BHUBANESWAR

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-21-004-1285 MISCELLANEOUS
Dr. Subash Ch. Palo Vs. ICICI Prudential Life Ins. Co.Ltd.
Award dated 08th April, 2011

FACT:-

The Complainant had taken one Health Saver Policy allowing besides others, a benefit of Cash-Less facility on medical treatment of self. The policy commenced from 28.03.2009. The Complainant was hospitalized on 20.07.2010 for Angiography test and discharged from the hospital from 22.07.2010. Further as advised by the doctor on 04.08.2010 he underwent for Coronary Artery Bye-pass Grafting (CABG) at Aditya Care Hospital, Bhubaneswar. On 26.08.2010 he submitted his all his medical papers and bills for reimbursement of his medical expenses on Angiography and CABG operation which was rejected by the Opposite Party on the ground that the disease, for which expenditures were incurred, was pre-existing one and thus the claim was not acceptable by it. Being aggrieved by such action of the O.P., he has filed this Complaint seeking the relief of reimbursement of his medical expenses to the extent of Rs.1,60,367/- by the O.P. However, in the Self-Contained Note, the O.P. stated that in the Proposal Form the Complainant deliberately withheld material information and did not disclose complete and correct facts regarding his health which were very essential for underwriting the proposal for life insurance. So, the Complainant had not acted with utmost good faith which is very basic to the acceptance of the proposal by the Insurer.

AWARD:-

The Hon'ble Ombudsman observed that the insurance contract is based on good faith. Both the parties to the contract should have to maintain utmost good faith and honesty. The stand taken by the O.P. is on the twin grounds. First, there is suppression of material facts by the insured inasmuch as his is a known case of hypertension but such fact was not stated and disclosed in the form. Secondly, the tests, operation and treatment have arisen from the disease of hypertension and the same having been undertaken within the first two policy years, insurance benefits for such treatment and hospitalization being excluded as per the Policy terms and condition. It is also observed by the Hon'ble Ombudsman that in both the reports of Apollo Hospital, Visakhapatnam and Aditya Care Hospital, Bhubaneswar where it was mentioned that the Complainant was having hypertension for 6 ½ years and 6 years respectively. Had there been no such disease with the Complainant, in the medical papers of two such hospitals of two different states, mention of the fact of patient's continuous suffering from Hypertension would not have been mentioned. The policy in question commenced from 28.03.2009. The treatments and CABG operation have been taken within these two years. The ailment of hypertension has not been disclosed at the inception. This disease is one of the excluded diseases. Therefore, information relating to this disease of hypertension is very much material for acceptance of the risk by the insurer. This fact having not being shown by the Complainant in the proposal form there is suppression of material fact by him. Copy of the policy does not even show coverage of this ailment for grant of insurance benefit for any period. The exclusion clause of the policy also

has made it very specific that not only hypertension but also complications arising out of hypertension are excluded from grant of benefit on treatment under the policy. Medical Opinion of the doctor obtained by the O.P. and the extracts of authoritative writings on the field of medical science collected by the Complainant are filed by them to show the link between coronary disease and hypertension. Reading of these materials bring out that hypertension is clearly a risk factor for coronary artery disease. It has been found that Complainant's illness is a known case of continuing hypertension, he underwent the angiography test and CABG was done to him. Obviously his coronary arterial complications are linked with disease of hypertension from which the Complainant has been suffering from last several years. So, as per the terms and conditions, the disease has been excluded from grant of insurance benefit. Considering the matter from the above perspectives, the action of the O.P. in repudiating the claim on the grounds of suppression of material fact and of the exclusion clause cannot be faulted with. In the circumstances, the Complainant is not entitled to the insurance benefit as claimed by him. In turn, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-22-013-1287 MISCELLANEOUS
Sri Debendranath Routray Vs. Aviva Life Ins. Co. India Ltd.
Award dated 13th April, 2011

FACT:-

The Complainant had taken from the O.P. its Save Guard Policy of Insurance commencing from 07.12.2009 on a yearly premium of Rs.1,00,000/-. It is stated by him that at the time of the sale of the product to him, the sales representative of the O.P. had told him the extent of policy benefits by stating that he would get back 25% returns every year on the policy and after three years no surrender charge would be levied and on completion of five years, withdrawal of the full amount would be allowed with a small deduction of 2% towards allocation charges. Being told about the above policy benefits, he gave his proposal to them for taking a single policy on annual premium of Rs.1,00,000/-. But, after receipt of the policy papers, he found that two policy bonds each for Rs.50,000/- instead of one bond for Rs.1,00,000/- have been sent to him showing investment of only Rs.13,000/- out of the total deposit of Rs.1,00,000/- in the market with the deduction of the balance amount towards allocation charges, administrative expenses and management charges which facts were not at all told to him while selling the product to him. Being aggrieved, he has filed this complaint asking for the relief as aforementioned. In the Self Contained Note while denying the allegation of mis-sale and forgery, the O.P. has stated that the Complainant had submitted two proposal forms dated 03.12.2009 for taking two numbers of Save Guard Unit Linked policy from it. Its representative had fully explained to him on the product details and had provided him the Key Feature Documents of the policy whereafter the Complainant being satisfied with the policy benefits, submitted the proposal forms. After observance of the formalities, it issued two policies to him – one commencing from 05.12.2009 and other one from 07.12.2009 with a assured sum of Rs.2,50,000/- on an annual premium of Rs.50,000/- in respect of each policy. It is further stated that the with the policies which were

issued to the Complainant, all other connected documents including the right to reconsider notice wherein it was indicated that if the policy-holder would not agree to the policy terms and conditions or to the benefit available under the policy, he had the option to seek for cancellation of the policy within 15 days from the date of receipt of the policies which were sent to him vide Speed Post on 11.12.2009 and 10.12.2009 respectively. The Complainant did not exercise the option and remained quiet for about 7 months and on 23.07.2010 he sent a complaint letter raising the dispute regarding issue of two policies being sent to him as against one applied for by him. He also disputed about the value of the Annual Return. On receipt of the above letter from the Complainant, it asked him to send Bank Attested signatures which he furnished. On verification of the bank-attested signatures with the signature in the proposal form, no mis-match in the signature was noticed. As the Complainant did not approach it within the free-look period of 15 days from the date of receipt of policy documents, it did not accept his contention of mis-sale and declined his request for refund of the amount. It is stated that in the meantime, for non-payment of the premium, the policies come under lapsed status category. As per the terms and conditions of the policy, refund of the deposit at this belated stage is not allowable. With the above contentions, it asks for dismissal of the Complaint.

AWARD:-

The Hon'ble Ombudsman observed that though in the SCN fact of dispatch of the policies on 10.12.2009 and 11.12.2009 is mentioned, nothing is stated as to on which dates the policy papers were exactly delivered to him (Complainant). However, this fact is not very material in the present nature of the controversy since the Complainant has not taken the stand that within the free-look period he has applied for cancellation of the policies. His is a case of mis-sale and forgery. It is categorically contended by the Complainant that he had submitted one proposal form for taking a single policy giving only one cheque for Rs.1,00,000/-. But two policies were issued to him for Rs.50,000/- each . The assertion in the Complaint by the Complainant that he paid Rs.1,00,000/- through a single cheque is not refuted in clear words by the O.P. in the SCN. Copies of the two proposal forms which, as per the O.P. were furnished by the Complainant for taking the policy are submitted along with the SCN by the O.P. At the cost of repetition, it may be stated here that the Complainant has specifically stated that he submitted only one proposal form and not two and that in one of the proposal form filed by the O.P. his signature has been forged as the same is not in his hand. It appears that Proposal Numbers have been noted in the proposal forms. One of the two proposal bears the no-NNU15412924 and the other one contains the proposal no-NNU15412920. It appears that the proposal dates in both the forms are one i.e., 02.12.2009. The product names of the policies to which the proposals relate are also one and the same i.e., Unit Linked Aviva New Freedom Life Plan. The sums assured and premium amounts in both proposals are the same and so also the term of the plan and premium paying term. The nominees in both the proposals are one and the same person. It is not stated by the O.P. that there is any difference in benefit available to the intending insurer when two policies each for the equal yearly premium amount of Rs.50,000/- is taken under the same scheme in place of a single policy under the same plan with yearly premium of Rs.1,00,000/-.The proposal copies submitted would show that the Agents of the proposals are different persons. It is not understood why a

proposer who desired to take one product on the same date with same conditions and benefits would choose to take two policies through two different Agents paying the total amount both through single cheque since the fact of payment of Rs.1,00,000/- by the Complainant through one cheque has not been controverted by the O.P.. in the SCN. It further also appears strange from the entries made in the Proposal form that amount in respect of one Proposal was paid by Demand Draft and the amount in respect of other was paid in cash on the same date. Why two modes were chosen for payment on the same date for the same purpose has gone unexplained particularly when as the proposal forms indicate the proposer had two bank accounts, one of Union Bank and the other of Axis Bank. From the side of the O.P. no material is produced to corroborate the fact of payment through two modes. All these facts make the contention of the O.P. regarding submission of two proposals for two policies by the Complainant doubtful. To add to the above facts, the Complainant clearly asserts that the signature in one of the two proposal forms does not belong to him. The signatures of the Complainant available in Complaint petition and in Form No-P-II are referred. The signature of the proposer available in proposal NNU15412924 clearly appears to a plain -eye observation different from the signatures of the Complainant available in the Complaint petition as well as in Form No-P-II. This goes a long way to support the stand of the Complainant that he is not the author of the signature in one of the two proposal forms and he did not submit two proposal forms. As already mentioned, the O.P. has not bothered to come to participate in the hearing to explain the position. When the above proposal form containing dissimilar signature is eliminated from consideration, there remains only one proposal form in the field which finding substantiates the contention of the Complainant that he filed only one proposal form and paid Rs.1,00,000/- through single cheque for taking a single policy. The above discussion has brought out that the O.P. has utilised the entire amount issuing two policies each for the half of the amount paid creating another proposal form which as has been found, does not contain the genuine signature of the proposer. Clearly, the O.P. has acted not in good faith and has mis-sold the product to the Complainant. Therefore, the action of the O.P. in denying refund of the entire amount to the Complainant cannot be upheld. It would thus follow that the O.P. has unjustly held the money of the Complainant so far. So, the Complaint is allowed. The O.P. is directed to refund the entire amount of Rs.1,00,000 with interest @8% per annum from 05th December, 2009 till payment.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-21-001-1293 MISCELLANEOUS
Sri Manoranjan Meher Vs. Life Ins. Corporation of India
Award dated 19th April, 2011

FACT:-

The Complainant had taken a Health Insurance Policy for himself and for his wife from the O.P. under the plan-Health Plus (Table/Term-901/24) for a sum assured of Rs.2,00,000/- with the policy commencing from 20.03.2008 with yearly premium. He has been regular in payment of the premium. There occurred sudden retinal detachment in his left eye which was diagnosed in L.V. Prasad Eye Institute, Bhubaneswar on 05.12.2009. Immediate surgical intervention being

needed, surgery in his left eye was undertaken on 07.12.2009 in the hospital. As post-operative precaution, he was advised by the doctor to take 30 days complete bed-rest to prevent retinal infection/further detachment. After a month of bed rest, he took a check-up and thereafter lodged his health claim with the O.P. for the medical expenses incurred by him on the surgery. But in a very casual manner, treating his disease as one relating to his left ear in place of left eye, it rejected his claim on the grounds (1) that his hospitalisation was for less than the minimum payable duration of 52 hours, (2) that surgery undertaken is not one of the covered items for allowing the surgical benefit and (3) that claim made was after 30days from the date of discharge from the hospital. Being dissatisfied with such interpretation of the terms of the policy with the further mistake committed in categorisation of the disease by the O.P., he represented against the order of rejection of his claim with a request to reconsider the matter in the proper perspective. As no action is taken on his representation, he has filed this Complaint claiming Rs.8,906/- towards expenses incurred him on the surgery and medicines and Rs.10,000/- towards the mental agony and harassment he is put to by the improper action of the O.P. However, the Opposite Party in its Self-Contained Note submitted that the Insured-Complainant was discharged from the hospital on 08.12.2009. But his claim papers were received as late as 14.01.2010 which was beyond the stipulated period of 30 days from the date of his discharge from the hospital. It is stated that as there was delay in preferring the claim and as surgery in question is not included in the Schedule of Allowable Surgeries and that as hospitalisation period was for less than 52 hours, the claim of the Insured-Complainant was rejected. As regards mention of the word "Left Ear" in place of "Left Eye: rrd" in the Diagnosis Column, it states that the same was a clerical mistake and has been rectified. A correct rejection letter has been accordingly issued to the Insured on 20.12.2010. It is further stated that the Claim papers of the Complainant were scrutinised by the TPA which recommended for rejection of the claim on the above grounds. It is also stated by the O.P. that its Zonal Authority (ECZO:Patna) has taken the claim file to review the matter. Stating that utmost care has been taken in examining the claim of the Complainant, it contends that the claim of the insured has been rightly repudiated.

AWARD:-

The representative of the O.P. adds that as per the terms and conditions of the policy, MSB claim raised on surgery arising only from accident is allowable to the insured to the extent as specified in the Surgical Benefit Annexure. Simultaneously, he is asked to submit the policy Bond of Health Plus Plan (Table No-901) which neither party has produced. It appears that clarifications in the matter along with the Health Kit, Circular of the Central Office and the decision of the Zonal Office have been received from the O.P.'s representative on 07.03.2011. In the clarifications furnished on behalf of the O.P., it is mentioned that as per the policy condition, the insured has to submit his written claim in the prescribed form within 30 days from the date of the discharge. In this connection it is cleared that delay being otherwise condonable under certain circumstances, such rigid and theoretical approach by the O.P. to the extent of rejecting the insured's claim by using this as one of the grounds was not appropriate particularly when the delay was for about 7 days only. The Hon'ble Ombudsman examined the fact that the surgery is not included in the list as per the policy conditions, repudiation has been made. The policy terms

and conditions in respect of Major Surgical Benefit (MSB) would show that the claim of this category is payable if the surgery performed is one coming within the list of surgeries specified in the policy. The Complainant has made the claim for his retinal surgery. The Surgical Benefit Annexure appended at the last in the book-let on conditions and privileges of LIC'S Health Plus Insurance plan (T.No. 901) would show that concerning 'eye' the surgical benefit allowable is "any Eye Surgery requiring corneal or retinal repair due to accident". This condition makes it clear that in consequence of an accident met, if surgery becomes necessary for repair of cornea or retina, such surgery and no other, is payable to the extent of the percentage of sum assured as specified therein. In other words, if surgery to the retina or cornea does not arise from the accident suffered, claim made upon such surgery is not entertainable at all under Health Plus Plan (T.No. 901). Thus, as per the terms of the policy the eye-surgery done to the Complainant is not one coming within the category for which benefit is extended under the policy. In view of the conclusion reached above, the Hon'ble Ombudsman found no good reason to interfere with the ultimate order of repudiation passed by the O.P. in respect of the Claim of the Complainant and in turn the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-22-013-1294 MISCELLANEOUS
Mrs. Sagarika Mishra Vs. Aviva Life Ins. Co. India Ltd.
Award dated 18th April, 2011

FACT:-

Refusal by the O.P.–Insurer to cancel the Complaint's policy of insurance has made the Complainant to approach this forum with a written Complaint against the former. In the Self Contained Note, it is contended by the O.P. that the policy was delivered to the Complainant on 30.03.2010 along with other policy documents including the Right to Reconsider notice for exercise of the option within the free-look period if the same would be so desired by her. After receipt of the above policy document, the Complainant by letter dated 06.04.2010 made a request to it only for change of the premium paying term in respect of the policy. On her such request, the change was effected in respect of the premium paying term by changing the same from 15 years to 03 years. A new policy in place of the previous one was issued and delivered to her on 04.06.10. But, the Complainant by her letter dated 07.06.2010 made a request for cancellation of the changed policy. Since, the free-look cancellation condition was not available in respect of this policy and she had exercised her option during the free look period in respect of the earlier issued policy for getting the premium paying term changed, it did not entertain her request for cancellation of the policy. Alleging that the Complaint is made on false ground and is also misconceived, it asks for dismissal of the Complaint.

AWARD:-

The Hon'ble Ombudsman observed that the free-look provision makes it clear that free look benefit option is, as a right, available to be exercised by the Insured within 15 days from the date of receipt of the policy document. As per the own showing of the O.P., the policy bond with

changed term has been issued by the O.P describing it a "new" policy. There cannot be any room for doubt that the policy bond is a vital part of policy document. Obviously therefore, until the policy bond is received by the Insured, receipt of policy document as envisaged in the free look clause cannot be said to be complete. In other words, the date for free-look period would start running from the date when all material policy documents are delivered to the insured. As already noted, the O.P. itself has treated this policy bond as a new policy. The Complainant indisputably received the policy bond on 04.06.2010 and she has exercised her option for free-look cancellation on 07.06.2010. So, the free-look period shall have to be counted from 04.06.2010. It is thus clear that within the free look period of 15 days, this option has been exercised by the Complainant. In view of the above analysis, the contention of the O.P. that such benefit is not available for the policy cannot be supported. Hence, the Complaint is allowed and the Complainant is entitled to get her policy cancelled and to refund of the refundable deposit from the O.P. who is directed to refund the amount due to the Complainant after deduction of the charges as envisaged under free look cancellation condition of the policy.

******

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-24-013-1297 MISCELLANEOUS
Sri Sangram Kishori Nayak Vs. Aviva Life Ins. Co. India Ltd.
Award dated 10th May, 2011

FACT:-

This is a Complaint filed by the Complainant for repudiation of his Medi-claim by the Opposite Party-Insurer on the ground of non-coverage of such benefit by his policy of insurance. After commencement of policy of insurance, the Complainant met with a serious accident causing brain haemorrhage in him. In his medical treatment that followed the accident, he incurred an expenditure of around of Rs.3,00,000/-. Being one of the joint-life beneficiaries under the policy, his wife preferred a claim on his medical treatment with the O.P. who asked her to submit the original policy bond and other connected documents which she furnished. But, after few days, the O.P. returned the documents with intimation of denial of payment of the accidental benefit to him on the ground that such benefit is not covered by the policy taken by him. After some days when he recovered little more from his illness and verified the policy documents, he could then notice that tampering had been made in his proposal application with a cross mark being fraudulently put at Item no-6 under the heading "cover level" against the word "Standard" which he had originally chosen for. Being aggrieved by the above order and fraudulent action of the O.P., he has filed this Complaint claiming full medical benefit by payment of the total expenditure incurred by him in his treatment arising from his accident. In its Self Contained Note, it is contended by the O.P. that on the basis of the proposal form and the subsequent letter of request dated 28.03.2006 of the Complainant asking for removal of Hospital Cash benefit, the policy without attachment of the rider 'Hospital Cash Benefit' was issued to the insured-Complainant on 28.03.2006 along with which the Key Features document, copy of the proposal form, First Premium Receipt, Standard Terms and Conditions and Right to Reconsider Notice. The policy-holder did not choose to exercise the option under the Free-look clause of the

policy and thereby accepted the policy terms and conditions. It is further stated by the O.P. that since the policy-holder did not finally opt for Hospital Cash Benefit Rider, he is not entitled to any benefit which is allowed under the rider 'Hospital Cash Benefit'. The claim of the Complainant being beyond the ambit of coverage of the policy taken by him, his claim has been repudiated by it. It further denies the allegation of tampering of the proposal form at point no-6 describing the same as baseless and malafide. With the above contentions, the O.P. prays for dismissal of the Complaint.

