Bank by ECS Cell, GDO resulting in wrong recovery of Rs.12,000/- from the Bank Account of the policy holder through ECS. The error in program was evident from the fact that a rectified program was released by SDC vide Service Pack SP 11-Jul08-02 on 30.07.2008"

Keeping in view the above facts, the Insurer is directed to refund the amount of Rs.12,000/- to the Complainant within 15 days alongwith interest @ 9% P.A. and the

interest shall be calculated from the date of recovery of the amount from the Bank Account of the Complainant till the date of release of the amount.

HYDERABAD

Hyderabad Ombudsman Centre

Case No: L-21-001-0337-2008-09

Shri V.N.Prajwal

Vs.

LIC Of India, Divisional Office II, Bangalore

Award Dated:: 05.12.2008 **Award No: I.O.(HYD) L-0037-2008-09**

The complaint is about the repudiation of claim on Policy No:363897571 by LIC Of India, Divisional Office II, Bangalore.

Late Shri V.N.Prajwal, aged 22 yrs, submitted a proposal dt.20.2.2008 under LIC's Health Plus policy for a coverage of Major Surgical Benefit of Rs.2,00,000 Sum assured and Initial Daily Hospital Cash Benefit of Rs.1,000 by paying an amount of Rs.3,000 under Hly.mode. The policy commenced from 21.2.2008 and the coverage is for a period of 43 years. The life assured had met with an accident on 22.2.2008 and he was admitted in Hosmat Hospital on 16.3.2008 where he had undergone "Anterior Cruciate Ligament Tear" Surgery, for which the hospital charged him Rs.52,860=00 and he was discharged on 18.3.2008.

When nominee claimed for the monies, the Insurer LIC Of India rejected the claim on the plea that the surgery undergone does not fall in the list of specified surgeries as mentioned in their policy document.

The complainant contended that there was a lot of delay in processing the claim. He submitted the claim papers on 11.4.2008 and they rejected the claim on 4.9.2008. TPA had processed the claim and rejected the claim on 11.7.2008 and subsequently LIC upheld the decision. He expects the claim to be processed by LIC and he has no need to deal with the TPA. LIC had adopted illogical and strange ways of processing of claims. The policy document dt.4.5.2008 was delivered to him on 24.5.2008 and the accident occurred i.e. on 22.2.2008 much before the date of the policy and by then, the claim papers were also submitted to LIC i.e. on 11.4.08 for settlement. The final rejection was done by LIC by their letter dt.4.9.2008 with abnormal delay of 5 months time, for processing.

The complainant stated that LIC has defined the causative factors such as accident, bodily injury and sickness, which are fully satisfied in his case, they have no right to restrict or exclude the remedy i.e. surgical benefit. It is the professional responsibility to provide fully for remedy. He further stated that non-inclusion of ACL surgery in the list of major surgical benefit (1-49) is the fault of the Insurer and for the mistake/negligence, and lack of professional competence the insurer is responsible and therefore, should reimburse the claim amount fully and also pay interest equal to the claim amount.

Both the parties were heard on 28.11.2008 and all the documents submitted were perused.

The life assured met with an accident on 22.2.2008. He was admitted in Hosmat Hospital, Bangalore on 16.3.2008 at 4 PM and undergone a surgery "Arthroscopic Anterior Cruciate Ligament" (ACL Reconstruction) on 17.3.2008 and was discharged on 18.3.2008 at 4 PM. He submitted the Claim forms dt.5.4.2008 to LIC Of India on 11.4.2008 claiming an amount of Rs.52,860=00 as reimbursement. The Third Party Administrator (TPA) Family Health Plan Ltd. called for some requirements from the life assured, by their letter dt.20.6.2008 to which he complied with, vide his letter dt.30.6.2008.

The TPA rejected the claim by a letter dt.11.7.2008 stating that the surgery does not fall under the purview of the policy conditions. The reason for rejection, as stated in their letter dt.11.7.2008 was "the present hospitalization surgery not listed in the allowed list of surgeries (1-49)". In case he was not satisfied with their decision, he might appeal for a re-look to the Manager (Health Insurance), LIC Of India, Bangalore.

The life assured then submitted a complaint to the TPA, by his letter dt.23.7.2008 for which, LIC Of India confirmed by upholding the decision of the TPA, by letter dt.4.9.2008.

It is very clear that from the documents produced, there was inordinate delay in issuing the policy document and also in processing the claim papers by LIC of India, as detailed below. This is a clear violation of the I.R.D.A.(Protection of Policy Holders' Interests) Regulations, 2002.

a) The policy has commenced from 21.2.2008 but the policy document dt.4.5.2008 was received by the party on 24.5.2008, with a delay of more than 3 months. By then, he submitted his claim papers also on 11.4.2008 for settlement.

b) The claim papers received by LIC on 11.4.2008 were referred to TPA on 13.6.2008 as acknowledged by them in their letter dt.11.7.2008, with a delay of more than 2 months.

c) The claim rejection letter was sent by TPA by their letter dt.11.7.2008

d) The final rejection of claim letter was sent by LIC on 4.9.2008

Coming to the point of rejection of claim , the policy document dt.4.5.2008 clearly states the list of specified surgeries and the percentage of Sum assured of Major Surgical Benefit payable for each type of surgery.

The complainant therefore, should note that the benefit under the policy, does not provide for reimbursement of actual amount of expenses incurred but a percentage of Sum assured of MSB and that too, if the surgery undergone finds a place in the list of the specified surgeries.

It is observed from the list of the specified surgeries mentioned in the policy document, that the surgery undergone "'Arthroscopic Anterior Cruciate Ligament" (ACL Reconstruction) by the life assured, does not find a place.

Further the conditions and privileges of the policy document, sl.no.22 (vii) on Claim payments, clearly mentions about the use of the services of one or more licensed Third Party Administrator (TPA) by LIC and the insured also agrees to provide all necessary and accurate information to such TPA and follow the processes and instructions as stipulated by such TPA, for smooth administration of the policy.

The complainant therefore, cannot raise any objection to the settlement of claims by TPA.

In this case, a peculiar situation is observed. By the time the policy document is received by the life assured, he had submitted his claim forms for settlement and was awaiting the payment. The life assured had no opportunity to read and understand the features, benefits and also the terms and conditions of the policy and avail the free look period of 15 days, which is available to all the policyholders. Hence, the contention of the Insurers' representative that the insured could have returned the policy within 15 days from the date of receipt of the policy cannot be accepted. Though the rejection of claim by the Insurer has to be uphold with reference to the terms and conditions of the policy, It is felt just and proper to allow an opportunity to the insured to return the policy if he is not willing to continue the same as per the terms and conditions. He is allowed to take an informed decision after understanding all the features, benefits, inclusions etc., If the complainant exercises the option to return the policy, the insurer is directed to refund the amount as per condition No. 26 'Cooling-off period" of the policy. The insurer is also advised to strictly adhere to the regulations issued by IRDA with regard to issue of policy and settlement of claims in future.

The complaint is **partly allowed**.

Hyderabad Ombudsman Centre

Case No: L-21-001-0358-2008-09

Smt.P.Prashanthi

Vs.

LIC Of India, Divnl.Office, Visakhapatnam

Award Dated:: 12.1.2009 **Award No: I.O.(HYD) L-0041-2008-09**

The complaint is about the repudiation of claim on Policy Nos:692715061,692369614,692369618,690540818,692368487,692479503 on the life of Shri P.Ramakrishna.

Late Shri Peravali Ramakrishna took 6 policies at different times, and died on 14.8.2006 within 1 year after taking the policy no:692715061, by drowning in sea.

When nominee claimed for the monies, the Insurer LIC Of India settled the basic sum assured on five policies and rejected the claim on Policy 692715061 and also rejected the accidental benefit on all the six policies, stating that no accident is established.

The complainant contended that the life assured was in good health before taking the policies and was performing his duties to the utmost satisfaction of his superior officers. He was also promoted as Jr. Officer after passing exams written on 30th 31st August 2005 and also on 12.12.2005 recently, which shows that he was in good health. The final investigation report of the Police confirms that the death was accidental and so, requested for settlement of claim on Policy 692715061 and also the Accident benefit on all the six policies.

Both the parties were heard on 9.1.2009 and all the documents submitted were perused.

As per the FIR dt.16.8.2006, on 14.8.2006 the life assured dropped his wife at her sister's house and came to his father's house to Visalakshinagar. From there, he went to the house of his cousin Shri P.Nageswararao to attend a birthday function. His father while talking to Mr.Nageshwara Rao over phone, came to know that the life assured did not reach their house for the function. Then he and his friends searched for the life assured and found his vehicle at Sagarnagar gate at 10.30 PM. On 16.8.2006 at 9.00 AM the dead body was found at beach near Sai Priya Resorts.

The life assured's father gave a statement to the Police that since two years, his son, i.e. the life assured "used to suffer himself depressed".

The post-mortem report dt.16.8.2006 states that the dead body was found dressed in cream and snuff colour full hands shirt, and there were no injuries. The final opinion of cause death as per letter dt.27.11.2006 was "Asphyxia due to Ante Mortem "Drowning".

The final report dt.30.11.2006 by the Police states that the life assured was leading a happy marital life and does not have any type of problem. On the way to attend the birthday function, he met his neighbour Mr.Kilari Satyanarayana and during chitchat, the life assured invited him to accompany him to beach to spend leisure but the latter denied as he had some urgent work. The final report ruled out the possibility of committing suicide as he invited his friend to spend time at beach along with him. The report stated that the deceased while relaxing in the beach, might have been struck down and swallowed by a heavy tide at high force which caused Accidental death. The report concluded that "the death was an accidental one due to ante-mortem drowning in sea waters" and hence further action was dropped.

In the claim enquiry report dt.31.3.07 of the Insurer, the officer states the cause of death as "sunk in sea and died". The investigation officer states that the life assured went to sea for swimming and unexpectedly he was sunk in the sea and died and no evidences could be gathered about any illness of the deceased or any treatment taken. He recommended the claim for admission. But the insurer conducted another investigation and the officer in his report dt.5.12.07 states that the life assured did not avail any sick leave but he was mentally depressed for the past 2 years and was not moving closely with others. He opined that the death could be a planned suicide by the life assured. This is only a surmise and not based on any evidence.

Basing on these reports and the statement of the father of the deceased, the claim on Policy 692715061 was first repudiated by the Insurer by letter dt.8.1.2008 .

On representation to the Zonal Office, ZO CRC admitted the claim for Basic Sum Assured + Accrued Bonus on Policy 692715061 and Accident Benefit Claim was rejected on all the six policies, and communicated the same to the Sr.Divisional Manager by letter dt.17.9.08.

We have called for the notes of the ZOCRC as to the grounds on which the accident benefit was rejected and received the same by their letter dt.6.1.2009. On perusal of the notes, the comment "Admitted BSA on 692715061-- AB rejected on all the policies. Swimming in treacherous beach, Danger widely known to public." It is noted that the accident Benefit was rejected as they were of the opinion that the life assured was swimming in treacherous beach and so died.

The admission of Claim by ZOCRC on policy 692715061 while the suicide clause is operative; clearly means that the death is not regarded as suicide. They appear to have opined that swimming at treacherous beach caused the death, which amounts to negligence.

The dead body found, was in full dress with pant and full hand shirt and so, it cannot be taken as death caused while swimming, as normally before swimming, one will remove the pant and the shirt.

The final investigation report by the Police concluded that while the deceased was relaxing in the beach, he might have been struck down and swallowed by a heavy tide at high force and caused accidental death. They concluded that the death is an accidental one due to ante-mortem drowning in sea waters.

No doubt, the death is occurred due to drowning in sea waters. Suicide is ruled out and the possibility of swimming is also ruled out as the body was found in full dress.

In these circumstances, I regard the final report of the Police concluding the death caused by accident as proper and direct LIC Of India to admit the Accident Benefit on all the six policies. The insurer conveniently ignored all these relevant documents and reports and rejected the claim by solely relying and quoting one sentence from the FIR out of context.

It was told by the complainant that she did not receive the settlement of the basic sum assured on Policy 692715061 which was reported to have been settled by the branch by cheque no:573686 dt.6.1.09 for Rs.52,350=00. From the settlement of the amount, it is observed that the full risk cover benefit i.e. 3 times Sum Assured on death (Jeevan Mitra triple cover), which amounts to Rs.1,50,000 was not paid to her and the cheque was also not sent to her correct address.

The following observations are also made by us, in the case :-

1 The claim forms dt. 11.12.2006 were submitted to LIC by the claimant
2 The first enquiry report was dated 31.3.07
3 The second enquiry report was dated 5.12.07
4 The repudiation letter was dated 8.1.08
5 ZO, CRC date: 20.8.08 as mentioned in their office note
6 Zonal Office communication to Divnl.Office by letter dt.17.9.2008

Normally LIC settles the claims within a reasonable time but in the present case, much delay is observed. LIC of India is therefore, directed to settle the full death benefits on policy 692715061 (Jeevan Mitra Triple cover) as per policy conditions, along with the interest at the rate applicable as per IRDA guidelines from 1st September 08 to the date of settlement and also to admit the accident benefit on all six policies without any interest. The concerned officials are advised to take care of the latest address of the claimants to send the communications, as otherwise the benefits would reach late and cause inconvenience to the beneficiaries.

Hyderabad Ombudsman Centre

Case No: L-21-001-0392-2008-09

Shri K.Srinivasu

Vs.

LIC Of India, Divisional Office,Rajahmundry

Award Dated:: 26.2.2009 **Award No: I.O.(HYD) L-0047-2008-09**

The complaint is about the repudiation of illness benefit on Policy No:801728517 on the life of

Shri Kanikineedi Srinivasu, aged 27 yrs, who took Asha Deep II Policy bearing No:801728517, for a sum assured of Rs.1,00,000 from LIC Of India. The policy commenced from 28.9.1998. The policy provides for immediate payment of 50% of sum assured plus 10% of sum assured every year plus waiver of future premiums payable and the balance of 50% of sum assured at the end of the term or earlier death, along with vested bonuses, in case of occurrence of any of the contingencies mentioned in the 11 (b) of the policy document.

