Miscellaneous

Ahmedabad Ombudsman Centre
Case No. 21.001.0132
K. M. Patel
Vs
Life Insurance Corporation of India

Award Dated 25.10.2005

Under 2 Annuity Policies, instalment of Annuity incorrect amount was shown and paid by the Insurer. On complaint having been made, the mistake was corrected and difference of Annuity amount was paid. In the third Annuity Policy the date of vesting was erroneously shown as 1.9.2003 in place of 1.10.2003. The Complainant sought to receive the Annuity with effect from 1.9.2003 mentioned though erroneously in the Policy. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 21.001.0042
R. S. Patel
Vs
Life Insurance Corporation of India

Award Dated 26.10.2005

Disability Claim under life Policy was repudiated on the ground that the disability of the Life Assured did not confirm to the norms specified in the Policy Conditions. In the present case the Life assured got his one leg amputated and claimed disability benefit. The Respondent repudiated the Claim as per policy Conditions which required that not only one Limb but two Limbs' amputation qualify for disability benefit. Had the other leg or hand been amputated the disability benefit would have become due. Repudiation upheld.

Ahmedabad Ombudsman Centre
Case No. 21.004.0033
J. M. Prajapati
Vs
ICICI Prudential Life Insurance Corporation of India

Award Dated 21.11.2005

Claim for critical illness Benefit was repudiated on the ground of said rider being not covered under the subject Policy. The claim was for treatment of fractured leg. According to the Complainant Policy certificate and its enclosures clearly mention that "Critical illness Benefit is available" The scrutiny of the Policy document revealed that only endowment benefit was available. The enclosures revealed that an option for rider was to be exercised by the Complainant and subject to underwriting guidelines it was to be finalized. The critical illness benefit rider was available only to the Insured Person upto age 50 whereas the Complainant was aged 60 at the time of taking Policy. So obviously there was no question of allowing this rider even it had been opted by the

Complainant. In this case even the Option was not exrecised. So the question of allowing the benefit obviously did not arise.
The Repudiation was upheld. Complaint failed to succeed.

Ahmedabad Ombudsman Centre
Case No. 21.001.0072
Smt. S. C. Joshi
Vs
Life Insurance Corporation of India

Award Dated 27.12.2005

Repudiation of Claim lodged under Extended Permanent Disability Benefit : In an accident, the Complainant got injured and was treated by an Orthopaedist who diagnosed Fracture of Clavicle and fracture of Greater Trochanter Femur with 20 % of the limb being permanently disabled with no possibility of recovery. As per his opinion, the Age of the Patient and her injury caused the disability. The Claim was repudiated since the extent of disability was 20 % only. The Policy Clause does not expressly refer to the percentage of diability. It refers only to the functionality aspect. The treating Orthopaedist's Certificate stated that Functional Disability was for Pain in Left Shoulder specially of lifting weight and for Pain in Left Hip Specially on prolonged standing and walking. Since the assessment of the functional disability was not restrictive enough to warrant Extended Permanent Disability Benefit, the Repudiation of the subject EPDB Claim was upheld with no relief to the Complainant.

Ahmedabad Ombudsman Centre
Case No. 24.001.0153
Shri K.M. Raju
Vs
Life Insurance Corporation of India

Award Dated 27.02.2006

The Complainant's Life Insurance Policy was issued by Jabalpur Divisional Office. On his transfer to Vadodara, he had applied for transfer of his records in 1987. The records could not be traced out at Vadodara. Subsequently, on registration of the Complaint at this Office, the records could be traced and since three years premiums had been paid by the Complainant, a Discharge Voucher for payment of Paid-up Claim with Interest was sent to the Complainant. The Complainant argued that since he was denied opportunity to continue his policy, he should be compensated by payment of full maturity proceeds. Insurance laws do not permit such a payment. As such, the respondent was directed to pay the paid up value with interest as compensation.

Ahmedabad Ombudsman Centre
Case No. 21.001.0283
Smt. Dipikaben N. Solanki
Vs
Life Insurance Corporation of India

Award Dated 27.02.2006

The Complainant's husband held a Jeevan Suraksha Policy with endowment option. On his death, payment of annuity was done for four months. Later, suddenly a refund order was issued for excess pension paid. The Complainant made a specific query as to the particular Policy Condition resorted to by the Respondent to arrive at the lowered

annuity rate. Since, a satisfactory reply was not given to her, she registered a Complaint with this Forum. It was observed that the Policy Document stated that "Annuity Rates for the various options will be quoted on application". It was observed that from the Internal Annuity Tables, that the Monthly Pensions have been claculated correctly. However, no relief was warranted for the Complainant.

Bhopal Ombudsman Centre
Case No.: LI-657-24/12-06/JBP
Shri Shivprasad
Vs. Life Insurance Corporation of India

Award Dated 28.03.2006

Shri Shivprasad, complainant took 3 life insurance policies viz., 371470530, 371290201 and 371470040 from the Respondent under Salary Savings Scheme of Pashchim Madya Railway, Nai Katni. When the policies were in force, the Complainant met with a train accident while on duty, for which Disability claim was sought with the Respondent but the same was repudiated. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

It is observed from the Disability Certificate issued on 16.02.05 by West Central Railway Hospital, New Katni that the complainant met with a train accident as a result of which both his lower limbs were amputated and that the extent of his disability being life long and permanent nature. It is also observed from the Premium Certificate issued by the Complainant's employer dated 01.10.04 that under Policy numbers in question, premiums were being deducted from the Complainant's monthly salary. Also, the same document shows that the complainant is still under Secondary duties and the premium is also being deducted from his salary.

During hearing, the complainant informed that he is not in a position to discharge the duties assigned to him by his Employer. He received his monthly salary from November, 2004 to May, 2005 by way of performing secondary duties and he was also frequently taking Earned Leave during the same period till his leave was accrued. Thereafter, he was neither in a position to attend his duties nor got payment on the basis of "No work no Pay". The complainant further informed that he has to appear before the Railway Medical Board the next day, i.e. on 24th to arrive at a decision.

The Respondent contended that the Employer's Certificate of complainant shows that he is undergoing Secondary duties for which he is paid and also the premiums were deducted from his salary. Hence the disability claim was repudiated on the basis of clause 10(4) of Policy conditions.

The complainant informed vide his letter dated 18.02.2006 that the Medical Board Examination could not be held up to 7th Feb. 2006.

It is observed from records that the Complainant is continuously on sick leave from 31.12.2004 and he is unable to perform his secondary duties. His salaries were paid till the leaves were in his credit up to May, 2005 and thereafter no salary was paid to him as no work no pay. Hence, the repudiation of disability benefit is not justified.

In view of the circumstances stated above, I am of the considered opinion that the denial of Disability Benefit claim by the Respondent on this ground is unfair and unjustified. However, the Complainant is directed to submit the outcome report of medical examination before the Medical Board to the Respondent and the Respondent

is directed to reopen the case and consider on merits within 30 days from the receipt of the outcome of medical examination before Medical Board. If the complainant is not satisfied with the decision taken by the Respondent, the complainant would be free enough to approach this forum with a fresh complaint. The complaint is thus disposed off.

Bhopal Ombudsman Centre
Case No.: LI-661-24/12-06/IND
Smt. Tarabai
Vs. Life Insurance Corporation of India

Award Dated 27.03.2006

Smt. Tarabai, Complainant is the wife of late Shri Mangilal Teli, DLA. DLA took a life insurance policy numbered 341423190 from the Respondent. The DLA died on 21.05.05. The death claim was preferred by the Complainant, being nominee under the policy, with the Respondent. But the same was delayed. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The Complainant stated that the DLA was her maternal uncle who had taken two policies, one of them was nominated in her Aunty's favour while the other policy was nominated in Complainant's favour. The death claim for the policy in question is to be paid to her, being nominee.

The Respondent informed that the matter was found suspicious and the same was put to investigation and decision shall be taken only on receipt of investigation report.

It is observed that there is no concrete reason found to accept the delay in settlement of claim by respondent even after a period of 8 months from submission of all claim papers in July, 2005.

Hence, the Respondent's decision of delaying the claim payment under the policy is not tenable. It is further observed that in the instant case, the relationship between the DLA and nominee is maternal uncle & niece. Thus the nomination was not made in favour of any stranger.

In view of the circumstances stated above, I am of the considered opinion that the delay in settlement of claim by the Respondent on this ground is unfair and unjustified. However, the Respondent is directed to decide the claim on merits within 30 days from receipt of this Order. If the complainant is not satisfied with the decision taken by the respondent, the complainant would be free enough to approach this forum with fresh complaint.

The complaint is thus disposed off.

Bhopal Ombudsman Centre
Case No.: LI-662-23/12-06/RPR
Shri Santosh Kumar Shrivastava
Vs. Life Insurance Corporation of India

Award Dated 15.02.2006

Shri Santosh Kumar Shrivastava, complainant took a life insurance policy numbered 380762741 under Jeevan Suraksha Pension Plan from the Respondent. The Policy was taken on 28.02.1997 with yearly premium of Rs. 9958/-, the pension instalment being Rs. 1267 and cash option of Rs. 130000/-. When the policy matured in Feb. 2005, he

was due for Pension amount of Rs. 1267/- but he was paid only an amount of Rs. 844/- . Later on, when the matter was taken up by him with the Respondent, he was paid an amount of Rs. 1125/- instead of 1267/-. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

During hearing, the Respondent explained to the complainant that he had teken the policy under individual pension plan under table 122 on 28.02.1997 and as per his proposal monthly annuity of Rs. 1267/- is payable, which copies under option 'D'. While as per option 'F' the complainant will get pension @ Rs. 1125/- per month till his survival and at the time of death of the complainant, the nominee will get capital amount of Rs. 130000/-. This is considered to be beneficial for the complainant as per his revised option dated 20.09.2004.

The complainant was convinced with the Respondent's explanation.

In view of the above, the decision taken by the Respondent is just and fair and does not require any intereference.
The complaint is thus disposed off.

Bhopal Ombudsman Centre
Case No.: LI-717-25/02-06/IND
Shri Ajij Khan
Vs. Life Insurance Corporation of India

Award Dated 23.03.2006

Shri Ajij Khan, Complainant took a Future Plus Policy from the Respondent. The complainant reported to have paid a single premium of Rs. 50000/- under Miscellaneous Receipt No. 783 on 31.03.2005. The complainant is not in receipt of either any completion particulars or Policy bond from the Respondent. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The complainant contended that he neither received Policy bond nor original receipt for the abovementioned proposal.

The Respondent handed over the Policy bond to the complainant with the corrections duly effected therein and the same was received by the Complainant.

In view of the above, it is clear that the complaint has been redressed by the Respondent. Thus the complaint is filed without any relief.

Bhopal Ombudsman Centre
Case No.: BA-687-23/01-06/RPR
Shri Ajay Agrawal
Vs. Bajaj Allianz Life Insurance Co. Ltd.

Award Dated 28.02.2006

Shri Ajay Agrawal, Complainant holds a life insurance policy numbered 0006691457 from the Respondent. The complainant had applied for switch over from Allianz Bajaj balance plus pension to Allianz Bajaj equity plus Pension on 28th October, 2005 but the same was made effective by Respondent only on 8th November, 2005 which led to unit

loss to the Complainant. Also, certain aspects of plan, viz., deduction of units against life cover and tax liability of maturity proceeds were not explained to him properly by the Respondent. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The Respondent informed that the request letter to switch over the fund was signed by the policyholder on 28.11.2005 without signature of witness, which was returned by hand on the same day to the policyholder asking him to submit the same with the signature of witness. Further the Respondent stated that the switching form was submitted on 07.11.2005 during late hours duly signed by witness and finally switching was done on 08.11.2005. The respondent produced the copy of request letter duly signed by policyholder and witness.