AWARD:-

The Hon'ble Ombudsman observed that from the contentions of the parties, it is clear that for non-coverage of the Hospital Cash Benefit in the policy taken by the Complainant repudiation of the claim has been made by the O.P.. Parties take contrary stand on this aspect inasmuch as while the Complainant claims that he had opted for this benefit, the stand of the O.P. is that no such rider is attached to the policy taken by the policy-holder. The crux of the controversy lies on the question whether the rider of 'Hospital Cash Benefit' was attached to the policy taken by the Complainant. The proposal form would show that at the stage of the proposal which was signed by the proposer on 10.02.2006, the proposer namely the present Complainant under the heading - Details of the plan applied for' had opted for two riders, such as – "Accidental Death and Dismemberment" and "Hospital Cash Benefit". But the policy schedule as well as the First Premium Receipt shows that the policy was issued with only the rider of Accidental Death & Dismemberment. On behalf of the O.P., the letter of request of the lives-assured requesting for withdrawal of Hospital Cash Benefit which bears the date 28.03.2006 is relied to show that Hospital Cash Benefit rider was withdrawn by the policy-holder and his wife. The letter bears the signatures of both the life assured. The Complainant in course of the hearing admit his signature and the signature of his wife in the letter of request. But, he disputes the contents of the letter. It would appear from the letter that through this letter, the policyholder along with his wife has applied for removal of Hospital Cash Benefit from his policy. The Complainant does not say that the Rider of Hospital Cash Benefit had been wrongly omitted in these policy papers. Both these documents bear the date 28.03.2006. The policy has commenced from 28.03.2006 also. It is not disputed by the Complainant that along with the policy bond, the Standard Terms and Conditions, First Premium Receipt and Right to Reconsider Form were sent to him by the O.P. It is clear that the Complainant had not sought for cancellation of the policy within the Free-look period. There is nothing on the record to show that he raised any objection when the Hospital Cash Benefit Rider was not included in the policy bond issued to him. In these circumstances, the conclusion to follow is that though initially the policyholder in his proposal had opted for the Hospital Cash Benefit rider also, yet subsequently he applied for removal of this rider and accordingly the first premium receipt and the policy schedule which were dated 28.03.2006 – this rider was not included. Hospital Cash Benefit having not been finally taken by him, the Complainant is not entitled to so-called expenses incurred by him on his treatment. Thus rejection of the claim of the Complainant as has been made by the O.P. is in order. Therefore, the Complainant is not entitled to Medical Benefit as has been claimed by him on his alleged treatment and hence, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-25-001-1304 MISCELLANEOUS
Sri S.K. Patra Vs. Life Ins. Corporation of India
Award dated 28th April, 2011

FACT:-

The grievance of the Complainant is that on the strength of the Money Back Policy of Insurance bearing no-583500268 taken by him from the Insurer, he had availed himself of a loan from the O.P. on depositing his policy bond. He repaid the full loan amount with interest due on 30.07.2010. But, in spite of his repeated request, the policy bond is not released and given back to him. Being thus aggrieved, he has filed this Complaint seeking for an order for return of his policy bond by the O.P. However, the Insurer in their Self-Contained Note stated that the policy bond has been dispatched on 05.01.2011 to the policyholder by Speed Post vide RL No-EO-399599988IN. With the above contention, it is asked to close the case. Along with the SCN, a copy of Speed Post bulk booking journal in support of the above dispatch is filed**.**

AWARD:-

The Hon'ble Ombudsman observed that at the Oral hearing, the O.P. alone has made its appearance while the Complainant has chosen to remain absent. It appears from the record that a letter has been received from the Complainant in this Office on 19.04.2011 wherein it is mentioned by the Complainant that policy bond has been returned to him. He has requested to close the matter. From the Speed Post bulk booking journal, it appears that a letter has been dispatched to the Complainant on 05.01.2011 from the O.P.'s Branch Office, Bhubaneswar Division. Further, the Complainant has intimated about the receipt of the policy bond by him. As such, the grievance of the Complainant does not subsist anymore and hence, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-24-008-1308 MISCELLANEOUS
Sri Mukesh Chandra Agrawal Vs OM Kotak Life Ins. Co.
Award dated 4th May 2011

Fact: The refusal of the O.P. to cancel under the free-look-option exercise clause the policy bearing No-01946375 for S.A Of Rs.1,00,000/- for 15years term with yearly mode taken by him on 29.03.2010 from the O.P.-Insurer is the grievance of the Complainant against the former. On receipt of policy bond along with letter dated 20.04.2010 on 29.05.2010 and being not satisfied , he requested the O.P. to cancel the policy on 03.06.2010 which was not accepted by the O.P. , as cancellation has not been sought within the free-look period. His representation evoked identical reply from the O.P. Thus being aggrieved, he has filed this Complaint for cancellation of his policy under free-look cancellation clause and for refund of money paid by him with interest from the date of 29.05.2010 to till the date of payment and for compensation.

In the S.C.N. the O.P. has furnished its reply on the Complaint stating that by way of goodwill gesture, it has accepted the request of the Complainant for cancellation of the policy and has resolved all issues raised by the Complainant. It has initiated the process to cancel the policy.

Award: In the Complaint petition, besides asking the relief of refund of his money, the Complainant has also sought for interest on his withhled money and also compensation. It is evident that the Complainant has exercised his option for cancellation of the policy under free-look period clause. The contention of the Complainant that on 03.06.2010 he submitted his option letter for cancellation of the policy at the Bhubaneswar Office of the O.P. is not disputed by the O.P. Clearly within the free-look period, option has been exercised by the Complainant. But, the deposit was refunded by the O.P. to him as late as in March, 2011 i.e., around 11 months after the receipt of Complainant's option letter on 03. 06.2010. Obviously, delay made in cancelling and making the refund of the amount deposited by the Complainant towards the premium is quite long in time. Having regard to the provision in clause -8 (5) of Insurance Regulatory and Development Authority (Protection of Policyholders Interest) Regulations, 2002, it would be appropriate to allow interest @8% per annum for commission of delay by the O.P. in processing the matter. Hence the Complaint is allowed in part. The O.P. is directed to pay the Complainant interest @8% per annum on the refunded amount from 03.06.2010 upto the date of credit of the said amount to the Bank Account of the Complainant.

****

BHUBANESWAR OMBUDSMAN CENTRE
Complaint No-24-001-1310 MISCELLANEOUS
Smt. Manjushreebala Mohanty Vs. Life Ins. Corporation of India
Award dated 28th April, 2011

FACT:-

It is stated in the Complaint by the Complainant that she had taken the Money back policy of insurance bearing no.- 582670513 from the O.P. for a sum assured of Rs.25,000/- with the policy commencing from 28.03.1988. As per the terms of the policy, she was to receive the Survival Benefit amounting to Rs.3750/- every five years. Such Survival Benefit was due to her on 28.03.2008, but the amount was not paid in time to her. After lapse of two years, the O.P. sent her a cheque for the basic amount of Rs.3750/- on 18.11.2010 without any interest being paid for the period of delay made for two years in effecting payment of the Survival Benefit. Being aggrieved, she has filed this application to get the interest on the Survival Benefit amount for the delayed period of two years. However, in the Self-Contained Note, it is stated by the O.P. that the Insured took the policy under Salary Savings Scheme of Govt. of Orissa. As the monthly premiums for the period from April'2007 to March'2008 were received late from the Kendrapara treasury, the policy remained under lapsed condition on the date the Survival Benefit became due in March'2008 on the policy. Afterwards, the Survival Benefit for Rs.3750/- was paid to the policyholder through cheque no-526732 dated 13.11.2010. For the delayed payment of the Survival Benefit, interest @8% per annum for the period from 28.03.2008 to 13.11.2010 vide cheque no-536753 dated 13.11.2010 for Rs.800/- drawn on Axis Bank, Cuttack has also been sent to her on 14.01.2011. With the above contentions, it is urged to close the case.

AWARD:-

The Hon'ble Ombudsman observed that at the Oral hearing, the O.P. alone has made its appearance through its representative. The O.P.'s representative submits that interest amounting to Rs.800/- for the delayed period has been paid to the insured through cheque. A Xerox copy of the cheque is filed by the O.P. along with the SCN. It is submitted by the O.P.'s representative that the amount sent to the Complainant has been encashed by her. Soon after the hearing, for record purpose he puts in writing that they have confirmed that the amount of Rs.800/- sent towards delayed interest has been encashed by the Complainant on 25.01.2011. As already noted, the Complainant has not appeared to raise any dispute on the contention made in the SCN and submission made by the O.P.'s representative at the time of oral hearing. Since there is no objection raised, it is to be concluded that the correct amount due towards interest has been paid to the Complainant obviously in respect of the Claim raised before this forum which does not survive anymore and hence, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 22-004-1311 Miscellaneous

Sri Binay Kumar Nayak Vs. ICICI Prudential Life Ins. Co. Ltd.

Date of Award : 22.06.2011

Fact: The complaint is for refund of premium on cancellation of policy due to mis-sale.

The Complainant took a O.P.'s Life Stage Pension Advantage policy of insurance with date of commencement 01.07.2010 paying Rs.49,000/- towards one-time premium deposit for the policy. When he received the policy documents he found that the mode of payment of the premium of the policy has been changed from one-time deposit to yearly. He contacted the Relationship Manager of the O.P. but he did not get any positive response from the O.P. Being thus aggrieved, he filed this Complaint seeking for relief as afore-mentioned.

The O.P. stated that the Complainant applied to it in the Proposal Form which was filled up and signed by him, to take the product in question opting for yearly premium. On 30.06.2010 the Complainant also signed the Electronics Benefit Illustration vide Annexure-C wherein the mode of payment of premium on yearly basis was reflected. The policy documents along with the copies of the Proposal Form, Terms & Conditions of the Policy and Free Look Option Form etc were dispatched on 09.07.2010 to the Insured by post under certificate of posting. The Complainant did not exercise his option for cancellation of policy under Free-Look provision clause of the policy. But, after lapse of several months i.e., on 21.12.2010 he asked for refund of his premium deposit. It is stated by the O.P. that as per the policy terms and conditions, the Complainant is not entitled to get the refund of premium at this stage, but as a gesture of goodwill, it has offered to the Complainant to change the product to single deposit premium mode on receipt of the consent letter. It has also issued a reminder to the petitioner on 10.01.2011 but no consent letter has yet been received by it.

Award: A reading of the claim application which undeniably is signed by the Complainant would show that as against item no. where particulars of plan applied for are to be mentioned, the 'tick' marks against the word "regular premium" and against the word "yearly" have been put. These marks only signify that while applying for the policy of insurance, the applicant had opted for Yearly Premium. The authorization letter for payment of cash of Rs.49,000/- in respect of the above application which bears the signature of the proposer reflects that the amount of Rs.49,000/- paid was towards the first premium deposit which fact indicates that the proposer selected Regular Premium Plan of the policy. The clear contention of the O.P. that the policy documents were sent to the Complainant on 09.07.2010 is not disputed by the Complainant. It is not the case of the Complainant that he has sought for cancellation of the policy exercising option under Free-Look clause which allows a period of 15 days to the Insured from the date of receipt of the policy document to exercise his option to seek for cancellation of the policy in the event the policy conditions are found unsuitable to him. The Complainant has not availed of the benefit of this clause. Thus, the several papers filed by the O.P. would show that the Complainant had exercised his choice for yearly premium. However the O.P is still agreeable to change the policy to single mode deposit premium if the Complainant would convey his willingness to accept such change in his policy. While dismissing the Complaint ,it is directed that on submission of the consent letter by the Insured, the O.P. would do well to change mode of payment of deposit from Yearly to Single mode and issue a revised policy accordingly in favour of the Complainant.

****

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 22-004-1312 Miscellaneous

Sri Raj Kishore Nayak Vs. ICICI Prudential Life Ins. Co. Ltd.

Date of Order : 30.06.2011

Fact: The Complainant is for refund of his premium amounts on cancellation of his two policies of insurance.

The Complainant took two numbers of policies of insurance of the O.P.under plans- i) Life Stage Pension Advantage and ii) Life Stage Wealth- for a term of 10 years each paying Rs.3 00,000/- and Rs.50,000/- respectively towards one-time premium deposit on the policies which commenced from 06.07.2010 and 08.07.2010 respectively. When he received the policy documents he found that the mode of payment of the premium of the policy has been changed from one-time deposit to a regular and yearly mode. He contacted the Relationship Manager of the O.P. but he did not get any positive response from the O.P. Being thus aggrieved, he filed this Complaint seeking for relief as afore-mentioned.

The O.P. stated that earlier policy of the complainant was cancelled and in its place Life Stage Pension Advantage policy was issued. The policy documents including the copies of the Proposal Form, Terms & Conditions of the Policy and Free- Look Option Form were dispatched to the Insured by post under certificate of posting on 16.07.2010 in respect of first policy and on 19.07.2010 in respect of 2nd policy.The Complainant did not exercise his option for cancellation of policy under Free-Look provision clause of the policy. But, on 21.12.2010 he asked for refund of his premium deposits. It is stated by the O.P. that as per the

policy terms and conditions, the Complainant is not entitled to get the refund of premium at this stage. However the OP has vide its letter dated 27.12.2010 offered to the Complainant to change the products to single deposit mode of payment of premium on receipt of the consent letter. It has also issued a reminder to the insured on 10.01.2011 but has not got the consent letter from the Insured.

Award: A reading of the claim application which undeniably is signed by the Complainant would go to show that as against item no. where particulars of plan applied for are required to be mentioned, 'tick' marks against the words "regular premium" and against the word "yearly" have been put. These tick marks would only signify that while applying for the policy of insurance, the applicant had clearly opted for Yearly Premium. The Benefit Illustration Paper of the insurance which is shown to form a part of policy document and bears the signature of the Complainant ,also indicates that the mode of payment of premium chosen by the Complainant in respect of the above Proposal for the policy was 'Yearly' mode. Thus, all these documents clearly support the contention of the O.P. that the Complainant has opted for yearly premium in respect of the policies applied for by him. It is not the case of the Complainant that he has sought for cancellation of the policy exercising option under Free-Look clause which allows a period of 15 days to the Insured from the date of receipt of the policy document to exercise the option to seek for cancellation of the policy within such period in the event the policy conditions are found unsuitable to him. The Complainant has not availed of the benefit of this clause. To sum up, therefore, the documents as are filed by the O.P., the authenticity of which are not disputed by the Complainant, would show that the Complainant had selected and had clearly chosen for yearly Premium. In the circumstances, the relief for refund of the deposited amounts of premium on the ground of mis-sale is not available to be granted to the Complainant. However, the O.P is agreeable to change the nature of the policies to single premium modes. If an application for refund of money deposited on the policies would be made with supporting medical papers, the same would be dealt early on humanitarian consideration.

While dismissing the Complaint it is directed that on submission of the application by the Complainant for refund of the amounts under the two above policies, the O.P. would consider such application liberally subject to the Complainant showing to its (the O.P.'s) satisfaction about the existence and continuance of his suffering from the critical illness as mentioned by the Complainant during hearing. If, however, the refund matter does not materialize for some reason or other, upon receipt of the consent letter from the Complainant, O.P. would do well to change the mode of payment of the premium from "Yearly" to "Single" mode.

****

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 22-004-1313 Miscellaneous

Smt. Parbati Nayak Vs. ICICI Prudential Life Ins. Co. Ltd.

Date of Award :- 23.06.2011

Fact: The complaint is for refund of premium on cancellation of policy due to mis-sale. The Complainant took a O.P.'s Life Stage Pension Advantage policy of insurance

with date of commencement 29.06.2010 paying Rs.99,000/- towards one-time premium deposit for the policy. When he received the policy documents he found that the mode of premium of the policy has been changed from one-time deposit to yearly mode. He contacted the Relationship Manager of the O.P. but he did not get any positive response from the O.P. Being thus aggrieved, he filed this Complaint seeking for relief as afore-mentioned.

The O.P. stated that the Complainant applied to it in the Proposal Form which was filled up and signed by him, to take the product in question opting for a regular premium with payment of premium on yearly mode. On 28.06.2010 the Complainant also signed the Electronics Benefit Illustration vide Annexure-C wherein the mode of payment of premium on yearly basis was reflected. The policy documents along with the copies of the Proposal Form, Terms & Conditions of the Policy and Free Look Option Form etc were dispatched on 12.07.2010 to the Insured by post under certificate of posting. The Complainant did not exercise his option for cancellation of policy under Free-Look provision clause of the policy. But, after lapse of several months i.e., on 21.12.2010 he asked for refund of his premium deposit. It is stated by the O.P. that as per the policy terms and conditions, the Complainant is not entitled to get the refund of premium at this stage, but as a gesture of goodwill, it has offered to the Complainant to change the product to single deposit premium mode on receipt of the consent letter. It has also issued a reminder to the petitioner on 10.01.2011 but no consent letter has yet been received by it.

Award: A reading of the claim application which undeniably is signed by the Complainant would show that as against item no- 27- A where particulars of plan applied for are to be mentioned, the 'tick' marks against the word "regular premium" and against the word "yearly" have been put. These marks only signify that while applying for the policy of insurance, the applicant had opted for Yearly Premium. The authorization letter for payment of cash of Rs.99,000/- in respect of the above application which bears the signature of the proposer reflects that the amount of Rs.99,000/- paid was towards the first premium deposit which fact indicates that the proposer selected Regular Premium Plan of the policy. The clear contention of the O.P. that the policy documents were sent to the Complainant on 12.07.2010 is not disputed by the Complainant. It is not the case of the Complainant that he has sought for cancellation of the policy exercising option under Free-Look clause which allows a period of 15 days to the Insured from the date of receipt of the policy document to exercise his option to seek for cancellation of the policy in the event the policy conditions are found unsuitable to him. The Complainant has not availed of the benefit of this clause. Thus, the several papers filed by the O.P. would show that the Complainant had exercised his choice for Regular Premium with payment of premium on yearly mode. However the O.P is still agreeable to change the policy to single mode deposit premium if the Complainant would convey his willingness to accept such change in his policy.

While dismissing the Complaint, it is directed that on submission of the consent letter by the Insured, the O.P. would do well to change mode of payment of deposit from Yearly to Single mode and issue a revised policy accordingly in favour of the Complainant.

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 22-004-1314 Miscellaneous
Ms. Tanuja Nayak Vs. ICICI Prudential Life Ins. Co. Ltd..
Date of Award :- 23.06.2011

Fact: The complaint is for refund of premium on cancellation of policy due to mis-sale.

The Complainant took a O.P.'s Life Stage Pension Advantage policy of insurance with date of commencement 03.09.2010 paying Rs.100000/- towards one-time premium deposit for the policy. When he received the policy documents he found that the mode of payment of the premium of the policy has been changed from one-time deposit to a yearly. He contacted the Relationship Manager of the O.P. but he did not get any positive response from the O.P. Being thus aggrieved, he filed this Complaint seeking for relief as afore-mentioned.

The O.P. stated that the Complainant applied to it in the Proposal Form which was filled up and signed by him, to take the product in question opting for yearly premium. On 28.06.2010 the Complainant also signed the Electronics Benefit Illustration vide Annexure-C wherein the mode of payment of premium on yearly basis was reflected. The policy documents along with the copies of the Proposal Form, Terms & Conditions of the Policy and Free Look Option Form etc were dispatched on 08.09.2010 to the Insured by post under certificate of posting. The Complainant did not exercise his option for cancellation of policy under Free-Look provision clause of the policy. But, after lapse of several months i.e., on 21.12.2010 he asked for refund of his premium deposit. It is stated by the O.P. that as per the policy terms and conditions, the Complainant is not entitled to get the refund of premium at this stage, but as a gesture of goodwill, it has offered to the Complainant to change the product to single deposit premium mode on receipt of the consent letter. It has also issued a reminder to the petitioner on 10.01.2011 but no consent letter has yet been received by it.

Award: A reading of the claim application which undeniably is signed by the Complainant would show that as against item no. where particulars of plan applied for are to be mentioned, the 'tick' marks against the word "regular premium" and against the word "yearly" have been put. These marks only signify that while applying for the policy of insurance, the applicant had opted for yearly Premium. The authorization letter for payment of cash of Rs.100000/- in respect of the above application which bears the signature of the proposer namely, Tanuja Nayak reflects that the amount of Rs.100000/- paid was towards the first premium deposit which fact indicates that the proposer selected Regular Premium Plan of the policy. The clear contention of the O.P. that the policy documents were sent to the Complainant on 08.09.2010 is not disputed by the Complainant. It is not the case of the Complainant that he has sought for cancellation of the policy exercising option under Free-Look clause which allows a period of 15 days to the Insured from the date of receipt of the policy document to exercise his option to seek for cancellation of the policy in the event the policy conditions are found unsuitable to him. The Complainant has not availed of the benefit of this clause. Thus, the several papers filed by the O.P. would show that the Complainant had exercised his choice for Regular Premium with payment of premium on yearly mode. However the O.P is still agreeable to change the policy to single mode deposit premium if the Complainant would convey his willingness to accept such change in his policy.

While dismissing the Complaint ,it is directed that on submission of the consent letter by the Insured, the O.P. would do well to change mode of payment of deposit from Yearly to Single mode and issue a revised policy accordingly in favour of the Complainant. The Complaint is accordingly disposed of.