The policyholder Shri Srinivasu had undergone Heart surgery at NRI General Hospital, Chinakakani on 15.6.2007 and submitted all the relevant documents to LIC Of India for payment of the benefit under the policy.

When nominee claimed for the monies, the Insurer LIC Of India rejected the claim on the plea

that the life assured had undergone Mitral Valve replacement which is not covered and therefore, the benefit is not payable to him under the policy.

The complainant contended that he undergone Open heart surgery for Mitral Valve replacement on 15.6.07 but the Insurer rejected the benefit on the policy.

Both the parties were heard on 20.2.2009 and all the documents submitted were perused.

It is observed that the Policy document of Asha Deep II, states under the Conditions and Privileges, 11(b) (i) that the benefit under the policy is payable on the occurrence of the contingency if the Life assured undergoes **Open Heart By-pass Surgery** performed on significantly narrowed/occluded coronary arteries to restore adequate blood supply to heart and the surgery must have been proven to be necessary by means of coronary angiography. All other operations (e.g. angioplasty and Thrombolysis by coronary artery Catheterization) are specifically excluded.

In the present case, the Insurer referred the documents to their Medical Referee and obtained his opinion by their letter dt.17.9.2007. The Medical Referee opined that the MVR was done on 15.6.2007 and he further added that according to the condition of Asha Deep, Valve Replacement is not eligible for benefit.

It is very clear from the condition of 11 (b) (i) of the policy document, that the benefit is payable only on undergoing Open Heart By-pass Surgery and it specifically excluded all other operations. The rejection of the benefit by LIC Of India is proper and therefore upheld.

The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0450-2008-09

Smt.M.Chittemma

Vs.

LIC Of India, Divisional Office, Kadapa

Award Dated:: 13.3.2009 **Award No: I.O.(HYD) L-0052-2008-09**

The complaint is about the repudiation of accident benefit on Policy No:653828230 on the life of

Late Shri M.Adeppa, aged 27 yrs who took the po9licy for Rs.50,000 with double accident benefit. The policy commenced from 28.9.2005 and he died on 19.12.2006 due to inhalation of pesticides poisonous gas on 12.12.2006 while spraying in the field.

When nominee claimed for the monies, the Insurer LIC Of India settled the basic sum assured but rejected the accident benefit on the policy on the plea that life assured did not sustain any bodily injury resulting solely and directly from an accident caused by outward, violent and visible means, as per the policy terms and conditions and the reported accident does not satisfy the other conditions stipulated for eligibility for payment of accident benefit under policy conditions 10 (b).

The complainant contended that LIC Of India rejected the accident benefit but the life assured died while spraying Monocrotophos Pesticides in the agricultural field. Because of the wind – the incident occurred accidentally and there was no intention of committing suicide. The incident was rarest of the rare case.

The case was heard on 12.3.2009 and all the documents submitted were perused.

From the document FIR No:13/06 registered at Belugappa Police Station u/s 174 of Cr.p.c., the death of the life assured was due to inhalation of pesticide poison. As per the report, on 12.12.2006 the life assured, agricultural labour, went into a field to spray the pesticide and after

completion of the work, he returned home in the evening. Due to inhalation of the pesticides, he started vomiting when he was taken to a RMP doctor who had treated him but the life assured did not get relief. So, on 13.12.2006 he was taken to Govt. Community Hospital, Kalyandurg where he was admitted. The Doctor referred to Govt. General Hospital, Ananthapur and so on 14.12.2006 he was admitted there. While undergoing the treatment there, he died on 19.12.2008.

The Claim Form B obtained from Govt. General Hospital, Ananthapur states that the life assured was exposed to spraying of "Monocrotophas inhalation Poisoning on 12.12.2006. The Post Mortem was done on 20.12.2006. The cause of death as per the Forensic Science Laboratory report dt.20.12.06/26.5.07 was reportedly due to unknown poison only – the nature of which not detected by chemical analysis.

The investigation officer in his report clearly stated that there was no suspicion regarding the bonafides of the claim and he clearly stated that it was "purely accidental" -- the life assured came in contact with poisonous gas while spraying in the fields. The life assured was hired for spraying the chemicals and the incident occurred was purely accidental and also he categorically stated that it was not a case of suicide and the claim is genuine. The police final investigation report also confirmed the "accidental death due to inhalation of pesticides poison".

But the insurer while paying the basic sum assured on the policy, rejected the accident benefit under the policy, stating in his letter dt.1.7.08 that since the life assured did not sustain any bodily injury resulting solely and directly from an accident caused by, outward, violent and visible means, as per the policy terms and conditions and further, the reported accident falls within the scope and terms of 10 b(1) and does not satisfy the other conditions stipulated for eligibility for payment of accident benefit, under policy conditions 10 (b).

In this connection, we refer to the below-mentioned two decisions dealing with the issue of "accidental death".

1 AP State Consumer Disputes Redressal Commission, Hyderabad – FA No.1205 of 2005 against CD No.278 of 2003 District Consumer Forum, Kakinada, East Godavari decided on 12.10.2007 -- Karri Kameswari W/o Late Karri Kamaraju & Pinapathu Mutyalamma W/o Pinapothu Raju Vz. M/s United India Insurance Co.Ltd.

In the first case, the AP State commission, Hyderabad clarified that the word "Accident" – generally denotes an event that takes place without one's foresight or expectation; an event which proceeds from an unknown cause, or is an unusual effect of a known cause and therefore, not expected; chance, casualty, contingency (Webster Dictionary). In this narrower sense of the word, an accident must be "nobody's fault" 12 App.Cas.526

From this definition, it can be observed that an accident is some sudden and unexpected event taking place without expectation upon the instant rather than something which continues. The commission decided that the death of the insured by Sunstroke can be termed to be an

accident and set aside the order of the District Forum and directed the United India Insurance Co Ltd. to pay sum insured of Rs.1 lakh with interest @9% p.a. under Janata Personal Accident Policy.

2 National Consumer Disputes Redressal Commission, New Delhi – Revision Petition No.973 of 2007 decided on 24.10.07 – Rita Devi @ Rita Gupta Vs. National Insurance Co.Ltd. & Others.

In the second case, the National Commission, New Delhi held that death which does not occur in the usual course or natural course of events or events/causes which could not be reasonably anticipated is considered to be accidental one. It is stated that the injury or death caused by lightening, sun-stroke or earthquake has been held to be accidental. Similarly, where a man in the course of his work is exposed to excessive heat coming from a boiler and becomes exhausted or has to stand in icy cold water and sustains pneumonia or having got overheated, is exposed to a draught resulting in pneumonia or sustains sub-acute rheumatism as a result of **bailing** out of a flooded mine, his injuries have been held to be accidental.

The expression "Accident caused by external, violent and any other visible means" is dealt as below:-

EXTERNAL :: In an insurance against " bodily injury caused by violent, accident, external and visible means" but excepting "natural disease, or weakness or exhaustion consequent upon disease" "external" is used in contradistinction to such unnatural cases as disease or weakness.

VIOLENT :: Unjust or unwarranted use of force, usually accompanied by fury, vehemence or outrage; physical force unlawfully exercised with the intent to harm.

VISIBLE :: (1) Perceptible to the eye discernable by sight

(2) Clear, distinct and conspicuous

"Violent" does not necessarily imply actual violence but include any external, impersonal cause, such as drowning or the inhalation of gas or even undue exertion on the part of the assured. The word violent is merely used in antithesis to "without any violence at all".

Similarly, "External" is used to express anything which is not "internal" and any cause which is "external" in this sense is also "visible" within the meaning of an accident policy. These words refer to the accident, not the injury and are used to distinguish injuries covered by the policy from those due simply to such causes as disease or senility which arise in the body of the deceased.

Death resulting from the threats by miscreants is also considered to be an accidental caused by external violence and visible means. In substance, death which does not occur in the usual course or natural course of events or events/causes which could not be reasonably anticipated is considered to be accidental one.

In the present case, the death is accepted by all as due to "inhalation of Monocrotophas Poisonous gas" pesticides while spraying and the forensic report also confirms due to unknown poison only and the investigating officer categorically stated that it was not a suicide but the incident occurred was accidental.

In the light of these two above cited case laws, It is held that the incident occurred was only accident and the LIC Of India is directed to pay the Accident Benefit on the policy.

The complaint is allowed. ----------

Hyderabad Ombudsman Centre

Case No: L-21-004-0485-2008-09

Shri M.Bhaskara Rao

Vs.

ICICI Prudential Life Insc.Co.Ltd. Mumbai

Award Dated:: 31.3.2009 **Award No: I.O.(HYD) L-0057-2008-09**

The complaint is about the repudiation of claim and cancellation of Policy No:05970562 on the life of Shri M.Bhaskara Rao. Shri M.Bhaskara Rao, aged 60 yrs. submitted a proposal dt. 2.8.2007 for a policy under "Hospital Care" to ICICI Prudential Life Insc.Co.Ltd., for an annual limit of Rs.4,00,000 and obtained a policy bearing No:05970562. The policy commenced from 13.11.2007. He was admitted in KIMS, Hyderabad on 29.4.08 for angiograph and again on 7.5.08 and got **stented** for both legs femoral arteries. He submitted the claim form dt. 30.6.2008 to the Insurer, for reimbursement of the medical expenditure, as per the terms and conditions of the policy.

When the life assured claimed for the benefit on the policy, the Insurer , ICICI Prudential Life Insc. Co.Ltd. .. not only rejected the claim on the policy but also cancelled the policy forfeiting the premium paid on the policy, on the plea that the life assured was suffering from Right leg claudication since 10 years and also he had a history of smoking 1 packet of cigarettes per day since last 25 years., which were not disclosed in the proposal dt.2.8.2007 and the answers to Q.No.19(E), 21(a) and 22 (g) of the proposal were found to be false.

The complainant contended that the Unit Manager of Insurer obtained his signature on the blank proforma and filled all columns in it. He never showed the filled in application to him. The Unit Manager saw many times when he was smoking but he never asked him about his smoking habit even while filling the proforma. In 1999, he developed pain in his right leg while walking and approached NIMS and managed with medicines up to May 2008. He started getting pain in his left leg in the month of Feb.2008 and when he was getting pain in both legs, he approached Dr.Rajendra Kumar Jain who performed Angiogram and operated and stents were

implanted in his femoral arteries of both legs on 7.5.2008. He incurred Rs.1,74,250=00 towards operation expenditure and claimed for reimbursement from the Insurer, under the policy. But they rejected the claim accusing him that he suppressed the facts. The fault does not lie with him and the Unit Manager of the Insurer who filled the application is at fault, as he had not even showed the filled in application.

The case was heard on 19.3.2009 and all the documents submitted were perused.

From the document of Discharge Summary of Krishna Institute of Medl.Sciences Ltd., Secunderabad submitted to us, I observe that the life assured was admitted in the hospital on 29.4.2008 and was discharged on the same day and the diagnosis made was Right Leg claudication since 10 yrs; Left leg claudication since 3 months, Smoker, Hypertension since 15 yrs; CAG + PAG on 29.4.08 – Normal coronaries, Bilateral Femoral disease, Left Total occlusion, Right 99% occlusion. The life assured was admitted for CAG + PAG in the hospital on 7.5.08 and was discharged on 9.5.08, as per the Emergency certificate issued by them.

From the Claim statement Form dt.1.7.08 submitted to the Insurer by the life assured, I observe that the life assured stated that he suffered in 1999 for right leg where blood flow in Femoral artery was very slow due to narrow passage. He used tablets for all these years prior to operation and same symptoms occurred for left leg also in January 2008 and was unable to walk even for 3 minutes duration for not having proper blood circulation in legs. He had undergone angiogram on 29.4.2008 and operation for both the legs and stents implanted for both femoral arteries on 7.5.08.

Further, from the documents submitted to us, It is noted that along with the policy document, a zerox copy of the proposal form filled in and signed by the life assured was sent with a covering letter dt.13.11.2007 by the Insurer, giving him a free look period of 15 days.

The argument of the life assured that the Unit Manager of the Insurer had induced him to take the policy, who filled in the application and not showed him even the filled in application, is not tenable, as he had an opportunity to go through the zerox copy of the filled in application sent to him by the Insurer along with the policy document.

It is evident that he was suffering from the claudication of Right leg since 1999 and had been on medication prior to submission of the proposal to the insurer, which is a material fact and he was supposed to disclose the same at the time of taking the policy. The answers to questions 19(E), 21 (a) and 22 (g) (viii) of the proposal form given by the life assured misled the insurer and induced him to issue the policy.

The policies of Life insurance are the policies of Utmost Good Faith and both the parties to the contract have to reveal all the facts in full.

The Insurer, ICICI Prudential Life Insc.Co.Ltd. is therefore, justified in treating the policy as Null and Void since inception, forfeiting the premiums paid there-under and rejecting the claim benefit on the policy. The complaint is Dismissed.

KOLKATA

Kolkata Ombudsman Centre

Case No. 167/21/003/L/06/08-09.

Smt. Reena Choudhary

Vs.

TATA AIG Life Insurance Co. Ltd.

Award Dated : 01.10.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of Sickness Benefit.

The complainant purchased a policy under Health Protector Scheme with risk date 27.03.2006 and with Critical Illness Rider of Rs.1,00,000. She stated that her policy was in full force but her claim for Critical Illness Benefit was denied by the Insurer. She alleged that one representative of the Insurer took her signature in some documents and the action of denial was not proper and against the Rule of IRDA. So she approached this Forum but did not submit P-Form as yet.