It is observed from the copy of the request letter to switch over the fund that the same was signed by witness on 07.11.2005 and switching was effected on 08.11.2005. Hence the contention of the Complainant for delay in switching over the fund from 28.10.2005 to 08.11.2005 is not tenable.

In view of the above, the action taken by the Respondent in switching over the fund is just and fair hence does not require any interference. The complaint is dismissed without any relief.

Bhopal Ombudsman Centre
Case No.: IC-599-23/10-06/MUm
Shri Rajeev Lahoti
Vs. ICICI Prudential Life Insurance Co. Ltd.

Award Dated 09.01.2006

Shri Rajeev Lahoti, Complainant took a life insurance policy numbered 00455489 from the Respondent on 14.07.2003. The complainant has complained that there was wrong allocation of premium by the Respondent for the year 2004 in Protector fund instead of Balancer fund, which is more financially beneficial. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The Policy No. 00455489 was issued to the Complainant by the Respondent under Life Time Pension Plan with risk date 14.07.2003 and the Policy was issued on 16.07.2003 with premium instalment of Rs. 10000/-.

The Respondent stated that the complainant had opted for 100% premium allocation of Protector fund in the Proposal form. Thereafter on 15.12.2003, the complainant had applied for 100% fund switch over from Protector to Balancer fund. However, the complainant has not opted for premium redirection along with the switch over option. Hence his request was not acceded to.

It is observed from records that the Application for Funds Switch/Premium Redirection submitted by the Complainant to the Respondent on 15.12.2003 shows that the complainant had opted for switching over the whole fund i.e. 100% from Protector to Balancer fund under the head ‘Fund Switch’ of the said application and the first portion has been left blank, unanswered by the complainant under the head ‘Premium Redirection’.

It is further observed that the Respondent has acceded to the request of the Complainant by Switching over the Fund from Protector to Balancer fund only for the year 2003. The complainant's grievance is that the Switching over option has not been carried out by the Respondent for the year 2004 only. Whereas, the Respondent has taken the plea that the Complainant has given his reply only under the head 'Fund Switch' in the application for funds switch/premium redirection by unanswering under the head 'Premum Redirection', which has also to be answered for availing the option of 100% fund switch over from Protector to Balancer fund for the whole life time.

But the Respondent failed to adduce documentary proof to show that any follow-up action was made with the complainant for getting clarification on the unanswered portion of the said application viz., 'Premium Redirection'.

In view of the above, it stands that the Respondent's decision of disallowing the option of 100% fund switch over from Protector to Balancer fund for the year 2004 is not tenable. Thus, in the absence of proper communication, the premium cannot be redirected to the old option.

Hence, the Respondent is directed to shift the said fund from Protector fund to Balancer fund for the year 2004 with retrospective date, within 15 days of receipt of this Order.

Bhopal Ombudsman Centre
Case No.: LI-664-25/12-06/IND
Shri Rajendra Seiwal
Vs. Life Insurance Corporation of India

Award Dated 28.02.2006

Shri Rajendra Seiwal, Complainant took a Future Plus life insurance policy numbered 342793951 from Respondent. The complainant had noticed in his policy bond that the details of nominee & Accident benefit were mentioned incorrectly. The complainant has complained that he did not opt for the Accident Benefit but still the same option has been shown on the Policy Bond as 'Yes'. The Respondent did not bother to rectify the same in spite of several visits and reminders. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The Complainant contended that the only correction in the name of Nominee has been effected but the units are not changed accordingly due to exclusion of life cover and double accident benefit.

The Respondent contended that the accident benefit was given due to an oversight and now they have made the correction in the name of nominee and further stated that the difference in number of units in credit without life cover and double accident benefit could not be rectified earlier due to technical problem in software.

It is observed from the records that the Respondent carried out necessary corrections but did not inform the Complainant about difference in number of units credited after correction. During hearing the Complainant also agreed with the difference in number of units in credit as informed by the Respondent.

In view of the above, the Respondent is directed to give the credit of units from the date of application from removal of life cover and double accident benefit submitted by the complainant within 15 days from the receipt of this Order.

Bhopal Ombudsman Centre
Case No.: LI-685-24/01-06/RPr
Shri Sadhuram
Vs. Life Insurance Corporation of India

Award Dated 15.02.2006

Shri Sadhuram, Complainant took a life insurance policy numbered 381415101 from the Respondent. The policy fell due for Survival Benefit claim for an amount of Rs. 5000/- on 12.08.2004. The payment was delayed. The claimant preferred a complaint to this Office.

Observations of Ombudsman:

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follows:

The Respondent requested for 15 days' time to redress the grievance. Hence, the Respondent was allowed 15 days' time from the date of hearing to settle the claim. Accordingly as directed, the Respondent confirmed vide its letter dated 14.02.06 about the payment particulars of SB claim under the Policy.

In view of the above, as the complainant's grievance has been redressed by the Respondent, the complaint is thus disposed off without any other relief.

Chandigarh Ombudsman Centre
Case No. LIC/011/Chandigarh/Chandigarh-II/22/06
Smt. Kusum Lata
Vs
Life Insurance Corporation of India

Award Dated 04.10.2005

FACTS : Smt. Kusum Lata got a policy bearing no. 162522737 with DOC 28.10.03 from BO Chandigarh, Unit-II. The policy was assigned to E.P.F.C., Jalandhar as premium was to be paid out of her EPF account. She contended that the agent got blank proposal papers signed from her, without informing her about pros and cons of the policy. Besides, Rs. 22,101/- was deducted out of her account in October 2003 towards first premium instalment, while her annual contribution to EPF account was only Rs. 16,386/-. Upon her representation, EPF Commissioner, Jalandhar stopped deducting premium. She deposited Rs. 24,000/- in lieu of amount paid to LIC as the first premium instalment inclusive of interest and got the policy reassigned in her name. After going through the terms and conditions of the policy, she decided to discontinue the policy and urged that premium instalment be refunded to her.

FINDINGS : It was admitted on behalf of the insurer that the premium payment was received through EPFC and the case was completed on 28.10.2003. The policy was assigned in favour of EPFC, Jalandhar on 15.12.2003. Since the policy has not run for three years, surrender value was not payable to the policyholder. The complainant stated that she filed a representation with LIC on 31.05.2004 stating that as annual deduction towards insurance premium was more than her contribution towards EPF, the policy be discontinued and the first premium instalment be refunded. She was informed that as the policy was assigned in favour of EPFC, the amount of premium could not be refunded. She, accordingly, approached the office of EPFC. She was advised to deposit premium amount together with interest so that the policy could be reassigned in her favour. Accordingly, she deposited the same together with interest and the policy was reassigned in her name on 07.03.2005. It was admitted by the insurer that the

terms and conditions as required under Regulation 6(2) of IRDA Regulations, 2002 for Protection of Policyholders' Interests were not conveyed to the policyholder.

DECISION : Held that the complainant was obviously misled into buying the policy by the agent for his pecuniary benefit. Besides, terms and conditions were not explained to her nor were these conveyed to her as required under Rule 6(2) of IRDA Regulations, 2002 for Protection of Policyholders' Interests. Therefore, ordered that the amount of premium deposited by the complainant be refunded to her after deducting initial expenses and the amount of risk premium for the period the policy remained in force.

Chandigarh Ombudsman Centre
Case No. HDFC/144/Mumbai/Moga/22/06
Shri Nitish Jain
Vs
HDFC Standard Life Insurance Co. Ltd.

Award Dated 28.10.2005

FACTS : Shri Nitish Jain purchased a policy bearing no. 10080280 on 02.11.04. The policy bond was received on 10.07.2005 after repeated requests through Mrs. Shweta Jain, the Financial Consultant. He was dismayed to find that Mrs. Shweta Jain had put herself as the beneficiary instead of his mother. She also claimed herself to be as his sister, while he has only one 18 years old sister as shown in the family history in the proposal form. He checked up the other two policies bearing nos. 10028435 and 10010568 and observed that his signatures appeared to have been forged. Besides, in policy no. 10010568 she had given her own address instead of his father's who was the nominee. He sought refund of premium with interest as he did not wish to have any dealings with the company any more. He also complained about non-receipt of cheque for refund of premium under policy no. 337133, supposedly issued by the insurer on 17.05.05.

FINDINGS : The representative of insurer stated during hearing that it could not be verified whether signatures of the policyholder had been forged. It is for the complainant to establish the same by obtaining opinion from a handwriting expert. It was suggested that complainant be advised to furnish correct particulars of the nominee/beneficiary so that the same could be taken on record. Besides, the complainant having admitted that he signed the blank proposal forms, he was himself to be blamed. It was pointed out that the policies were issued in 2004 and the request for refund of premium made belatedly. It was stated that the company has already taken penal action against financial consultant by terminating her services. As regards non-receipt of payment in respect of policy no. 337133, it was admitted that cheque for Rs. 20192/- issued on 16.05.05 was misplaced by the Chandigarh Branch. Another cheque for Rs. 20,393.92 was issued on 19.08.2005. It was, however, urged that allegations of the complainant in respect of policies bearing nos. 10028435 and 10010568 could not be taken cognizance of, unless correct information was furnished. As the complainant was negligent in not returning the policy within "free look period", initial premium could not be refunded. But surrender value as per terms and conditions of the policy can be refunded, provided a formal request is received from the complainant. The complainant sought refund of premium for policies bearing nos. 10028435 and 10010568 on the ground that his signatures were allegedly forged on the proposal forms, though he admitted that policies issued were the same as were sought by him.

DECISION : Held that in respect of policy bearing no. 10080280, as the financial consultant had declared herself as the beneficiary and put the financial interest of the complainant in jeopardy, the amount of premium paid under the policy was refundable. However, refund of premium under policies bearing nos. 10028435 and 10010568 cannot be allowed as request for the same was not received within "free look period".

Chandigarh Ombudsman Centre
Case No. LIC/166/Karnal/Gohana/22/06
Smt. Kamla Devi
Vs
Life Insurance Corporation of India

Award Dated 10.11.2005

FACTS : Smt. Kamla Devi had taken a money back policy for sum assured of Rs. 40,000/- from BO Gohana. First SB instalment of Rs. 10,000 was due in November'2004. She was, however, given a cheque for Rs. 3,336/- by Shri Mehar Singh, Headmaster, G.H.S. Thaska. She stated that Shri Mehar Singh, who also acts as LIC agent got issued a fresh policy bearing no. 173928939 with DOC 15.11.04, by forging her signatures just to get commission. She met the Branch Manager, Gohana and complained about it. She was assured that her policy has been cancelled and she would get the refund of Rs. 6664/-, being the annual premium after some months. Later she was informed that the policy could have been cancelled only within a month of its issuance and was advised to keep it in force. She requested this office to get her refund for the balance amount.

FINDINGS : Insurer informed that the complainant's request was received on 19.07.05, eight months after issuance of policy bond. It was stated that since the request for cancellation was not within the "cooling off period", it could not be entertained and she was informed accordingly. It was pointed out that B.O., Gohana had also received consent letter from the life assured for deduction of premium instalment in respect of new policy out of survival benefit payable to her. As regards alleged forging of her signatures, it was stated that explanations of the agent and the Development Officer were called. Shri Rajesh Kumar, agent stated that signatures on the proposal form were not fake and the complainant had signed in the presence of Development Officer.