****

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 22-004-1315 Miscellaneous
Sri Thakur Ch. Nayak Vs ICICI Prudential Life Ins. Co. Ltd.
Date of Award : 22.06.2011

Fact: The Complaint is for refund of his premium amount on cancellation of his policy of insurance due to mis-sale.

The Complainant took a Life Stage Pension Advantage policy of insurance for a term of 30 years by paying Rs.2,00,000/- towards one-time premium deposit for the policy from the OP. The policy is made effective from 29.06.2010. Subsequent to the receipt of the policy documents by him, he found that the mode of payment of the premium of the policy has been changed from one-time deposit to yearly mode. Having thus got the knowledge of above change he contacted the Relationship Manager of the O.P. but he did not get any positive response from the O.P. Being thus aggrieved, he filed the Complaint seeking for relief as afore-mentioned.

The O.P. has stated that the Complainant applied to it in the Proposal Form which was filled up and signed by him, to take the product in question opting for a yearly premium. The policy documents was dispatched on 12.07.2010 to the Insured by post under certificate of posting. The Complainant did not exercise his option for cancellation of policy under Free-Look provision clause of the policy. But, after lapse of several months i.e., on 21.12.2010 the Complainant asked for refund of his premium. It is stated by the O.P. that as per the policy terms and conditions, the Complainant is not entitled to get the refund of premium at this stage, but as a gesture of goodwill, it has vide letter dated 27.12.2010 offered to the Complainant to change the product to single deposit premium mode on receipt of the consent letter to that effect from him. It has also issued a reminder to the petitioner on 10.01.2011 but no consent letter has yet been received by it. Denying the allegation of mis-sale, it finally asks for dismissal of the Complaint.

Award : A reading of the proposal form which undeniably is signed by the Complainant would go to show that as against item no. where particulars of plan applied for are mentioned, the 'tick' marks against the word "regular premium" and against the word "yearly" have been put. These marks would only signify that while applying for the policy of insurance, the applicant had opted for yearly premium. That apart, the clear contention of the O.P. that the policy documents were sent to the Complainant on 12.07.2010 is not disputed by the Complainant. The Complainant has not availed of the benefit of free look option. Thus, the several papers filed by the O.P. which are not disputed by the Complainant would show that the Complainant had exercised his choice for yearly premium. The allegation of fraud/ misrepresentation as raised by the Complainant is thus not substantiated. In the circumstances, the relief for refund of the deposited amount of premium on the ground of mis-sale is not available to be granted to the Complainant. However, the O.P is still agreeable to change the policy to single mode deposit premium if the Complainant would convey his willingness to accept such change in his policy. In the above premises, while dismissing the Complaint for failure of the Complainant to substantiate the allegation of fraud, it is directed that on submission of the consent letter by the Insured, the O.P. would do well to change mode of payment of deposit from Yearly to Single mode and issue a revised policy accordingly in favour of the Complainant.

****

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 24-009-1316 Miscellaneous
Sri Biren Kumar Mohanty Vs. Bajaj Allianz Life InsuranceCo. Ltd.
Date of Order: 12.07. 2011

Fact : The complaint is forfeiture of the entire premium deposit of Rs. 50,000/- made by him with the Insurer.

The Complainant had taken a unit-linked Capital Unit Gain policy of insurance with death benefit bearing policy no.0041992358 from the O.P. for a term of 15years commencing from 19.03.2007 on the sum assured of Rs.5,00,000/- paying the 1st annual premium of Rs.50,000/-. He gave next annual installment of the premium to the Agent who did not deposit but returned the amount to him. In 2010, he deposited the premium amount for two policy years amounting to Rs.1,00,000/- with the O.P. at its Rourkela Branch. along with the medical report. But raising the plea that medical report was adverse, the insurer refunded the above amount to him with the instructions to him to come after six months. Accordingly, in November, 2010 when he met the Manager of the above Branch of the O.P. he was informed that his policy had been foreclosed and the deposit of Rs.50,000/- made by him towards the first premium forfeited. Being dissatisfied with the above action of the O.P. he represented through e-mail to the O.P. on 30.10.2010 asking for refund of his deposited amount. Since the amount was not refunded, he filed this Complaint.

The O.P. that the Complainant did not pay the premium which became due on 19.03.2008. Consequently, the policy fell into lapsed status with consequent loss of all insurance covers with effect from 19.04.2008. The deposit of Rs.1,00,000/- given by the Complainant through Banker's Cheque dated 17.03.2010 towards annual premiums for 19.03.2008 and 19.03.2009 could not be accepted for revival of the policy as his medical examination report furnished by him in terms of the condition 5 (b) of the policy was found not satisfactory and the amount deposited by him was refunded. It is stated that the Complainant is not entitled to any relief as per the terms and conditions of the policy.

Award : As per his own showing in the Complaint, the deposit of the second annual premium was not made with the O.P. by the Complainant. The Complainant of the case has defaulted in payment of the regular premium from the second policy year. So, as per the terms of the policy nothing is payable to him out of the Capital Unit since the entire unit value of the first year premium would go towards surrender charges. In the circumstances, it was found that no illegality committed by the O.P. in foreclosing and forfeiting the premium deposit of the Complainant made for the first year of the policy. Therefore, the Complainant is not entitled to refund of the amount as is asked for by him. Hence, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 21-001-1325 Miscellaneous
Sri Bhagyadhar Behera Vs. Life Insurance Corporation of India
Date of Order :- 30.06.2011

Fact : Non-payment of the annuity equal to the sum fixed as annuity instalment by the Opposite Party-Insurer at monthly intervals.

The Complainant had taken a Jeevan Dhara policy of insurance with deferred participation in profit under Plan Table No-96 for a term of 21 years commencing from 28.12.1987 on payment of monthly premium of Rs.120/-. As specified in the policy, the date of vesting of the annuity was fixed to 28.12.2008 and annuity instalment payable is determined at Rs.10, 000/-. The Gross Insurance Value Element (for short 'GIVE' hereinafter) amount is fixed at Rs.1, 00,000/-. When the policy matured, instead of paying Rs.10,000/- per month towards annuity instalment, the O.P. sent him cheques for Rs.997/- as the monthly annuity amount. For such short payment when he made enquiry, it was explained to him by the O.P. that on the annuity amount of Rs.10, 000/- , the monthly instalment computes at Rs.997/-. Since determination of the annuity instalment payable at monthly intervals to him by the O.P @ Rs.997/- is contrary to the policy stipulations, he filed the Complaint praying for issue of a direction to the O.P. – Insurer to pay him the annuity instalment @ Rs.10,000/- at monthly interval with interest .

The O.P. stated that the annuity amount became due for payment from 28.12.2008. Accordingly, cheque for Rs.129/- in respect of the fraction period of the month i.e., from 28.12.2008 to 31.12.2008 and next cheques @ Rs.997/- per month from 01.01.2009 onwards were sent to the annuitant. It is further stated that at the point of time when the policy was taken, on the GIVE amount of Rs. 1,00,000/-, the rate of annuity payable on monthly mode was 10.025% per annum as per which the monthly pension worked out to Rs.832.52 paisa which was rounded up to Rs.833/-. But the above rate of annuity payable at monthly mode was enhanced to 12% per annum as per L.I.C. Circular No-1481/4 dated 17.05.1991 and accordingly the monthly pension on the GIVE amount of Rs.1,00,000/- of the Complainant has been revised to Rs. 997/- from Rs.833/-. It is further stated that the mention of the amount of Rs.10,000/- in the policy is the amount of annuity instalment payable yearly which fact was also reflected in the proposal form dated 29.12.1987 of the Complainant. Since the annuity pension is payable at monthly intervals, the total annuity amount due for the year has been divided into twelve parts in order to find out the extent of amount payable as monthly pension and such amount being found at Rs.997/-, the cheque for Rs.997/- has been issued towards monthly pension .

Award: A reading of the policy schedule would show that the amount of annuity instalment as was determined is Rs.10,000/- and the instalment of the annuity which the annuitant is to get on his policy is Rs.10,000/-. Annuity is a fixed sum of money paid to some person each year. In the policy schedule, as against the words 'Amount of annuity instalment' amount mentioned is Rs.10,000/. Mention of such fact makes it clear that the total amount payable towards annuity instalment per year is only Rs.10,000/-. If this amount is to be paid at monthly interval total payable sum would come to Rs.1,20,000/- which is much beyond the fixed annuity instalment of Rs. Rs.10,000/-, payable under the policy. A harmonious reading of the above two entries in the policy schedule would make the position clear that the amount of annuity payable to the annuitant is the sum of Rs.10,000/-. The above clauses do never mean that when monthly payment of the annuity is made, the full annuity amount payable per year is to be paid every month of the year. The annuity instalment being Rs.10,000/-, total amount to be received in a year by the annuitant is Rs.10,000/-. Therefore, payment of Rs.997/- at monthly intervals towards annuity cannot be held to be contrary to the policy features as reflected in the policy schedule. In the above view of the matter, the Complaint is not entitled to the same amount of annuity instalment at monthly intervals. Hence, the Complaint is dismissed.

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 25-008-1326 Miscellaneous
Sri NiranjanTripathy Vs. Kotak Mahindra OM Life Ins. Co. Ltd.
Date of Award : 28.06.2011

Fact : The Complaint is for refund of the premium amount paid by Complainant with interest.

It is stated by the Complainant deposited a sum of Rs 20000/- vide Receipt no-OT1238843 dated 20.04.2010 in OP's Branch for taking a Life Insurance product for Rs.20,000/-. After the lapse of some period when he did not receive the policy bond, he contacted the Branch Office of the O.P. again and again. But he was informed that the policy documents had been delivered to him through the Blue Dart courier which made over the same to one Soumya. Since no person bearing the name Soumya ever resided with him, he intimated the O.P.'s Branch office to have not received the policy papers and requested for issue the policy documents to him. But they did not co-operate with him and asked him to deposit Rs.500/- for taking a duplicate copy of policy of insurance. Being disgusted, he filed the Complaint for getting refund of the deposited amount of premium with interest.

The O.P. state the policy document was dispatched to him on 26.04.2010, in the same address as was furnished by him in the proposal form, through Blue Dart Courier vide AWB NO-44834117086 and the documents were received by one Ms. Soumya on 04.05.2010 as per the delivery statement submitted to it by the courier . It is further also stated that the policy documents which were sent to the Complainant had also not returned undelivered to it. It is stated that all sincere efforts were made to deliver the policy papers to the Complainant who, if has not got the same, could very well apply to take the duplicate copy of the policy document from it.

Award : The complainant had written a letter dated 26.11.2012 to the insurer at its Cuttack Branch duly acknowledged by Some Ashis where in he had intimated the O.P. about the non-receipt of the policy documents by him and also about the fact that no one having the name Soumya had stayed in his house. The policy was applied by the Complainant on 20.04.2010. e that the Complainant has paid Rs.20,000/- for the policy and has been approaching the O.P. since several months to get the policy documents. Taking all above facts into consideration, it becomes clear that the O.P. has not acted bonafidely in observance of good faith which the Complainant reposed on it with payment of the money for the policy. There is no dispute that the Complainant paid the premium value on 20.04.2010 and this amount has continued to lie since that date with the O.P. who has not supplied him the basic policy document. In the circumstances, the Complaint deserves to be allowed. Hence the Complaint is allowed. The O.P. is directed to refund the entire premium amount of Rs.20,000/- to the Complainant with 6% interest per annum from the date of deposit i.e. from 20.04.2010 till payment.

****

BHUBANESWAR OMBUDSMAN CENTRE
COMPLAINT NO- 25-008-1327 Miscellaneous
Smt. Geetashree Mishra Vs. Kotak Mahindra OM Life Ins. Co. Ltd.
Date of Award :- 29.06.2011

Fact : The Complaint is for refund of the premium amount paid by Complainant with interest.

It is stated by the Complainant deposited a sum of Rs 20000/- vide Receipt no-OT1238843 dated 20.04.2010in OP's Branch for taking a Life Insurance product for Rs.20,000/-. After the lapse of some period when he did not receive the policy bond, he contacted the Branch Office of the O.P. again and again. But he was informed that the policy documents had been delivered to him through the Blue Dart courier which made over the same to one Soumya. Since no person bearing the name Soumya ever resided with him, he intimated the O.P.'s Branch office to have not received the policy papers and requested for issue the policy documents to him. But they did not co-operate with him and asked him to deposit Rs.500/- for taking a duplicate copy of policy of insurance. Being disgusted, he filed the Complaint for getting refund of the deposited amount of premium with interest.

The O.P. state the policy document was dispatched to him on 26.04.2010, in the same address as was furnished by him in the proposal form, through Blue Dart Courier vide AWB NO- 44834118011 and the documents were received by one Ms. Soumya on 04.05.2010 as per the delivery statement submitted to it by the courier . It is further also stated that the policy documents which were sent to the Complainant had also not returned undelivered to it. It is stated that all sincere efforts were made to deliver the policy papers to the Complainant who, if has not got the same, could very well apply to take the duplicate copy of the policy document from it.

Award : The complainant had written a letter dated 26.11.2012 to the insurer at its Cuttack Branch duly acknowledged by Some Ashis where in he had intimated the O.P. about the non-receipt of the policy documents by him and also about the fact that no one having the name Soumya had stayed in his house. The policy was applied by the Complainant on 20.04.2010. e that the Complainant has paid Rs.20,000/- for the policy and has been approaching the O.P. since several months to get the policy documents. Taking all above facts into consideration, it becomes clear that the O.P. has not acted bonafidely in observance of good faith which the Complainant reposed on it with payment of the money for the policy. There is no dispute that the Complainant paid the premium value on 20.04.2010 and this amount has continued to lie since that date with the O.P. who has not supplied him the basic policy document. In the circumstances, the Complaint deserves to be allowed. Hence the Complaint is allowed. The O.P. is directed to refund the entire premium amount of Rs.20,000/- to the Complainant with 6% interest per annum from the date of deposit i.e. from 20.04.2010 till payment.

****

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 24-009-1344 Miscellaneous

Sri Ajaya Kumar Dalai Vs. Bajaj Life Ins. Co. Ltd.

Date of Order: 07.09. 2011

Fact: The Complaint is for short payment of Surrender Value on his Unit Linked Policy of Insurance to the extent of Rs.11, 118=91 paisa, by the Opposite Party.

The Complainant had taken a Unit Gain Plus policy of insurance from the O.P. bearing no-0015526575 on payment of Half-yearly premium of Rs.7,500/- with commencement from 28.01.2006. After payment of ten half-yearly installments of premiums in five years, on 26.10.2010 he opted for surrender of his policy whereupon he was told that the Surrender Value of his policy was Rs.1, 02,059.65.But he was paid Rs 90,940. Being aggrieved thereby, he filed the Complaint quantifying the amountof relief sought for by him at Rs.12,550/- .

The O.P. stated that premium due for January, 2007 paid vide Cheque No 520426 dated 03.01.2007by the the Insured for Rs.7,500/- was dishonored on 28.01.2007. It is further stated that when dishonor of the cheque occurred, no reversal action on the accumulated units could be done by reallocation of the units as per actual of premiums paid on account of systemic error. By taking the deposit of all ten half-yearly premiums to the account, on the basis of the NAV on 25.10.2010 Surrender Value was shown at Rs.1, 02,059=65 paisa though in fact the insured had actually made deposit of nine installments of the premium as per which Surrender Value was recalculated to Rs.90,940.74 and credited to the Bank Account of the insured as maintained with State Bank of India by him .

Award: From the materials as are made available by the parties, it bears out that the insured had actually made deposit of nine premiums. Thus, the contention of the Complainant that he had made deposit of all the ten premiums is not substantiated. It follows that the Complainant has made altogether 9 premium deposits .It is explained by the O.P. that the fund statement showing the Surrender Value of the policy of the insured at Rs.1, 02,059=65 paisa was issued taking into calculation premium deposits in respect of all ten installments. But, as later on it was found that the insured had actually paid only nine premiums, the calculation was accordingly recast and the Surrender Value was found at Rs.90,940.74 paisa. The Complainant does not dispute the correctness of the calculations made as above, first taking all ten premium deposits and then taking nine premium deposits into account. It has been found that the Complainant had in fact made deposit of nine premiums on his policy. In such circumstances, his entitlement to the Surrender Value is to be determined on the basis of nine such deposits of premiums made by him. As per the calculation, the units value of nine such premium deposits as made by the Insurer is Rs.90,940.74 paisa. It is stated by the O.P. that the above amount has been credited to the Bank Account of the Complainant. Therefore, no further amount is due to the insured towards the Surrender Value of his policy. Hence, the Complaint is dismissed.

****

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 21-001-1348 MISCELLANEOUS

Sri Pradeep Kumar Patra Vs. L.I.C. of india, Dhenkanal B.O.

Award Dated 26th September, 2011

FACT :- This complaint is filed against partial repudiation of health insurance claim.

It is the case of the Complainant that he had taken a Unit-Linked Health Plus

Policy from the O.P. for himself and for his wife with yearly premium of Rs.7500/- having Rs.800/- Initial Daily Hospital Cash Benefit(HCB) and of Rs.1,60,000/- for Major Surgical Benefit (MSB). The Policy commenced from 31.03.2008. He took treatment as an in-patient at Sparsh Hospital & Critical Care (P) Ltd., Bhubaneswar from 11.10.2010 to 16.10.2010 during which he underwent operation in his spinal region and incurred an expenditure of Rs.65,256/-. He lodged the medi-claim with the O.P. submitting the Cash Memo and other medical papers relating to his above treatment. But, the O.P. paid him only Rs.2640/- towards his claim disallowing the major portion of his medi-claim. Upon his personal contact, when the servicing Branch did not pay heed to his protest against such less payment, he has to file this Complaint seeking relief of payment of the balance amount.

In the counter, the O.P. has stated that the surgery undertaken by the Complainant, which was Central Laminatory Discetomy L-3, L-4 and L-5, is not one of the covered items of 49 specified surgeries listed in the schedule of Surgical Benefit Annexure of the policy. As per the Policy Conditions and Privileges , above surgery being not included in the list of payable items, no Major Surgical Benefit claim was payable for the same and accordingly MSB Claim of the Complainant was rejected. As regards, Daily Hospital Cash Benefit, it is stated that the period of hospitalization being for 5 days and the first 48 hours of hospitalization as per the policy conditions being not payable, HCB claim was allowed for 3 days. Since the policy had completed 2 policy years, as per policy conditions, increased amount @5% on the basic daily Cash Benefit computing thereby at Rs.880/- per day became payable. Hence, Rs.2640/- for 3 days of hospitalization has been allowed. It is stated that the settlement of the claim has been made in accordance with the policy conditions.

At the hearing, the Complainant submitted that the doctor of the hospital told him that spinal surgery which was done in him is one of the items of surgeries allowed under the policy. The O.P.'s representative submitted that for settling the claim of the Complainant, opinion of the TPA was taken who opined that the surgery undertaken by the Complainant is not a covered item under the policy for grant of MSB. She submits that as the TPA has not given its opinion in writing, it would take the opinion of the Divisional Medical Referee(DMR), a Doctor, in the matter and would furnish its report for perusal by this forum and on 14.09.2011, the DMR's opinion is received in this forum wherein the doctor has clearly opined that the surgery undertaken by the insured does not come within the list of surgeries made payable under the policy conditions.

AWARD :- Hon'ble Ombudsman observed that policy of insurance is a contract of insurance and rights and liabilities of the parties to the contract are to be determined on the basis of the terms and conditions of the policy and not otherwise. It is clearly stated by the DMR of the O.P. that the surgery undertaken by the insured does not come within the list of surgeries made payable under the policy conditions. No opinion of the doctor in writing is produced by the Complainant to substantiate his claim. There being no other material to the contrary, the opinion of the medical expert i.e. DMR of the O.P. has to be accepted. It would therefore follow that the surgery undertaken by the insured is not covered. As per the policy conditions, as regards HCB, no benefit is payable for first 48 hours of hospitalization. In the above premises, the Complainant is not entitled to any further amount other than what has been already paid to him.

Hence, Hon'ble Ombudsman dismissed the complaint.

BHUBANESWAR OMBUDSMAN CENTRE

COMPLAINT NO- 24-001-1376 MISCELLANEOUS

Sri Prafulla Ku. Pradhan Vs. L.I.C. of india, Sambalpur II B.O.

Award Dated 2nd August, 2011

FACT :- This complaint is filed against delay in settlement of disability claim.