The Insurer have submitted their Self Contained Note (SCN) stating that the policy became lapsed due to non-payment of premium due 04/2007 and was reinstated in 08/2007 on the basis of a health declaration dated 06.08.2007. The Life Assured (LA) submitted claim for hospitalization benefit on 22.11.2007 which was within 3 months from the date of re-instatement of the policy. This, being an early claim, the insurer took some investigation and established that the LA was suffering from some chest pain even before her Health Declaration dated 06.08.2007 and she had been diagnosed as having Mitral Stenosis in 02/2007 and had an Echocardiography done on 21.02.2007. This adverse health condition was not mentioned in Health Declaration dated 06.08.2007 which according to them was suppression of material facts.

According to policy condition "Critical Illness" means illness the signs or symptoms of which first commence more than 180 days following the issue date or the commencement date or the date of reinstatement of the policy, whichever is the latest, and shall include either the first diagnosis of any of the following illnesses or first performance of any of the covered surgeries. As such they repudiated the claim.

HEARING:

In response to a notice of hearing, the representatives of the insurance company have stated that her policy lapsed in April, '07 and the same was revived after obtaining health declaration w.e.f. 6th August, '08. As the policy was treated as a fresh policy and on investigation, it was found that the life assured (LA) was diagnosed as having Mitral Stenosis in February, '07. This fact of Mitral Stenosis in February, '07 was not disclosed in the health declaration given by the life assured at the time of revival of the policy. Therefore, the representative of the insurance company invoking the order given by the Hon'ble Supreme Court of India in P.C. Chako & Ors, Appeal (Civil) No. 5322 of 2007, maintained that the revived policy was ab initio void. Therefore, they held that question of paying for the "critical illness" does not arise. Further, they stated even if the policy is not held to be ab initio void , the disease suffered by the life assured (LA) is not one of the diseases under "critical illness" which would be covered by the policy. Further, they stated that with respect to the revived policy the disease has occurred within the lien period of 180 days from the date of inception of the fresh policy. Keeping in view the above, according to them, the claim has been correctly repudiated.

On the other hand, the Life Assured (complainant) has stated that the health declaration was prepared by agent and therefore she was not in the knowledge that her proper health condition has not been mentioned. She pleaded that her claim may be settled.

DECISION:

The complainant was explained why the insurance company could not pay the claim. The policy was in lapsed condition and revival was done only from August, '07 . Under the insurance law, the policy will be treated as a fresh policy. However, in this case, since there was suppression of material fact in the health declaration made at the time of the revival of the policy due to the decision of Hon'ble Supreme Court of India as mentioned above, the insurance contract gets vitiated for the reasons of suppression of material facts by the insured. According to their Lordships, a deliberate wrong answer which has a great bearing on the contract if discovered may lead to policy being vitiated in law. She was further informed that even if the policy is deemed to be existing the reasons she has suffered viz., Mitral Stenosis is not covered under the head critical illness of the policy conditions. Further, in any policy if this disease occurs within 180 days of the policy cover, same is not allowed under "critical illness" clause of the policy.

Keeping in view the above decision of the Hon'ble Supreme Court, we have to hold that the policy has become ab initio void as the insurance contract is vitiated due to suppression of material facts. Therefore, the petition is dismissed and the complainant does not get any relief.

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Kolkata Ombudsman Centre

Case No. 227/22/001/L/07/08-09

Sri Bablu Das.

Vs.

Life Insurance Corporation of India.

Award Dated : 22.10.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against Non-payment of risk premium within Free Look Period.

The complainant purchased LIC Policy No. 419906027 with DOC 28.09.2007 for SA Rs.5,00,000/- under T/T 165-35 paying quarterly premium of Rs.6125/-. He stated that he received the Policy Bond on 10.10.2007 and applied on 11.10.2007 for cancellation of policy and refund of risk premium within the Free Look Period as available under IRDA Regulations. He approached this Forum and submitted P Form giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

They furnished their SCN dated 28.08.2008 admitting that the Policy Bond was received by the concerned Development Officer as per their hand delivery Register on 12.10.2007. The Life Assured (LA) did not return the original policy bond and instead submitted application for refund of premium within Free Look Period at their counter. They wondered how could he apply for refund of premium before delivery of the Policy Bond.

HEARING:

In response to a notice of hearing on 16.10.08, both the parties attended. The representative of the insurance company came in the morning while the complainant attended little later. According to the insurance company, the complainant could not have

given any letter requesting for refund of premium in the free look period as the policy bond was given after such letter was allegedly received. According to them, no such letter was received by them and therefore, the complainant cannot claim refund of the premium. On the other hand, the complainant had produced the copy of the letter dated 11/10/07 in which he has requested refund of the premium even before the policy bond was received. This letter contains the stamp of the insurance company.

DECISION:

We are unable to agree with the arguments of the representative of the insurance company as receipt of the policy bond after receiving the request for dis-continuation of the policy for the refund of the premium does not in any stand in the way of the complainant receiving the refund. Therefore, we direct the insurance company to refund the premium received within 15 days from the receipt of this order along with the consent letter from the complainant. No interest on refund is payable as LICI, was on the premise that the refund was not due for the reasons mentioned above. Accordingly, the complaint is disposed of.

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Kolkata Ombudsman Centre

Case No. 304/21/003/L/08/08-09

Sri Bhawani Singh
Vs.

TATA AIG Life Insurance Co. Ltd.

Award Dated : 20.11.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of hospitalization benefit.

The complainant purchased "Health First" Policy No. C-201545788 with risk date 01.03.2004 under 39 years premium paying term. He was admitted to Alfa Medical Services Pvt. Ltd. on 09.10.2006 for treatment of Malignant Malaria and was released on 14.10.2006. He approached the insurer to reimburse Rs.12679/- being the cost incurred for treatment which was denied. He has not yet submitted P Form.

They furnished copies of Policy Application Forms and Policy Conditions and Medical Reports as well as their letter to the complainant dated 01.11.2006 along with SCN. They informed the claimant that since he was admitted in an unapproved Hospital for a non-emergency condition the claim did not meet the requirements under this policy and also the illness suffered did not fall under the definition of "critical illness" as per policy conditions.

HEARING:

During the course of hearing , the complainant was informed that the policy is a life insurance policy also covering some medical benefits in respect of critical illness etc.

In response to this, he stated that the agent told him that the policy was very good and it was a medi-claim policy and it would cover all the claims with regard to medical treatment. Therefore, he felt that he would get relief from out of this policy.

On the other hand, the representatives of the insurance company have stated that this is an insurance policy linked with health and only some types of illnesses under head "critical illness" are covered under the policy to the extent of cover taken by the insured. They have stated that the disease suffered was "falciparum malaria" which is not covered under critical illness. Therefore, according to them, they have correctly repudiated the claim. In response to this, the complainant has stated that he has already spent a lot of money to claim this amount and that he does not want to continue the policy anymore and he requested that whatever money he has expended may be re-imbursed.

DECISION:

On going through policy documents, we find that the averments made by the insurance company are correct with respect to policy being essentially for life cover and to some extent medical benefits only in the case of "critical illness", and the disease known as 'falciparum malaria' is not included under the definition of critical illness. Further under the RPG Rules, 1998, we do not have the powers to grant any damages. Therefore, we are unable to compensate with regard to expenses incurred by him. However, we will direct the insurance company to refund the total premiums received from the complainant as an ex-gratia payment.

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Kolkata Ombudsman Centre

Case No. 201/22/013/L/07/08-09

Shri Jyoti Prakas Nath
Vs.

AVIVA Life Insurance Co. Ltd

Award Dated : 25.11.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against Refund of premium.

The complainant had taken a policy no. LLG – 1155823 under Life Long Unit Linked Balanced FD with date of commencement 31.03.2005 and last paid premium – 31.03.2007. He had paid three premiums @ Rs.50,000/- for last 3 years on 03/2005. 03/2006 & 03/2007 amounting to Rs.1,50,000/-. He stated that his accumulated units are gradually decreasing over last 3 years and he shall get back only Rs.67,000/- (approx), if he opts to exit now. So he wanted refund of his premium. But as he did not receive any response, he appealed this forum seeking for justice for refund of premium. He has not submitted the P forms till date.

Self Contained Note (SCN) received from the Insurer dated 27.08.2008 stated that complainant had taken a Life Long Unit Linked Policy for Rs.4,00,000/- on 31.03.2005 after paying annual premium of Rs.50,000/-. The policy document was despatched on 08.04.2005 and was delivered on 11.04.2005. The policy schedule, FPR and other documents mentioned the 'Free Look Period' of 15 days from date of receipt of policy document. But the policy holder requested for cancellation of the policy after lapsation of 3 years. In spite of this, the insurer has agreed to cancel the policy and has requested him to submit the "Original" Policy Document. They assured that the policy will be cancelled and the premium amount will be refunded to the policy holder.

HEARING:

In response to a notice of hearing, only the representatives of the insurance company attended. The complainant also did not send any request for adjournment. Further, the complainant has not submitted the P-forms which are mandatory to take up the petition.

The representatives of the insurance company have stated that the policy has lapsed after 3 premiums were paid and however, since the policyholder has requested for cancellation of policy they were prepared to pay the premium collected. They further stated that they have requested the policyholder to send the original policy document along with first premium receipt so that they are able to cancel the same.

DECISION:

Since the complainant did not attend we propose to deal with the matter on ex-parte basis. As per the petition of the complaint, his prayer is to get the refund of premium paid along with any monetary compensation. It may be stated here that the Insurance Ombudsman does not have powers to give any damages for mis-sell of the product by the insurance company.

However, since the insurance company is willing to pay entirely all premiums received, we direct the insurance company to refund the premiums received.

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Kolkata Ombudsman Centre

Case No. 200/22/013/L/07/08-09

Smt. Jharna Nath
Vs.

AVIVA Life Insurance Co. Ltd

Award Dated : 25.11.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against refund of premium.

The complainant purchased a Life Long Policy No. LLG – 1155827 on 10.03.2005 and since then paid 3 yearly premiums of Rs.50,000/- each. According to her, the agent misguided her in believing that she would receive back the invested amount with interest after 3 years. She found that after paying a total premium of Rs.1,50,000/- she would receive Rs.67,000/- only as surrender value. She, as a senior citizen and pensioner, requested for refund of premium. However, she did not submit any P Forms.

Intervention was made with the insurer and we received their SCN stating that :-

i) The insured submitted her proposal on 10.03.2005 for policy under this Plan after signing and received the Key Feature Documents and other papers on completion of formalities. The insurer issued Policy Bond on 30.03.2005 and the same was delivered on 06.04.2005.

ii) The insured did not avail refund of premium within Free Look Period as specified in IRDA Regulations. Her application for refund of premium

paid was received on 28.05.2008 only after the policies acquired paid up values.

iii) According to them the question of mis-selling is a mere after thought. However, the insurer is agreeable to refund the premium paid after receiving the FPR and Policy Bond from the complainant.

HEARING:

In response to a notice of hearing, only the representatives of the insurance company attended. The complainant did not come nor did send any request for adjournment. Further, the complainant has not submitted the P-forms which are mandatory to take up the petition.

The representatives of the insurance company have stated that the policy has lapsed after 3 premiums were paid and however, since the policyholder requested for cancellation of policy they were prepared to pay the premium collected. They further stated that they have requested the policyholder to send the original policy document along with first premium receipt so that they are able to cancel the same.

DECISION:

Since the complainant did not attend we propose to deal with the matter on ex-parte basis. As per the petition of the complaint, her prayer is to get the refund of premium paid along with any monetary compensation. It may be stated here that the Insurance Ombudsman does not have powers to give any damages for mis-sell of the product by the insurance company.

However, since the insurance company is willing to pay the entire premium received, we direct the insurance company to refund the premiums received.

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Kolkata Ombudsman Centre

Case No. 324/23/001/L/08/08-09

Shri Rajendra Drolia
Vs.

Life Insurance Corporation of India

Award Dated : 31.12.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against Change in policy term affecting claim.

The complainant purchased a Joint Life Policy No. 510016948 with DOC 28.02.1988 for SA Rs.50,000/- and FUP 02/2009. The copy of the policy bond showed 20 years term and date of maturity as 28.02.2008 but maturity claim was not paid. The insurer informed them that the policy bond was erroneous and the policy would mature on 28.02.2013 i.e., after 5 years. The insurer did not respond to their notice so they approached this Forum but did not submit P Form.
Intervention was made with the Insurer but so far we have not received their SCN.

HEARING:

In response to a notice of hearing, both the parties attended. According to the representative of the insurance company there was a genuine mistake made in the policy certificate by mentioning plan & premium term as 89/20 instead of 89/25 and that they have corrected the policy document and are sending back the same to the complainant.

However, the complainant refused to accept the corrected document as he was of the firm opinion that he had only sought for policy plan 89/20 and not 89/25. The representative of the insurance company then showed him the proposal in which it was clearly written that the insured has opted for policy plan 89/25. In response, the complainant has stated that all the entries in the proposal form were filled up by the agent and therefore, he did not know that plan 89/25 was written in place of 89/20. He further queried that why LICI committed similar default with regard to policy no.510015606 and they themselves paid the maturity amount under plan 89/20 after deducting the extra premium payable by the insured. Therefore, he requested that a similar treatment may be given to this policy no.510016948.

DECISION:

On discussing with the representative of the insurance company, we find that the request made by the complainant is acceptable. Therefore, we direct the LICI to re-compute the premium payable under policy plan 89/20 and deduct the balance premium from the maturity amount payable on 28.2.2008 to the insured.

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Kolkata Ombudsman Centre

Case No. 342/23/L/005/08/08-09.

Sri Sudesh Raj Gope
Vs.
HDFC Standard Life Insurance Co. Ltd.

Award Dated : 30.12.2008

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against change in policy term affecting the total premium.