The complainant stated that she did not ask for any fresh policy. Her signatures were obtained on a blank paper and she was given to understand that these were meant for payment of survival benefit amount. She admitted her signatures on the authorization letter, but vehemently denied the same on the proposal form. She further stated that as soon as she got the policy bond, she deposited it with the B.O. She was assured that it would be cancelled and amount refunded very soon. She also sent a letter for cancellation of the policy and refund of premium amount on 4.10.05. A copy of this letter was shown by her. The insurer confirmed that the version of the complainant was correct as the policy bond was lying in the branch office. It was evident that neither the policy bond was cancelled nor returned to the policyholder. She sent another letter through registered post on 17.07.2005.

DECISION : Held that the complainant's version was credible, as copies of letters addressed to the Branch Office for cancellation of the policy were shown. The policy was thrust upon her fraudulently and after she deposited it for cancellation, no action was taken. Ordered that the premium deposited be refunded after deducting initial expenses along with risk premium for the period the policy has been in force. The insurer was advised to take preventive steps to avoid recurrence of such lapses in future.

Chandigarh Ombudsman Centre
Case No. Aviva/207/Delhi/Gurgaon/21/06
Shri Prithipal Singh Bhatia
Vs
Aviva life Insurance Co. Ltd.

Award Dated 22.12.2005

FACTS : Smt. Harjit Kaur purchased a policy bearing no. LLG-1011077 from Aviva Life Insurance on 18.07.2002 for sum assured of Rs. three lakhs with critical illness rider. She fell ill and had to undergo open heart surgery. She lodged a claim for Rs. 2,70,250 which was declined by Aviva Life Insurance on the ground that she did not satisfy the eligibility criteria under the policy. She urged that the insurer was liable to pay the claim together with damages and interest w.e.f. 09.04.2003, when she filed the claim.

FINDINGS : The life assured reportedly had complaint of chest pain. She underwent ECG and Echocardiography and was advised to undergo angiography followed by heart surgery (CABG). Based on the findings, the claim was filed on 10.04.2004, before undergoing heart surgery. After receipt of claim form, reports submitted by the life assured were analyzed. It was revealed that there was no history of typical chest pain and ECG also did not indicate new elecrocardiographic changes suggestive of heart attack. It was stated on behalf of the insurer that article 9.1 of the critical illness rider of the life long policy has been duly approved by the IRDA. Under the said article, heart attack has been defined as death of a portion of the heart muscle as a result of abrupt interruption of adequate blood supply to the area which must be evidenced by history of typical chest pain and new electrocardiographic changes. It was stated that as the criteria was not satisfied, the claim was declined and the claimant informed accordingly. Besides, the company had received claim form for day care in Dr. Ved Prakash Kohli Medical Centre and not for hospitalization in Escort Heart Institute and Research Centre.

On behalf of the insurer it was urged that life assured had chest pain and was taken to hospital. She did not suffer from heart attack and was advised to go in for angiography and heart surgery (CABG). It was contended that life assured had filed the claim before undergoing heart surgery which is corroborated by the medical findings. The opinion taken from Dr. Balwant Kalra, Cardiologist indicated that the complainant had no condition of heart attack and the treatment taken did not cover heart attack. The claimant has been suffering from rheumatic heart disease. Besides, invoice/documents supporting claim form have not been submitted, despite reminders.

DECISION : Held that the complainant failed to submit documents called for by the insurer despite reminders. In the absence of requisite documents, the admissibility of claim cannot be determined. Besides, as per expert medical opinion the claim does not fall under critical illness enumerated under article 9.1 of the Critical Illness Riders of the policy. Hence the complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. Birla Sun Life/179/Mumbai/Ldhiana/22/06
Shri Gulzar Singh
Vs
Birla Sun Life Insurance Co. Ltd.

Award Dated 26.12.2005

FACTS : Shri Gulzar Singh obtained a Flexi life-line policy (whole life) bearing no. 000424901 from Birla Sun Life Insurance Co. Ltd. He contended that he was persuaded to purchase the policy by Shri Prabhjot Cheema, agent through misrepresentation. He

made him believe that if he deposited Rs. one lakh per annum for four years, he would get Rs. seven lakhs and fifty thousand at the end of fourth and beginning of 5th year. He went abroad from 19th May, 2005 to 18th July, 2005. After return, he fell sick and underwent treatment for depression and heart problem. After consulting a friend he came to know that the policy received in his absence was an insurance policy and there was no provision for refund of money, as he was made to believe. He also found some inaccuracies viz., his annual income was recorded as four lakh while it was less than Rs. 1.25 lakh. The agent did not record in the proposal form the pre-existing diseases suffered by him. He felt cheated and therefore, sought refund of Rs. one lakh deposited by him and requested that action be taken against the agent.

FINDINGS : On behalf of the insurer it was stated that the policyholder did not approach the company for cancellation of policy within "Free Look Period", nor did he disclose in the proposal form any of the ailments which he claimed to be suffering from. On behalf of the complainant, it was stated that the life assured being an undergraduate, his understanding of business was poor and he was made to believe by the agent that the investment will fetch him good return. When he discovered that it was not true, he approached the company for cancellation of policy. The representative of the insurer stated that the request for cancellation of policy was received from the policyholder only through this office. It was admitted that the proposer was suffering from heart problem and was under-treatment for depression. As per the proposal form, the policyholder was a graduate and his annual income was Rs. four lakh per annum. On behalf of the complainant, it was pointed out that as per Income Tax returns, the annual income of the policyholder was below Rs. 60,000/- during 2003-04 and 2004-05. The representative of insurer stated that as the sum assured was below Rs. 15 lakhs, proof of income was not obtained and only financial statement was taken from the policyholder. And since it was a non-medical case, no medical examination was conducted.

DECISION : Held that there were discrepancies in the proposal form regarding complainant's income and health status. As the policyholder has disclosed truthfully his annual income as well as health status, this may jeopardize the insurer's interest. Had these facts been recorded correctly in the proposal form, the underwriting decision might have been different. The policyholder was abroad when the policy was received by his family members, and later on return he was taken ill. Therefore, he could not apply for cancellation within the "cooling off period" for reasons beyond his control. Giving him the benefit of doubt, ordered that policy be cancelled and premium refunded subject to deduction of risk premium and other necessary administrative charges as per IRDA regulations.

Chandigarh Ombudsman Centre
Case No. LIC/225/Karnal/Bhiwani/22/06
Shri Dalbir Singh
Vs
Life Insurance Corporation of India

Award Dated 29.12.2005

FACTS : Shri Dalbir Singh had taken a money back policy bearing no. 220953998 from Branch Office, Bhiwani. When he visited the B.O. to collect payment of survival benefit, he was prevailed upon to buy a fresh policy bearing 174592602 for sum assured of Rs. 55000/- and the amount of survival benefit was adjusted towards first premium instalment. He contended that he was misguided by some officials in the B.O. When he consulted another agent, he came to know that this was not the policy he intended to

buy. He requested for change of policy, but was informed that the change could be effected only after one year. He submitted that his request for cancellation of policy was also not acceded to.

FINDINGS : During hearing, the complainant reiterated that he did not want to continue the policy as the policy in question was not the same as he wished to have. The representatives of insurer pointed out that the complainant himself proposed to get a policy under Table-Term 14-15 by depositing Rs. 4097/-. He deposited Rs. 4000/- through SB instalment cheque and Rs. 97/- in cash on 22.08.2005. The complainant again visited the B.O. on 20.10.2005 and submitted a letter for cancellation of policy but he failed to explain why he wished to have the policy cancelled. An offer was made to the complainant on behalf of the insurer during hearing to change the policy as per his requirement, but he was insistent upon cancellation.

DECISION : Held that as the complainant was pressurized to go in for the second policy, it would be fair to let him have the policy cancelled since he had approached within "cooling off period". Ordered that the policy be cancelled after deducting initial expenses and the risk premium as admissible under Rule 6(2) of IRDA Protection of Policyholders' Interests Regulations 2002.

Chandigarh Ombudsman Centre
Case No. LIC/199/Shimla/Dharamshala/25/06
Smt. Yeshi Dolkar
Vs
Life Insurance Corporation of India

Award Dated 30.12.2005

FACTS : Smt. Yeshi Dolkar and her husband deposited 1.50 lakhs each for purchase of Bima Plus Policy under risk fund. She found that while her husband had been issued 7278.680 units for 1.5 lakh, she was issued units for sum of Rs. one lakh only and that too under secured fund. The balance amount of Rs. 50,000/- was kept in deposit. She took up the matter with Branch Manager, Dharamshala requesting him to rectify the error. While taking corrective action, "switchover charges" @ 2% of the fund value were charged for conversion from secured fund to risk fund and after adjusting Rs. 50,000/- lying in deposit, she was issued 2304.444 units @ 21.4164 each. The number of units issued to her under both the policies added to 6702.568. Her grievance is that she should have received more units than her husband, as she was younger to him. However, she was issued 576.112 units less than her husband on account of bungling by the branch officials.

FINDINGS : The insurer admitted that the policyholder had deposited Rs. 1.50 lakhs on 22.01.05 for purchase of Bima Plus policy under risk fund, but due to wrong keying in of data the policy was issued for Rs. one lakh on 25.01.05. When she pointed out the mistake, another policy bearing no. 151653248 for Rs. 50,000/- with DOC 11.02.05 was issued. It was acknowledged that policy for Rs. 1.50 lakhs should have been issued to her effective from 25.01.05. However, under Bima Plus plan there is no provision for back - dating the policy. As the rate of units on different dates varies, the policy effective from 25.01.2005 could not be issued. The representative of the complainant stated that switchover charges @ 2% were charged for conversion from secured fund to risk fund, though she was not at fault. It was urged that she should be compensated for the loss of Rs. 11,678/- suffered by her on account of increase in the price of units on the date of issue for Rs. 50,000/-.

DECISION : Held that recovery of switching-over charges @ 2% from secured to risk fund was unwarranted. Besides, the plea taken on behalf of insurer that there is no

provision for back dating of policy and waiving of switchover charges was not acceptable. The complainant was made to suffer financial loss as the number of units issued to her was less compared to the units issued to her husband, when both of them had applied on the same date for the same sum assured. Ordered that in lieu of 576.112 units given short by the insurer, the complainant be paid a sum of Rs. 11,678/- (576.112 units @ Rs. 20.27 each unit, the rate on the date of issue of policy). Further, to assuage her hurt feelings, insurer was advised to express regrets for the lapses assuring her of better service in future.

Chandigarh Ombudsman Centre
Case No. LIC/249/Chandigarh/Cha-II/25/06
Shri Amarjit Singh & Balwinder Kaur
Vs
Life Insurance Corporation of India

Award Dated 24.01.2006

FACTS : Shri Amarjit Singh and Smt. Balwinder Kaur purchased policies from Branch Office-II, Chandigarh in July 2004. The policy bonds were not received even after a lapse of one year despite repeated requests to the agent and the Development Officer. The delay caused them mental harassment and they sought compensation for the Same.