It is the case of the Complainant that he had taken Asha Deep Policy of Insurance for a term of 20 years commencing from 28.11.1993 for a S.A of Rs.58,000/-. On 04.04.2004 he met with an accident while going on the motor-cycle and sustained bodily injuries. Gradually, there developed spinal cord problem for which he had to undergo two successive major operations in his Cervical and Lumbar regions at Christian Medical College Hospital, Vellore in the years 2005 and 2006. Even after undergoing the operations and prolonged physiotherapy, he was not fully cured and ultimately he became disabled. In his above treatment, he incurred an expenditure of more than Rs.5,00,000/-. The District Medical Board issued the Disability Certificate and he lodged disability benefit claim on 15.12.2009 with the O.P. enclosing his medical treatment papers and the disability certificate. Despite his several approaches, his claim is not settled.

In the counter, the O.P. has stated that the Complainant met with the accident on 04.04.2004 but his disability arose and the same was confirmed several years after the accident i.e., as on 16.10.2009. As per the policy condition vide clause 10 (a), no disability benefit is payable if such disability does not occur within 180 days of the accident. Further, as per the policy condition under clause 11 (a) and (b) which relate to category 'B' benefit, disease of Cervical Spondylitis for which operation was undertaken by the Complainant is not covered for the purpose of grant of benefit under the policy. On the above two reasons, the claim of the insured has been rejected by it and the fact of such rejection has been communicated to him on 30.06.2011.

At hearing, the Complainant submits that his disability is to the extent of 60%. He also submits to have not received the letter of rejection of his claim from the O.P. Finally, he asks for grant of disability benefit to him which as per the policy condition he is entitled to. On the other hand O.P.'s representative submits that the Cervical problem for which the claim was lodged by the Complainant did not occur due to the accident and that the Complainant does not suffer total i.e., 100% disability which alone is payable and that he has preferred his claim beyond the stipulated period of 180 days from the date of accident. Therefore, no claim is payable to the Complainant. Subsequent to the hearing, the Complainant submitted a letter stating that he became permanently disabled within three months after the accident and hence, he is entitled to the disability benefit.

AWARD :- Hon'ble Ombudsman observed that as per the policy conditions, the requirements to be satisfied for grant of disability benefit are that(1) the disability must result from the accident, (2) such disability must be total and permanent and (3) the disability arises within 180

days from the date of accident. The medical papers filed by the Complainant do not indicate that the spinal cord problem was in any manner linked to or arose out of the injuries during the accident. The disability certificate would show that the percentage of his disability is 60%. The medical papers do not show that within 180 days from the date of accident the present disability in the Complainant arose. Thus the Complainant is not entitled to any disability benefit. Hence, Hon'ble Ombudsman dismissed the Complaint.

******

CHENNAI

MISC

Complaint no-21.01.2675.

Mr Milap Chand Surana vs LIC Chennai.

The complainant had taken Asha Deep policy from LIC for a sum insured of rs2lakhs with a yearly premium of rs19,552/-from 28.07.2004.He stated that he had an Acute Myocardial Infarction on 21.08.2009 and later undergone CABG surgery on 25.09.2009.He lodged a claim under benefit B of the policy and his claim was rejected without mentioning any reason.He had revived the policy in Feb 2009 after undergoing various medical tests and also paid health extra premium.The insurer denied the claim on account of the fact that LA had history of hypertension for 6 years and DM for 5 years.The date of revival of the policy was 14.02.2009.LA had undergone CABG surgery on 25.09.2009 and contingency occurred within one year from the date of revival.Lien clause is applicable and hence the claim was repudiated for Benefit B as per policy condition.

Award no-IO(CHN)L-070/2010-11 dt 8thApril 2011.

The complainant had taken Asha Deep policy for a sum insured of rs2,00,000/- commencing from 28.07.2004.The policy provides two types of benefits-(A)Sum Assured with Vested bonus on Life Assured surviving to maturity date,(B)on the happening of any one of the contingencies mentioned in para 11(b)subject to conditions in Para (a)-immediate payment of 50%of SA, Balance 50%of SA on death or maturity and payment of an amount of 10%of SA every year and waiver of premiums. The contingencies referred are (i) LA undergoing Open Heart Bye Pass surgery (ii)LA undergoes Renal Dialysis or Renal Transplantation (iii)LA suffers from cancer and (iv) LA suffering from paralytic stroke.

The complainant underwent surgery for CABG on 25.09.2009 and has preferred a claim for benefit –B under the policy on 09.11.2009.Prior to undergoing the surgery for CABG, the LA had revived the policy under dispute which had lapsed for nonpayment of premium due since 7/2008 on 14.02.2009 by submitting a personal statement of health dated 31.12.2008 and a medical report dated 20 12 2008.LA was admitted to Apollo First Medical Hospital from 21.08.2009 to 25.08.2009 and at Apollo Hospital from 07.09.2009 to 09.09.2009 and was diagnosed for Coronary Artery disease. In the discharge summary it has been mentioned that patient is having history of diabetes mellitus for 5 years duration and history of Hyper tension for 6 years. He underwent surgery on 25.09.2009 and was discharged on 2.10.2009 which is within one year from the date of revival of the policy.

During the hearing the complainant had submitted that he has not been told the reason for rejecting the claim As per policy condition 11(a) and (b),a lien clause is applicable ,if any of the contingencies mentioned in para 11(b) occurs within a year from the date of commencement of

risk or from the date of revival. Though the insurer referred to non disclosure of diabetes and HT suffered by LA in the personal statement of health submitted for the revival of the policy which can make the revival void, the ground for repudiation as the one year lien clause effective from the date of revival.

The complaint is dismissed.

DELHI

MISC LI

Case No.LI-BK/132/10
In the matter of Shri Ravinder Singh Khinda
Vs
Life Insurance Corporation of India

AWARD dated 19.07.2011:- Cancellation of policy

1. This is a complaint filed by Shri Ravinder singh (herein after referred to as the complainant) against the decision of LIC of India (herein after referred to as respondent Insurance Company) for cancellation of policy.

2. Complainant stated that he had requested to cancel the policy within the free look period. He had submitted the letter to that fact on 26.12.09 through register post no. 3906-3907 to approach the manager of Anupgarh. He also approached the GRO. He submitted that the Ins. Co. had not stated the correct facts that policy document was send through Post Office by Register Post. The term s and conditions of the policy were not acceptable to him, therefore he had made request to cancel the policy. He has stated further that he cannot afford to pay the huge premium of the policy and requested this forum to get the policy cancel.

3. Representative of the company stated that policy documents were sent through register post no. 18477 on 20.11.09. The insured had applied for cancellation on 30.12.09; therefore such request was made beyond the free look period. He also filed letter dated 3.3.10 of the company informing the insured that request to cancel the policy was made beyond the free look period.

4. I have considered the submissions of the complainant as made in the complaint. I have also considered the submissions of the representative of the company. After due consideration of the matter, I hold that company was not justified in not cancelling the policy because insured requested to cancel the policy within the free look period. I have no reason to differ that the insured that he had submitted request on 26.12.09 within the free look period. There is no confidence placed on record by the Ins. Co. to the effect that

policy document was served on the insured it only state that the policy document was sent through register post on 290.11.09 under the circumstances. In my view I considered it the fair and reasonable to accept the request of the complainant to cancel the policy. Accordingly an Award is passed with a direction to the company to cancel the policy and refund the premium.

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

6. Copies of the Award to both the parties.

Case No.LI/257/ING Vysya/10

In the matter of Shri Harsh Sharma

Vs

ING Vysya Life Ins. Co. Ltd.

AWARD dated 19.07.2011:- Misselling of policy

1. This is a complaint filed by Shri Harsh Sharma (herein after referred to as the complainant) against the decision of ING Vysya Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to Misselling.

2. Complainant stated that he had taken a policy from Ins. Co. in Jaipur. He had not been issue the policy in accordance with the terms and conditions before taking the policy. He had approached the Ins. Co. within free look period for making amendments in the policy. The officer of the company continued to assure him that policy will be amended as per the terms promised to him but ultimately the officer left the company. He submits that the policy is not acceptable to him. He is a retired Sr. citizen and the policy was missold to him giving false promises. The company had not responded to his request. He had requested to this forum to resolve the issue. He did not attend the proceedings. He was contacted on phone and he stated that matter may be decided on merit as he was unable to attend the proceedings.

3. Representative of the company stated that it is not possible to cancel the policy as request was not made within the free look period. Company also filed written reply dated 31.08.2010 wherein allegations of misselling have been denied by the company. I have considered the submissions of the complainant as well as representative of the company. I also perused written reply dated 31.04.2010 of the company. After due consideration of the matter, I hold that policy has been missold to him and therefore the same deserves to be cancel. The complainant approached the officer of the company to make amendments in the policy within free look period but his request was not attended. **Accordingly an Award is passed with the direction to the Ins. Co. to cancel the policy and refund the premium to the complainant.**

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

5. Copies of the Award to both the parties.

Case No.LI-Aviva/365/10

In the matter of Shri Ashok Kumar Gupta

Vs

Aviva Life Ins. Co. Ltd.

AWARD dated 11.07.2011:- Misselling of policy

1. This is a complaint filed by Shri Ashok Kumar Gupta(herein after referred to as the complainant) against the decision of Aviva Life Ins. Co. (herein after referred to as respondent Insurance Company) for misselling.

2. Complainant submitted that he was given an Ins. Policy bearing no. LLG1242784 by Aviva Ins. Company. It is a Life Ins. Policy given to him against bank loan. He has taken house loan to be paid in 15 years but the policy was given to him for a term of 35 years. He requested the company to either refund the amount to him so far in the policy or pay him the current (N.A.V) but the company had denied the request. He had approached the company in number of times but he was not given any reply. He submitted further that issue of policy to him was a clear cut case of misselling of Life Ins. Policy against House Ins. There was mutual understanding between "Centurion Bank of Punjab" and "Aviva Ins. Co." for their personal interest. He meant to say that for securing housing loan, there was no requirement of taking the Ins. Policy. He had applied for a "House loan " with Centurion Bank of Punjab- Nagpur Branch and the bank officer asked him to sign documents for House Ins. as it was required by the bank to sanction the loan. He immediately inquired from the person when he saw the form that it look like personal Ins. ULIP, but the company officer ignored his observations and stated that it will work as a House Ins. Only and he is required to pay only for 3 years. He was not informed about the other terms of the policy. He did not receive the policy document even after 1 month.

Ultimately he collected the same from the bank office. He came to know that policy issued was not for House Ins. But it is a Life Ins. When he switched Home loan to P.N.B because the P.N.B required him for a separate House Insurance. When he approached the Ins. Co. he was informed that the policy term is 35 years and he would not receive the surrender value equal to the fund value. During the course of hearing, Complainant stated that policy was issued to him though it was not required. The Ins. Policy was issued in the garb House Ins. Policy.

3. Representative of the company defended the action of the company. He filed written reply on behalf of the company dated 29.06.2011. He stated further that the insured had not utilized free look period and had denied allegations of the complainant of misselling.

4. I have very carefully considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply dated 29.06.2011 of the company. After due consideration of the matter, I hold that Ins. Policy was missold to the insured, because he did not apply for the Ins. Policy. He had secured the House loan and for that there was no requirement of issue of Life Ins, policy. The policy has been issued to the insured stating that if would serve as housing insurance. He was issued Life Long policy without giving full details of the policy to him. As a matter fact the policy was thrust upon the insured. Thus policy missold to the insured deserves to be canceled. Accordingly an Award is passed with the direction to the Ins. Company to cancel the policy and refund the premium paid by him.

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

6. Copies of the Award to both the parties.

PLACE: NEW DELHI-110002 **(S.P.SINGH)**
DATE: 11.07.2011 **INSURANCE OMBUDSMAN**
(Delhi & Rajasthan)

Case No.LI-Bharti Axa/377/10

In the matter of Shri Shyam Bihari Goyal

Vs

Bharti Axa Life Ins. Co. Ltd.

AWARD dated 26.07.2011:- Cancellation of policy

1. This is a complaint filed by Shri Shyam Bihari Goyal (herein after referred to as the complainant) against the decision of Bharti Axa Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for cancellation of policies.

2. Complainant stated that direct sale agent of the company contacted him on phone several times in month of Feb, March 09, to sell the insurance policy while making proposals the agent afforded him a policy for term of 15 years and with the assurance that he would get 175% of the first year regular premium as guaranteed special addition on maturity. This was also informed telephonically by one Mr. Madan purported to be regional manager of the company on his assurance, he opted for 2 policies, in the name of his wife *(Smt. Beena Goel and his son Sourabh Goel). He received the policy bonds on 3.04.2009 form which he came to know that bond of 175% of the first year regular premium guarantee special addition on maturity was mentioned for policy term of 25 years. He returned both the policies to the company's branch office at Jaipur 08 april,2009 for free look cancellation and refund of the premium on 09.04.2009. Shri Nitin Gupta branch manager approached him personally at his residence and assured him that necessary correction would be carried out in the policy bonds to fetch him 175% of first year regular premium Guaranteed Special Addition on the maturity of the policy of 15 years term. Accordingly he drafted a letter to the company in his own hand writing expressing willingness to continuing the policy, he signed this letter on the condition that necessary changes would be made and policies would be revised. He did not receive the policy documents. Later on all policy documents were sent to him without making any correction with regard to Regular special Addition Clause.

He again approached the company for not doing the needful as desired by him and promised by the company branch manager. Therefore he sent the policy documents to the company through registered post on 12.07.2009. He approached this forum for settling his complaint by cancelling the policies. During the course of hearing complainant argued that company had not cancelled the policies for which he requested the company within the free look period, on the ground that desired policies were not issued to him. Therefore he applied for the cancellation.

3. Representative of the company defended the action of the company he also referred to the written reply dated 13.12.2010 of the company already on record. Wherein company denies the baseless allegations of the insured. Company had verified its record and found that it had received the letter from the complainant withdrawing the free look request for 2 policies.

4. I have considered the submissions of the complainant as well as representative of the company. I have also perused the written reply of the company. After due consideration of the matter, I hold that company was not justified in not accepting the request of the complainant to cancel both the policies because he put the request to cancel the policies within the free look period. The branch manager of the company Shri Nitin Gupta did not keep his promises of making corrections in the policies as desired by the insured as a condition to continue with the policies. He desired to have policies of 15 year term with 175%of the regular premium as Guaranteed Special Addition but again he was sent the old policies which he submitted for cancellation on April, 2009 without making any corrections. Therefore in my considered view both policies deserve to be cancel by the company. Accordingly an Award is passed with the direction to the Ins. Company to cancelled both the policies in the name of complainant‘s wife and in the name of complainant’s sun. Company shall also be liable to pay the penal interest @ 8% on the amount of premiums to be refunded from 01.05.2009 to the date of actual payment.

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

6. Copies of the Award to both the parties.

Case No.LI-MAX/465/10

In the matter of Smt. Leena Bhargava

Vs

Max New York Life Ins. Co. Ltd.

AWARD dated 21.07.2011:- refund of installments

Date of hearing: 30.06.2011
Present for the complainant: Shri Sandeep Bhargava, Husband
Present for the Insurance Company: Shri Akash Singh, Dept. Manager-OPS
Policy No: 00238701

1. This is a complaint filed by Smt. Leena Bhargava (herein after referred to as the complainant) against the decision of Max New York Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for refund of installment.

2. Complainant stated that she had taken Life Ins. Policy from Max Ins. Co. Ltd. on 20.12.2008. She paid first installment of Rs. 14999.56/- with a service tax. She paid premium for 2009 installment vide cheque no. 132495 dated 21.11.09 for an amount of Rs. 15215.89/- on 22nd sep, 2010. She received an SMS on her mobile that her policy lapsed due to non payment of premium, on enquiry she found that her cheque was bounced due to technical error. She again wrote to the company, she came to know latter on that cheque was bounced due to mistake of the company and the cheque is not traceable. Therefore after on 25.10.2010 she wrote to the company that she is not interested in continuing the policy and requested the company to refund the amount paid by her, but her request was returned down by the company. She stated that she had been harassed by the company officials and policy becomes lapsed due to the fault of the company. She requested this forum to help in this matter. During the course of hearing

complainant husband stated that second installment was paid through cheque and he got the receipt, later on it was informed that the cheque was bounced.

3. Representative of the company stated that policy cannot be cancelled. He also referred to the written reply dated 11.04.2011. Wherein it has been submitted that complaint made by the complainant is devoid of any merit and it deserves to be dismissed.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply dated 11.04.2011. After due consideration of the matter, I hold that policy became lapsed due to the failure of the company to receive the credit of the cheque given to the policy holder the cheque was not bounced due to any error on the part of the policy holder. To me it appears justified if the request of the complainant is accepted with regard to cancellation of the policy. Accordingly an Award is passed with a direction to the company to cancel the policy and refund the premium.

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

6. Copies of the Award to both the parties.

Case No.LI-Future/499/10

In the matter of Smt. Monu Devi

Vs

Future Genrali Life Ins. Co. Ltd.

AWARD dated 11.07.2011:- Double Accident Benefit

1. This is a complaint filed by Smt. Monu Devi (herein after referred to as the complainant) against the decision of Future Genrali Life Ins. Co. (herein after referred to as respondent Insurance Company) for double accidental claim.

2. Complainant stated that her husband late Shri Phool Chand Meena died on 19.6.2010 in road accident, he was insured. She has been paid a sum of Rs. 275,000/- vide demand draft no. 010361 dated 30.09.2010. She was paid only basic sum assured but since her husband died in road accident she is entitled to (D.A.B) equalent to the sum assured in the policy, But the Ins. Co. repudiated the (D.A.B). She has approached this forum for getting (D.A.B) paid by the insurance company. Complainant did not attend the hearing at Jaipur.

3. Representative of the company stated that (D.A.B) is not payable because (D.L.A) died while on duty. Written reply dated 07.02.2011 was also filed on behalf of the company. Wherein it has been stated that claim was rejected due to exclusion in the policy as per which in case there is accidental death to a police official during his duty as a police official, accidental rider is not payable. The company had already paid basic sum assured. He also referred to Article-24 of the policy terms and conditions for rejecting the claim.

4. I have duly considered the submissions of the complainant as well as the representative of the company. I also perused the written reply dated 07.02.2011 along with annexures of the company. After due consideration of matter, I hold that company was not justified in rejecting the claim of (D.A.B) because the (D.L.A) died in the road accident. Though the (D.L.A) was in police but the (D.A.B) cannot merely be denied on that account. As a matter of fact, he died in a road accident while on way to his actual place of duty.

(D.L.A) was a driver and was going along with other police officials on assigned duty but while on his way he had to stop due to road blockage due to standing of the truck and while standing, he was hit fatly by speeding jeep RJ 14-C 3867 and consequently died. In my considered view the answers given by the (D.L.A) to the questions as mentioned in "Arm Forces Questioners" at the time of proposal of the policy were not found false. Accordingly (D.A.B) is payable and Award is passed with a direction to the Ins. Co. to make the payment of (D.A.B).

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

6. Copies of the Award to both the parties.

Case No.LI-kotak/520/10

In the matter of Shri P.S Gyani

Vs

Kotak Mahindra Life Insurance Company

AWARD dated 01.08.2011:- Non Receipt of Policy Bond

1. This is a complaint filed by Shri P.S Gyani (herein after referred to as the complainant) against the Kotak Mahindra Life Ins. Co. (herein after referred to as respondent Insurance Company) for not receipt of policy bond. The brief facts of the case are as follows:

2. Complainant stats that he has saving bank account in Kotak Bank in GK-11 branch. Mr. Khan who was customer relationship manager and who used to visit him to promote various schemes on behalf of the bank in sep,08. He offered him to make an investment in Kotak Life Ins. Policy. He clearly stated to him that he retired from service and not capable of making any kind of investment. However he persuaded him to make one time investment and had taken a cheque bearing no. 0007 dated 21.10.2008. After reassuring him that it was only one time investment. He had not received the policy document but latter on he received premium lapse notice as per bank policy has been has been delivered at home address. However no proof of delivery was given to him. He had tried to take help from Branch Manager Chetan Kapoor but that was of no use to that. He says that he is a retired employee and cannot afford to pay Rs. 1 Lakh every year. He is already 64 years of age he had a Kidney Transplanted in 2004 and has to incur an expenditure on medicines. He also approached (GRO) of the company. During the course of hearing, he

submitted that he wanted to have a single premium policy whereas he had been issued a regular premium paying policy. He had not received the policy document so far.