The complainant purchased the policy no. 11778615 paying Rs.1,00,000/- assuming that it was a single premium policy but found, on receipt of the policy bond, that it showed instalment premium @ Rs.1,00,000/- payable yearly for 10 years. He requested the insurer to rectify the mode of premium citing financial problem. The insurer investigated the complaint but did not accede to his request. So he approached this forum. He submitted the P Forms and his consent for mediation by the Ombudsman on the date of hearing.

SCN mentioned that the Life Assured (LA) was provided with all features of the Insurance Plan. They agreed that he applied for withdrawal of invested amount within Free Look Period but, after pursuation and several correspondences between the Insurer and the policy holder, the complainant agreed to continue the policy vide his letter dated 30.09.2008. They further forwarded on 02.12.2008 a number of correspondences and maintained that no alteration in mode of premium could be possible.

HEARING:

In response to a notice of hearing both the parties attended. The representatives of the insurance company stated that the insured has sent a letter within the 'free look period' requesting for changing the policy terms and conditions. According to them, after discussing with their officials, the insured consented to continue with the policy after receiving clarifications from the officials of the insurance company. Therefore, the insurance company did not initiate any process to change the premium payment terms as requested by the LA in his letter. According to them, the complaint does not have any relevancy and therefore, need not be adjudicated upon.

On the contrary, the complainant has stated that though he has given a consent he immediately sent a letter to the insurance company dated 5/12/08 stating that the continuation of the policy was not to his satisfaction and therefore, the consent letter given on 30/09/08 may be treated as null & void. He requested the insurer that the policy may be treated as a single premium policy or in default the insurer should refund the principal amount back to him. Therefore, he requested that he may be paid back the premium he has deposited as he was not satisfied with the terms and conditions of the policy.

DECISION:

From the above, it is clear that though the insured has given a consent letter on 30/09/08, the letter written to insurance company during the free look period requesting from changing the instalments of premium has been revived by a letter dated 5/12/08 in which he has requested that the policy may be treated as single premium policy or refund the premium paid. Therefore, it is our considered opinion that the letter written in the free look period is to be treated as a request for refund of premium. Keeping in view of the above, we direct the insurance company to refund the premium in full within 15 days from the receipt of this order along with the consent letter. The petition is accordingly disposed of.

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Miscellaneous

Kolkata Ombudsman Centre

Case No. 433/23/001/L/10/08-09

Smt. Arpita Basu

Vs.

Life Insurance Corporation of India

Award Dated : 19.01.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against change in policy clause.

The complainant had taken a policy under T/T – 122-12 for yearly premium of Rs.10,000/- with DOC 28.12.1996. As per the policy bond, she was under the impression that she would have to pay annual premium upto Dec 2007 and the monthly annuity would commence from Jan 2009. Accordingly, she continued paying the annual premiums till December, 2007. But after long 11 years from DOC, she was intimated by the insurer that the policy term will be 17 years instead of 12 years and the premium term was extended to till December 2012 and the monthly pension will start from January, 2014 instead of January, 2009. She expressed her inability to continue premium payments and requested for refund of an amount of Rs.1.20 Lacs . In spite of her repeated correspondence with the insurer, she did not get any favourable response and so she appealed to this forum seeking justice and submitted the P Forms along with the unconditional and irrevocable consent for the insurance Ombudsman to act as a mediator between the Insurance Company and the complainant.

In spite of our correspondence vide our letter dated 17.10.2008, we have not received the SCN from the insurer till date. But the correspondence of the insurer made to the complainant show that the policy term then was wrongly printed as 12 years instead of 17

years. As per terms & conditions, the minimum vesting age under this plan is 55 years and so, LA was requested to continue paying the premium till 28.12.2012 to get the Annuity started from January 2014.

HEARING:

In response to a notice of hearing, the complainant has stated that she was expecting the pension to be payable w.e.f. January, '09. However, the insurance authorities has stated that there was a mistake in the policy bond which actually should have been made for 17 years as the assured would have attained the age of 55 years. Actually, they made it payable after 12 years as per the policy certificate. According to her, she would not be able to pay the premiums for 5 more years. Therefore, she requested that either she may be paid the entire sum as per terms and conditions or she may be paid annuity after 5 years without insisting payment of premium for the next 5 years.

On the other hand, the representative of the Insurance Company has stated that it would not be possible to pay annuity after 12 years and also annuity for premium term of 17 years without further payment of premium in which case the policy would become paid-up (causing financial loss to Life Assured). They also intimated the Life Assured that if she pays premium for 17 years the NCO & Annuity instalment will also be enhanced from Rs.2,69,906/- to Rs.5,33,333/- and from Rs.2515/- to Rs.5107/- respectively. Therefore, they stated that they would follow the order passed by the Hon'ble Ombudsman.

DECISION:

Since there are no impediments in payment of the surrender value after 12 years, the LICI is directed to pay the amount due to the complainant (the calculation sheet indicated an amount of Rs.2,44,679/-) immediately

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Misecellaneous

Kolkata Ombudsman Centre

Case No. 442/22/005/L/10/08-09

Shri Monotosh Kumar Mandal

vs.

HDFC Standard Life Insurance Co. Ltd

Award Dated : 20.02.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against refund of risk premium.

The complainant had applied for home loan from HDFC to secure home loan amount of Rs.3,00,000/- for which he was asked to take a Unit Linked Endowment Plan Policy for Sum Assured (SA) of Rs.3,00,000/- with premium of Rs.15,000/-. But after taking the policy with Plan start date 26.12.2007, the home loan was not given to him. The proposal for home loan was cancelled by him on 21.05.2008. He was assured by a financial consultant of HDFC that Rs. 15,000/- will be refunded after receiving the cancellation letter. But after repeated follow-ups with the insurer, he neither got the home loan, nor did he get the refund of the premium amount of Rs.15,000/- which remained blocked since January, 2008. So, he claimed a compensation of Rs.30,000/-. He approached this forum seeking justice for the above mentioned grievances and has submitted the P-forms along with the unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant.

Self Contained Note (SCN) submitted by the insurer stated that Life Assured (LA) had taken one Unit Linked Endowment Plus Plan (Pol. No. 11508124) on his own life on the basis of the proposal form dated 29.10.2007 for a yearly premium of Rs.15,000/- and term of 10 years. He was given the illustrations, Addendum to Unit Linked Plans proposal, source of fund declaration etc., wherein the details of the policy were mentioned. They had also intimated to the policy holder vide their letter dated 26.08.2008 that as the 'Free Look Period' of 15 days from receipt of policy documents was over, the request for cancellation could not be processed. They also informed that the policy could be surrendered any time during the term but the amount payable will be the unitized fund value after applying additional surrender charges. The surrender charges are not applicable if premium are paid for at least 3 years. According to the insurer, the LA submitted the proposal after having full knowledge and consented about the plan and it was merely his apprehension that if he did not open the policy he might not be given loan. The insurer never made any promise to the LA to provide him with home loan.

HEARING:

In response to a notice of hearing only the representative of the insurance company attended. The complainant has sent a letter dated 2/2/09 in which he requested that his case may be considered sympathetically as he was not in a position to appear in person at Kolkata.

The representative of the insurance company has reiterated all the points that have been mentioned by the insurer in the paragraph 9 (b) above. Therefore, she pleaded that the request for refund of premium should not be acceded to.

DECISION:

As the complainant did not attend and as he has requested that his case may be disposed of sympathetically we propose to deal with the matter on ex-parte basis.

From the above it is clear that this policy was taken by him only to secure a home loan from the company. He was issued the policy w.e.f. 07/01/08, however, he was informed of the cancellation of home loan proposal only on 21/05/08 long after the time for availing free look period was over.

Therefore, in the interest of justice, it is felt that the complainant who does not want any policy should not suffer as his desire of availing a home loan was not fulfilled. In fact, it is felt that the free look period should be reckoned from the date of rejection of the home loan.

Keeping in view the above points, it is felt that though the company is correct in rejecting the plea of refund of premium, we direct the insurance company to refund the premium on ex-gratia basis. However, while refunding the premium, they may deduct normal charges with regard to stamp duty and administrative charges, if any.

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Misecellaneous

Kolkata Ombudsman Centre

Case No. 532/22/007/L/12/08-09

Smt. Gargy Ganguly

vs.

Max New York Life Insurance Co. Ltd

Award Dated : 26.02.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against non-refund of premium.

The complainant purchased policy no. 370804312 under 5 years level Term Plan with risk date 30.07.2008 for SA Rs.1,00,000/- and half yearly premium Rs.1064.44 and another policy no. 372718254 with risk date 24.07.2008, No of Units-4 and half yearly premium Rs.1454.89. She applied for refund of risk premium within free look period and being regretted she approached this Forum submitting P-forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

Intervention was made with the insurer but we have not received their Self Contained Note (SCN). However, they informed the complainant vide letter dated 10.10.2008 that they were unable to cancel the policy and refund the money since the free look period was lapsed.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was represented by her husband as she herself could not attend being not well. The representative of the insurance company stated that there was a short delay in claiming the refund of premiums paid as the time given under Free Look Period was only 15 days. The policy documents were received by the complainant on 18/08/08 and she has requested for cancellation of the policy on 03/09/08 and subsequently on 09/09/08. Since actual written request was received only on 10/09/08, the insurance company treated the same as being received after 15 days allowed under the Free Look Period Clause. Therefore, the representatives stated that they were correct in denying the refund of the premiums.

On the other hand, the representative of the complainant stated that he has not received the policy on 18/08/08 but he received the same on 27/08/08. Therefore, he requested that the premiums may be refunded.

DECISION:

From the above data it is clear that there is only less than 15 days delay in seeking for the refund of the premiums beyond the free look period of 15 days. According to the records available, the period is not very substantial to deny the request of the complainant. Therefore, we propose to condone the delay in requesting for refund of the premium within the free look period. Hence, we direct the insurance company to pay the refund of premiums against the policy no. 370804312 and 372718254.

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Miscellaneous

Case No. 543/22/003/L/12/08-09

Shri Ambika Charan Sahu

vs.

TATA AIG Life Insurance Co. Ltd

Award Dated : 26.02.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against wrong adjustment of premium.

The complainant, a retired Commercial Tax Commissioner and Advocate, purchased the above policy paying a sum of Rs.1,00,000/-. He stated that he received a Policy Bond on 09.05.2008 and immediately applied for refund of premium on 12.05.2008 (within free look period as allowed under IRDA Regulations), since he was undergoing treatment for heart ailment and had not given his consent for the policy. He made a number of correspondences with the Insurer but did not receive refund. So, he approached this forum, submitted P-forms and gave his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

The complainant furnished documentary evidence of major Bypass Surgery on 27.11.2007. He denied existence of any S.K. Sahu in his house. He felt that the courier had no business delivering the documents to a third person. He felt that the courier acted as an agent of the insurer under Indian Contracts Act, 1872. So, the insurer might take up the matter with courier and not deny him refund.

Intervention was made with the insurer but we have not yet received their Self Contained Note (SCN). However, they informed the Life Assured (LA) that as per their records the original policy bond was delivered to one S.K. Sahu on 20.03.08 at the recorded address of the complainant. According to them, the application for refund was made after the expiry of free look period. So refund was not possible. They mentioned that the LA could obtain surrender value after paying 3 years premium.

HEARING:

In response to a notice of hearing only the representative of the insurance company attended. The complainant sent a letter dated 12/02/09 received in this office on 16/02/09 in which he stated that the documents like policy bond had not been served on him but served on S.K. Sahu and that he was not aware of such person in his address. He also stated that he sent the request for refund of premium within the 'Free Look Period'.

On the other hand, the representative of the insurance company stated that they have served the policy bond on one Shri S.K. Sahu on 20/03/08 and request for cancellation by the complainant under Free Look Period as given on 19/05/08 was clearly more than one and half months from the lapsation of Free Look Period. Therefore, he claimed that the insurance company was correct in not refunding the premium.

DECISION:

From the above data, it is clear that the insurance company served the policy bond on Shri S.K. Sahu on 20/03/08. The person (S.K. Sahu) was not known to the policyholder as per his statement. The insurer also admitted that the policy document was not delivered to the Life Assured in person. Therefore the service of document is clearly bad in law. So, we are unable to consider the argument of the insurance company that there was a delay on the part of LA in request for refund as it was beyond the Free Look Period. Therefore, we direct the insurance company to refund the premium

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Miscellaneous

Kolkata Ombudsman Centre

Case No. 571/22/001/L/12/08-09

Smt. Priti Mukherjee

vs.

Life Insurance Corporation of India

Award Dated : 16.03.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against wrong adjustment of premium.

The complainant purchased policy no. 415648457 from LICI, College Street Branch and the copy policy shows the name of the policy holder as Priti Mukherjee with DOC 23.03.2004 for Sum Assured (SA) Rs.30,000/- under T/T 14-15 with monthly SSS premium Rs.193/-.

It appears that she wished to convert the SSS policy to ordinary yearly mode policy and handed over a blank cheque to Agency Code No. 23009/412 for paying the requisite amount for conversion into yearly mode. However, she received a premium receipt of Rs.10578/- against policy no. 415645457 (transaction No. 50219 dated 23.10.06) in the name of another person and the premium amount varied widely. She took up the matter with the insurer but there was no result. So she approached this forum and submitted P-form giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.
Intervention was made with the insurer but we have not received any response till date.

HEARING:

In response to a notice of hearing both the parties attended.

The complainant stated that she had issued a cheque no. 566430 in favour of LICI and for Rs.10,678/- was debited to her bank account on 26/10/06. However, she received renewal premium receipt against policy no. 415645457 in the name of one, Tapas Kanti Bose of the same amount from the agent and immediately the agent was informed that the receipt did not pertain to herself. She maintained that she wanted to convert her SSS policy into ordinary mode since her employer was not deducting premium from salary and in good faith she handed over a blank cheque to her agent for paying the requisite amount. Since her saving had been misutilised to pay another person's premium, she pleaded the amount debited from her bank account should be adjusted against the premiums payable against her own policy.