FINDIANGS : The insured contended that policy of Shri Amarjit Singh was sent to him under registered post on 09.10.2004 which was not received back undelivered and that if the policyholder so desired, a duplicate policy bond could be issued after completing requirements. The other policy of Smt. Balwinder Kaur was sent through the agent, Shri Rama Sharma for prompt delivery. The explanation of the agent was called for by B. O. vide letter dated 26.12.2005, but nothing was heard from him. The insurer urged that penalty for issuance of duplicate policy be imposed on the agent and all other charges should also be borne by him.

There was no lapse on the part of insurer in so far as issue of policy to Shri Amarjit Singh was concerned as the policy was sent through registered post. The presumption in law is that the same must have been received by the complainant.

So far as non-receipt of the policy of Smt. Balwinder Kaur was concerned, the agent failed to deliver the same to the policyholder. As agents work under the control of the insurer, for any misdemeanour or misconduct, the insurer should take him to task. However, the interest of the policyholder should not be allowed to be jeopardised due to negligence on the part of this intermediary who is supposedly a service provider and a facilitator.

DECISION : Held that the duplicate policy be issued to Smt. Balwinder Kaur and she be also paid compensation of Rs. 1,000/- for the mental harassment suffered by her. It is for the insurer to decide whether charges for preparation of duplicate policy and the compensation to be paid to the complainant are to be recovered from the agent.

Chandigarh Ombudsman Centre
Case No. LIC/291/Shimla/Dharamshala/24/06
Shri Purshotam Lal
Vs
Life Insurance Corporation of India

Award Dated 25.01.2006

FACTS : Shri Purshotam Lal had taken a policy under pension plan from Branch Office, Dharamshala. The payment of annuity was due from March 2005. On an enquiry from

B. O., he was informed that the documents have been sent to IPP Cell, New Delhi. He sent three reminders to know the status of the case, but there was no response. Feeling aggrieved, he filed a complaint in this office on 11.01.2006 and sought intervention.

FINDINGS : When the complaint was referred to Sr. Divisional Manager, Shimla, it was confirmed through e-mail that annuity cheques had already been issued to the policyholder on 19.01.2006, and the grievance of the complainant stood redressed. It was not clear whether interest for the period of delay was paid.

DECISION : Held that the interest @ 7 % for the period of delay be paid to the complainant, if not already paid.

Chandigarh Ombudsman Centre
Case No. LIC/279/Karnal/Yamunanagar/22/06
Shri R. P. Bansal
Vs
Life Insurance Corporation of India

Award Dated 31.01.2006

FACTS : Shri R. P. Bansal had taken five policies for self and members of his family during the period November 1996 to March 1998. The policies lapsed after discontinuation of payment of premium for six months to 1 ½ years. He pleaded that the amount of premium paid by him should be refunded to him as he is 55 years old and has marriageable daughters.

FINDINGS : The insurer confirmed vide letter dated 27.01.06 that all the five policies were lying in a lapsed condition for more than five years. As per rules these could not be revived. The policies also did not acquire any paid up value, as the premium had been paid for less than three years. Therefore, under terms and conditions of the policies, nothing was payable and policyholder was duly informed.

Parties were heard on 30.01.2006. The complainant pleaded that he could not contiunue the policies due to financial constraints. The policy bonds were with the agent who had assured him that these would be got revived. On behalf of the insurer, it was reiterated that there is no provision for refund of premium, nor have the policies acquired paid-up value.

DECISION : Held that in terms of policy conditions it was not possible to refund premium nor was it possible to revive the policies. Hence the complaint was dismissed.

Chandigarh Ombudsman Centre
Case No. LIC/313/Ludhiana/Bathinda/22/06
Shri Jaswant Rai
Vs
Life Insurance Corporation of India

Award Dated 14.02.2006

FACTS : Shri Jaswant Raj took a Jeevan Surabhi policy on 03.11.1993 for sum assured of Rs. 25,000/- from Branch Office, Bathinda. As per provisions of the policy, he received two instalments of survival benefit of Rs 7,500/- each after 4th and 8th years respectively. However, third instalment of Rs. 10,000/- which became due in November 2005 was not released. He visited the B. O. many times personally, but the amount was not paid to him.

FINDINGS : The complaint was referred to Sr. Divisional Manager, Ludhiana on 20.01.2006 for para-wise comments and submission of a self-contained note giving full facts of the case. Manager (PS/SSS/CRM) informed vide letter dated 03.02.2006 that the payment has been made to the complainant on 30.01.2006, the receipt of which has duly been acknolwdeged by him.

DECISION : Held that while the grievance of the complainant was redressed, interest @ 8 % p.a. for the period of delay was also payable to him.

Chandigarh Ombudsman Centre
Case No. TATA AIG/147/Mumbai/Amritsar/22/06
Dr. Sandeep Sharma
Vs
TATA AIG Life Insurance Co. Ltd.

Award Dated 16.03.2006

FACTS : Dr. Sandeep Sharma had taken a Maha Life policy on 08.12.2004 from B.O., Chandigarh for sum assured of Rs. four lakh. He was given to understand that while he would pay premium for 12 years, the accident and disability benefits would remain in force for life. He was informed that the policy has in-built rider for life. When he made inquiries from TATA AIG Help Line, he was told that these benefits are co-terminus with the term of the policy i.e. for 12 years only and if he wished to avail of rider benefits beyond maturity, he will have to pay additional premium. He felt that this was unethical way of doing business and lodged a complaint with the Help Line, three months prior to filing complaint in this office. He pleaded that either the rider benefit should be discontinued, so that annual premium comes down to Rs.27,560/- against Rs. 29,060/- or else the policy may continue in the present form but the rider benefits should be allowed for life as promised by the consultant.

FINDINGS : Comenting on the complaint, it was informed vide letter dated 05.09.05 that rider benefits are applicable till the premium paying term of 12 years. In this connection, relavant extract from the policy contract was reproduced which reads as under :

"Unless otherwise specified, the Expiry Date for a Supplementary Contract or Rider falls on the Policy Anniversary equal to the number of years for which premiums for the relevant Supplementary Contract are payable as shown in the Schedule of Coverages, Benefit and Premiums of the Policy Information Page."

In was further stated the TATA AIG does not indulge in mis-sale to customers and is committed for procuring business in an ehical manner. The contract specially provides for payment of premium for continuance of rider cover on the policy achieving anniversary. The complainant was given suitable advice whenever he contracted helpline executives.

The complainant stated that at the time of purchase of policy he was given to understand by the agent that rider benefits are life-long and build-in in the policy. After receipt of policy bond he discovered that these are co-terminus with maturity date, and additional premium was payable if these were required to be availed after maturiry. This was also confirmed by the helpline. He represented to the insurer that either commitment given by the consultant be honoured or the policy altered by dispending with the rider benefit and the premium instalment reduced accordingly. He further stated that having had bad experience with insurer, he would rather prefer cancellation of policy.

The representative of insurer stated that the complainant had failed to exercise the option of surrendering the policy **"within cooling off period".** This provision takes care of complaints regarding mis-sale, if any. The policyholder is not at liaberty to ask for cancellation, as and when he pleases. After consulting his Head Office, he, however, offered that :

i) the sum assured can be raised to Rs. 4.13 lakh, keeping the premium and rider benefits intact; or

ii) the sum assured can be raised to Rs. 4.30 lac against the same premium and rider benefits would be discontinued. In effect, the premium on account of rider benefits will be merged with the main plan.

The complainant, when contacted telephonically, did not accept any of these conditions.

DECISION : Held that cancellation of policy as insisted upon by the complainant at a belated stage is not in conformity with the terms and conditions of the policy. Having regard to flexibility shown by the insurer, it was ordered that alternative offers be made to the complainant formally within 15 days of receipt of this order subject to fulfilment of requirements by him for making necessary alterations in the policy, if so wished.

Chandigarh Ombudsman Centre
Case No. Birla Sun Life/373/Mumbai/Jalandhar/22/06
Shri Pritpal Singh
Vs
Birla Sun Life Insurance Co. Ltd.

Award Dated 21.03.2006

FACTS : For purchase of a policy from Birla Sun Life, Shri Pritpal Singh issued a cheque bearing no. 547754 dated 01.07.05 for Rs. 10,144/-. The cheque was debited to his saving account. However, he was informed that the cheque was returned unpaid by the company's broker, Citibank. He felt insulted as the amount had already been debited to his account, and it was not adjusted in his policy account. He formally lodged a complaint with the insurer, but he did not get any response. He spoke to Branch Manager, Jalandhar, who instead of helping him found fault with him and asked him to check up the matter from his banker. He was upset as it is for the insurer to check where the cheque was duly accounted for. So far he was concerned, the same had been debited to his saving account. He stated that efforts made by him for over six months to get the credit for the premium paid, did not bear any fruit. He was suffering loss as the sensex has gone very high and rates of units have increased since July 2005. He sought intervention in getting the amount credited to his policy account. He also demanded compensation of Rs. One lakh as company had given him false information that his cheque was retured unpaid. He further demanded that the amount should be credited to his policy effective from July 2005 and units should also be computed accordingly.

FINDINGS : The insurer with whom the matter was taken up informed vide letter dated 09.03.2006 that the policy has been reinstated since July 2005 and the complainant has been informed about it. The inconveninence caused to the policyholder was regretted.

The complainant had to wait for six months and represent at various levels before his grievance was redressed. The issue was very simple. He issued a cheque which was debited to his saving account. The lapse was on the part of banker as credit was not given in the insurer's account. The complainant obviously was under considerable

stress and felt harassed at the hands of the Branch Manager and branch officials, as nobody was ready to listen to him. On the contrary, they unjustifiably found fault with him.

DECISION : Held that since it was a case of serious deficiency in service, a token compensation of Rs. 1,000/- be paid to the complainant for the harassment suffered and mental agony undergone. The insurer was also advised to avoid recurrence of such lapses.

Chandigarh Ombudsman Centre
Case No. LIC/347/Chandigarh/BO-III/22/06
Shri Dinesh Kumar Mittal
Vs
Life Insurance Corporation of India

Award Dated 27.03.2006

FACTS : Shri Dinesh Kumar Mittal purchased a policy on 28.09.2003 from Branch Unit-III, Secrtor 34 - A, Chandigarh. The policy was assigned in favour of Central Board of Trustee, Employees Provident Fund. He felt aggrieved as he was made to sign on blank proposal papers without explaining the pros and cons of the policy. When he received FPR, he discovered that the annual premium payable was more than his contribution to EPF account. He felt that a fraud was perpetrated on him. On his request, further premium payment to LIC authorities was stopped by APFC and he got the policy reassigned in his favour. He urged that LIC authorities be directed to refund the first premium instalment of Rs. 16,014/- deducted out of his EPF account.

FINDINGS : During hearing on 13.03.2006, Shri Dinesh Mittal stated the policy was produced in September 2003 and he applied for cancellation in April 2004. He received the FPR in December 2003. He was given to understand by the agent that the premium will be financed out of interest accruals in his account. The agent misled him by stating that there was a tie up between the insurer and head office of the bank. He stated that one Shri Surinder kumar from the office of APFC accompanied the agent who had full details of the EPF accountss. When he received EPF account statement in April 2004, he noticed that the premium outgo was more than his annual contribution. A circular was issued by APFC that they cannot apply for withdrawal from the fund since premium for policy was being financed out of their contribution. Therefore, he tried to establish contact with the agent. He also made a representation to LIC authorities on 07.04.2004 for cancellation of policy. He was informed that the policy could have been cancelled only within 15 days after receipt of the policy bond. But he had neither received the policy bond nor were the terms and conditions conveyed to him. He was advised by the offices of APFC to deposit the premium amount together with interest to get the policy reassigned. He deposited the same with APFC and the policy was sent to the B. O. for reassignment. He came to know about the order of this Forum dated 04.10.2005 issued in the case of Smt. Kusum Lata. He urged that as the facts of his case were similar, the initial premium deposit be refunded to him.