3. Representative of the company stated that policy document was sent through courier. Policy was issued in Oct, 08 presently policy is lapsed on account of non-payment of premium. Complaint did not write to the insurer that he had not received the policy document written reply dated 27.1.2011 was filed wherein it has been stated that request for cancellation and refund was filed outside within a free look period and the same was rejected.

4. I have considered the submissions of the complainant as well as the representative of the company. I also perused the written reply of the company dated 27.1.2011. After due consideration of matter , I hold that the policy has been missold to the insured because where as he desired to have a single premium paying policy but he had been issued a regular premium paying policy (Term policy). He had already stated in the beginning before taking policy that he wanted to make one time investment as he is retired person and cannot afford to pay every year. Accordingly in my view policy was missold to him and deserves to be cancel led. Accordingly an Award is passed with a direction to the Ins. Co. to cancel the policy and refund the premium.

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

6. Copies of the Award to both the parties.

Case No.LI/338/SBI/10

In the matter of Shri M.S Hada

Vs

SBI Life Ins. Co. Ltd.

AWARD dated 01.08.2011:- Misselling of policy

1 This is a complaint filed by Shri M.S Hada (herein after referred to as the complainant) against the decision of SBI Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to Misselling.

2 Complainant stated that he is a retired Army officer and has been associated with State Bank of India since May 1974. Due to his long association with SBI, he had developed full faith in the banking system. At the time of retirement, he got retirement benefits and he wanted to invest it systematically and safely. Accordingly he chose to purchase SBI Life policy. This policy was proposed to him by the Area Manager SBI Life Ins. Co. Ltd. Shri Sharad Rastogi. The bank officer explained him the terms and conditions of the said policy as a single premium policy and not a regular premium policy. Having good faith on what he had been advised by the manager of the bank, he signed the required documents without reading. But later on when he came to know that he had been issued the regular premium paying policy, and then he approached the Operation Manager and also filed complaint with IRDA. He submitted that he is a retired person and cannot afford to pay a huge premium annually. He tried to get the solution from the Ins. Co. but he was replied that policy was issued according to the proposal signed by him. He submitted that such conditions were not explained to him at the time of signing proposal, it appears the policy was sold to him only with the motive to earn large commission. He has approached this forum to take corrective measures by changing the regular premium in to single premium policy or refund the amount. The insured had not attended the hearing, however he was contacted on phone and requested to decide the complaint on merits.

3 Representative of the company attended the hearing and argued that policy was issued on the basis of valid proposal. Complainant had not approached the company within free look period. Written reply was also filed on behalf of the company where in company had denied the allegations made in the complaint against the company. The policy holder had not approached the Ins. Co. within the free look period.

4 I have very carefully considered the submissions of the complainant as made in the complaint. I have also considered the verbal arguments of the representative of the company and considered the reply submitted by the complainant. After due consideration of the matter, I hold that policy has been missold to the complainant because the complainant wanted to invest in the single premium policy where as the regular premium paying policy was issued to him. He had paid a premium of Rs. 5,00,000/- and being a

retired person, he is not in a position to pay the huge premium every year for the term of the policy because he is a retired person and obtains annual pension of Rs. 3 lacs out of which it is not possible to pay the annual premium of Rs. 5, 00,000. Therefore it appears to me reasonable to hold that policy was missold to him and the same deserves to be cancelled. **Accordingly an Award is passed with the direction to the Ins. Co. to cancel the policy and refund the premium.**

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

6 Copies of the Award to both the parties.

Case No.LI/407/Reliance/10

In the matter of Smt. Heena Ben Shah

Vs

Relience Life Ins. Co. Ltd.

AWARD dated 01.08.2011:- Misselling of policy

1 This is a complaint filed by Smt. Heena Ben Shah (herein after referred to as the complainant) against the decision of Reliance Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to Misselling.

2 Complainant stated that she had taken a policy bearing no. 16949340 from Reliance Life Ins. Co. Ltd. she was informed that policy will be issued of 3 years term where as she desired a policy for 15 years term. She was also assured of medical benefits in the policy without any charge but when she received the policy bond it was found that what were stated to her were not in the policy. She was sold this policy by Chitra she had returned this policy at Jaipur in the office of Reliance Life Ins. Co. Ltd. and requested for return of the amount. She was informed by Chitra on phone that she would not get her refund. She found that she had been cheated by Chitra while issuing this policy. She received the policy bond in month of June 2010 which she also returned on 1 July, 2010 for

cancellation. She was informed that she would get the amount within 10 days but it remained a false promise. She was informed that she would not get the money as she had not requested within free look period. She has approached this forum for get her money paid. During the course of hearing husband of the complainant argued that she requested to cancel the policy on 01.07.2010 and the policy documents was received on 25.06.2010 but the company had not cancelled the policy.

3 Representative of the company stated that complainant had not mentioned correctly the policy no. in the request to cancel the policy. Company also filed written reply dated 13.12.2010 where in it has been stated that complainant had not given the policy no. correctly. The policy no. which she had given appears to belong to other customer. Company also directed to give a correct policy no. so that company give some solution.

4 I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company. After due consideration of the matter, I hold that company was not justified in not acting upon the request of the complainant to cancel the policy within the free look period. I have no reason to not to believe the version of the complainant that she had received the policy documents on 25.06.2010 and applied for cancellation of the policy on 01.07.2010. Thus she made the request to cancel the policy within the free look period. **Accordingly an Award is passed to direct the Ins. Company to cancel the policy bearing no. 16949340 and refund the premium.**

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

6 Copies of the Award to both the parties.

Case No.LI/521/Kotak/10

In the matter of Shri Roshan Lal

Vs

Kotak Mahindra Life Ins. Co. Ltd.

AWARD dated 01.08.2011:- Misselling of policy

1 This is a complaint filed by Shri Roshan Lal (herein after referred to as the complainant) against the decision of Kotak Mahindra Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to Misselling.

2 Complainant stated that he wanted a policy to be issued in his name but the policy was issued in the name of his grandson. Thus policy was missold to him. He further submitted that he approached the company within free look period. He submitted further that he wanted his grandson to be nominee in the policy where as the same ought to have been issued in his name. He requested this forum to get the policy cancelled and refund the amount paid by him.

3 Representative of the company stated that policy was issued on the basis of valid proposal duly signed by the complainant. Company also filed written reply dated 08.02.2011 wherein it has been stated that there were no false commitments on behalf of the company and company acted diligently and desired the complaint to be dismissed.

4 I have considered the submissions of the complainant as well as the representative of the company. I have also perused the written reply of the company. After due consideration of the matter, I hold that policy had been missold to the complainant because complainant wanted the policy to be issued in his name where as the policy was issued in the name of his grandson. Therefore this policy deserves to be cancelled as per request of the complainant. **Accordingly an award is passed with the direction to the Ins. Co. to cancel the policy and refund the premium.**

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

6 Copies of the Award to both the parties.

Case No.LI-Bharti/605/10

In the matter of Shri Yogesh Kumar Kamani

Vs

Bharti AXA Life Ins. Co. Ltd.

AWARD dated 02.08.2011:- Misselling of policy

1. This is a complaint filed by Shri. Yogesh Kumar Kamani (herein after referred to as the complainant) against the decision of Bharti AXA Life Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for misselling.

2. Complainant stated that he received policy no. 500-6576408 through courier dated 26.11.2010. The policy has been missold to him by Delhi Office. He received a call from Ms. Pooja Saxena for bonus of Rs. 88,000/- and for when he was to deposit Rs. 25,000/- against the security and such security is refundable within 1 year. This fact was also confirmed by Ms. Arti Malhotra, similar promises were made by Ms. Neha Sharma. Again he received the call from N.K. Aggarwal for giving him PDC cheque of Rs. 35,000/- against Rs. 55,000/- bonus. He knew all facts about his policy. During the course of hearing complainant stated that policy was missold to him and wants to get this policy cancelled and refund of the premium.

3. Representative of the company stated that policy was issued on the basis of proposal given by the insured. He filed reply of the company dated 20.05.2011 where in company had denied each and every allegations made by the complainant. It is further stated that the complainant has availed the benefits, services of the company and covered in the premium. Therefore at this stage policy cannot be cancelled.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply dated 20.05.2011. After due consideration of the matter, I hold that policy has been missold to the complainant under false premises. Therefore it was a cheating and such policy deserves to be cancelled. **Accordingly an Award is passed with the direction to the Ins. Co. to cancel the policy no. 500-6576408 and refund the premium.**

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

6. Copies of the Award to both the parties.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 21/009/109/L/10-11/Ghy

Mr. Parag Das

- Vs -

Bajaj Allianz Life Insurance Co. Ltd.

Date of Order : 20.09.2011

Complainant : The Complainant stated that he procured an insurance policy "Bajaj Allianz Family CareFirst" bearing policy No. 0104713481 from Bajaj Allianz Life Insurance Co. Ltd. with the date of commencement on 28.07.2008 for a Basic Sum Assured of Rs.2.00 Lacs. While the policy was in force, the Insured Parag Das was admitted in G.N.R.C. Hospital, Guwahati on 13.08.2009 for treatment of "Acute Lumbar Prolapsed Intravertebral Disc" wherefrom he was discharged on 16.08.2009 which was developed for last 15 days. During hospitalization, an operation was done for Lumbar D.I.V.D.. On completion of usual treatments, a claim was lodged under the policy seeking reimbursement of an amount of Rs.83,209/- which was supported by relevant documents. But the Insurer has repudiated the claim stating that the disease on which the Insured was treated was pre-existing. Being highly aggrieved, the policyholder filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that the Life Assured Mr. Parag Das was hospitalized for Prolapsed Intervertebral Disc and has undergone diskectomy. He is suffering from low back-ache on and off since 12 years. The Insurer has repudiated the claim on the ground that the complaints related to the illness are pre-existing to the policy and also expenses for diskectomy has a waiting period of 4 years in the Policy.

Decision : I have carefully scrutinized the entire materials on record including the statements of the parties. The claim of the Complainant has been repudiated by the Insurer stating that the Insured had pre-existing disease. According to the Complainant, the disease for which he was operated upon occurred after taking the policy and was not pre-existing. The Complainant has relied upon the certificate issued by the operating Surgeon Dr. Navanil Barua. Though the Case History in the Discharge Summary shows

that the policy holder Parag Das was brought to GNRC with complaint of low back ache on and off since 12 years which has increased for 15 days prior to hospitalization, the operating Surgeon, in Care First Claim Form, mentioned the date of First Consultation as "27.07.2009". In the said form, the operating Surgeon also mentioned the previous medical history of the patient as "Not Significant". In Question No. 6, "Is the ailment a complication of a pre-existing disease or condition?" The Surgeon answered in the negative. This makes it clear that the ailment of Lumbar D.I.V.D. is not a complaint of pre-existing disease. In the certificate issued by Dr. Navanil Barua, Chief Consultant, GNRC Hospital, Guwahati. The operating Surgeon has categorically mentioned that Mr. Parag Das was operated by him for "Acute Lumbar Prolapsed Intravertebral Disc" and it has been wrongly recorded as suffering for 12 years of back pain due to typographical errors. The Surgeon also mentioned in the certificate that Disc Prolapsed is acute and clinically it is impossible to survive for 12 years with such severe symptoms caused by a disc prolapsed of 12 years duration. He also categorically mentioned in the certificate that it is not a pre-existing disease of 12 years duration. The certificate of Neurosurgeon from GNRC Hospital, Guwahati makes it ample clear that the policy holder Parag Das was hospitalized in GNRC Hospital and was operated for "Acute Lumbar Prolapsed Intravertebral Disc" which was not a pre-existing disease.

Considering all aspects of the matter as discussed above, I have absolutely no hesitation to hold that the decision of the Insurer repudiating the claim of the Complainant is not justified. Hence, the complaint is allowed. Insurer is accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the settled amount.

KOLKATA

AWARD IN THE MATTER OF

Smt. Anamika Mishra
AND
ICICI Prudential Life Insurance Co. Ltd.

Date of Award – 13th April, 2011

Complaint No.	:	1009/21/004/l/12/2010-11
Nature of Complaint	:	Repudiation of Health Insurance Claim
Category under RPG Rules 1998	:	12 (1) (b)
Date of Hearing	:	08.04.2011

Facts and Submission :-

1. **Complainant :-**

Smt. Anamika Mishra is the complainant and the Life Assured of the abovementioned ICICI Policy No. 06009328. She stated in her complaint that she had purchased a health policy of SA 1,50,000/- for Critical Illness cover for 20 years in the year 2007 on 30th August.

She felt uneasy and was admitted at Apollo Gleneagles Hospital, Kolkata on 14.02.2010 and discharged on 16.03.2010. The diagnosis was "Subarachnoid hemorrhage". The reason for admission was sudden onset of Headache followed by drowsiness on 14.02.2010. A CT Scan on brain was done at the hospital and various treatments were done as per discharged summary. She was discharged from the hospital on 16.03.2010 and submitted her health claim bills to the insurance company on 31.03.2010. The insurer after verifying the bills denied to pay the claims due to the fact that she did not suffer from "stroke" as defined in the policy terms and conditions. The complainant further submitted a representation to the insurer. But the insurer in their letter dated 01.11.2010 informed the complainant that they uphold their earlier decision. So finding no other alternative the complainant lodged the complaint along with 'P' form and unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 08/04/2011. The complainant attended and stated before this forum that she was issued an insurance policy covering critical illness for a sum of Rs.1.50 lakh. She had suffered a brain haemorrhage which is covered under the policy terms and conditions. However, her claim was repudiated by the insurer on flimsy and arbitrary ground. She further, stated that claim for similar ailments were granted to her by HDFC Standard Life Insurance and National Insurance Company.

The representative of the insurance company on the other hand defended the repudiation of the claim on the ground that the LA did not suffer any permanent neurological deficit which was a pre-requisite condition under clause 2(c) of the policy terms and condition. He further stated that they have taken the opinion of an independent specialist Dr. C.H. Asrani who has opined that the LA's clinical course from 14/02/2010 onwards confirms that she satisfies two of

the three conditions for eligibility under the policy documents. She had haemorrhage and infarction of brain tissue which met the two criteria of the stroke as given in Clause 2(c) of the policy terms and condition.

3. **Decision** :

We have heard both the parties and examined the documents and medical records produced before this forum. We have also perused the policy condition 2(c) which defines the terms "stroke" as under :

"*Any cerebrovascular incident resulting in permanent neurological deficit and including infarction of brain tissue. Haemorrhage and embolisation from an extra cranial course. Diagnosis has to be confirmed by a neurologist and by typical symptoms and CT scan or MRI of the brain. Evidence of neurological deficit for atleast 3 months has to be produced*."

The contention of the insurer is that the LA did not suffer any permanent neurological deficit, which is a pre-requisite condition under Clause 2(c) of the policy terms and condition. The insurer has submitted an opinion from Dr. C.H. Asrani vide his certificate dtd.07/04/2011 which says that the LA's clinical course confirms to two of the three variables of the policy documents and it does not confirm the third variable i.e. permanent neurological deficit that should last for atleast three months. On the other hand the treating doctor is of opinion that the patient had suffered a severe subarachnoid haemmorhage from a raptured anterior communicating artery aneurysm. She underwent microsurgical clipping and had a very stomy course in ICU due to the severity of the bleeding. The patient's condition was so serious that she nearly died from severe brain haemorrhage, whom the doctors managed to save with a good functional result and therefore the insurer cannot deny the claim showing that her condition was not serious enough. This advice of the treating doctor showing the severity and critical nature of the ailment has not been appreciated by the insurer in the right spirit. They have repudiated the claim on a very technical ground based on the opinion of an independent specialist, but while doing so, the treating surgeon's opinion regarding the severity of the problem was not considered by them.

We are of the opinion that technically the patient's conditions did not confirm all the three conditions of the stroke but she definitely had a severe brain haemorrhage which could

have been fatal. Considering her critical condition as certified by the treating surgeon the total repudiation is definitely not justified in this case. It is also seen that two other insurers have settled her claim in her favour.

After careful evaluation of all the facts and circumstances of the case we allow an ex-gratia payment of Rs.30,000/- purely on humanitarian ground. The insurer is directed to make the payment within 15 days of the receipt of the order along with the consent letter from the complainant.

AWARD IN THE MATTER OF

Shri Netai Kumar Mukherjee,
AND
Life Insurance Corporation of India

Date of Award – 13th April, 2011

Complaint No.	:	1110/24/001/L/01/2010-11.
Nature of Complaint	:	Non-receipt of pension.
Category under RPG Rules, 1998.	:	12 (1) (e) [wrongly admitted under Rule 12(1)(f)]
Date of hearing	:	27th June, 2011.

Facts and Submissions:-

1. **Complainant**:-

Shri Netai Kumar Mukherjee is the complainant and Life Assured of the above policy. He stated that he had purchased a Jeevan Akshya policy and initially he had been receiving his annuity cheques regularly. Subsequently, a new Zonal Office came in Bihar and his policy was transferred to the new Zone at Patna without his consent. Since then the annuity cheques were stopped. After several correspondences made with the ECZO, the complainant received the annuity cheques covering the period from May, 2009 to April, 2011 i.e. total 24 cheques on Axis Bank which were not at par. Since, there is no branch of Axis Bank at Panagarh, he had to deposit 15 cheques in the Oriental Bank of Commerce who deducted Rs.51/= per cheque i.e.

total (Rs.51 x 15) Rs.765/= (Rupees seven hundred sixty-five) as collection charges. He requested the insurer, by his letter dated 14th September, 2010, to issue 'at par' cheques on State Bank of India or to credit the pension amount directly to his S.B.I. account in Panagrah Bazar Branch to avoid collection charges. He also returned 9 cheques out of 24 for the period 1st August, 2010 to 1st April, 2011. But the insurer sent him back 2 cheques on Axis Bank for annuity payable for the month of July, 2010 and August, 2010. Being dissatisfied with the decision of the insurer, the complainant approached this Forum and submitted 'P' Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 27/06/2011. The insurer did not send their representative, but submitted their written submissions stating that they have reimbursed Rs.867/- towards collection charges for 17 cheques issued by them. As regards issuance of 12 monthly pension cheques payable from 01.05.2009 to 01.04.2010, the same were promptly issued on 23.03.2010 on compliance of the requirements of existence certificate on 19/03/2010 by the complainant. So there is no delay on the part of the insurer in paying the pension. The complainant however, requested for interest for delay in payment of the yearly premium. According to him, the existence certificate was submitted in time but the matter was delayed by the bank.

3. **Decision** :

We have heard the submissions of the complainant and perused the written submissions of the insurer. The complaint regarding collection charges has been resolved by the insurer as they have sent a cheque for Rs.867/- on 21.06.2011. As regards the interest for delay in paying the pension from 01.05.2009 to 01.04.2010, the insurer has explained the reasons but considering the fact that the existence certificate was given by the complainant (senior citizen) in time, we direct the insurer to allow the interest for late payment of the pension for these periods purely on ex-gratia basis.

AWARD IN THE MATTER OF

Shri Jayanta Ghosh
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award - 27th May, 2011

Complaint No.	:	1205/22/009/L/02/2010-11.
Nature of Complaint	:	Refund of Premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	25.05.2011

Facts and Submissions:-

1. **Complainant**:-

The complainant purchased a policy under "Unit Gain Plus Gold" Plan from the above insurer and received the policy bond on 1st February, 2008. After receiving the same, he observed that the terms and conditions of the policy were totally different from what was explained to him at the time of taking the policy. He, therefore, submitted an application on 12th February, 2008 (within free look period) to the insurer for cancellation of the policy and refund of premium of Rs.30,000/= (Rupees thirty thousand). At the time of follow-up with the insurer in this regard, he was assured that he would get Rs.46,000/= (Rupees forty-six thousand) after 3 years, without paying any further premium. As a result, he remained silent for next 3 years. After 3 years, he approached the insurer on 25th January, 2011 for refund of his premium of Rs.30,000/= (Rupees thirty thousand) along with interest. The insurer, in turn, sent a cheque for Rs.7,735/= (Rupees seven thousand seven hundred and thirty-five) to him on 7th February, 2011 after foreclosing his policy. However, he has not encashed the said cheque. Instead, he approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer :-**

The insurer has admitted in their SCN that they have received an application on 12th February, 2008 from the complainant for free look cancellation of the policy. But they mentioned that their sales person convinced the complainant for paying further premiums to enjoy the benefits of the policy and the complainant agreed to continue the policy. After that, the policy bond was returned to the complainant. They further mentioned that since premiums were not received by them in the 2nd and 3rd policy year, they dispatched a cheque for Rs.7,735/= (Rupees seven thousand seven hundred and thirty-five) on 31st January, 2011 after taking foreclosure action of the policy.