On the other hand, the representatives of the insurance company stated that the whole problem arose due to the agent mentioning wrong policy number on the reverse of the cheque. According to them, they were in the process of rectifying the mistake. They stated that the last premium paid was for March,'07 and latest due was Februrary,'09.

DECISION

From the above it is clear that an amount of Rs.10,578/- is lying with the LICI belonging to the complainant and not adjusted against the premiums payable by her against the policy no. 415648457. Therefore, we direct the LICI to adjust the amount of Rs.4632/-, being premium payable from March 2007 to February, '09 without charging interest and take a letter from the complainant for converting the mode of premium from monthly to yearly premium paying facility and adjust the remaining amount against yearly premium due March 2009 after the desired conversion. The remaining amount lying with them may be refunded with interest immediately on making such adjustment.

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KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-372/2008-09

Shri A.P.Varghese

Vs

LIC of India

AWARD DATED 27.01.2009

The complainant was issued with a Jeevan Suraksha Pension policy with monthly premium of Rs.749/- and Notional Cash Option [NCO] of Rs.2,14,000/- guaranteeing a monthly pension of Rs.2,074/-. At the time of taking policy, he was under the impression that, on the date of vesting, he will be getting NCO of Rs.2,14,000/- along with terminal bonus. One month before vesting, he visited the branch office, but he didn't get satisfactory reply from the Branch Officials. Later he was informed by the Divisional Office that there are 6 options for pension and he has to opt any of the 6 options before date of vesting. Not satisfied with this, he has given surrender application. He was told that he will be getting Rs.2,13,987/-. However, after few days, he got only an amount of Rs.2,09,440/-, Rs.4,547/- less than what is offered. The insured approached this forum to get the balance surrender value of Rs.4,547/- and terminal bonus.

It is to be noted that terminal bonus will become payable only if the policy runs for 5 policy years. Here the insured opted for surrendering the policy before vesting date. Further he was aware of the various options available at the time of vesting. Hence his contention that he is eligible for terminal bonus is not standing. The other complaint is regarding shortage of Rs.4,547/- on payment of surrender value. It was clarified by the insurer that in the surrender value quotation, due to some program error, the surrender value factor was shown wrongly. At the time of actual payment, the calculation was manually checked and the correct surrender value was given. As the insurer has paid the correct surrender value, the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-011-112/2008-09

Shri Ashok Kumar Bhartia

Vs

AVIVA Life Insurance Co.Ltd.

AWARD DATED 26.09.2008

The complainant had submitted a proposal for Unit Linked Insurance Policy with AVIVA Life Insurance Co.Ltd. by payment of premium of Rs.2,50,000/- on 24.09.2007. The policy was issued w.e.f. 30.09.2007 with terms and conditions other than proposed by the proposer. A letter to this effect was placed among the policy documents and also allowed 30 days to cancel the policy, if he is not agreeable to revised terms and conditions. The letter was left unnoticed by the insured till he verified the policy document. Soon he contacted the insurance company to cancel the policy and refund the premium paid by him, as he is not satisfied with the revised terms and conditions. But it was rejected by the insurer as he has not requested for refund within 30 days of receipt of policy document. Upon persistent request of insured, the insurance company refunded premium of Rs.2,50,000/- on 18.08.2008 without interest. The insured approached this Forum for settling interest for the premium paid by him.

It was submitted by the insurer that first premiums are received as non-interest bearing deposit and hence they are not liable to pay any interest. Also as per Rule 6[2] of Protection of Policyholders' Interest Regulations 2002, the insurer is liable to refund the premium only subject to deduction of proportionate risk premium and other expenses. They are also not liable to pay any interest. On going through the submission of insurer and the insured, it looks that the policy was cancelled not according to Rule 6[2]. The policy was cancelled as it was issued under terms and conditions other than proposed by the insured. The proposer was not willing to accept the counter offer made by the insurer. Also the insurance company has made inordinate delay in refunding the premium. They are enjoying the benefit out of the premium collected by them. Hence the insured is eligible for interest for the amount paid by him. An award is, therefore, passed directing the insurer to pay interest up to 18.08.2008 for the amount of Rs.2,50,000/- from 28.11.2007, with a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-005-278/2008-09

Shri B.Rajendran

Vs

HDFC Standard Life Insurance Co.Ltd.

AWARD DATED 03.12.2008

The complainant had taken a Unit Linked Insurance Policy for an assured sum of Rs.50,000/- with yearly payment of premium of Rs.10,000/- w.e.f. 31.01.2007. On 17.12.2007, the total value under the plan was only Rs.3,403.37 and this went on decreasing. Not satisfied with the fund management of the company, he requested for refund of available balance fund with 18% interest. As his request was turned down, he approached this Forum for justice. It was submitted by the insurer that the company has been continuously taking efforts to see that the fund value is increasing. The insurance policy is designed for a long term and not for short term savings. All the moneys have been invested as per option of the insured and also, the company has to abide all the rules and regulations framed by IRDA. The company is not entitled to pay any interest as claimed. It is to be noted that the insured has not requested for refund within free look period. Hence he can claim benefits only as per policy conditions. The policy condition 5[i] stipulate a minimum lock-in-period of 3 years. Hence he can apply for surrender only after 3 years. As the action of the insurer is well within the policy condition, the complaint is **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-344/2008-09

Shri Binu Thomas

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 01.01.2009

Pursuant to a proposal submitted in April 2005, the complainant was issued with a Unit Gain Policy for a sum of Rs.50,000/- on payment of Rs.10,000/- as initial premium. On 2008, he claimed repayment of the amount, but it was denied as policy was in a lapsed condition and 3 year premium has not been paid. In the complaint, it was stated that he took the policy as a tax savings measure and his intention was to invest in a single premium policy. The agent had made it as yearly premium policy. He got a letter in 2006 stating that the policy was lapsed. On contacting the insurer, he was told that in case the policy is not revived, he will not get insurance coverage but he can claim the amount invested after 3 years. In June 2008, he approached the insurer for repayment, but he was told that nothing is payable as policy has lapsed without accruing paid up value, as 3 year premium has not been paid. Had it been informed that for getting the refund, 3 year premium has to be paid, he would have paid the premium for 3 years.

It was submitted by the insurer that the insured opted for a yearly mode of premium payment policy and policy document was issued strictly according to the proposal condition. As he had not cancelled the policy invoking free look option, he can claim benefit only as per policy condition. As per policy condition, nothing is payable as policy has lapsed without paying 3 years premium.

The copy of proposal form and policy document was produced, which shows that the complainant opted for a yearly premium policy and policy was issued according to the proposal submitted by him. As per policy condition, nothing is payable, if policy lapses without paying 3 year premium. It is to be noted that the complainant is a Manager of a Bank who is well versed with investment of fund. Such a person will never believe that one can get a policy for Rs.50,000/- by just paying a premium of Rs.10,000/-. Again in 2006, he was told that the policy was in a lapsed condition and it is to be revived. But that was not done. Then he would have gone through the policy condition. That was also not done. The copy of policy and premium

receipt shows that the policy is a yearly premium policy. Hence the complaint is devoid of any merits and hence, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-010-181/2008-09

Dr.Mathew George

Vs

Reliance Life Insurance Co.Ltd.

AWARD DATED 29.09.2008

The complainant had paid a premium of Rs.25,000/- by cheque dated 25.01.2008 along with a proposal for a policy under Reliance Automatic Investment Plan. He received the policy document by courier on 22.02.2008 with some conditions other than proposed by him, by tampering and correcting the proposal form. Immediately he telephoned the insurance company and on 26.02.2008, he returned the policy with a request to make correction in accordance with the proposal submitted by him or refund the entire premium of Rs.25,000/- paid by him. The insurance company strongly denied the tampering of proposal form and also stated that they have not received any letter said to have been sent on 26.02.2008. As 15 days free look period is over, surrender value can be availed only after 3 years, as per policy condition.

Even though the insurance company has strongly denied tampering of proposal form, they have not produced original proposal form, inspite of 2 adjourments of the case, as per request of insurer. The photocopy of proposal form submitted by the insurer and the insured have some difference with regard to sum assured, plan, etc, though the proposal number is the same. As the insurer has not produced the original proposal form which is in their file, the contention of the insured only is to be believed. The policy document was issued on 15.02.2008 which was received by the insured on 22.02.2008. He has requested to correct the policy document as per his proposal form or refund the entire premium paid. As per IRDA Regulations, there is a free look period of 15 days from the date of receipt of policy document within which time, the insured can ask for refund of premium. Here refund application was given immediately on receipt of policy document. Though, the insurer denies having received such a request, the insured produced photocopy of courier receipt as a proof of having sent such a request. Insurer was not able to produce any documents received by them after 26.02.2008. Hence the

insured is eligible to get refund of premium. An award is, therefore, passed directing the insurer to refund the premium of Rs.25,000/- with an interest of 8% from 26.02.2008 and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-203/2008-09

Smt.K.A.Chandrika Devi

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 13.11.2008

The complainant had submitted a proposal for insurance with Bajaj Allianz Insurance Co.Ltd. She received the policy document on 21.12.2006. As the condition was not found satisfactory, she returned the policy document on 26.12.2006 for cancellation of policy document and get the premium refunded invoking free look option. As the request was not accepted, she sent reminders on 16.01.2007, 22.06.2007, 20.11.2007. She got a reply on 22.01.2008 stating that premium paid cannot be refunded as the policy document was received after free look period. It was submitted by the insurer that they issued the policy document on 18.12.2006 and as they received a complaint regarding non-receipt of policy document, they, as a very special case, issued a duplicate policy on 04.01.2008. As the refund request was received after free look period, they are not in a position to refund the premium paid. The complainant had submitted that she neither complained about non-receipt of policy document nor requested for issue of duplicate policy. She also did not receive the duplicate policy said to have been sent by them on 04.01.2008. She also produced manuscript copy of her letter dated 26.12.2006 requesting for cancellation along with postal receipt and also copy of her reminder dated 22.06.2007. In all these, she requested for refund of premium. It is curious to note that though the insurer is denying the request for refund of premium, they have not produced any copy of the letter received by them. Hence it is clear that the insurer is taking inconsistent stand to deprive the insured of the benefit under clause 2 of policy document. Hence the complainant is entitled for refund of premium paid. It looks that though the request was made on 26.12.2006, they responded only in January 2008 inspite of several reminders and finally they took a false decision. Hence it is proper to award cost and interest. An award is, therefore, passed directing the insurer to refund the premium paid amounting to Rs.10,000/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/22-001-202/2008-09

Smt.K.A.Chandrika Devi

Vs

LIC of India, Kottayam

AWARD DATED 13.11.2008

The complainant took a LIC Future Plus policy under single premium mode with a term of 6 years on 07.07.2006. She approached for availing the surrender value of policy on 30.05.2008. She was told that she had applied for a regular premium policy only and in the policy document, it was wrongly shown as single premium policy. As it is a regular premium policy, the policy is now in a lapsed condition and it is to be revived. It was submitted by the insured hat her intention was only to take single premium policy and policy document issued was also a single premium policy. Hence she is entitled to get surrender value treating it as a single premium policy. The insurance company produced copy of proposal which shows that she has proposed for a regular premium policy with a premium paying term of 6 years. However, by oversight the policy was issued as a single premium policy. As per the Principles of Contract Act, acceptance must be in terms of the offer. If some variation is made, it must be treated as a counter offer. If the counter offer is accepted by the other party, it is to be treated as a valid contract. Here though the proposal was for a regular premium policy, the policy was issued as a single premium policy. As the insured accepted this counter offer, the policy is to be treated as a valid policy with single premium. Hence the complainant is eligible for surrender value as on 30.05.2008 treating it as a single premium policy. An award is, therefore, passed directing the insurer to allow surrender value as on 30.05.2008 treating it as a single premium policy.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-437/2008-09

Smt.K.Maheswari Amma

Vs

LIC of India

AWARD DATED 05.03.2009

The complainant had 2 annuity policies with LIC of India, which was surrendered on account of ill health. While settling surrender value, an amount of Rs.1,000/- each was deducted from the surrender amount. Also due to Onam holidays, she got the cheque cleared only after few days and she approached this forum for getting interest for delayed payment and to get refund of Rs.1,000/- each deducted from claim amount. It was submitted by the insurer that the surrender value was settled on 27.08.2008. At the time of settlement, the pension for August 2008 has already been paid and hence the amount of Rs.1,000/- each was deducted from the claim amount. The proportionate pension from 01.08.2008 to 28.08.2008 amounting to Rs.867/- each was paid to the insured along with surrender value. Hence nothing more is payable. Regarding the delay in getting the surrender amount, it was submitted by the insurer that there was absolutely no delay on their part. The discharge voucher for surrender value up to 28.08.2008 was sent to the insured on 04.09.2008, which was returned duly signed on 09.09.2008. The cheque was handed over to the complainant on 10.09.2008, the very next day of getting the discharge form. From the records submitted, it looks that the recovery of Rs.1,000/- each from the surrender value is in order, as the cheque for pension due in 08/2008 has already been issued. Also broken period pension up to 28.08.2008 was paid with surrender value. Regarding the interest for delayed payment, the complainant herself had admitted that it was due to Onam holidays. It is not due to the fault of the insurer. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-133/2008-09

Shri K.N.Ravi

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 14.10.2008

The complainant had approached the office of insurer on 21.01.2008 for getting surrender value of his policies. He was given computer generated statement showing surrender value as on 21.01.2008 as Rs.3,24,836.88 and Rs.5,97,148/-. However, after two weeks, he got a cheque for Rs.2,81,130/- and Rs.5,16,964/- respectively. A total amount of Rs.1,23,890.88 was reduced from the amount already offered. It was submitted by the insurer that it being a unit linked policy, surrender value depends upon unit value on each date. Surrender application received upto 3:00 PM will be unitized for that day and all applications received after 3:00 PM will be unitized for the next day. The application might have been received after 3:00 PM and hence, unit value as on 22.01.2008 was only given and that is why the difference of Rs.1,23,890.88 in the surrender value. However, the complainant had stated that he approached the office at around 11:00 am. To this, representative of insurer stated that though he reached the office before noon on 21.01.2008 and collected the computer generated surrender offer, he requested for further processing only after getting his telephonic confirmation. The insured denied this and stated that he insisted for immediate processing as he was in urgent need of money for registration of a property. There is no contention by the insurer that surrender offer given on 21.01.2008 is wrong and also if surrender was made on 21.01.2008, he could not be entitled to that much amount offered earlier. The only dispute is regarding date of surrender, whether on 21.01.2008 or 22.01.2008. There is no dispute to the fact that the insured approached the office before noon on 21.01.2008. It is not probable that a person reaching the office for surrendering the policy will leave the policy there and request to process the same, after getting telephonic confirmation. Even if he had made such a request, it might have been noted in the surrender application itself. It is also relevant to note that no such stand is taken in the self contained note. In the self contained note, it is merely stated that the policy was surrendered on 22.01.2008. Hence it is only probable that the surrender application was given on 21.01.2008 and, therefore, an award is passed directing the insurer to pay the balance amount of Rs.1,23,890.88 with interest at 8% p.a. and a cost of Rs.1,000/-.

INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-273/2008-09

Shri M.K.Kunjikrishnan

Vs

LIC of India

AWARD DATED 31.12.2008

The complainant was issued with New Bima Nivesh Policy with compound guaranteed addition for a sum assured of Rs.1 lakh and term 5 years. It was issued w.e.f. 28.06.2002. On maturity date, the insured was paid only the sum assured and guaranteed addition. The contention of the complainant is that the policy envisages loyalty addition also apart from guaranteed bonus. At the time of taking policy, he was told that he would be getting loyalty addition at least equal to the amount of bonus. The insurer has not paid any amount towards loyalty addition. It was submitted by the insurer that loyalty addition is not a guaranteed benefit. Loyalty additions are declared depending upon the experience of insurer with regard to mortality and interest earned. For this type of policy for a term of 5 years, no loyalty addition was declared and hence no loyalty addition is payable under the policy. The policy condition is very clear that loyalty addition is not a guaranteed benefit. It becomes payable depending upon the experience of the insurer. Taking all factors into consideration, the insurer was not in a position to declare loyalty addition to this type of policy. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-004-310/2008-09

Shri M.T.Thomas

Vs

ICICI Prudential Life Insurance Co.Ltd.

AWARD DATED 31.12.2008

The complainant deposited Rs.1,00,000/- each under 3 policies on 18.5.2008. Later he came to know that there were some charges up to 18%. Hence he gave a letter of cancellation on 30.05.2008 even before getting the policy documents. The policy documents were received on 08.06.2008 which was returned to the insurer on 09.06.2008. The free look cancellation was allowed by the insurer, but they deducted a total amount of Rs.20,417.13 towards policy preparation charges and difference in the value of units invested. The insured wants the entire amount of Rs.3 lakhs refunded with interest as to have given letter of cancellation before issuance of policy documents. It was submitted by the insurer that they got the cancellation letter only on 16.06.2008 and they have sanctioned full unit value as on 16.06.2008 after deducting allowable expenses as per IRDA regulation.

In the instant case, the real dispute is as to the date of cancellation. The contention of insurer is that they got the cancellation letter along with policy document only on 16.06.2008. It was

submitted by the complainant that he had submitted the cancellation letter to ICICI Bank, Kanjirapally Branch on 31.05.2008 and produced acknowledgement for the same. 31st being a Saturday, the next valuation date is 2nd June. Hence the complainant is eligible to get NAV as on 2nd June. The representative of the insurer also agreed to this and as per revised calculation, insured is eligible to get an amount of Rs.8,550.78 more in 3 policies. An award is, therefore, passed directing the insurer to pay the balance amount of Rs.8,551/- with 8% interest p.a. since 01.07.2008 till payment and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-004-310/2008-09

Shri M.T.Thomas

Vs

ICICI Prudential Life Insurance Co.Ltd.

AWARD DATED 31.12.2008

The complainant deposited Rs.1,00,000/- each under 3 policies on 18.5.2008. Later he came to know that there were some charges up to 18%. Hence he gave a letter of cancellation on 30.05.2008 even before getting the policy documents. The policy documents were received on 08.06.2008 which was returned to the insurer on 09.06.2008. The free look cancellation was allowed by the insurer, but they deducted a total amount of Rs.20,417.13 towards policy preparation charges and difference in the value of units invested. The insured wants the entire amount of Rs.3 lakhs refunded with interest as to have given letter of cancellation before issuance of policy documents. It was submitted by the insurer that they got the cancellation letter only on 16.06.2008 and they have sanctioned full unit value as on 16.06.2008 after deducting allowable expenses as per IRDA regulation.

In the instant case, the real dispute is as to the date of cancellation. The contention of insurer is that they got the cancellation letter along with policy document only on 16.06.2008. It was submitted by the complainant that he had submitted the cancellation letter to ICICI Bank, Kanjirapally Branch on 31.05.2008 and produced acknowledgement for the same. 31st being a Saturday, the next valuation date is 2nd June. Hence the complainant is eligible to get NAV as on 2nd June. The representative of the insurer also agreed to this and as per revised calculation, insured is eligible to get an amount of Rs.8,550.78 more in 3 policies. An award is, therefore, passed directing the insurer to pay the balance amount of Rs.8,551/- with 8% interest p.a. since 01.07.2008 till payment and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-003-114/2008-09

Shri Mathew Abraham

Vs

Tata AIG Life Insurance Company Limited

AWARD DATED 13.10.2008

The complainant had taken a regular premium payment policy from Tata AIG Life Insurance Co.Ltd. w.e.f. December 2004. He paid premium for 3 years and requested for surrender value on 6.9.2007 and the insurer offered a surrender value of Rs.6,119/-. Being not satisfied with the surrender value offered, the insured withdrew his surrender application and requested to continue in a reduced paid up condition. He was informed, the reduced paid up value will be Rs.26,250/- payable either at the time of maturity in 2067 or at the time of his earlier death. Not satisfied with the condition, he again opted for surrender value, but this time, the insurance company gave only Rs.1,519/- by way of surrender value. The contention of insurance company is that as the policy has already been made a reduced paid up one, the surrender value will be different from what was offered earlier.

The insured had complained that as he was offered Rs.6,119/- as surrender value, he is eligible for the same, as he was has not claimed any benefit under the policy since then. The policy was eligible for a paid up value of Rs.26,250/- payable at the date of maturity in 2067 or at the time of earlier death. The present value of this paid up value is paid as surrender value. Paid up value is arrived by the formula

$$\frac{\text{No.of Premiums paid}}{\text{No. of Premiums payable}} \times \text{SA}$$

As no further premium has been paid, there will not be any change in paid up value arrived at. As long as the paid up value is not changed, there will not be any reduction in the surrender value. Hence the insured is eligible for the amount of Rs.6,119/- as offered earlier. An award is, therefore, passed directing the insurer to pay the balance amount with interest @ 8% pa and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-289/2008-09

Smt.Mercy Kuriyan

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 19.01.2009

The complainant had taken a Bajaj Allianz Care First Policy w.e.f. 14.07.2007. On 11.11.2007, she was admitted to the hospital with history of pain in the left breast and history of vomiting. She underwent laproscopic cystectomy on 12.11.2007 and was discharged on 16.11.2007. The claim was repudiated on the ground that mesenteric cyst of size 7.5 x 6.5 cm cannot develop to such a stage within 4 months and hence, this is a pre-existing illness, which is not covered under policy condition.

The only ground for repudiation is that mesenteric cyst will never grow to the size of 7.5 x 6.5 cm within a period of 4 months. The policy was taken only 4 months prior to admission in hospital and hence the illness is existing at the time of taking the policy. However, the insurer has not stated within how much time the cyst will grow to such a size. No supporting evidence was also produced to show that it takes more than 4 months for a cyst to grow a size of 7.5 x 6.5 cms. In the absence of any supporting material, the advantage of doubt must be given to the insured and hence repudiation is to be set aside. Though the insured claimed an amount of Rs.44,386/-, bills for only Rs.28,374/- has been produced. As there is separate limit for each item of the bill such as medicine, room rent, doctor's fee, etc., the claimant is eligible for Rs.17,495/- only. An award is, therefore, passed directing the insurer to pay Rs.17,495/- with interest @ 8% p.a. from the date of claim till payment and a cost of Rs.1,000/-.

INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-286/2008-09

Shri N.Chandran

Vs

LIC of India

AWARD DATED 03.12.2008

The complainant, then a Police Officer, has been issued with Asha Deep Policy w.e.f. 01.09.1996 on the basis of proposal submitted by him on 08.03.1997. On 02.08.2004, he had undergone coronary artery bypass graft surgery. The claim for 50% SA as per policy condition was repudiated on the ground that, at the time of taking policy, he was a diabetic patient and the policy was obtained by non-disclosing the material fact. Had it been disclosed, special reports might have been called for and underwriting decision would be different. As diabetes is a risk factor for CAD, the non-disclosure is of a material nature and non-disclosure was made willfully and with fraudulent intention and hence they are justified in repudiating the claim.

The medical reports at the time of surgery in 2004 was produced which shows that he was a known case of diabetes since 2004. The complainant himself admitted that he was suffering from diabetes at the time of proposal but it was of a mild nature and he could control the same by controlling diet and exercises, on the advice of a medical practitioner. But no treatment records were produced by the insured to show that the illness was of mild nature. In the proposal form, all the questions regarding health is answered as if he is hale and healthy. As it was found beyond doubt that he was diabetic at the time of taking the policy, and the insured was well aware of that, the repudiation cannot be said to be faulty and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-458/2008-09

Shri P.B.Haneefa

Vs

LIC of India

AWARD DATED 12.03.2009

The complainant was issued with a Jeevan Anand Policy with Critical Illness Rider. He was admitted at Thrissur Heart Hospital from 09.01.2008 to 12.01.2008 for treatment of triple vessel disease. The claim for hospital expenses were repudiated on the ground that the type

of treatment undergone for the hospitalization is not covered under the policy. It was submitted by the complainant that during the currency of the policy, he was admitted to Thrissur Heart Hospital and an emergency surgery was conducted. As per terms and conditions of the policy, he is eligible for reimbursement. The insurer repudiated the claim on the ground that there was no surgery done in the hospital. Policy covered only bypass surgery. No surgery was done at all. On referring the file to the DMR, he has also opined that the treatment undergone will not cover under the policy. On going through the medical report, it can be seen that no surgery was done and only angioplasty was done. What is done is cancellation of blockage of artery by application of a stent. This type of non-surgical techniques such as balloon angioplasty, intra arterial, catheter based techniques, etc. are specifically excluded from the scope of the policy. Hence what is done from the hospital comes under exclusion category and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/22-011-403/2008-09

Shri Paul K.Joseph

Vs

ING Vysya Life Insurance Co.Ltd.

AWARD DATED 10.03.2009

The complainant was issued with a life policy which was allowed to lapse due to non-payment of premium due on 02.05.2006 and 02.11.2006. Those premiums were paid together on 16.01.2007 for revival of policy. He was asked to undergo a medical examination and blood test. Thereafter, he was informed that the policy cannot be revived then and for revival, he was asked to approach the insurer after one year. The premium paid for revival was refunded. The complainant has complained that he was not informed of the reason for rejection of revival inspite of his repeated requests. His request to undergo a further medical examination was also turned down by the insurer. As the revival was denied by the insurer for no fault of his, he is demanding refund of the entire premium paid by him. It was submitted by the insurer that the revival was not allowed as medical report shows relatively higher blood sugar value. As they have already covered risk under the policy, they are not in a position to refund the premium paid during the period when the policy was in force. Amount remitted for revival was refunded. Also it is submitted by the insurer that it is not their practice to reveal the details of medical examination, as it is done only to the satisfaction of the insurer to decide whether the policy can be accepted or not. This practice is followed only to avoid unnecessary interference by the insured.

There is no dispute to the fact that the policy was lapsed due to non-payment of premium. Policy condition specifically states that insurer reserved the right to accept or reject revival or reinstatement. In order to reinstate, they can insist an evidence of insurability to their satisfaction. As per the blood sugar report, it is evident that the blood sugar level is much higher than the normal level. Hence the insurer is entitled to say that they are not satisfied with the insurability on account of his health condition. Regarding the refund of the premium paid during the period for which the policy was in force, it is to be noted that the insurer has covered risk under the policy during the period and also the policy has not acquired paid up value as per non-forfeiture regulation. Hence there is no reason to interfere in the decision of the insurer and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/22-001-206/2008-09

Smt.Sheeba Elgin

Vs

LIC of India, Thiruvananthapuram

AWARD DATED 12.11.2008

The complainant was having a money back policy with LIC of India, Kollam Branch Office. She remitted 5th year premium due March 2007 on 23.04.2007, but a consolidated receipt was issued along with premium payment of other two policies of different policyholders, payment partly by cheque and partly by cash. As the cheque was dishonoured, remittances under all the 3 policies got reversed and cash portion of payment was brought to deposit in respect of first policy. The complainant had submitted that she had remitted her premium by cash only. By this time, premium due March 2008 also became due and survival benefit payable in March 2008 also got delayed. On getting the complaint, the insurer has advised their Branch Office by letter dated 08.11.2008 to adjust the premium due March 2007 by utilizing the amount held in deposit under a wrong policy and receive premium due March 2008 without interest. They also advised their Branch Office to release survival benefit due with penal interest. The complainant is satisfied with this decision of the insurer. Hence an award is passed directing the insurer to adjust premium due March 2007 and receive premium due March 2008 without interest and also to pay survival benefit due in March 2008 with 8% interest p.a.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-272/2008-09

Shri Solomon Francis Maliakkel

Vs

LIC of India, Ernakulam

AWARD DATED 25.11.2008

The complainant was issued with a Money Back Policy of P&T 75-20 w.e.f. 28.03.2001. After payment of 7 quarterly premiums, the policy was allowed to lapse. The complainant applied for surrender value of the policy. His request for settling surrender value was not allowed by the insurer on the ground that 3 years premiums have not been paid. Also his request for revival of policy also was not allowed as a period of 5 years has elapsed after lapsation. It was submitted by the insurance company that the policy will acquire paid up value only if 3 years premiums are paid. Here in the present case, only 1 ¾ years premiums have been paid and no surrender value is acquired. Also policy cannot be renewed after 5 years of first unpaid premium. Copy of policy document is produced. As policy condition is very specific that 3 years premium is to be paid for acquiring paid up value, the contention of insurer is to be upheld and complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/22-001-158/2008-09

Shri P.B.Sourabhan

Vs

LIC of India, Thiruvananthapuram

AWARD DATED 28.10.2008

The complainant had taken a Health Plus policy with Hospital Cash Benefit under Unit Linked Health Insurance Plan. He was charged an extra premium of about 60% of

standard premium, on the ground that his blood sugar level varies from normal reading. The submission of the complainant is that his blood sugar level is only within the international standard. His FBS reading is 100 mg/dl and HbA1c 6.2%. As per international standard, both these readings are normal. He has also complained that the reason for charging such a heavy extra premium was not properly explained to him and the guidelines of arriving at EMR was not made known to him inspite of his repeated requests.