The representative of insurer, however, pleaded that nature of complaint was similar to those pending before the Supreme Court. However, the facts of this case are exactly identical with the case of Smt. Kusum Lata, as in her case also the main argument in favour of cancellation of policy was that annual premium outgo was more than her EPF contribution. It was admitted by the representative of insurer that terms and conditions were not sent to the policyholders, as the policy was directly assigned in favour of Central Board of Trustees, EPF.

After considering the facts on file and hearing the parties, it was noticed that the amount deducted out of EPF account was more than annual contribution which was beyond the affordable limit of the complainant. The complainant was obviously misled into buying the policy by the agent for his pecuniary benefit. The complainant could not seek cancellation of policy within **"cooling off period"** as the terms and conditions of policy were not conveyed to him. Besides, reassignment of policy also took considerable time. The LIC authorities took the standard plea that as the premium was forwarded by the office of APFC, the matter was required to be resolved between the parties. After he deposited premium with interest in the office of APFC, the policy was reassigned and he filed a complaint in this office.

It was also noticed that the complainant was coerced into buying this policy by making him sign blank proposal forms. The fact that blank papers were got signed was further established by the fact that blank assignment formats were also got signed and pasted on the policy bond at the time of registration of assignment. Ordinarily the process for assigning the policy is initiated after receipt of policy bond by the insured. In this case, the place of execution of proposal and assignment is shown as Chandigarh, while the complainant denied having ever visited Chandigarh Thus, the prescribed procedure for assigning the policy was circumvented and the complainant was deprived of the opportunity of knowing the terms & conditions of the policy. Nor were these conveyed to him as required under Rule 6(2) of IRDA (Protection of Policyholder's Interests) Regulations, 2002. He came to known of the terms and conditions sometimes in June 05, when he received the policy bond after reassignment. The representation filed by him earlier for refund of premium was declined.

DECISION : Having regard to the fact that the complainant was misled into buying the policy by getting blank proposal forms and assignment documents signed and that he was not conveyed the terms and conditions of the policy as required under IRDA Regulations, held that the amount of premium deposited by the complainant be refunded to him after deducting initial expenses and the amount of risk premium for the period the policy remained in force, as the facts of the case were not different from that of Smt. Kusum Lata decided vide Order dated 04th October, 2005 which has since been complied with.

Also held that the order would mutatis mutandis hold good in respect of complaints filed by S/Shri Harbans Singh (Pol. No. 162506746, Case No. 346), Lakhvir singh (Pol. No. 162506742, Case No. 349), Harbans Lal (Pol. No. 162522947, Case No. 360), Hajinder Singh (Pol. No. 162522727, Case No. 361), Naresh Kumar (Pol. No. 162521631, Case No. 362) and Smt. Hardev Kaur (Pol. No. 162506747, Case No. 348).

Chandigarh Ombudsman Centre
Case No. Aviva Life/318/Gurgaon/21/06
Shri Mandeep Mohindru
Vs
Aviva Life Insurance Co. India Pvt. Ltd.

Award Dated 31.03.2006

FACTS : Mandeep Mohindru took a Life Long Policy for sum assured of Rs. 2,04,000/- on 25.02.2003 from Branch Office, Gurgaon and paid six half yearly instalments of Rs. 3,000/- each. In view of financial constraints, he surrendered the policy on 28.12.2005 and requested for refund of premium deposited by him. He was, however, paid a sum of Rs. 5,441/- after deducting Rs. 12,459/- without giving any details. Nor was he informed that by surrendering the policy he would lose more than Rs. 12,459/-. It was, therefore, urged that the insurer be directed to refund the balance amount.

FINDINGS : Commenting on the complaint, insurer stated that the life assured was provided documents titled **"your policy"** which contains standard terms and conditions of the policy, article 15 of which refers to full surrender of the policy. It stipulates that, "the surrender value is equal to the surrender value of initial units, which is equal to the value of all initial units less an early redemption charge determined at the time of surrender, and the value of all accumulated units". The early redemption charge had also been defined as "a deduction to the policy value based on the number of initial units in the unit account on termination of insurance". It was stated that upon surrender of policy within two years, the policyholder is entitled to a surrender value subject to deduction of early redemption charges. It was urged that the complainant was fully aware that upon surrender of policy there will be deduction of early redemption charges. The request of the complainant for surrender of policy was accordingly accepted and after deducting applicable charges, the balance amount was refunded. It was urged that the complainant be estopped from challenging deduction of charges from the policy amount as he was fully aware of these provisions. The policyholder had the option of getting the policy cancelled within fifteen days of its receipt if terms and conditions did not suit him. The company was not liable to pay the claimed amount as deductios are in accordance with the terms of the policy.

During hearing held on 27.02.2006, Shri T. R. Mohindru, father of DLA, stated that his son had taken the policy under some misgiving. Since he lost the job and needed money badly, he found if dificult to continue the policy and he surrendered the policy and sought refund of premiums paid. He was refunded Rs. 5,441/- only as surrender value against premium payment of Rs. 18,000/-. The option of **"free look period"** of 15 days was not exerciesd as he did not wish to have the policy cancelled. He surrendered the policy to tide financial constraint, but what he got was of little help to him. He further stated that neither details of deductions were explained nor it was clarified that on surrender he would be paid a paltry sum of Rs. 5,441/-. He pointed out that had he known this, he may have continued the policy. He further pointed out that desperate efforts were made to contact the insurer, but to no avail. He urged that premium paid by his son be refunded as deduction of almost 75 % from the amount paid was neither just nor fair.

Ms Sujata Bhaduri, Sr. Manager - Legal, representative of insurer, however, took the stand that application for surrender of policy was duly accepted and as per regulations, leviable penalty and administrative charges were deducted and balance amount of Rs. 5,441/- was paid to the policyholder. The cheque was got encashed by him which signifies acceptance of the value. She stated that policy can be reinstated subject to certain conditions. Complainant's representative pointed out that he was not willing to get the policy reinstated due to bitter experience he had with the company. He reiterated that his son was not informed that he would be losing heavily by surrendering the policy.

After hearing the parties, it transpired that while amount paid as surrender value is as per terms and conditions of the policy, but before releasing surrender value the policyholder was not given any surrender value quotation nor cautioned that he would lose heavily in the process. In that event, he may have had second thought on his decision. This is a serious omission on the part of insurer. In this background, the insurer was advised to consider full or partial waiver of penalty imposed for surrender for fair and equitable redressal of grievance, but the insured denied to waive the penalty for surrender.

DECISION : The basic issue is whether the insured was given an opportunity to weigh the pros and cons of surrendering the policy by issuing surrender value quotation. The

complainant lost a sum of Rs. 12,561/- against deposit of Rs. 18,000/- which seems to be quite unfair. While the decision of the insurer is technically correct, the insured was not given any surrender value quotation to enable him to assess the loss in the event of cancellation of policy. The policy should not have been cancelled in a tearing hurry. If the life assured was not contactable, a communication could have been sent to him. Therefore, the manner the policy was cancelled has harmed the financial interest of the insured unfairly.

Held that the surrender value penalty amounting to Rs. 12,561/- be waived and refunded to the complainant. The insurer should be content with the recovery of administration and regular management charges of Rs. 5,503/-. The payment be made to him within 15 days of the receipt of this order.

Chennai Ombudsman Centre
Case No. IO(CHN)/21.003.2275/2005-06
Shri V. Sankaran
Vs
TATA AIG Life Insurance Company Ltd.

Award Dated 09.02.2006

Shri V. Sankaran of Tuticorin insured his life with TATA AIG Life Insurance Company for Rs. 1,25,000/- under Maha Life Policy and Rs. 1,00,000/- under Assure 20 years security and Growth Plan with Critical Illness for Rs. 1,25,000/- and Rs. 50,000/- respectively under both the policies. The policies came into effect from 12th November 2002. The assured was diagnosed for Coronary Artery Disease and Non Q Wave Acute Myocardial Infarction and he underwent 'Coronary Artery Byepass Grafting' on 17th August 2004. The assured approached the insurer for a claim for 'critical illness rider' benefit under both the policies. The claim was rejected by the insurer on the ground that the assured did not divulge in the proposals his suffering from hypertension for 15 years, as mentioned in the Discharge Summary of the Apollo Hospital, Madurai. The insurer further informed that the policies were also voided from inception. The complainant challenged the insurer's decision.

All the relevant case records were received and scrutinized. Both the contending parties were called for a personal hearing and their oral submissions were recorded. The complainant stated that he was having 'borderline hypertension' and was taking medicines as per his doctor's advice for the last 5 years. In the application for insurance he replied to the question pertaining to 'blood pressure and heart condition' in the negative, as he had only marginal hypertension and he never suffered from any of the symptoms mentioned in the question. He produced a Stress Test Report dated 15th August 2002, which was earlier to proposal date. The insurer contended that the Critical Illness benefit was declined due to material suppression in the application about the hypertension the insured suffered for 15 years. Had he disclosed, their requirements for underwriting would have been different and the policyholder would have been subjected to necessary medical examinations before taking a decision to cover risk. This information was not disclosed in the proposal. Since this information was very vital for them to undrwrite the risk and since the information relating to health was misrepresented to them, they resorted to repudiation of the claim, they put forth. This forum gave the insurer further time to come forward with concrete evidence and waited for more than a month for the insurer's response. In their written submission later, they said that the stress test report produced proved that the assured was taking treatment for hypertension and his haemo-dynamic response was 'hypertensive BP response'. though the final impression of the strees test was negative for 'inducible

ishemia'. They also mentioned that they would consider continuing the policy subject to revived underwriting decision, as a customer-friendly measure.

This forum concluded that the decision of the insurer to repudiate the claim for 'critical illness benefit' for heart surgery was justified and directed the insurer to reinstitute the basic risk cover without any break and collect the necessary premiums without any penal interest thereon. It was also directed that the 'Critical Illness Benefit' cover should not be denied for ailments other than those related to or connected with heart.

The Complaint was, therefore, **Partly Allowed.**

Chennai Ombudsman Centre
Case No. IO(CHN)/21.003.2482/2005-06
Shri N. Rajagopal
Vs
TATA AIG Life Insurance Company Ltd.

Award Dated 27.02.2006

Shri N. Rajagopal, had taken a Health First policy bearing no. C340110663 with M/s. Tata AIG Life Insurance Co. The proposal was dated 21.07.2003 and the same was accepted by the Insurer. The assured suffered a Heart Attack and was treated therefor in a hospital. He also underwent Coronary Artery Bypass Grafting on 19.09.2005 and claimed Critical Illness Cover benefit for both. The Insurer repudiated the claim for the critical illness benefits cover on the ground that the insured had withheld material information in the proposal relating to the suffering from renal stones 4 years before taking the policy. They also rescinded the policy from inception. Hence, Shri N. Rajagopal approached this Forum for intervention.