3. **Hearing** :

Both the parties were attended hearing on 25/05/2011. The complainant explained the grounds of his complaint and produced the evidence to show that he had submitted an application within the free look period on 12/02/2008 for cancellation of policy and refund the premium of Rs.30,000/-. He denied that he had ever agreed to the proposal of the insurer to pay further premium to enjoy the benefit of the policy and approached them for payment only after the revival period.

The representative of the insurance company, on the other hand, reiterated their stand as mentioned in their SCN dt.20.05.2011 wherein they have admitted that they have received an application for free look cancellation on 12/02/2008. However, their sales person persuaded the complaint to continue the policy for enjoying the benefits under the policy. They also stated that the complainant had agreed to their proposal to continue the policy. However, they could not produce any evidence to show that the complainant had agreed to their proposal and withdrawn the application for cancellation of the policy.

4. **Decision** :

We have heard both the parties and perused their written submissions. There is no dispute about the fact that complainant had submitted an application on 12.02.2008 within the free look cancellation period and requested for cancellation of the policy and refund of the premium. But insurer has no evidence to show that policy holder had consented to the proposal of the sales person to revive the policy by paying further premium. Therefore, the foreclosure action taken by the insurer is not justified.

We are therefore, of the opinion that the complainant's request for cancellation of the policy was received by the insurer within free look cancellation period and the same is to be accepted by the insurer. We, therefore, set aside the decision of the insurer and direct them to cancel the policy and refund the premium of Rs.30, 000/- along with interest due as company's policy.

The complaint is allowed.

AWARD IN THE MATTER OF

Smt. Aparna Moitra
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award - 27th May, 2011

Complaint No.	:	1237/22/009/L/03/2010-11.
Nature of Complaint	:	Dispute with premium
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	25.05.2011

Facts and Submissions:-

1. **Complainant**:-

The complainant purchased a Unit Linked Policy from the above insurer in the month of February, 2005. After paying 3 yearly premiums, she applied for surrender of the said policy in the month of September, 2010 with all necessary documents. She stated that she is holding all the yearly premium receipts as also the insurer's annual statement in respect of her policy. She alleged that after lapse of 5 years, the insurer is demanding bank statement in respect of the 1st premium paid by her on 8th February, 2005. She approached her banker for the same but they expressed their inability to supply such old bank statement since their whole process was computerized from last one and a half years. She mentioned that her Pass Book was also not

traceable after 5 years. She further alleged that if the cheque had bounced after payment of 1st premium, the same would have been returned to the insurer and in turn, her policy would have been cancelled. But nothing was heard. So, she approached this Forum and submitted 'P' Forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer :-**

The insurer mentioned in their SCN that after receiving the request for surrender of the policy, the process was initiated in the year 2008. During the process, a technical error was detected by them due to CDA against the policy. No further comment as well as any documentary evidence was found in the SCN.

3. **Hearing** :

Both the parties were called for a hearing on 25/05/2011. The complainant did not attend the hearing, so we propose to deal with the matter on the basis of her written submissions and other documents available on file. The representative of the insurance company attended and stated that they have taken a decision to allow the claim and refund the premium amount at the NAV prevailing at that point of time.

4. **Decision** :

Since the insurer has decided to refund the amount, no further action is called for. The insurer is directed to make the payment within 15 days on receiving the consent of the complainant. Interest as per company's policy for delayed payment is also to be paid to the policyholder.

The complaint is allowed.

AWARD IN THE MATTER OF

Capt. Vijay Kumar Sharma
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award – 27th May, 2011

Complaint No.	:	1296/22/009/L/03/2010-11.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	25.05.2011

Facts and Submissions:-

1. **Complainant**

Capt. Vijay Kumar Sharma is the complainant and Life Assured (LA) of the above policy. He stated that he purchased one policy from Bajaj Allianz Life Insurance Company Limited and paid two premiums in due time and the 3rd premium also was paid after due date with late fine on 14th December, 2004. But on 1st January, 2005, the complainant received a default intimation from the insurer wherein it was stated that the policy was in lapsed condition for non-payment of 3rd premium. After receiving the default intimation, the complainant sent several emails to the insurer stating that the 3rd premium was due on September, 2004 and the same was paid by him on 14th December, 2004 also the status of the policy is up-to-date. As proof of evidence, he also sent Bank Statement and Xerox copy of the premium cheque to the insurer. The insurer vide their email confessed that due to irregularity of the bank, the 3rd premium cheque was not encashed in due time. Now the 3rd premium was received by them. Since four years have elapsed due to exchange of various calls, emails etc., the policy was in lapsed condition purely due to the fault on the part of the insurer. In this situation, the insurer sent one email on 27th November, 2008 to the policyholder stating their willingness to refund a sum of Rs.1,01,226/= (Rupees one lakh one thousand two hundred and twenty-six) after cancellation of the policy. The details are as "cancellation of the policy from inception and refund his complete premium back to him i.e. Rs.78,609 for 3 years premium @ Rs.26,203/= + average interest cost (over last 4 years) of 6% per annum which works out to Rs.1,01,226/=". But thereafter, no positive response was received from the insurer pursuant to the above email dated 27th November, 2008. On the other hand, the insurer sent another email dated 6th October, 2010 stating therein that since the policy is in lapsed condition, an amount of Rs.41,649.39

(Rupees forty-one thousand six hundred forty-nine and Paise thirty-nine) is payable towards surrender value. On receiving this email, the complainant became puzzled and further sent one email to the insurer for granting an amount of Rs.1,01,226/- towards cancellation of the policy as agreed by them vide their email dated 27th November, 2008 but no response is received as yet. Finding no other alternative, the complainant approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 25/05/2011. The complainant did not attend the hearing so we propose to deal with the matter on ex-parte basis for him. The representative of the insurance company explained that the policy was issued based on the proposal form filed and signed by the policyholder, where he had opted for a regular mode and yearly frequency. As per their investigation, they have found that the cheque was deposited in the drop box on 14/12/2004 but due to delay on the part of the bank, the same was credited to the insurer's account much later. They informed him that they were ready to revive the policy on payment of the premiums after waiving of the interest for late payment. However, the policyholder was not satisfied and he had demanded vide his letter dtd.16/09/2010 the surrender value of the policy and accordingly they have paid him Rs.41,649.39 on 06.10.2010. The insurer has also admitted that they had offered him vide their e-mail dtd.27/11/2008 to refund total premium of Rs.78,609/- + average interest cost for 4 years @ 6% p.a. which works out Rs.1,01,226/-. However, they did not receive the consent of the policyholder and therefore, the offer of Rs.1, 01,226/- was not made. After remaining silent for over two years, the policyholder has again requested for the surrender value of the policy and compensation for the services. In reply to his request they have informed him that he can receive Rs.41,649.39 as a surrender value.

3. **Decision** :

We have heard the submission of the insurer and perused the written submissions of the policyholder and also examined the documents and other evidences filed by both the parties before this forum. There is no dispute about the fact that the 3rd premium cheque was deposited by the policyholder in time. The delay in adjustment of the premium is mainly due to the service deficiency on the part of the bank/the insurer. They failed to adjust the 3rd premium due to their

own fault which has been admitted by them and accordingly they adjusted the premium and revived the policy without charging any interest. Meanwhile, due to the inordinate delay in taking a decision, three more premiums have become due and it may be difficult for the policyholder to pay the pending premiums in a lump sum to revive this policy. He has therefore, requested for refund of the premiums paid by him along with interest for late payment, which comes to Rs.1,01,226/- as offered by the insurer themselves in their mail dtd.23.11.2008. However, we have also noted that the policyholder also did not give his consent to the offer of the insurer for payment of Rs.1,01,226/- towards cancellation of the policy. From the copies of the mail filed by him we find that he has nowhere written that he is not interested in continuing the policy and he has also not given any reason for not accepting the offer for payment of Rs.1,01,226/- given by the insurer. He kept silent for two years after receiving the offer from the insurer and then he requested for this amount.

Thus after evaluation of all the facts and circumstances of the case, we are of the opinion that there were lapses on the part of both the parties in arriving at a mutual agreement. The insurer's decision to give him only the surrender value of Rs.41,649.39 against the promised sum of Rs.1,01,226/- is not justified. On the other hand, the complainant's demand for interest and compensation is also not justified since he did not take timely action in accepting the proposal of the insurer. We therefore, set aside the judgment of the insurer and direct them to refund the total amount of premium of Rs.78,609/- without any interest within 15 days after receiving the consent from the complainant.

The complaint is partly allowed.

AWARD IN THE MATTER OF

Shri Shuk Nath Das
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award - 30th May, 2011

Complaint No. : 1199/22/009/L/02/2010-11.

Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	25.05.2011

Facts and Submissions:-

1. **Complainant**

Shri Shuk Nath Das is the complainant and Life Assured (LA) of the above policy. He stated that he purchased one policy under single premium mode of Rs.5,873/= (Rupees five thousand eight hundred and seventy-three) from the insurer on 28th March, 2010 but did not get the policy document or receipt of premium paid from the insurer for a period of 5-6 months inspite of repeatedly requesting the agent to arrange for the same. Ultimately, after collecting the address of the insurer, he met the officials who advised him to apply for policy bond along with deposit of Rs.251/= (Rupees two hundred and fiftyone) towards bond issue charge. Accordingly, he applied for the same and deposited a sum of Rs.251/= with the insurer on 25th October, 2010 along with Indemnity Bond. After that, he received the policy bond on 1st December, 2010. On going through the policy bond, he found that the policy was issued on yearly premium of Rs.5,873/= for 10 years instead of single premium of Rs.5,873/= as desired by him. Moreover, the insurer has taken Rs.6,000/= as first premium when the premium value is Rs.5,873/= which is not understandable to the policyholder. Immediately he applied for free look cancellation on 3rd December, 2010 i.e. within 15 days to the insurer. But the insurer replied on 27th January, 2011 to the policyholder informing that free look cancellation is not possible in case of submission of duplicate policy bond though there is no such mention in the terms and conditions of the policy bond as per the version of the policyholder. Finding no other alternative, the complainant approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 25/05/2011. The complainant attended and submitted before this forum that he purchased a policy no.0163378494 with premium of

Rs.5873/- from Bajaj Allianz Life Insurance Co. Ltd. However, he had paid Rs.6000/- by cheque for the above policy but he did not receive the policy bond/receipt for 5 to 6 months and on his complaint they issued a duplicate policy bond on payment of Rs.251/- along with indemnity bond. The policy papers were received by him on 01/12/2010. He also produced the proof of delivery and copy of the letter for cancellation of the policy dtd.03.12.2010 submitted to the insurer.

The representative of the insurance company on the other hand stated that the original policy bond was dispatched on 09/03/2010 by speed post RL No.EW6218772931N which was not returned to them undelivered. However, on receiving the complaint from the policyholder they issued a duplicate policy bond on 22/11/2010 through speed post which was delivered to the policyholder. They further stated that they received the request from the policyholder for free look cancellation on 19/01/2011. As it was received beyond free look period they could not cancel the policy. However, they could not produce any proof of delivery in respect of their original policy bond.

3. **Decision** :

We have heard both the parties and considered the documentary evidences filed by them before this forum. It is clear that the policyholder received duplicate policy bond on 01/12/2010 and he submitted his letter requesting for cancellation of the policy and refund of premium on 03/12/2010 as he found that the policy terms were not suitable for him. The complainant has produced the proof of delivery as well as the copy of the letter dtd.03/12/2010 which was duly received by the insurer. It is therefore, not clear how the insurer mentioned that they received the request for cancellation on 19/01/2011. As regards the original policy bond, since the insurer could not produce the POD, we give the benefit of doubt to the policyholder and direct the insurance company to allow the free look cancellation period in respect of the duplicate policy since the original policy was never received by the policyholder. As the policyholder made a request for cancellation of the policy within 15 days from the receipt of the duplicate policy bond (to be treated as original bond), the insurer has to accept the request and act accordingly. They are further directed to make the refund the full amount of the premium i.e. Rs.6000/- paid by the policyholder within 15 days from the date of receiving the order along with the consent letter.

The complaint is allowed.

AWARD IN THE MATTER OF

Sk. Kamal Uddin
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award - 30th May, 2011

Complaint No.	:	1203/22/009/L/02/2010-11.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	27.05.2011

Facts and Submissions:-

1. **Complainant**

Sk. Kamal Uddin is the complainant and Life Assured (LA) of the above policy. He stated that he purchased one policy under single premium mode of Rs.45,000/= (Rupees forty-five thousand) from the insurer on 28th March, 2010 but did not get the policy document or receipt of premium paid from the insurer for a period of 5-6 months inspite of repeatedly requesting the agent to arrange for the same. Ultimately, after collecting the address of the insurer, he met the officials who advised him to apply for policy bond along with deposit of Rs.251/= (Rupees two hundred and fiftyone) towards bond issue charge. Accordingly, he applied for the same and deposited a sum of Rs.251/= with the insurer on 30th October, 2010 along with Indemnity Bond. After that, he received the policy bond on 27th November, 2010. On going through the policy bond, he found that the policy was issued on yearly premium of Rs.45,000/= for 20 years instead of single premium of Rs.45,000/= as desired by him. Immediately he applied for free look cancellation on 3rd December, 2010 i.e. within 15 days to the insurer. But the insurer replied on 27th January, 2011 to the complainant informing that free look cancellation is not possible in case of submission of duplicate policy bond though there is no such mention in the terms and conditions of the policy bond as per the version of the policyholder. Finding no

other alternative, the complainant approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 27/05/2011. The complainant attended and submitted before this forum that he purchased a policy no. 0163441865 with premium of Rs.45000/- from Bajaj Allianz Life Insurance Co. Ltd. However, he had paid Rs.45000/- in cash for the above policy but he did not receive the policy bond for 5 to 6 months and thereafter they issued a duplicate policy bond on payment of Rs.251/- along with indemnity bond. The policy papers were received by him on 27/11/2010. He also produced the proof of delivery and copy of the letter for cancellation of the policy dtd.03.12.2010 submitted to the insurer.

The representative of the insurance company on the other hand stated that the original policy bond was dispatched on 09/04/2010 by speed post RL No.EW6210913571N which was not returned to them undelivered. However, on receiving the complaint from the policyholder they issued a duplicate policy bond on 22/11/2010 through speed post which was delivered to the policyholder. They further stated that they received the request from the policyholder for free look cancellation on 19/01/2011. As it was received beyond free look period they could not cancel the policy. However, they could not produce any proof of delivery in respect of their original policy bond.

3. **Decision** :

We have heard both the parties and considered the documentary evidences filed by them before this forum. It is clear that the policyholder received duplicate policy bond on 27/11/2010 and he submitted his letter requesting for cancellation of the policy and refund of premium on 03/12/2010 as he found that the policy terms were not suitable for him. The complainant has produced the proof of delivery as well as the copy of the letter dtd.03/12/2010 which was duly received by the insurer. It is therefore, not clear how the insurer mentioned that they received the request for cancellation on 19/01/2011. As regards the original policy bond, since the insurer could not produce the POD, we give the benefit of doubt to the policyholder and direct the insurance company to allow the free look cancellation period in respect of the duplicate policy

since the original policy was never received by the policyholder. As the policyholder made a request for cancellation of the policy within 15 days from the receipt of the duplicate policy bond (to be treated as original bond), the insurer has to accept the request and act accordingly. They are further directed to make the refund the full amount of the premium i.e. Rs.45000/- paid by the policyholder within 15 days from the date of receiving the order along with the consent letter.

The complaint is allowed.

AWARD IN THE MATTER OF

Shri Bimal Ghosh
AND
Bajaj Allianz Life Insurance Co. Ltd

Date of Award – 30.05.2011

Complaint No.	:	1204/22/009/L/02/2010-11.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	27.05.2011

Facts and Submissions:-

1. **Complainant**

Shri Bimal Ghosh is the complainant and Life Assured (LA) of the above policy. He stated that he purchased one policy under single premium mode of Rs.6,000/= (Rupees six thousand) from the insurer on 30th May, 2010 but did not get the policy document or receipt of premium paid from the insurer for a period of 4-5 months in spite of repeatedly requesting the agent to arrange for the same. Ultimately, after collecting the address of the insurer, he met the officials who advised him to apply for policy bond along with deposit of Rs.251/= (Rupees two hundred and fifty one) towards bond issue charge. Accordingly, he applied for the same and deposited a sum of Rs.251/= with the insurer on 25th October, 2010 along with Indemnity Bond. After that, he received the policy bond on 7th December, 2010. On going through the policy

bond, he found that the policy was issued on yearly premium of Rs.6,000/= for 20 years instead of single premium of Rs.6,000/= as desired by him. Immediately he applied for free look cancellation on 18th December, 2010 i.e. within 15 days to the insurer. But the insurer replied on 27th January, 2011 to the complainant informing that free look cancellation is not possible in case of submission of duplicate policy bond though there is no such mention in the terms and conditions of the policy bond as per the version of the policyholder. Finding no other alternative, the complainant approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 27/05/2011. The complainant did not attend the hearing.

The representative of the insurance company stated that the original policy bond was dispatched on 08/07/2010 by speed post RL No.EM393307561N which was not returned to them undelivered. However, on receiving the complaint from the policyholder they issued a duplicate policy bond on 22/11/2010 through speed post which was delivered to the policyholder. They further stated that they received the request from the policyholder for free look cancellation on 19/01/2011. As it was received beyond free look period they could not cancel the policy. However, they could not produce any proof of delivery in respect of their original policy bond.

3. **Decision** :

We have heard the representative of the insurance company and considered the written submission of the complainant and documentary evidences filed by them before this forum. It is clear that the policyholder received duplicate policy bond on 07/12/2010 and he submitted his letter requesting for cancellation of the policy and refund of premium on 18/12/2010 as he found that the policy terms were not suitable for him. The complainant has produced the proof of delivery as well as the copy of the letter dtd.18/12/2010 which was duly received by the insurer. It is therefore, not clear how the insurer mentioned that they received the request for cancellation

on 19/01/2011. As regards the original policy bond, since the insurer could not produce the POD, we give the benefit of doubt to the policyholder and direct the insurance company to allow the free look cancellation period in respect of the duplicate policy since the original policy was never received by the policyholder. As the policyholder made a request for cancellation of the policy within 15 days from the receipt of the duplicate policy bond (to be treated as original bond), the insurer has to accept the request and act accordingly. They are further directed to make the refund the full amount of the premium i.e. Rs.6000/- paid by the policyholder within 15 days from the date of receiving the order along with the consent letter.

The complaint is allowed.

AWARD IN THE MATTER OF

Shri Pawan Kumar Singh
AND
Birla Sun Life Insurance Co. Ltd

Date of Award - 22nd June, 2011

Complaint No.	:	1254/22/006/L/03/2010-11.
Nature of Complaint	:	Non-adjustment of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	20th June, 2011.

Facts and Submissions:-

1. **Complainant**:-

The complainant purchased a ULIP policy under yearly mode of payment on 23rd October, 2008 from the above insurer. He paid his 2nd yearly premium of Rs.20,094/= (Rupees twenty thousand ninety-four) on 16th November, 2009, vide Cheque No.145450 dated 13th November, 2009 drawn on Gramin Bank, Chapra and obtained a premium receipt against the same. But the said cheque was not presented to his Banker for realization of the amount. He made his complaint to the insurer in person as well as through his letter dated 4th October, 2010.

In the said letter, he requested the insurer to adjust his cheque towards yearly premium for October, 2009 due. Since he did not receive any response from the insurer, he approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a hearing on 20/06/2011. The complainant attended and stated before this forum that he is ready to continue the policy and pay the two premiums due provided he is given the benefit of continuity from the due date and no interest or revival charges are levied.

The representative of the insurance company requested for 15 days adjournment for submission of the SCN which was not allowed. He stated before this forum, that the company will look into the issue afresh and settle the matter amicably.