It was submitted by the insurer that though clinically his blood sugar reading may be normal, LIC considers condition on a prognosis basis. Extra premiums are charged based on some actuarial calculations and also in consultation with re-insurers. As per underwriting circular dated 10.04.2008, if the FBS reading is less than 100 and HbA1c more than 6%, it attracts EMR of +75 which is equal to Cl.3 extra. In the instant case, FBS is 100 and HbA1c is 6.2%. Hence they have correctly charged the extra premium. They way in which they have arrived at will not be disclosed. It is to be noted that insurer can charge extra premium if health condition of proposer is not satisfactory, to meet the extra liability. LIC is not expected to provide insurance to all people at ordinary premium. They can charge extra premium to meet the extra liability due to adverse health condition of proposer. Further, extra premium as demanded by insurer is paid by the insured. He can very well reject the offer for extra premium and get the premium paid by him refunded. Extra premium charged by insurer is well within their norms and hence, the complaint is **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/22-003-338/2008-09

Smt.Stella Stephen

Vs

Tata AIG Life Insurance Co.Ltd.

AWARD DATED 27.01.2009

The complainant had taken a Health First Policy from Tata AIG with annual premium of Rs.3,414/-. The policy was issued with date of commencement 28.09.2004 and premium paying period 21 years. She continued payment of premium @ Rs.3,414/-. Since 2006, she was paying service tax also. On 30.08.2008, she was served with a premium notice demanding yearly premium @ Rs.4,811.76. It was submitted by the complainant that nowhere in the

policy, there is such a condition that premium will change after 5 years. As the enhancement of premium is arbitrary and against the terms and condition of the policy, she approached this forum for giving direction to the insurance company to continue the policy at the premium already agreed.

It was submitted by the insurer that it is basically a 5 year term policy, but due to a system error, date of maturity has wrongly been shown as 65 year of age. In the draft given to IRDA for approval of the scheme, the term of policy was shown as 5 years with provision to renew at the end of 5 years. They are not permitted to make any change in the scheme approved by IRDA. Another contention is that as risk will increase as age increases, there will not be sufficient consideration, if premium is not increased every 5 years.

The contention of the insurer is that it is a 5 year term policy and is required to be renewed at the end of 5 year term. But it is to be noted that nowhere in the policy or proposal form, it is mentioned as 5 year term policy. Instead, term is given as 21 years and expiry date as anniversary date prior to assured's 65th birthday. There is also a provision to renew the policy before age 65. The contention of the insurer is that expiry date was wrongly shown due to a system error. But it is relevant to note that entry into the scheme by various persons is at various ages. Hence age at entry and expiry date has to be keyed in. Hence there is no possibility of a system error. Another contention of the insurer is that in the draft given to the IRDA for approval, it is intended as a 5 year term policy and they are not permitted to make any changes or alteration in the policy condition. But it is to be noted that what is submitted before the IRDA is a matter between the insurer and IRDA. The insured has nothing to do with it. Also the IRDA stipulations are only to safeguard the interest of the policyholders and not that of the insurance company. Another defence of the insurer is that if premium is not changed after every 5 years, there will not be sufficient consideration. But it is to be noted that there are various types of policies with the same premium throughout the term. It is likely that the insurer might have taken care of fluctuations in risk while fixing premium at the beginning. In the light of the above, there is no reasonable justification on the part of the insurer to demand higher premium at the end of every 5 years. The insurance company is, therefore, directed to continue the policy at the same rate of premium already agreed upon.

INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-012-265/2008-09

Smt.Usha Nambiar

Vs

Metlife India Insurance Co.Pvt.Ltd.

AWARD DATED 02.12.2008

The complainant took a policy with monthly premium of Rs.4,486/-. Though she was regularly paying monthly premium, she was not getting premium receipts properly. Her telephonic and other complaints were not properly responded. As she is not satisfied with the service of insurer, she has requested for cancellation of policy and refund of entire premium paid with interest. It was submitted by the insurer that premium upto 24.03.2006 was paid regularly. As subsequent premia were not paid regularly, they are not in a position to appropriate further premium unless the policy is revived. Regarding the receipt for payment of premium, a receipt for Rs.17,944/- was forwarded, but considering her complaint, another receipt was also sent. If she so requires, they are prepared to issue a consolidated receipt.

There is no dispute regarding the premium paid. The only plea of the insured is that as she is not satisfied with the service of the insurance company, she wants to cancel the policy and get the premium remitted back, with interest. It was submitted by the insurer that they have rendered all possible service and they are only happy to continue their good service. As the policyholder has not requested for cancellation of the policy invoking free look period, they can allow refund only by way of surrender, in which case, surrender charges as per policy conditions will be deducted. As they have covered risk under the policy, they are not in a position to refund the premium paid. They are also prepared to revive the policy, if the insured so desires. As the insurance company is willing to satisfy all the policy conditions, there is no point in the contention of the insured and complaint is, therefore, DISMISSED.

LUCKNOW

Lucknow Ombudsman Centre

Case No.L-361/21/001/07-08

Shri.Manish Ranjan Pandey

Vs

SBI Life

Award Dated : 17.12.2008

Complaint filed against SBI Life by Shri.Manish Ranjan Pandey in respect of non-payment of death claim on the life of his mother Smt.Alka Pandey.

Facts : : Smt.Alka Pandey, aged about 51 years took out a master home loan policy from SBI Life for a S.A. of Rs.8,50,000/- vide proposal dated 17.6.2006. The insured died on 5.8.2006 due to cardio respiratory failure. The respondent repudiated the claim on the ground that LA suppressed material facts in the DGH signed by the LA at the time of taking policy as a collateral security against home loan from State Bank of India. The contention of the respondent is that the LA was suffering from very severe blood disorder but she did not disclose these facts in the DGH at the time of entry into the contract of insurance. On the other hand the complainant stated that the proposal papers were signed in a hurry along with other papers of the loan document and advisor did not explain the importance of declaration made in the proposal form and also the policy has been taken as a precondition of the housing loan and not for insurance purpose.

Aggrieved with the decision of the respondent the complainant approached the Grievance Redressal Committee and this committee concurred with the decision of respondents. Thereafter, the complainant approached this forum giving rise to this complaint.

Findings : On careful perusal of the records it was observed that DLA submitted a proposal form cum DGH form alongwith health questionnaire dated 17.6.06 and on the basis of which she was admitted in the scheme with effect from 17.6.06. The duration of the policy is 1 month and 19 days. The proposal form contains a clearly worded declaration that the assured is in good health and never suffered or have been suffering , or have been hospitalized for any critical illness or have been treated or told that he/she have diseases (which includes blood disorder also). The DLA has answered all the questions in affirmative. From the pathologist report of Dr. Rama Gupta dated 14.01.06, consultant pathologist Dr. Praveen Saraswat dated 8.3.06 and prescription of Dr.R.B.L. Mathur dated 25.12.05 it is clear that LA was suffering from serious anemia before the date of proposal.

Decision : Held that although taking a housing loan from a banking institution and an insurance policy from an insurer is two different transaction but disclosure of truthful information at the time of proposal constitutes a vital part of the proposal form and enables the underwriter to make a true and fair assessment of the LA and any suppression/misstatement affects the underwriting decision .The repudiation of the claim under the policy was therefore, held to be in order.

Lucknow Ombudsman Centre

Case No.L-465/21/001/08-09

Shri.Vijay Ram

Vs LIC of India

Award Dated : 6.11.2008

Complaint filed against LIC of India by Shri.Vijay Ram in respect of non-payment of disability benefit on his own life.

Facts : Shri.Vijay Ram, aged about 29 years, by occupation a cobbler, took out a policy from LIC of India for a S.A. of Rs.30,000/ vide proposal dated 26.03.2005. The insured met with a fire accident on 4.6.2005 in which both his hands got burnt. The respondent repudiated the claim on the ground that the claim under the policy does not fall under the policy conditions.

Aggrieved with the decision of the respondent the complainant approached the Grievance Redressal Committee but this committee also concurred with the decision of respondents. Thereafter the complainant approached this forum giving rise to this complaint.

Findings : On careful examination of all the documents the forum found that the assured met with an accident in which both his hands were severely burnt and lost their movements. Due to this accident he is not able to perform the job as a cobbler which is the source of his living. Although no FIR was lodged, the case was published in a local newspaper. Further as per the treatment papers the LA's injuries were about 80% and would take a long time to heal. The contention of the respondent is that the disability of the LA does not fit into the category to qualify for accident benefit.

Decision : Taking into consideration the relevant policy clause "The disability referred must be disability which is the result of an accident and must be total and permanent and such that there is neither then nor at any time thereafter any work, occupation or profession that the LA can ever sufficiently do or follow to earn or obtain any wages, compensation or profit. Accidental injuries which independently of all other causes and within 180 days from the happening of such accident, result in the irrevocable loss of the entire sight of both eyes or in the amputation of both hands at or above the wrists, or in the amputation of both feet at or above the ankles, or in the amputation of one hand at or above the wrist and one foot at or above ankle shall also be deemed to constitute such disability." Held that the LA does not qualify the above criteria and the attending doctor has also written that it will take long time to heal the wounds i.e. it is not an irrevocable loss. The repudiation of the claim under the policy was however, held to be in order but taking into account the special circumstances and keeping in view the penury and mental agony of a poor labourer and considering the case with some degree of magnanimity an ex-gratia payment of Rs.15,000/- was awarded.

Lucknow Ombudsman Centre

Case No.L-499/21/001/08-09

Shri.Yatendra Kumar Sharma

Vs

LIC of India.

Award Dated : 12.01.2009

Complaint filed against LIC of India by Shri.Yatendra Kumar Sharma in respect of non- payment of double accident benefit(DAB) on the life of his mother Smt.Sarvesh Kumari Sharma.

Facts : Smt.Sarvesh Kumari Sharma, by occupation an owner of gas agency, took out two policies from LIC of India for S.A. of Rs.1,30,000/- & Rs.5,00,000/- each vide proposal dated 10.10.93 & 15.04.03 respectively. The insured received burn injuries on 4.8.07 and died on 18.8.07. The respondent accepted the claim for basic sum assured and repudiated the claim for DAB vide their letter on the ground that the DLA got burnt in a fire accident in her own gas agency while illegally refilling the gas cylinders.

Aggrieved with the decision of the respondent the complainant approached the Grievance Redressal Committee but this committee also concurred with the decision of respondents. Thereafter the complainant approached this forum giving rise to this complaint.

Findings : On careful examination of all the documents the forum found that the claim was rejected by the respondent on contention that as per FIR lodged on 4.8.07 at Thana Kosi Kalan, Mathura the case is registered under sec.420/379/337/338 IPC. However the police investigation, orders of DM and CJM confirms that there was no evidence of any foul play and the fire broke out accidentally.

Decision : Held that the LA died in a fire accident which broke out in the premises of her own gas agency but the police authorities as well as DM and CJM vide their orders have made explicitly clear that the fire had broken out accidentally and there is no evidence of any breach of law involved as alleged in the FIR dated 4.8.07. The repudiation of the claim was, therefore, set aside and the complainant nominee awarded the amount of double accident benefit available under the policy.

Lucknow Ombudsman Centre

Case No.L-637/21/001/07-08

Smt. Anoop Sheela

Vs

LIC of India.

Award Dated: 22.01.2009

Complaint filed against LIC of India by Smt.Anoop Sheela in respect of rejection of double accident benefit (DAB) on the life of her brother Shri.Mitan Singh.

Facts : Shri.Mitan Singh, aged around 42 years, by occupation an agriculturist, took out a policy from LIC of India for S.A. of Rs.1,50,000/- vide proposal dated 18.01.2005. The insured was found dead on 30.08.2006. The respondent paid the claim for basic sum assured but was not releasing the amount of DAB on the ground that the cause of death of the deceased life assured is not due to an accident.

Aggrieved with the decision of the respondent the complainant approached the Grievance Redressal Committee but this committee also concurred with the decision of respondents. Thereafter the complainant approached this forum giving rise to this complaint.

Findings: On careful examination of all the documents the forum found that the claim was rejected by the respondent on the contention that there is no proof that the DLA had died due to an accident. It is also mentioned that an unidentified body was recovered from the railway crossing which was later identified as the LA and the police authorities also did not register any formal FIR and submitted their report that no offence is found to be committed and the LA had no enmity with anybody. As per the PM report the cause of death is shock and hemorrhage as a result of ante mortem fire arm injury. On the basis of papers produced before this forum, it is difficult to presume whether LA committed suicide or was murdered, and if murdered was it intentionally or otherwise.