A personal hearing was conducted on 12.01.2006 and both the parties to the dispute were present. The representative of the complainant stated that his father suffered a heart attack and was treated at Trichy. After submission of claim only Rs. 250/- towards bed charges was settled. Later he underwent Angiogram and CABG. This Claim was also rejected by the Insurer. He confessed that his father had kidney stones 4 years back and it was treated. The treatment was only for 10-15 days and it did not recur. Their doctors told them that the kidney stone had nothing to do with the heart ailment. The Insurer contended that the critical illness benefit for heart attack could not be given as the heart attack in this case did not satisfy the three conditions stipulated in the policy. Hence they settled only one-day bed charges. Regarding the second claim he stated that the details relating to 'renal calculi' were not disclosed in the proposal and also the assured did not mention in the proposal the name and address of his usual medical attendant. Stating that the policy in question is not one of 'pure life insurance' but of health insurance and that in case of pure life insurance the suppression of renal calculi might not be material but in health insurance such as this one non-disclosure became material.

As Section 45 of the Insurance Act was applicable it was for the insurer to prove material suppression. The Insurers could not substantiate their argument with clinching documentary evidence. The non-disclosure was only due to the fact that it was only a passing ailment.

The Complaint, therefore, is allowed.

Delhi Ombudsman Centre
Case No. LI / 306 / Delhi - II
Shri Om Prakash
Vs

Life Insurance Corporation of India

Award Dated 01.02.2006

The complaint was heard today. The complainant, Shri Om Prakash, was present. LIC was represented by Shri Pradeep Kumar, Manager (CRM / PS), Delhi Divisional Office - III.

The brief of the case are as under :-

- The complaiant, Shri Om Prakash, had taken a policy No. 330266099 for Rs. 1,00,000/- on 28.07.1997 and had applied for a loan as per his letter dated 24th August, 2004 and had not surrendered the policy.
- The complainant, Shri Om Prakash, had taken a policy. Shri Om Prakash vide his letter dated 2nd May, 2004 had requested for surrender value under policy No. 330266099 and, accordingly, surrender value of Rs. 16,148/- was paid to Shri Om Prakash on 6th May, 2004.
- When Shri Om Prakash had gone to deposit the premium under the above said policy, he was told that the policy stands surrendered. He contested in his letter dated 24th August, 2004 addressed to Branch Manager that he had applied for a loan and not surrendering the policy.
- LIC of India vide its letter dated 06.10.2004 has mentioned that the policy bond was surrendered along with the surrender application and his request stands complied with. This letter of LIC does not give any reference to the complainant's letter. Shri Om Prakash again wrote a letter to Branch Manager, LIC of India dated 24th August, 2004 reiterating that he had not surrendered the policy but asked for a loan.
- The above complaint was registered by this office on 12.10.2004 and the complainant was advised on 14.10.2004 that he may seek redressal of his grievance from Sr. Divisional Manager, Delhi DO - III. However, the complainant vide his letter dated 25th November, 2004 requested again to consider his request as LIC of India, Janak Puri Branch has not resolved his grievance. The representative of LIC of India has also not objected during the hearing.

While going through the correspondence exchanged between LIC of India and the complainant, it is observed that LIC has not attended to the complaint seriously. A policy, in case, it is surrendered can be reinstated within 6 months and the same should have been conveyed to Shri Om Prakash with the following options :

(i) Revival + the interest to be paid on the loan amount

OR

(ii) The payment of the surrendered value + the premium payable + Interest payable on the loan.

LIC should have also mentioned therein a compliance date so as to revive the policy failing which Shri Om Prakash would have no option.

To avoid such confusion in future, LIC should examine whether separate application forms for surrender and loan are introduced.

After careful consideration of the facts of the case, I pass the Award that Life Insurance Corporation of India should revive the complainant's policy and allow him to pay the amounts as per the above two options giving the time schedule of not less than one month for payment from the receipt of the letter. The letter should be sent by Registered A. D. Post to the complainant.

The Award shall be implemented immediately. The compliance of the same shall be intimated to the office for imformation and record.

Delhi Ombudsman Centre
Case No. LI / DL - II / 288
Shri Challa Venkateshwarlu
Vs
Life Insurance Corporation of India

Award Dated 29.03.2006

The Insurance Ombudsman office received a complaint on 26.10.2004 from Shri Challa Venkateshwarlu and Shri Challa Punyavathi that LIC of India has not made payment of long due survival benefit of Rs. 15,000/-, Rs. 5,000/- and Rs. 5,000/- under three policies Nos. 110250620, 110860384 and 110860471 respectively.

On intervention of this office, LIC of India, vide their letter dated 25.03.2006, informed this Forum that survival benefit payments due under the above said policies have been made to the complainant along with the penal interest. The details of the same are as under :-

Policy No.	Date S. B. Due	Amount (Rs.)	Penal Int. (Rs.)	Total (Rs.)	Cheque Number	Paid Date
110860471	10.2000	5000	2149.00	7149.00	026529	04.03.2006
110860384	09.1994	5000	4573.00	9573.00	026518	04.03.2006
110250620	09.1999	5000	7750.00	22750.00	26946	15.03.2006

There is no further relief to be granted to the complainant. Complaint. Complaint is disposed of finally.

Guwahati Ombudsman Centre
Case No. 24.01.037 / L / 05 - 06 / GHY
Dr. Chetan Datta Poduri
Vs
Life Insurance Corporation of India

Award Dated 28.10.2005

Facts

The insurer (LICI, Guwahati BO - 1) did not honour the the request of the policyholder (dt. 27.1.2005) till 3.9.2005 for conversion of mode of two policies 482948300 & 482334709 to yly & then transfer of the policies to Habsiguda, Hyderabad Branch. The Policyholder had to pay late fee of Rs. 822.60 (Rs. 365.20 + Rs. 457.40) due to non conversion of mode of the policies from SSS to yly & transfer of the policies to Hyderabad in time.

The complaint was lodged at Insurance Ombudsman, Kolkata which was transferred to Insurance Ombudsman, Guwahati on 31.08.05 & registered at Guwahati on 22.09.2005. The change of mode done by the Guwahati BO 1 & policies transferred to Hyderabad City Br. No. 1 & informed to the complainant vide their letter dtd. 3.9.05.

The complainant also wanted relief for this late fee amount of Rs. 822.60 which he had to pay for no fault on his part.

Issue Involved

Whether complainant is entitled to appropriate relief from the insurer for penalty / late fee paid by him for the the fault of the insurer.

Decision & Reasons

It was opined that saying sorry is not enough for the delay & the complainant should be given the benefit of adjustment of late fees for the premium in order to give him appropriate relief as sought for.

Award / Order

The appropriate authority of Guwahati Branch of LICI has been directed to issue advice to its Hyderabad Branch within ten days from the date of order for adjustment of Rs. 822.60 from the next premium to be paid by the complainant in connection with the two policies. Payment of interest on the amount had been left with the LICI authority to decide & award.

Guwahati Ombudsman Centre
Case No. 22.09.048 / L / 05 - 06 / GHY
Dr. Chetan Dutta Poduri
Vs
Bajaj Allianz Life Insurance Co. Ltd.

Award Dated 29.11.2005

Facts

The Complainant took a policy (0001158057) from Allianz Bajaj Life Insurance Co. Ltd. The Name of Insurer has been changed from Allianz Bajaj Life Insurance Co. Ltd. to Bajaj Allianz Life Insurance Co. Ltd. Default intimation sent to the insured by the insurer with change of name on the letter pad & asked for transfer of policy records. The insured lodged a formal complaint. He intimated his change of address from Guwahati to Hyderabad. Simultaneously he asked for revival of his lapsed policy. He was waiting for a reply but reply not received for which he could not pay his dues. Hyderabad Office of Bajaj Allianz Life Insurance Co. Ltd. intimated revival on payment of Rs. 7584/- inclusive of Late fee of Rs. 302/-. The complainant contends that he lodged complaint in October, 04, June, 05 & September, 05 for adjustment of excess amount of Rs. 302/- (paid as fine) in the next premium due but did not get satisfactory reply. The complainant sought following relief.

i) Adjustment of the excess paid along with interest into the next premium.

ii) Transfer of policy documents from Guwahati to Hyderabad.

iii) Issuance of fresh policy by Bajaj Allianz Life Insurance Co. Ltd.

iv) Plugging of all the loopholes if any any so as to see that there shall be no inconvenience in future etc.

Opponent's view

Rs. 7,548/- was paid on 17.06.2005 for dues of 11.07.2004 & 11.01.2005 for which interest charged @ 10 %. The change of name of the company has been approved by Registrar of Companies & IRDA & such a change has not effected the constitution of the company in any manner except amending the name. The change in name was published in 'Times of India' and 'Economic Times' in August, 2004. The Company has Central System and servicing can be done at any of the branches in India and there is no question of transfer of policy etc. because all papers are retained in Central Office at Pune and only mailing addresses are changed when needed. That the Company will take measures to stop inconvenience of Customers in future.

Issue Involved

Whether the insurer was justified in charging Late fee at the time of revival of policy & whether change of name is as per law etc.

Decision & Reason

The insured seems to be more emotional than practical business oriented. It cannot be denied that it is obligatory on the part of the insured to pay premium due if & when he desires the insurer to accept the risk. A contract is always a mutual obligation of the parties thereto. Here the complainant is obliged to pay the premium due irrespective of other relief sought under the contract. Insurer has no duty to serve notice for payment of premium due. It is generally done as a matter of courtesy. The correspondences the insured / complainant was making in this case had nothing to do with the question of timely payment of premium. Indisputedly there was delay in payment of premium & the insured himself asked for revival of the lapsed policy. Revival of a policy always is at the discretion of the insurer (Bajaj Alliance Life Insurance Co. Ltd.) and no objection can be entertained against the demand of late fee when such revival is prayed for. There was nothing wrong in asking for late fee when the premium were not paid within stipulated time / date. There is no question of adjustment of excess amount as stated in the complaint. Regarding transfer, reply of the insurer is appropriate & demand is unwarranted. Change of name done as per the publication in the newspapers. Moreover, accepting the premium by the Bajaj Allianz Life Insurance Co. Ltd. for & on behalf of Allianz Bajaj Life Insurance Co. Ltd. retaining the policy no. etc. will rule out any adverse presumption of liability. The insurer has already given the assurance that it will try to avoid inconveniences to the customer in future.

There is no merit in the complaint & no interference is needed. **Order**

The complaint stands dismissed.

Guwahati Ombudsman Centre
Case No. 22.01.066 / L / 05 - 06 / GHY
Shri Subhomoy Sinha
Vs
Life Insurance Corporation of India

Award Dated 22.02.2006

Grievance of complainant

Shri Subhomoy Sinha, the insured complains that he ivested Rs. 25,000/- in LIC's Furture Plus (Plan - 172) by depositing the sum on 30.03.2005 (receipt no. 989823) but while issuing policy no. 442652917 the Jorhat Division of LICI issued another receipt no. 166979 dated 12.08.2005 stating thereupon that proposal relates to 199679 dated 12.08.2005 stating thereupon that proposal relates to 12.08.2005 and he was allotted to 2215.867 units instead of 2500 units calculated on the basis thereuon of NAV (net asset value) on 12.08.2005. He claimed allotment of units as per NAV on the date of deposit, i.e. 30.03.2005.

Reply by Insurer / LICI

The contention of the LIC / insurer is that 'there were some accounting problem / anomalies which cropped up and cooling off action had to be taken in some cases of Future Plus Policies'. That 'after closing book of accounts for March, 2005 reconciliation of deposit was done and the anomalies could be ascertained'. Thereafter, 'remaining amount collected in March, 05 were kept in suspense account and adjusted in August, 05 and as such, the units allotted were as per NAV of the particular date of adjustment in August, 2005 and submitted that there is no provision

for allotment of units as per date of deposit in ULIP and units already allowed cannot be modified etc.