3. **Decision** :

We have heard the submissions of both the parties and perused the documents filed before this forum. It is seen that the policyholder had deposited his cheque in time, but due to some lapse on the part of the bank of the insurer, the cheque could not be encashed and the insurer did not receive the premium amount. However, since the mistake lies on the part of the insurer and the complainant is ready to pay premiums due, we direct the insurer to revive the policy by accepting the 2nd and 3rd premiums without any interest and revival charges. The policy should be revived without any break and the benefit of the continuity should be given from the due date of the premiums. The above exercise should be completed within 15 days of the receipt of this order by the insurer.

The complaint is allowed.

AWARD IN THE MATTER OF

Shri Bindesshwari Singh
AND
Birla Sun Life Insurance Co. Ltd

Date of Award - 22nd June, 2011

Complaint No.	:	1197/22/006/L/02/2010-11.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	20th June, 2011.

Facts and Submissions:-

1. **Complainant**:-

The complainant purchased a ULIP policy in the month of December, 2009 from the above insurer. He gave his consent for a policy with single premium of Rs.25, 000/= (Rupees twenty-five thousand). But after receiving the policy bond in the month of July, 2010, he noticed that the said policy was issued under half-yearly premium mode by forging his signature. He wrote to the insurer on 12th August, 2010 asking for refund of premium. Since no response was received till date, he approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing**:

Both the parties were called for a hearing on 20/06/2011. The complainant did not attend. We, therefore, propose to deal with the matter on ex-parte basis for him.

The representative of the insurance company submitted their written submissions during the course of hearing and stated that the allegation of misselling is not correct in this case. The policy was issued as per the option given in the proposal form which was duly signed by the policyholder. The complainant was given detailed description about the features of the policy

and was appraised with the terms & conditions before signing the application. He had voluntarily signed the proposal form and issued the cheque after going through the details of the policy. He also did not request for cancellation of the policy during the free look cancellation period. The policy documents were sent by DTDC courier on 04/01/2010 and the request for cancellation was received after six months on 12/08/2010. Hence, the request for cancellation could not be processed. He however, could not produce any proof of delivery of the policy bond to the complainant on 04/06/2010.

3. **Decision** :

We have heard the submissions of the insurer's representative and gone through the written submissions of the complainant. The allegation of misselling by the insurance policy is not proved in this case. However, in the absence of any proof of delivery we have to allow the benefit of doubt to the complainant, who has asserted that he received the policy bond in the month of July, 2010. Considering the date of delivery as July, 2010, we find that the request for cancellation of the policy was made within a reasonable period after receiving the policy bond. We, therefore, direct the insurer to accept the request of the policyholder and cancel the policy and refund the premium within 15 days of receiving this order along with the consent letter of the complainant. The complainant is allowed.

RECOMMENDATION IN THE MATTER OF

Mr. Lala Kishore Kanti Roy
AND
TATA AIG Life Insurance Co. Ltd

Date of Recommendation - 27th June, 2011

Complaint No.	:	1105/23/003/L/01/2010-11
Nature of Complaint	:	Dispute in terms and conditions.
Category under RPG Rules, 1998.	:	12 (1) (d)
Date of Hearing	:	24th June, 2011.

Facts and Submissions:-

1. **Complainant**:-

The complainant purchased a policy from the above insurer in July, 2007 with an annual premium of Rs.96, 000/= (Rupees ninety-six thousand). He regularly paid 'yearly' premium for 3 years due from July, 2007 to July, 2009 but he did not pay the premium for July, 2010 as he wanted to get benefit of "Premium Holiday" admissible as per terms of the policy.

On 27th November, 2010 he received a cheque from the insurer for Rs.71, 733.50 (Rupees seventy-one thousand seven hundred thirty-three and Paise fifty) towards the auto-surrender of his policy.

He alleged that the insurer never issued any notice explaining the rules and procedure of the policy. They have not even offered him any option to continue the policy before surrendering the same. As a result, he has suffered a loss to the tune of more than Rs.2, 00,000/= (Rupees two lakh). He wrote a number of letters to the insurer but did not receive any positive response from them. So, he approached this Forum and submitted 'P' Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer** :-

The Insurer has submitted only a copy of the letter dated 9th March, 2011 addressed to the complainant as their SCN. In the said letter, they have clarified about the benefit of the "Premium Holiday". They have mentioned that if the regular premiums are paid for at least 3 completed years, the policy will be maintained in force on "Premium Holiday" automatically without paying the regular premium, subject to policy contract provisions. They have termed this option as Automatic Premium Holiday (APH) for which the following conditions are to be fulfilled:-

1. The total fund value is sufficient to cover the policy charges and costs payable.
2. The surrender value does not fall below an amount equivalent to one annual regular premium.

3. The policy shall run under APH till two years from the due date of the first unpaid regular premium unless they receive the LA's written request to continue with the automatic deduction, subject to conditions (1) and (2).

Since the above criteria was not fulfilled in this case, the fund value post deduction of the surrender charge was refunded to the complainant on 27th November, 2010. They have also informed the complainant about the requirements for getting the policy regularized.

3. **Hearing** :

Both the parties were called for a hearing on 29/03/2011. However none of them attended the hearing. Accordingly, the case was re-fixed for hearing on 24/06/2011. The parties again failed to appear for the hearing. The matter is therefore disposed of on ex-parte basis for both of them.

4. **Decision** :

We have seen the written submissions of both the parties. The facts of the complaint are already mentioned above. The reply of the insurer has already been explained in the foregoing para. The insurer has mentioned the procedure of enjoying the Automatic Premium Holiday (APH) in their letter but did not mention specifically the reasons for non-fulfilment of the criteria under the policy conditions in respect of this case; such as the fund value, policy charges, cost payable and the surrender value.

Moreover, in the 3rd criteria, it is clearly mentioned that the policy should run under APH for 2 years from the due date of first unpaid premium (FUP) unless a written request is received by the insurer to continue with the automatic deduction subject to conditions (1) & (2). In this case, the due date of first unpaid premium was July, 2010. So, the waiting period should be maintained up to July, 2012. But the insurer has not followed this instruction and surrendered the policy of its own accord before expiry of 2 years.

Since clarification in this regard has not been received from the insurer, we are of the view that the policy was closed hurriedly without waiting for statutory period. We also find that the complainant did not apply for surrender of the policy; he only wanted to avail of the premium

holiday. Therefore, the decision of the insurer to surrender the policy before two years is not correct and fair and the same is set aside. The insuer is directed to allow the complainant an opportunity to pay the premium due for revival of the policy without any charges. They are further directed to complete this exercise within fifteen days of receiving this order along with the consent letter of the complainant.

AWARD IN THE MATTER OF

Shri Panna Lal Jain
AND
Kotak Mahindra Old Mutual Life Insurance Ltd

Date of Award - 11th July, 2011

Complaint No.	:	220/22/008/L/05/2011-12
Nature of Complaint	:	Non-adjustment of premium.
Category under RPG Rules 1998.	:	12 (1) (c)
Policy No.	:	00436095
Date of hearing	:	8th July, 2011

Facts and Submissions

1. **Complainant**

The complainant purchased a policy on 30th March, 2006 from the above insurer and paid the renewal premium for March, 2007 by cheque, which was dropped in the collection box of the insurer. He paid the next renewal premium for March, 2008 in time but the amount was not debited to his account and he did not receive the premium receipt. He approached local office of the insurer several times for the premium receipt but did not receive proper response from them. He then wrote a letter on 16th December, 2008 to the Mumbai Office of the insurer in this regard. After that, he received in the month of November, 2009 a cheque for Rs.28, 372/= without clarifying the basis of refund. He again wrote a letter dated 2nd September, 2010 to the Head Office of the insurer but till date he has not received any reply from them. In view of the above, he approached this Forum for redressal of his grievance and submitted "P" forms giving his

unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a personal hearing on 08/07/2011. The complainant attended and stated that he purchased the policy by paying an amount of Rs.30,000/- against the amount due of Rs.29,923/-. Thus there was an excess payment of Rs.77/-, which was not refunded to him. Moreover, he also did not receive any intimation for the 2nd premium due and after visiting the office several times, he was asked to pay a cheque of Rs.28,372/-, which he dropped in the collection box of the company. Later on he was told that the policy was lapsed because the amount paid by him was lying in suspense account as it was less than the amount due. He was also made to undergo certain medical tests for revival of the policy. He was not interested to continue and requested that the premium amount of Rs.30, 000/- paid by him may be refunded. He categorically stated that he did not receive any intimation from the company regarding any shortfall in the premium amount paid by him towards 2nd premium due.

The representative of the insurance on the other hand submitted their SCN during the course of hearing and stated that the company had not received the due premium from the complainant and they have sent a letter dtd.18.06.2009 intimating the same. In the said letter it was clearly mentioned that the policy was in lapsed mode and that he must deposit the full premium amount with a fresh revival form for processing the revival. They have filed a copy of their letter dtd.18.06.2009; however the representative could not confirm whether the policy renewal notice was sent to him giving full details of the premium to be paid. He also could not confirm whether the company separately intimated the complainant about the short fall in the premium amount.

3. **Decision**

We have heard the submissions of both the parties and seen the documents submitted to this forum. It is seen that the complainant paid Rs.30,000/- for purchasing the policy under consideration against the actual premium amount of Rs.29,923/-. The insurer issued the policy on the understanding that the excess amount of Rs.77/- will be adjusted in the next premium. The

complainant has made a categorical statement that he was not given a notice for the next premium due for March, 2007 intimating the exact amount of premium to be paid. He visited the office of the insurer several times and was told to pay a cheque for Rs.28,295/- which he dropped in the collection box. It is also seen that the company collected the cheque, but instead of adjusting the premium, they kept the amount in suspense and did not issue the receipt. When the complainant approached the insurer for paying the 3rd insurance due in March, 2008 he was told that the policy was in lapse mode as the premium paid for 2nd years was less than actual amount due. We asked the insurer to produce any evidence to show that they had intimated the complainant before sending the lapse notice to pay the balance amount due for the 2nd premium. The insurer could not produce the copy of any letter/notice issued to the policyholder in this respect. It is therefore, not the fault of the complaint that the exact amount could not be tendered in time. The mistake lyies on the part of the insurance company who failed to tell the policyholder the exact amount to be paid after adjustment of the excess amount of Rs.77/-. The complainant is not willing to continue the policy and has requested for cancellation.

After evaluation of all the facts & circumstances of the case, we are of the opinion that the complainant had full intention to continue the policy and he paid three premiums in time for the same. However, the policy got lapsed without any fault on the part of the policy holder. The insurer failed to intimate the policyholder the exact amount to be tendered. Considering this fact, we find that the decision of the insurer not to refund the premium is not correct and the same is set aside. The question of revival in this case does not arise as the payment was made in time. The insurer is directed to cancel the policy and refund the instalment premium of Rs.29,923/- paid by the complainant towards the risk premium under the policy within 15 days of the receipt of this order with the consent from the complainant. The complaint is allowed.

AWARD IN THE MATTER OF

Dhavala V.L.N. Sharma
AND
Birla Sun Life Insurance Co. Ltd

Date of Award - 14th July, 2011

Complaint No.	:	172/22/006/L/05/2011-12
Nature of Complaint	:	Refund of premium.
Category under RPG Rules 1998.	:	12 (1) (c)
Policy No.	:	002914102
Date of hearing	:	12th July, 2011

Facts and Submissions:-

1. **Complainant**

The complainant purchased a ULIP policy in October, 2009 with single premium of Rs.1,00,000/- on being convinced by a senior executive of the above insurer. He mentioned that from the second year, the insurer started demanding for payment of yearly premium of Rs.1,00,000/- to keep the policy in force. Being shocked, he immediately contacted the Jamshedpur Office of the insurer and they assured to extend to him "Reduced Premium" facility by paying Rs.10,000/= per year from the second year onwards. He then completed the formalities and deposited Rs.10,000/= on 14th June, 2010 towards the second yearly premium and obtained renewal premium receipt. He alleged that subsequently, the insurer denied to given him the "Reduced Premium" facility for his policy. He then made a number of correspondences with the insurer as also with the IRDA authority to get rid of this problem by way of reviving the policy or by refund of first year's premium. Receiving no fruitful result, he approached this Forum and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The insurer has submitted their SCN vide their letterdtd.08/07/2011 stating that the complainant's allegation of misselling is baseless and without any merit. He had signed the application form voluntarily after full understanding of all the terms and conditions of the policy. He also failed to exercise his free look option within 15 days. It is further stated that they could

not process the request of the complainant for reduction in annual premium as this option was no longer available at the time when he made the request.

3. **Hearing**:

Both the parties were called for a personal hearing on 12/07/2011. The complainant attended and submitted before this forum the grounds of his complaint. He stated that the insurance company had sanctioned the premium reduction facility from the second policy year and accepted the second year's reduced annual premium of Rs.10,000/- and also issued him a proper receipt for the reduced premium. However, they subsequently reversed the sanction and started demanding Rs.1 lakh towards yearly premium without giving any reason for going back on their promise. He further stated that he has paid the second premium on time as per insurance company's advice and post sanction stand taken by the insurance company is unethical and unwarranted.

The representative of the insurance company reiterated their stand as mentioned in their SCN in which they have denied the allegation of misselling and stated that the complainant failed to exercise the free look option. However, he admitted that on complainant's request the company had decided to reduce the premium payment for 2nd & 3rd year of the said policy to Rs.10,000/- p.a. However, subsequently they intimated the complainant that his request for reduction in the annual premium could not be processed as the features of reduction in premium from the 2nd policy year was available only for Gold Plus policies issued till 31/03/2009.

4. **Decision**

We have heard the submissions of both the parties and perused the documents submitted to this forum. The allegation of misselling is not proved in this case. The complainant could not establish that he had signed the application form under the agent's influence. He also did not care to read the policy terms and condition after receiving the policy bonds and failed to exercise his option for free look cancellation. . However, we find that when the complainant approached the insurer for cancellation of the policy after the free look cancellation period, he was advised to opt for the payment under reduced premium facility and the branch executive got the necessary documents prepared for reduction of premium and accepted the cheque of Rs.10,000/- towards

2nd yearly premium. It is further seen that the insurer has also issued a money receipt dtd.14/06/2010 towards the acceptance of the 2nd premium of Rs.10, 000/- . This proves that Insurer had realised the difficulty of the policy holder in meeting his commitment under the policy and genuinely tried to solve his problem by reducing the amount to an affordable level. Under the circumstances, their subsequent decision to withdraw this facility on a technical ground of non-availability of the option is not fair and justified. We are therefore, of the opinion that it was wrong on the part of the Insurer to accept the 2nd cheque for Rs.10, 000/- under reduced premium facility. Since it is not possible for them to reduce the premium as the option is no longer available, the only way to solve this problem is to cancel the policy and refund the premium. Accordingly, we direct the insurance company to cancel the policy and refund the premium of Rs.1, 10,000/- to the complainant within 15 days of the receipt of this order along with consent from the complainant.

AWARD IN THE MATTER OF

Mr. Yogendra Kumar Agarwal
AND
Aviva Life Insurance Co. Ltd

Date of Award - 20th July, 2011

Complaint No.	:	189/22/013/L/05/2011-12.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy No.	:	APN 2871548
Date of Hearing	:	18th July, 2011.

Facts and Submissions

1. **Complainant**

The complainant had taken the above policy in the month of January, 2010 after investing Rs.5, 00,000/= (Rupees five lakh) with three years lock-in-period. He was informed by the agent that the deposit was a single investment of premium and not annual premium but on receipt of

the duplicate policy bond on 8th January, 2011 (after one year from D.O.C), he came to know that the policy was not a single premium policy but the premium paying term for 20 years. As it was not possible for him to continue the policy, he applied for free look cancellation on 20th January, 2011 i.e. within free look cancellation period. But the insurer did not make any positive response. So, he approached this Forum seeking justice and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing**:

Both the parties were called for a hearing on 18/07/2011. The complainant did not attend the hearing, but he has sent a letter requesting for adjournment of the hearing. The representative of the insurance company attended and submitted the SCN wherein they have given the grounds for rejecting the request of the complainant.

3. **Decision**

We have heard the submissions of the insurance company and perused the submissions of the complainant. Since the complainant was not present, we propose to deal with the matter on the basis of material submitted by him before this forum. It is seen that the policy documents were dispatched by the insurance company vide speed post no.EW419537171 IN on 02.03.2010. However, the insurer could not produce the proof of delivery and also could not confirm whether the documents were returned undelivered. On the other hand, the complainant has categorically stated in the complaint that he did not receive the policy bond even after six months and he wrote two registered letters dtd.21.12.2010 and 30.12.2010 after which he was issued a duplicate policy bond on 08.01.2011. He immediately applied for cancellation of the policy on 20.01.2011, i.e. within 15 days of receiving the duplicate policy bond, as he was not satisfied with policy terms and conditions. In the absence of any proof of delivery, we give the benefit of doubt to the complainant and accept his contention that he did not receive the original policy bond. We, therefore, direct the insurance company to accept the request for cancellation of the policy submitted by the complainant within 15 days of receiving the duplicate policy. Since the original policy bond was not received, the duplicate bond is to be considered as original for free look cancellation purpose. The complaint is allowed.

RECOMMENDATION IN THE MATTER OF

Shri Subhra Jyoti Basu Roy
AND
Aegon Religare Life Insurance Co. Ltd

Date of Recommendation - 25th July, 2011

Complaint No.	:	201/22/019/L/05/2011-12.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	21st July, 2011.

Facts and Submissions

1. **Complainant**

The complainant is the Life Assured (LA) of the above 3 policies. He stated that he had purchased the above policies from Aegon Religare Life Insurance Co. Ltd. where the concerned agent confirmed that all were single premium policies. He has already paid premium for Rs.2,43,750/- against policy No. 090310432837; Rs.2,34,000/- against policy No. 090310482717 and Rs.50,000/- against policy No. 090110281726. So the total premium paid by him was Rs.5,27,750/= (Rupees five lakh twenty-seven thousand seven hundred and fifty) against the above 3 policies. He had applied for stoppage of ECS premium for policy Nos. 090310432837, 090310482717 on 8th April, 2010. Subsequently, on 29th November, 2010, he appealed to the insurer for refund of the entire amount as he was in acute financial problem and was not in a position to pay any more premiums against the above policies. He made several correspondences with the insurer but received no positive response. So, he approached this Forum seeking justice and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The SCN submitted by the insurer confirms the fact that out of the above 3 policies, the policy No. 090310482717 was issued in the name of Mrs. Emili Basu Roy, wife of the complainant and they have not received any allegation or request for cancellation from the said policyholder. The policy bonds for policy Nos.090110281726, 090310432837 and 090310482717 were delivered on 2nd February, 2009, 28th March, 2009 and 31st March, 2009 and received by the LA on 10th February, 2009, 2nd April, 2009 and 4th April, 2009 respectively. But on the request of the policyholder, the insurer issued duplicate policy bonds and delivered the same on 21st May, 2010 for the policy Nos. 090310432837 and 090310482717. The request for cancellation was received from the complainant on 29th September, 2010. Since the free look period was over and it was more than 18 months after issuance of the 1st policy bond, the free look cancellation was not accepted by the insurer.

3. **Hearing**:

Both the parties were called for a personal hearing on 21.07.2011. The complainant attended and submitted before this forum that he had intended to make one time investment, but the company issued him policy with regular premium mode increasing his financial liabilities many times. He has now realized that it is not possible for him to continue the policies because he has to pay a huge amount of nearly Rs.5.00 lakhs every year. He admitted that the policy bonds were delivered by the company but were immediately taken away by the agent on the same day and were never returned back to him. He has requested for reduction of the premium so that he could continue the policies.

The representative of the insurance company on the other hand, stated that the company did not receive any complaint from the policyholder during the free look cancellation period. All the three policies were issued based on the proposal form and benefit of illustration signed by the policyholder. Since the policyholder did not apply during the free look cancellation period, they are not in a position to entertain his request.

4. **Decision**

We have heard the submissions of both the parties and perused the policy conditions. The allegation of misselling is not established in this case. The complainant is a well educated young

man, holding a responsible position with annual income of Rs.8.00 lakhs. Therefore, it cannot be accepted that he was misguided or influenced by the agent of the company to take the above policies. It is also seen that he totally dependent on the agent and did not care to read the policy terms and conditions on receiving the policy bonds. He allowed the agent to take back the policy bonds and did not lodge any complaint about it. He also failed to exercise the option of free look cancellation of policy. Considering these facts, the decision of the insurer is found to be technically correct. However, to mitigate the hardship of the complainant and to enable him to continue the policies, we direct the insurance company to offer him the premium reduction facility, if available under the scheme. The premium should be reduced to the minimum level subject to the consent of the policyholders. The complainant should also realize that any reduction in the premium will proportionately reduce the benefits payable under the policies. The complaint is accordingly disposed off.