Decision: Taking into account the Supreme Courts observation in Rita Devi Vs New India Assurance Co. Ltd. IV (2000) SLT 179 = 11 (2000) ACC 291 that "if the dominant intention of the act of felony is to kill any particular person then such killing is not an accidental murder but is a murder simplicitor." It was held that since the actual cause of death is not proved, the insurer is not liable to pay the DAB. Hence the repudiation of the claim was, therefore, held to be in order.

MUMBAI

MUMBAI OMBUDSMAN CENTRE

Complaint No.LI-336 (08-09)

Award No.IO/MUM/A/ 263 /2008-2009

Complainant : Shri Rajendra Purshottamrao Sawarkar

V/s.

Respondent : SBI Life Insurance Company Ltd.

AWARD DATEDThe brief facts of the case are as follows:

Shri Rajendra Purshottamrao Sawarkar, had taken a Unit Plus II – Regular Plan, Life Insurance Policy bearing No.24031211002 from SBI Life Insurance Company Ltd. with Rider - Critical Illness with a premium of Rs.30,000/- annually for a Term of 10 years. The commencement of the policy was from 05.12.2007.

Shri Rajendra Purshottamrao Sawarkar was admitted for Heart Attack on 28.05.2008 for which he submitted a claim to SBI Life Insurance Co. Ltd. for payment of Critical Illness Claim under the policy. The claim was repudiated by the Insurer vide their letter dated 01.08.2008 stating the following:-

- As per policy limitations and exclusions "The Company shall not be liable to pay any sum under or in terms of this benefit, in the event of any Critical Illness diagnosed within six months from the Date of Commencement of the policy".
- Date of diagnosis of critical illness is 28.05.2008 and the date of commencement of the policy is 05.12.2007. Thus as per policy limitations and exclusions the claim is not payable.
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The Insurer repudiated the claim according to the Exclusions for the Critical Illness Rider stated in the Policy Schedule. The date of risk of the policy is 05.12.2007 and he was admitted in hospital on 28.05.2008. As per the policy limitations and exclusions, the Company is not liable to pay any sum, as the illness was diagnosed within six months from the Date of Commencement of the policy.

In view of the above facts and circumstances, there is no valid reason to interfere with the decision of the Insurance Company.

MUMBAI OMBUDSMAN OFFICE

Complaint No.LI – 376 of 2008-2009

Award No.IO/MUM/A/ 291 /2008-2009

Complainant : Smt. Rasilaben R. Shah

V/s

Respondent : Life Insurance Corporation of India, Mumbai Division I

AWARD 08.12.2008

Smt. Rasilaben R. Shah had taken a Jeevan Dhara Annuity Policy from LIC of India. The SA was Rs.70,000/- The DOC was 28.10.1997 and premium amount was Rs.323/- payable half

yearly for a period of 10 years. The GIVE amount mentioned in the policy bond was Rs.1,20,000/- and Annuity installment shown was Rs.1200/-.

Smt. Rasilaben R. Shah received a letter dated 07.01.2008 from LIC enclosing a cheque for Rs.197/- being the payment towards GMA. They also informed her that as per option opted by her, the pension payable was Rs.1182/- annually from 28.10.2008. She wrote to LIC vide her letter dated 22.04.2008, referring her original policy wherein the GIVE amount mentioned in the policy was Rs.1,20,000/-. LIC of India informed her vide their letters dated 23.04.2008, 28.04.2008 and 15.05.2008, explaining to her that while issuing the policy document, through an oversight, the GIVE amount was mentioned as 1,20,000/- instead of Rs.9,854/- The GIVE amount of Rs.1,20,000/- and the Annuity installment of Rs.1,200/- is a typing error on their part. They stated that for the captioned policy under Plan 96-10, the correct GIVE amount is Rs.9,854 corresponding to the premium payments of Rs.627/- p.a. They regretted for the inconvenience caused to her due to this clerical error. However, the complainant insisted that the GIVE amount as mentioned in the policy document is correct and insisted that she be paid annuity as per the GIVE amount as stated in the policy document.

At the hearing, the complainant had agreed to the pension amount as calculated by LIC and the complaint was closed. LIC was also directed to pay Rs.1000/- as penalty to the complainant for the above error.

MUMBAI INSURANCE OMBUDSMAN

Complaint No. LI – 313 of 2008-2009

Award No.IO/MUM/A/389/2008-2009

Complainant : Devidas Achut Kini

V/s

Respondent : Life Insurance Corporation of India, Mumbai Division II

AWARD DATED 22.01.2009

Shri Devidas Achut Kini had taken a Jeevan Dhara Annuity policy from LIC. Shri Devidas Achut Kini received a letter stating that while checking the premium vis-à-vis benefits under the policy, it was observed that a bonafide error with regard to monthly Annuity, GIVE amount has crept in the policy master and since the half-yearly premiums have been paid @ Rs.768.60, the benefits secured by this premium i.e. GIVE Amount will be Rs.94,815/- and Monthly Annuity will be Rs.948/- instead of Annuity @ Rs.1,000/- p.m. and GIVE amount of Rs. Rs.1,20,000/-.

The contention of the dispute between the parties is the GIVE amount and the annuity payable per month.

The documents have been perused. Shri Devidas A. Kini, while submitting his proposal had mentioned the Annuity Amount as Rs.1000/- and paid Rs.972/- on 05.04.1988 as deposit for first half-yearly premium. To ensure a monthly annuity of Rs.1,000/-, the Insurer while calculating the half-yearly premium payable for a term of 20 years, the half-yearly premium was calculated as Rs.968.60 on the calculation sheet

and the GIVE amount was mentioned as Rs.1,20,000/-. However, while writing the premium amount on the review slip, instead of writing Rs.968.60, inadvertently it was wrongly mentioned as Rs.768.60 and the same was incorporated in the policy bond. On vesting of the said policy on 10.07.2008, recalculation was done and the mistake was observed that corresponding to premium Rs.768.60 half-yearly premium, the GIVE amount and monthly annuity works out to Rs.94,815/- and Rs.948/- respectively for which cheques were sent to the Life Assured. The Insurer admitted their mistake and wrote to the policyholder stating that it was a bonafide mistake. The Life Assured, however, insisted upon the monthly annuity amount of Rs.1000/- and GIVE amount of Rs.1,20,000/-.

In the facts and circumstances of this case, the mistake of mentioning a higher GIVE amount and monthly Annuity in the policy schedule is a bonafide mistake and the present annuity amount payable to the annuitant by LIC is as per their tables.

During the hearing a proposal was made that for getting the Annuity of Rs.1000/- per month, the complainant has to pay the difference of premium for the entire period i.e. a difference of Rs.200/- per half-yearly premium for 20 years and for the mistake committed by the Insurance Company, no interest will be charged on this amount. Thus the complainant's complaint can be resolved by two Options.

Option 1 - As the mistake was a bonafide mistake and the Annuity has been worked out on the basis of the premiums actually paid, therefore, the monthly Annuity of Rs.948/- will be paid as per the endorsement on the policy bond. However, a penalty of Rs.2000/- is imposed on the Insurer for the mistake in premium amount and this penalty is to be paid to the Annuitant.

OR

Option 2 - The complainant to pay the difference of premiums as stated above for twenty years and no interest will be charged as there was a mistake on the part of the Insurance Company and the Annuitant will get Rs.1,000/- monthly Annuity as well as GIVE amount as stated on the face of the policy

With the above recommendations, the complaint was closed..

MUMBAI OMBUDSMAN CENTRE

Complaint No.LI - 151 of 2008-2009

Award No.IO/MUM/A/ 245 /2008-2009

Complainant : Shri Dineshchandra Bhikhalal Solanki

V/s

Respondent : Life Insurance Corporation of India

AWARD DATED 12.11.2008.

Shri Dineshchandra Bhikhalal Solanki is holding a Varishtha Pension Bima Yojana Policy No.905023322 under Table No.161 with Annual Pension Installment of Rs.24,000/-. The proposal date was 05.07.2004 and the date of pension payment mentioned in the Policy Bond is 05.07.2005. The 1st annuity installment of Rs.24,000/- with the broken period pension of Rs.1,742/- for the period 05.07.2005 to 31.07.2005 was paid on 06.08.2005.

Shri Dineshchandra B. Solanki is the pensioner and as per the policy bond, his pension was payable on 05.07.2005. He received on 11.08.2005 two cheques dated 06.08.2005 for the amounts of Rs.24,000/- (annual pension) and Rs.1,742 (broken period pension from 05.07.2005 to 31.05.2005). As LIC had not paid the pension on the due date i.e. 05.07.2005, he demanded interest for two months for the delayed payment. LIC of India wrote to him vide their letter dated 19.10.2005 & 28.02.2006 stating that the yearly annuity was due on 05.07.2005. As he had opted for ECS credit (which is sent by them on 1st of next month), they should have credited the annuity on 01.08.2005, but due to some technical problem in the ECS they could not send the same on 01.08.2005 and the cheques for amounts – yearly annuity of Rs.24,000/- and broken period pension of Rs.1,742/- for the period from 05.07.2005 to 31.07.2005 was sent on 06.08.2005. The Insurer admitted that there was a delay of six days at their end. If the delay is for more than one month, 2% additional interest than the bank rate as approved by Reserve Bank of India is paid. In this case, the annual pension was payable on 05.07.2005. LIC sent two cheques dated 06.08.2005. The delay is over a month. As the delay is for more than a month, LIC of India is directed to pay penal interest for the delayed payment at the rate of 8% per annum as per the guidance of the Insurance Regulator for the delayed period. The Insurance Company is also directed to inform the Annuitants if the Annuity is to be paid on some other date than written on the policy schedule due to some procedural convenience as a common practice.

MUMBAI OMBUDSMAN CENTRE

Complaint No.LI-581 of 2008-09

Award No.IO/MUM/A/ 501 /2008-2009

Complainant : Shri Udayan Anant Hundilkar

V/s.

Respondent : Kotak Mahindra Old Mutual Life Insurance Limited

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AWARD DATED 31.03.2009

Shri Udayan Anant Hundilkar had taken a Kotak Unit Linked Retirement Income Plan (Unit Linked Without Cover) Policy bearing No.01065699 from Kotak Mahindra Old Mutual Life Insurance Limited through proposal dated 27.05.2008, for an annual premium amount of Rs.8,00,002/-and for a term of 10 years. The date of commencement of the policy was from 28.05.2008. Shri Hundilkar wrote to the Company vide his letter dated 20.10.2008 stating that on scrutiny of the policy document, he found that there were variations in the representations made by the Manager Sales of the Company and the policy document and therefore requested them to refund the entire amount of Rs.8.00 lacs invested by him. According to him, he thought that the term of the policy was for 10 years and the premium paying terms was one-time i.e. single premium. The Company vide their letter dated 10.12.2008 cited the 15 days free look period from the date of receipt of the policy document whereby the policyholder may choose to reconsider his decision to hold the policy or may choose to return the same within the said 15 days and according to them the policy free-look period was applicable till 05.07.2008. They also regretted the inability for incorporating any alteration for premium paying term as they have not received any request for the same within free-look period.

We received a copy of letter dated 23.03.2009, addressed to Shri Udayan Hundilkar, by the Insurer, wherein they have agreed to the reduction of premium to Rs.10,000/- annually payable on the policy anniversary i.e. on 28.05.2009. They have informed him that on reduction of premium, the guaranteed value on maturity will fall away and he will be eligible to only the fund value on maturity. He was requested to furnish a GMV declaration for premium alteration prior to the policy anniversary date so that they are able to process his request.

In view of the above, the complaint is reverted back to the Company and hence stands closed at this Forum.

As the Company has agreed to reduce the premium amount to Rs.10,000/- as stated during the Hearing, and their letter dated 23.03.2009, issued to the policyholder, the complainant is requested to submit the requirements to the Company before the policy anniversary date so that they could process the same and make the necessary alterations in

the policy . The Company is also to reduce the annual premium to Rs.10,000/- for the next two years and convert the said policy into a Life Time Retirement Policy whereby the LA will start getting his Pension. Accordingly, the Alterations / Endorsements should be made in the policy document.

MUMBAI OMBUDSMAN OFFICE

Complaint No.LI - 187 of 2008-2009

Award No.IO/MUM/A/ 284 /2008-2009

Complainant : Shri Pramod M. Nishar

V/s

Respondent : Life Insurance Corporation of India, Mumbai Division II

AWARD DATED 03.12.2008

Shri Promod M. Nishar had taken a Jeevan Suraksha annuity policy from Life Insurance Policy from LIC, MDO II, with SA 70,000/- . The Date of commencement was 28.3.2000 with premium paying amount of Rs.9,577/- yearly. The GIVE amount mentioned in the policy bond was Rs.1,12,000 and monthly annuity amount of R.s2,811/-

Shri Promod M. Nishar received a statement dated 01.02.2008 showing the annuity figures that was payable after vesting of the policy on 28.03.2008. He wrote to Company vide his letter dated 06.02.2008 stating that as per policy document, his annuity per month was shown as Rs.2,811/- for 15 years guaranteed and thereafter till death. He insisted that he be paid monthly annuity of 2811/- with effect from 28.04.2008. He received a letter dated 25.03.2008 from the Company stating that "Due to programming mistake the annuity amount has been wrongly printed at the time of issuing the policy. The correct amount of annuity is Rs.1072/- only". The contention of the dispute between the parties is the amount of annuity payable per month.

At the hearing the complainant had agreed to choose the option and accept the pension as per the circulars/manual provisions of LIC, the complaint was closed. However the Insurance Company was directed to pay an amount of Rs.2000/- to Shri Pramod M. Nishar, the Annuitant, as compensation for the error.