Issue

Whether insured is entitled to refund of difference of NAV (net asset value) between date of actual deposit and date of issurance of units upon the sum deposited (single premium).

Decision & Reasons

We have considered the submissions made and perused the relevant documents. There is no explanation why the money had to be kept 'in suspense'. The policy was issued showing date of commencement as 12.08.2005 and it mentioned the proposal on the same date and the premium receipt of Rs. 25,000/- was issued on 12.08.2005 itself showing the receipt of the premium. So there is no explanation from the insurer why any such action was not taken when undisputedly such amount of premium was received by the insurer on 30.03.2005. Therefore, the complaint is entitled to the units calculated on the same date and not on the subsequent date. It is also supposed, under facts and circumstances, that as per the unit linked scheme, the date of proposal of such policy should be the date of commencement of the policy. It appears that due to slackness on the part of the insurer appropriate steps were not taken in calculating the NAV (Net Asset Value) on the date on which the money was received and accepted by LICI.

Award

It is hereby directed that the difference of amount should be paid / refunded by LICI to adjust the NAV dtd. 30.03.05 (date of actual deposit).

Hyderabad Ombudsman Centre
Case No. L / 21.001.0276 / 2005 - 06
Shri Ch. Venkata Ramudu
Vs
Life Insurance Corporation of India

Award Dated 18.11.2005

FACTS OF THE CASE :

One Shri Challa Venkata Ramudu, S/o Shri Kotaiah, working as doctor and a resident of Ranga Reddy District, took an Asha Deep-II life insurance policy from Yemmiganur Branch of LIC, under Cuddapah Divison. As per the terms and conditions governing this policy, it covered Sickness Benefits for four major diseases, Cancer, Paralytic Stroke, Renal Failure and Coronary Artery Diseases, where By-pass surgery has been actually done. The life assured underwent Off Pump CABG x 2 on 25.09.2003 at Shri Sathya Sai Institute of Higher Medical Sciences, Bangalore. The life assured lodged a claim with the LIC, claiming sickness benefits. But the claim was repudiated by LIC of India, citing the reason that the life assured, while executing the proposal for insurance, gave false answers to certain questions in the proposal form submitted by him. It was alleged by the insurer that they held indisputable proof to show that the life assured suffered from Angina on exertion and took treatment for the same in a hospital. Finding the life assured to be guilty of deliberate suppression of material facts relating to his health at the time of taking the insurance policy, LIC repudiated the claim for sickness benefits and treated the contract as void ab initio.

DECISION :

I heard the contentions of both sides and also perused all the documents, placed before me.

In support of their repudiation, the insurer obtained treatment particulars from Shri Sathya Sai Institute of Higher Medical Sciences, Puttaparthi in the form of hospital records. According to the records of this hospital (issued by Department of Cardiology), the life assured consulted them on **25.06.2002 (prior to taking the policy)** and the diagnosis arrived by them was **"AOE CL III, H/O REST PAIN"** and was prescribed **"LOW SALT / FAT DIET - AVOID HEAVY STRAIN".** Further, the life assured also had ECHO ECG and was advised to have CAG (@).

It would be very much pertinent to mention here that the life assured executed the proposal for insurance and underwent medical and other special test on 10.05.2002. But according to the documents submitted by the insurer, they were received by the insurer (LIC) only on 31.07.2002. The insured also paid the consideration amount for assessing the risk and issue the policy only on 31.07.2002, which was clearly after his consultation and treatment at Satya Sai Institute of Higher Medical Sciences, Puttaparthy in 06/2002. By 31.07.2002, the life assured was very well aware of his consultation at the above hospital and the medicines prescribed for treatment of heart related probelem The life assured, himself, was a literate person and he was by profession a doctor (medicine). He must be knowing the implications of his health problem relating to heart. Therefore, the life assured ought to have disclosed these vital facts to the insurer (LIC) for assessing the risk in the right perspective. Instead, he suppressed these facts, which establish his fraudulent intent. The medicines which were all prescribed by the hospital authorities were related to heart-related problem.

The above consultation and the diagnosis made in the hospital were very well before the issue of the policy. In fact, the proposal for the Asha Deep-II Insurance Policy was submitted by the life assured on **31.07.2002, which was after the above consultation at Puttaparthi.** According to the hospital reports (claim from issued by the hospital), the duration of illness was reported as 1 ½ years. Even the complainant reported in the claim form CABG - 1 that the duration of illness was 1 ½ years. These facts clearly established the fact that the life assured was not keeping good health and that he was suffering from heart disease and was on treatment. The life assured also paid the consideration amount of Rs. 10,542/- for the policy only on 31.07.2002, which was after his consultation in the hospital mentioned above.

It is consistent and positive case of the LIC (insurer) that the answers given by the deceased life assured to various questions in the proposal forms are not reflecting the real state of affairs and, that, as a matter of fact, he had suppressed the vital facts relatable to his health while submitting the proposals for insuring his life. According to the insurer, the life assured had Angina on exertion as per the medical evidences secured by them. In proof of the stand, they secured and submitted the relevant hospital records from Shri Satya Sai Institute of Higher Medical Sciences, Puttaparthy. Therefore, it can be said without hesitation that the deceased life assured willfully and deliberately suppressed the material facts relating to his health as getting revealed by the medical records referred above. Had these material facts been disclosed in the proposals submitted by the life assured, according to the underwriting norms of LIC, the insurer would not have accepted the proposal and issued the policy in question.

Insurance has been held to be a contract of utmost good faith. The life assured is bound to disclose honestly, truthfully and correctly all the answers in the proposal forms concerning the state of his health. In this case, the deceased life assured knowingly gave incorect information on the personal health in the proposal form for insurance. This ground of incorrect information and false statements regarding health make the insurance contract null and void.

According to the underwriting norms, had the life assured disclosed the above material facts at the time of taking the policy, the insurer would not have considered him for the Asha Deep-II Insurance Policy.

In view of the above facts, I am of the view that the repudiation/rejection of the claim for sickness benefits under the above Asha Deep Insurance Policy by the insurer on the ground that the life assured deliberately suppressed material is sustainable on law as well as on facts and also proper and justified and does not call for any interference at my hands.

In the result, the complaint is not allowed.

Hyderabad Ombudsman Centre
Case No. L / 21.003.0180 / 2005 - 06
Shri T. L. Srinivas
Vs
TATA AIG Life Insurance Co. Ltd.

Award Dated 06.12.2005

FACTS OF THE CASE :

One Shri Tammisetti Lakshmi Srinivas, S/o Venkateswara Rao, a resident of Vijayawada in Krishna District in Andhra Pradesh, took a Security & Growths Policy - Plan in 03/2002 for a Sum Assured of Rs. 60,000 from TATA AIG Life Insurance Company Limited, Mumbai. The mode of payment of premium was quarterly. Accordingly, the premiums were payable on 30th of March, June, September and December of every year. As per the terms and conditions of the policy, the policy provides benefits “Waiver of Premium - Rs. 60,000/-; Accidental Death Benefit - Rs. 60,000; Accident Death & Dismemberment Long Scale - Rs. 60,000”. In the instant case, the life assured submitted his application for the above policy on 31.03.2002. The life assured met with an accident on 14.12.2003. The insurer settled the claim for Dismemberment Long Scale Claim for Rs. 30,000/- in April for amputation of right leg but rejected the claim for waiver of premium in view of suppression of material fact relating to occupation by the life assured. It was also alleged by the insurer that the policy was in a lapsed state due to non-payment of quarterly premium due 30.03.2004.

In view of the terms and condition of the policy, the insurer repudiated/rejected the claim of the complainant for premium waiver benefit in view of suppression of material facts relating to occupation as also the fact that the policy was not in force when the insurer sought the benefit.

DECISION :

I heard the contentions of both sides and also perused all the documents, placed before me.

a) The life assured took Assured 30 years - Security and Growth Plan for Rs. 60,000/- in 03/2002. The policy was for a term of 30 years. The mode of payment of premium was quarterly. Accordingly, the premiums under the policy were payable on the 30th March, June, September and December every year. This policy provided for (i) Waiver of Premium - Rs. 60,000/-; (ii) Accidental Death Benefit - Rs. 60,000/- and (iii) Accident Death and Dismemberment Long Scale - Rs. 60,000/-.

b) The life assured met with an accident on 14.12.2003 and sought the benefit relating to right above knee amputation. Accordingly the insurer settled 50 % of the sum assured towards above amputation relating to right leg. Later, the insured claimed for premium waiver benefit also. But this was rejected by the insurer on the ground

that the life assured suppressed material fact relating to his occupation. It was also alleged by the insurer that the status of the policy was lapsed, due to non-payment of the Qly. Premium due 30.03.2004. Taking into account the totality of the facts and circumstances of the case, I directed the representative of the insurer to take up the matter with their head office and explore the possibility of considering the claim of the complainant on humanitarian grounds under ex-gratia. Accordingly, I have also allowed one month's time for taking decision.

c) Now, we are informed by the insurer vide their fax letter dated 05.12.2005 that they considered the claim for an ex-gratia payment of Rs. 14,600/- to the customer on humanitarian grounds and also agreed for reinstatement of the policy within three months, as per the rules governing the policy and that the waiver of premium rider would not be considered.

d) In view of the fact that the insurer had already considered the claim for benefits as mentioned in 'c' above, I decline to interfere with the decision of the insurer and accordingly the complaint stands closed.

Hyderabad Ombudsman Centre
Case No. L / 21.003.0343 / 2005 - 06
Shri Mahesh Kumar Gupta
Vs
TATA AIG Life Insurance Co. Ltd.

Award Dated 19.12.2005

FACTS OF THE CASE :

One Shri Mukesh Kumar Gupta, S/o late Muralidhar, doing business and a resident of Hyderabad in Andhra Pradesh took Health First - 2 Units Insurance Policy from TATA AIG Life Insurance Company Limited, Hyderabad. This policy covered benefits in case of hospitalization expenses of the life assured, as per the terms and conditions of the policy. The life assured underwent Inguinal Hernia repair with prolene mesh and Hydrocelectomy on 05.09.2005 and claimed hospitalization benefits from the insurer. But the insurer repudiated the claim of the complainant on the ground that the said surgery (operation) did not fall within the cover of the above policy.