5. Let the copies of this recommendation be sent to the parties.
6. Let the copies of this recommendation be sent to:
   a) Chairman, Governing Body of Insurance Council.
   b) Chairman, Aegon Religare Life Insurance Co. Ltd.
   c) The Head Customer Care, Aegon Religare Life Insurance Co. Ltd – for information and doing the needful.

AWARD IN THE MATTER OF

Shri Panna Lal Jain
AND
Kotak Mahindra Old Mutual Life Insurance Ltd

Date of Award - 11th July, 2011

Complaint No.	:	220/22/008/L/05/2011-12
Nature of Complaint	:	Non-adjustment of premium.
Category under RPG Rules 1998.	:	12 (1) (c)
Policy No.	:	00436095

Date of hearing : 8th July, 2011

Facts and Submissions

1. **Complainant**

The complainant purchased a policy on 30th March, 2006 from the above insurer and paid the renewal premium for March, 2007 by cheque, which was dropped in the collection box of the insurer. He paid the next renewal premium for March, 2008 in time but the amount was not debited to his account and he did not receive the premium receipt. He approached local office of the insurer several times for the premium receipt but did not receive proper response from them. He then wrote a letter on 16th December, 2008 to the Mumbai Office of the insurer in this regard. After that, he received in the month of November, 2009 a cheque for Rs.28, 372/= without clarifying the basis of refund. He again wrote a letter dated 2nd September, 2010 to the Head Office of the insurer but till date he has not received any reply from them. In view of the above, he approached this Forum for redressal of his grievance and submitted "P" forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing** :

Both the parties were called for a personal hearing on 08/07/2011. The complainant attended and stated that he purchased the policy by paying an amount of Rs.30,000/- against the amount due of Rs.29,923/-. Thus there was an excess payment of Rs.77/-, which was not refunded to him. Moreover, he also did not receive any intimation for the 2nd premium due and after visiting the office several times, he was asked to pay a cheque of Rs.28,372/-, which he dropped in the collection box of the company. Later on he was told that the policy was lapsed because the amount paid by him was lying in suspense account as it was less than the amount due. He was also made to undergo certain medical tests for revival of the policy. He was not interested to continue and requested that the premium amount of Rs.30, 000/- paid by him may be refunded. He categorically stated that he did not receive any intimation from the company regarding any shortfall in the premium amount paid by him towards 2nd premium due.

The representative of the insurance on the other hand submitted their SCN during the course of hearing and stated that the company had not received the due premium from the complainant and they have sent a letter dtd.18.06.2009 intimating the same. In the said letter it was clearly mentioned that the policy was in lapsed mode and that he must deposit the full premium amount with a fresh revival form for processing the revival. They have filed a copy of their letter dtd.18.06.2009; however the representative could not confirm whether the policy renewal notice was sent to him giving full details of the premium to be paid. He also could not confirm whether the company separately intimated the complainant about the short fall in the premium amount.

3. **Decision**

We have heard the submissions of both the parties and seen the documents submitted to this forum. It is seen that the complainant paid Rs.30,000/- for purchasing the policy under consideration against the actual premium amount of Rs.29,923/-. The insurer issued the policy on the understanding that the excess amount of Rs.77/- will be adjusted in the next premium. The complainant has made a categorical statement that he was not given a notice for the next premium due for March, 2007 intimating the exact amount of premium to be paid. He visited the office of the insurer several times and was told to pay a cheque for Rs.28,295/- which he dropped in the collection box. It is also seen that the company collected the cheque, but instead of adjusting the premium, they kept the amount in suspense and did not issue the receipt. When the complainant approached the insurer for paying the 3rd insurance due in March, 2008 he was told that the policy was in lapse mode as the premium paid for 2nd years was less than actual amount due. We asked the insurer to produce any evidence to show that they had intimated the complainant before sending the lapse notice to pay the balance amount due for the 2nd premium. The insurer could not produce the copy of any letter/notice issued to the policyholder in this respect. It is therefore, not the fault of the complaint that the exact amount could not be tendered in time. The mistake lyies on the part of the insurance company who failed to tell the policyholder the exact amount to be paid after adjustment of the excess amount of Rs.77/-. The complainant is not willing to continue the policy and has requested for cancellation.

After evaluation of all the facts & circumstances of the case, we are of the opinion that the complainant had full intention to continue the policy and he paid three premiums in time for the same. However, the policy got lapsed without any fault on the part of the policy holder. The insurer failed to intimate the policyholder the exact amount to be tendered. Considering this fact, we find that the decision of the insurer not to refund the premium is not correct and the same is set aside. The question of revival in this case does not arise as the payment was made in time. The insurer is directed to cancel the policy and refund the instalment premium of Rs.29,923/- paid by the complainant towards the risk premium under the policy within 15 days of the receipt of this order with the consent from the complainant. The complaint is allowed.

AWARD IN THE MATTER OF

Mrs. Laliya Bibi
AND
Reliance Life Insurance Co. Ltd

Date of Award – 25th July, 2011

Complaint No.	:	224/22/010/L/05/2011-12.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Date of Hearing	:	21st July, 2011

Facts and Submissions

1. **Complainant**

The complainant is the Life Assured (LA) of the above 2 policies. She stated that she had purchased the said policies in July, 2010 and after continuous persuasion for the policy bonds, she collected the same from Insurer's Behala office on 23rd February, 2011. As the terms and conditions of the policy bonds were not suitable to her, she returned the policy bonds for free look cancellation on 9th March, 2011. But the insurer refused to accept the cancellation request on the plea that 15 days free look period was over. She made several follow-ups with the insurer

but received no response from them. So, she approached this Forum seeking justice and submitted "P" Forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Hearing**:

Both the parties were called for a personal hearing on 21/07/2011. The complainant attended and explained the facts and circumstances of the case. She submitted that she is not in a position to continue the policy because of her financial problems. She had returned the policy bond for free look cancellation on 09.03.2011 and made several follow-ups. But her request was not entertained by the insurer. Since she did not receive the original policy bond, she collected duplicate policy bond on 23.02.2011 and applied for free look cancellation on 09.03.2011.

The representative of the insurance company did not attend the hearing. We therefore, propose to deal with the matter on ex-parte basis for them.

3. **Decision**

We have heard the submissions of the complainant. She has made categorical statement that she had not received the policy bond and requested for cancellation on the basis of duplicate bond which she collected personally from their office on 23.02.2011. The insurance company has not produced any counter argument/evidence in respect of their action. In view of this, we are of the opinion that the action of the insurer in rejecting the request of the complainant to cancel her policy is not justified and the same is set aside. The insurer is further directed to pay the refund of the premiums paid by the policyholder within 15 days of the receipt of this order along with consent letter from the complainant. The complaint is allowed.

AWARD IN THE MATTER OF

Shri Sujoy Roy Choudhury
AND
TATA AIG Life Insurance Co. Ltd

Date of Award - 9th September, 2011

Complaint No.	:	332/22/003/L/06/2011-12.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy No.	:	C243501573
Date of Hearing	:	8th September, 2011.

Facts and Submissions

1. **Complainant**

The complainant had taken a new policy No.243501573 in exchange of an old policy from the above insurer on persuasion by the Sales Executive of the insurer. He deposited an annual premium of `20,000/= to open the new policy after cancelling the old one. But, subsequently, after 45 days, he came to know that the insurer had issued a new policy without cancelling the old policy. As it was not possible for him to continue both the policies, he applied to the insurer for cancellation of the new policy on 29th April, 2011. But the insurer rejected his request on the ground that the free look cancellation period was over though it was well within the time of 15 days since the policy bond was received by him on 16th April, 2011. So, he approached this Forum seeking justice and submitted "P" Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The insurer submitted their SCN vide letter dtd.06.09.2011 wherein they have stated that they had dispatched the original policy documents at the customer's mailing address on 12.03.2011 by speed post no. EM 704292855IN. The customer approached them in April, 2011 stating that he received the policy documents on 16.04.2011 and requested them to cancel the policy. Since the policyholder did not apply for cancellation of the policy within 15 days of the dispatch of the original policy document, they were unable to cancel the policy.

3. **Hearing** :

Both the parties were called for a personal hearing on 08.09.2011. The complainant attended along with his father who explained the grounds of complaints. He stated that he submitted a request for cancellation of 2nd policy within the free look cancelation period, but his request was turned down unfairly on the ground that free look cancellation period was over. He further stated that he is not willing to continue the policy and prayed for cancellation of the same.

The representative of the insurance company on the other hand, justified their action by stating that they had dispatched the original policy document to the customer mailing address as mentioned in the proposal form on 12.03.2011 by speed post. However, the policy documents were returned undelivered and later at the request of the policyholder, it was sent at the office address of the policyholder's father on 07.04.2011.

4. **Decision** :

We have heard the submissions of both the parties and examined the documents submitted to this forum. We find that the original policy document sent by the insurer in March, 2011 was not received by the policyholder. Later on when the document was sent by a courier to his father's office address, this was received by him on 16.04.2011. The insurer has also confirmed that they had sent the document for the second time at the office address of the father of LA on 7.04.2011. It is seen that the policyholder after receiving the policy bond on 16.04.2011, immediately applied for cancellation of the policy vide his letter dtd.29.04.2011, which was duly acknowledged by the insurer. Since the policy documents dispatched earlier via speed post were not received by the policyholder, the free-look cancellation period cannot be reckoned from March 2011. Therefore, we find that the request for cancellation was lodged within the free look cancellation period of receiving the policy bond in April 2011 and the action of the insurer in rejecting the request is unfair and not valid. Their decision is set aside and they are directed to accept the request of the policyholder and cancel the policy and refund the premium within 15 days from the date of receiving the consent letter of the complainant. The complaint is allowed.

AWARD IN THE MATTER OF

Smt. Anita Guria (Jana)
AND
Birla Sun Life Insurance Co. Ltd

Date of Award - 14th September, 2011

Complaint No.	:	422/22/006/L/07/2011-12
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy Nos.	:	004132377 & 004128463
Date of hearing	:	13th September, 2011.

Facts and Submissions

1. **Complainant**

The complainant is the Life Assured (LA) of the above two policies. She has alleged misselling of two policies on false promise. She purchased the policies from the representative of the insurer with the understanding that those would be single premium policies. But, afterwards, she started receiving phone calls from the insurer for payment of renewal premium and came to know that the policies were with regular premium. She stated that the amount of premium in respect of the policies were about Rs.80,000/= and she is unable to pay such a huge amount as premium regularly. So, she requested the insurer vide her letters dated 10th March, 2011 and 18th May, 2011 for cancellation of the policies and refund of premiums. Since she did not receive any response from the insurer, she approached this Forum seeking justice and submitted 'P' Forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The insurer has submitted their SCN on 12.09.2011 vide their letter dtd.09.09.2011 stating that the request for cancellation was not received by the insurer within the free look cancellation period and as a result of which they could not entertain the request of the LA. They have further submitted that the terms & conditions of the policies were explained to the LA

before their application was accepted. However, they further contended that the complainant had enjoyed the benefits of insurance covered during the period of the said policies. However, the insurer has offered that the complainant can avail the option of surrendering the said policies as per terms and conditions of the policy contract and the company shall refund the cash surrender value as per the said terms and conditions after expiry of three years.

3. **Hearing**:

Both the parties were called for a personal hearing on 13.09.2011. The complainant attended along with her husband and explained the facts and grounds of her complaints. She categorically stated that she was advised by the officials of the insurance company to take the single premium policy for Rs.80,000/-, but the insurer issued her two policies under regular premium. They did not explain the terms and conditions of the policy and accepted her deposit by concealing the fact that she would be required to pay a regular premium of Rs. 80,000/- every year for a long period. Since she is a person of very ordinary means, it is not possible for her to pay Rs.80,000/- in regular premium. She and her husband both are not educated enough to understand the conditions of the policy which were mis-sold to them by the representative of the company after projecting a lucrative return. She further pleaded for sympathetic consideration of her case considering that it is a very big financial loss to her.

The representative of the insurance company reiterated their stand as mentioned in the SCN and discussed above. They have denied allegation of misselling and submitted that the request for cancellation was received after the free look cancellation period as a result of which they could not refund the premium. They further submitted that the company is ready to pay the surrender value of the policy after expiry of three years.

4. **Decision**

We have considered the submissions of both the parties and examined the documents submitted to this forum. From the facts narrated by the LA, it is clear that the couple became a victim of misselling by the agent who projected a very lucrative return from the investment and concealed the fact that they have a recurring liability of paying Rs. 80,000/- every year as premium. It is seen that the proposal forms were filled up by the agent and the annual income of

the LA is shown as Rs.3.00 lakhs and that of her husband as Rs.4.00 lakhs which is without any basis and done only to sell the policy. During the course of hearing, we found that the policyholder as well as her spouse are neither educated enough to understand the terms of the contract nor financially in a position to pay Rs.80,000/- p.a. Keeping in view their economic and educational background, we are of the opinion that these policies were taken by them without even a basic understanding of the terms and conditions of the policy. Insurance is a contract based on utmost good faith under which both the parties are liable to disclose the material facts truly and fairly. If they had been explained that they were required to pay annual premium of Rs.80,000/-, they would not have ventured to invest their hard earned money in the plan. The decision of the insurer is found to be technically correct, but not fair in the facts and circumstances of this case. Although the insurer has promised that they will refund the cash surrender value after expiry of three years, but the amount of such payment cannot be ascertained as of now. Therefore, after considering of all the facts and circumstances of the case, we think it proper to cancel the policies which were sold to the LA without proper briefing. The insurer is directed to refund the premium of Rs. 80,000/- within 15 days of receiving the order along with consent letter of the complainant. The complaint is allowed.

AWARD IN THE MATTER OF

Shri Kamal Moni Dutta
AND
Reliance Life Insurance Co. Ltd.

Date of Award - 21st September, 2011

Complaint No.	:	438/22/010/L/07/2011-12
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy No.	:	17110525
Date of hearing	:	20th September, 2011.

Facts and Submissions

1. **Complainant**

The complainant purchased the above policy on 3rd June, 2010 from Reliance Life Insurance Co. Ltd. He stated that he did not receive the policy bond for a long time in spite of making repeated correspondences with the insurer. Ultimately, he received the policy bond on 21st May, 2011 by speed post. Since he was very much annoyed with the insurer for his harassment in getting the policy bond, he decided to cancel the policy and submitted an application to the insurer for the same on 31st May, 2011. He, again, wrote a letter to the insurer on 20th June, 2011 for refund of premium but no response has been received by him till date. So, he approached this Forum seeking justice and submitted 'P' Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The insurer submitted their SCN during the course of hearing in which they have stated that they had sent the original document on 08.06.2010 vide Express Couriers and they received the request from the complainant in May, 2011 which was far beyond the free look cancellation period. As a result they could not cancel the policy.

3. **Hearing**

Both the parties were called for a personal hearing on 20.09.2011. The complainant attended and submitted the facts and grounds of his complaints. He categorically stated that he did not receive the original policy bond which was sent to a wrong address. After following up with the insurer he received the duplicate policy bond on 21.05.2011 and immediately lodged his complaint on 31.05.2011 for cancellation of the policy and refund of premium.

The representative of the insurance company on the other hand, did not make any counter argument and admitted the facts stated by the complainant.

4. **Decision**

We have heard the submissions of both the parties. The representative of the insurance company could not produce any documentary evidence to prove that the original policy bond

was delivered to the policyholder at his correct address. We have no reason to doubt the contention of the complainant and we find that his request for cancellation of the policy was lodged within 15 days of receiving the policy bond by him. In view of this, the decision of the insurer is not in order and the same is set aside. They are directed to accept the request of the complaint and refund the premium within 15 days of receiving the consent letter.

AWARD IN THE MATTER OF

Shri Yudhisthir Halder
AND
TATA AIG Life Insurance Co. Ltd

Date of Award - 21st September, 2011

Complaint No.	:	466/22/003/L/07/2011-12
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy No.	:	U142023709
Date of hearing	:	20th September, 2011.

Facts and Submissions

1. **Complainant**

The complainant purchased the above policy with annual premium of Rs.50,000/= from TATA AIG Life Insurance Co. Ltd. on 26th March, 2010. He stated that since he needed some money urgently for his son's education, he approached the insurer for cancellation of the policy and refund of premium. But the Branch Manager advised him to take up the matter with them after 4 days. Accordingly, when the complainant again approached him for cancellation of the policy, the Branch Manager expressed his inability to cancel the policy since "free look period" was over. In view of the above, he approached this Forum seeking justice and submitted 'P' Forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The insurer mentioned in their written submissions that they issued the above policy to the complainant on 27th March, 2010. The policy bond was dispatched on 6th April, 2010 and the same was delivered to the complainant's address on 9th April, 2010. The request for cancellation of the policy was received by them on 28th April, 2010, which was beyond the free look provision. They further mentioned that the complainant approached their Branch Office for cancellation of the policy twice i.e. on 26th April, 2010 and 28th April, 2010. The first visit of the complainant on 26th April, 2010 was also after the expiry of "free look cancellation period", they added.

3. **Hearing**

Both the parties were called for a personal hearing on 20.09.2011. The complainant did not attend the hearing. The representative of the insurance company attended and stated before this forum that they dispatched the policy document at the customer's address on 09.04.2010 and his request for free look cancellation was received on 28.04.2010. Meanwhile, the customer has visited their branch office on 26.04.2010 and 28.04.2010 and has expressed his desire for cancellation of the policy. Since the request of the customer was received few days after the expiry of the free look cancellation period it was not possible for them to accept his request.

4. **Decision**

We have heard the submissions of representative of the Insurance company and examined the documents submitted by both the parties to this forum. We find that there is a slight delay on the part of the policyholder in submitting his request for cancellation of the policy. However, considering the fact that he had visited and met the officials of the branch office immediately after receiving the policy document and expressed his desire to get the policy cancelled, we condone the delay and direct the insurance company to accept his request for cancellation of policy and refund the premium. They are further directed to make the payment within 15 days receiving the order along with the consent letter.

AWARD IN THE MATTER OF

Ms. Somosree Dey
AND
Life Insurance Corporation of India

Date of Award - 19th September, 2011

Complaint No.	:	384/22/001/L/07/2011-12.
Nature of Complaint	:	Refund of premium.
Category under RPG Rules, 1998.	:	12 (1) (c)
Policy No.	:	494660698
Date of Hearing	:	16th September, 2011.

Facts and Submissions

1. **Complainant**

The complainant had taken a New Bima Account-1 policy from the above insurer after paying a premium of Rs.14,000/- on 11th February, 2011. Within 4 days she requested the insurer to stop the policy as she was not satisfied with the terms and conditions. She wanted to take a new policy with Rs.7,000/- as yearly premium and Rs.7,000/- as top-up facility. Subsequently, on 25th May, 2011, she applied for cancellation of the New Bima Account-I policy and asked for refund of the money deposited with the insurer on 11th February, 2011. But, inspite of several follow ups, she did not receive any response from the insurer. So, she approached this Forum seeking justice and submitted 'P' Forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant for resolution of the complaint.

2. **Insurer**

The Self-Contained Note (SCN) submitted by the insurer dated 19th August, 2011 confirms the fact that the said policy was taken on 11th February, 2011 for sum assured of Rs.1,40,000/- and annual premium of Rs.14,000/-. They confirm the fact that the policyholder

had requested for discontinuing the policy and taking cooling off action. But due to some problem in the Front End Application Package, it was not possible for them to generate certain vouchers from the existing module. The matter has been taken up at the corporate level and they will dispose of this complaint as soon as the problem is solved.

3. **Hearing**:

Both the parties were called for a hearing on 16.09.2011. The complainant was represented by her father who explained the facts and circumstances of the complaint.

The representative of the insurance company submitted that they are still in the process of fixing the problem in their software and will dispose off the complaint as soon as possible. They have accepted the request for cancellation of the policy as it was received within the free look cancellation period.

4. **Decision**

We have heard the submissions of both the parties and find that there is no dispute about the fact that the complainant lodged her request for cancellation of the policy within the cooling off period. Hence the insurer is liable to cancel the policy and refund the premium. They cannot hold back the refund on the ground of some system related problem. The insurer is directed to cancel the policy and pay the refund premium along with penal interest for late payment to the complainant within 15 days of receiving the copies of the order along with consent letter from the complainant. The complaint is allowed.