DECISION :

I heard the contentions of both sides and also perused all the documents including the written submissions of both the parties.

a) The life assured took Health First - 2 Units Insurance Policy on **24.05.2005** from TATA AIG Life Insurance Company Limited, Hyderabad. This insurance covered the insurance benefit for **hospitalization expenses,** as per the terms and conditions of the policy. The insured, doing business, was a resident of Hyderabad. The life assured underwent surgery of Right Inguinal Hernia repair prolene mesh and Right Hydrocelectomy under GA on 05.09.2005 and claimed hospitalization expenses from the insurer.

b) The insurer repudiated the claim on the ground that as per the terms and conditions of the contract, the claim of the complainant did not fall within the cover of the above policy.

c) According to the insurer, the confinement (hospitalization) was not more than 3 days (24 hours stay as one day) in a pre-approved hospital. In support of their contention, the insurer relied upon the discharge summary of Aditya Hospital, Hyderabad, where the insured was admitted on 05.09.2005. Since the hospital authorities charged expenses for 3 days, the insurer treated the stay in the hospital

as 3 days. But the complainant submitted a certificate issued by the hospital authorities. As per this cetificate, the insured was admitted there on 05.09.2005 at 07.00 AM and discharged on 08.09.2005 at 04.50 PM. and therefore, the stay in the hospital goes beyond 3 days. Hence, I could not accept the contention of the insurer.

d) The insurer alleged that the life assured had symptoms of the disease or illness within 90 days from the date of issue of the policy. In support of this, the insured once again relied upon the discharge summary of the hospital. As per the discharge summary of the hospital, the life assured was admitted there on 05.09.2005 with h/o of swelling in the right inguinal scrotal region since 15 days. On the basis of this, the insurer concluded that 1st symptoms of the disease were observed on 20.08.2005, which was just within 90 days of issue of the policy (policy issued on 24.05.2005). This allegation of the insurer also could not be accepted by me, as it was only history reported and not supported by any documentary evidence. In respect of these, repudiation/rejection of the complainant's claim on this ground is not valid and proper and justified.

e) The other ground for repudiation/rejection of the claim was the fact that the disease 'hernia' was not included in the policy conditions. In this connection, it would be relevant to refer to policy condition (2) (b) "this policy shall not cover any hospitalization, treatment, surgery services of charges or follow-up treatment resulting from or related to, direct or indirectly, wholly or partly, by any one of the following : (d) Treatment or surgery for tonsils, adenoids, **hernia** or a disease of the female generative organs unless the Insured has been continuously covered under this Policy from the Issue Date or Commencement Date or last reinstatement, whichever is later, **for a period of 120 days immediately preceding hospitalization for such treatment or surgery".** On a reference to the discharge summary or the certificate issued by Aditya Hospital, Hyderabad, the life assured was admitted thereon 05.09.2005 with IP No. 50499 for treatment of Recurrent Big Inguinal Hernia with Hydrocele and underwent surgery of Right Inguinal Hernia repair with Prolene mesh and Right Hydrocelectomy. As could be seen from the above, the life assured had problem relating to Hernia, even prior to issue of the policy. Further, the surgery underwent by the life assured was well within 120 days of issue of the policy and it clearly comes under the exclusive clause of the policy in question. Therefore, the last two grounds of repudiation/rejection o the complainant's claim completely fits into the terms and conditions and provisions of the policy.

f) The construction of the insurance policy, which embodies the contract of insurance, is a question of law and its true and correct interpretation would give jurisdiction to the Insurance Ombudsman to pronounce upon the deficiency in service, if any. In view of the above facts and in view of the specific provisions in the insurance policy, unfortunately, the life assured is not entitled to receive the hospitalization Benefits claimed by him from the insurer.

g) In the light of the above discussion, I am of the view that the repudiation of the compainant's claim for hospitalization claim by the insurer invoking policy conditions is proper, correct and justified and I do not find it necessary to interfere with the order of the insurer.

In the result, the complaint is not allowed.

Shri C. S. Ananda Rao
Vs
Life Insurance Corporation of India

Award Dated 21.12.2005

BACKGROUND

One Shri C. S. Ananda Rao, S/o late C. Sanjeeva Rao, working as circle Engineer and a resident of Bangalore, took a Nav Prabhat Insurance Policy in 02/2000 for a Sum Assured of Rs. 3,00,000/- from Jayanagar Branch of LIC under Divisional office-I, Bangalore. The mode of payment of premium was yearly and the premium paying term was for five years. The policy matured for payment on 28.02.2005. The insurer accepted the insurance policy of the life assured with health extra of Rs. 32.30%. Accordingly, the instalment premium charged by the insurer was inclusive of this extra premium. According to the terms and conditions of the policy, the maturity value payable on the date of maturity was “Maturity Benefit”. In the event of the Life Assured surviving the Date of Maturity, a Sum equal to the total amount of premiums paid excluding all extra premiums together with Loyalty Addition, if any, shall be payable”. When the policy matured for payment, the insured issued discharge form for completion by the life assured and thereafter settled the maturity claim, as per the terms and conditions of the policy.

The life assured requested the insurer to refund the health extra premium amount recovered by the insurer from the maturity proceeds. Since the insurer did not agree to accede to his request, the life assured represented the matter to Zonal Office, Hyderabad requesting them to refund the health extra premium charged by them.

DECISION :

I have carefully perused the papers placed before me and heard the arguments presented by both the sides.

a) The life assured took Nav Prabhat Policy (without Profits) in 02/2000 for a sum assured of Rs. 3,00,000/- under yearly mode of payment of premium. The instalment premium charged for this 5 - year policy was Rs. 49,499.00. The life assured accordingly paid the premiums for 5 years and claimed the maturity proceeds payable under the policy. The LIC settled the maturity proceeds recovering the extra premium charged by them at the time of inception of the policy.

b) Not satisfied with the decision of the insurer in settling the full claim amount, the complainant approached this office. Now the dispute is with regard to refund the extra premium charged by the insurer. The three documents relied upon by the LIC in support of their rejection to refund the extra premium charged were (i) the policy bond (ii) acceptance - cum - first premium receipt and (iii) consent letter.

c) On a perusal of the policy bond, it is clearly mentioned, “the instalment premium stated in the policy is inclusive of an extra premium Health Extra of Rs. 32.30%o. Therefore, the life assured cannot plead that he was not totally aware of the extra premium charged by the insurer under the policy. As mentioned in the policy bond, had the life assured contacted the insurer (LIC) immediatly after receipt of the policy bond, perhaps, the insurer would have explained the implications of charging the extra premium so that the controversy surrounding the issue could have been avoided. Moreover, the life assured also submitted the consent form towards charging the extra premium. Even the LIC Agent and Development Officer through whom the policy was procured, submitted in their explanations to the LIC that they

had clearly explained the implications of charging the extra premium under the policy.

d) Equally, there appears to be some lapse on the part of the insurer (LIC). The policy under dispute was considered by the insurer (LIC) after obtaining some special reports and based on the findings of these reports, the insurer charged health extra. But in the acceptance-cum-first premium receipt, it was mentioned as “Ext. Prm. Rate : 32.30”. It was not clearly mentioned as “Rs. 32.30 per thousand sum assured”. An ordinary lay man like the policyholder in the first instance may not understand the implications of the symbol like %o. It can be understood and read by the insurance personnel like the officials/agents/development officers but not by an ordinary customer. The contention of the policyholder that it was Rs. 32.30 per annum could not also be simply brushed aside or ignored altogether. As a prudent underwriter, it would have been appropriate had the insurer clearly mentioned the extra premium charged in simple language (avoiding %o, etc.) so that any lay person, like the ordinary policyholder in question, can understand the same and satisfy himself about the terms and conditions of the policy.

e) In view of the facts mentioned above and the terms and conditions of the policy in question, I am of the view that the imposition of the health extra by the insurer and recovery of the same from the maturity proceeds of the policy is just, proper and correct and does not call for any interference at my hands.

f) Having regard to facts and circumstances of the case, I am of the opinion that although the imposition of health extra was in order, there also existed some deficiency of service on the part of the insurer in communicating the health extra to the life assured. The life assured was a senior citizen, with considerable age.

g) The policy was taken for a 5 - year period. The complainant also paid all the premiums regularly till the date of maturity. He was only demanding to refund the extra premium charges, which was just paid by him and his demand/request in reasonable and justified. Therefore, the total rejection of the insurer to refund the extra premium charged by them is not fully justified in view of deficiency of service on their part. Therefore, I am of the view that it is just and proper to meet ends of justice to direct the insurer to make a payment of Rs. 25,000/- (Rupees twenty five thousand only) as ex gratia by invoking Rule 18 of the Redressal of Public Grievances Rules 1998 and hence the insurance is directed to pay Rs 25,000/- (Rupees twenty five thousand only) as ex gratia to the complainant.

Hyderabad Ombudsman Centre
Case No. L / 21.001.0317 / 2005 - 06
Shri P. Narayana Sherigar
Vs
Life Insurance Corporation of India

Award Dated 12.01.2006

BACKGROUND

One Shri P. Narayana Sherigar, S/o Shri Sundara Sherigar, working as operator in KPTCL and a resident of Udupi District in Karnataka, took a life insurance policy from Udupi (Main) Branch of LIC, under Udupi Division. The policy covered the risk of disability benefits, in case event of the life assured becoming disabled, as per the policy conditions. The life assured met with an accident (electrical injury) on 17.05.2004 and sustained high-tension electical injury, invoking both upper limb, both feet and chest wall on (L) side. The complainant and the life assured under the policy claimed Extended Permanent Disability Benefits (EPDB) payable under the policy. But

the insurer (LIC) repudiated/rejected the complainant's claim for disability benefits alleging that the disability sustained by the life assured was only partial (only 60 % permanent disability) and that it was not permanent and total, as per the terms and conditions of the policy.

DECISION :

I have carefully perused the papers placed before me including the written submissions of the complainant/insurer and also heard the arguments of both sides.

a) The life assured took a New Money Back Life Insurance Policy in 12/2003 for a Sum Assured of Rs. 50,000/-. The policy also covered the risk of accident benefit/disability benefits, in case of accident/disability, as per the terms and conditions of the policy. The life assured was working as an operator in KPTCL. While he was on duty, he met with an accident and sutained high tension electrical injury. The life assured, therefore, claimed disability benefits. But the insurer (LIC) repudiated/rejected the claim of the life assured for disability benefits on the ground that such disability sustained by the life assured was only partial and that it was not total and permanent, as required under the policy conditions.

b) Before discussing the facts and circumstances and the documentary evidence available on file, it is useful to know the salient features of the relevant clause governing the Accident Benefit/Disability Benefit under a policy. **"If at any time when this policy is in force for the full sum assured the Life Assured before the expiry of the period for which the premium is payable or before the policy anniversary on which the age nearer birthday of the life assured is 70, whichever is earlier is involved in an accident resulting in either permanent disability as hereinafter defined or death and the same is proved to the satisfaction of the Corporation, the Corporation agrees in the case of (a) Disability to the Life assured (i) to pay in monthly instalments spread over 10 years an additional sum equal to the Sum Assured under this policy, if the policy becomes a claim before the expiry of the said period of 10 years, the disability benefit instalments which have not fallen due will be paid along with the claim (ii) to waive the payment of the future premiums and 10.4 : The disability above referred to must be disability, which is the result of an accident and must be total and permanent and such that there is neither then nor at any time thereafter any work, occupation or profession that the Life assured can ever sufficienctly do or follow to earn or obtain any wages, compensation or Profit. Accidental Injuries which independently of all other causes and within 180 days from the happening of such accident, result in the irrecoverable loss of the entire sight of both eyes or in the amputation of both hands at or above the wrists, or in the amputation of both feet at or above the ankles, or in the amputation of one hand at or above the wrist and one foot at or above the ankles, shall also be deemed to contstitute such disability".**

c) According to the hospital records of Kasturba Hospital, Manipal, the life assured was admitted to the hospital on 17.05.2004 with Hospital No. 01579842 with h/o of Electrical Injury sustained. It was recorded as "patient sustained high tension electical injury of 4 % of body surface area, involving both upper limb, both feet and chest wall on (L) side. There was compartmental syndrome (L) forearm, with pregangrenous charges in the (L) hand fingers. Emergency fasciotomy was done on (L) forearm on the same day. Wound debridement and LAD dressing was done on 20.052004 along with excision and closure of chest would. SSG (R) elbow wound done on 31.05.2004. Above wrist amputation was done on (L) 02.06.2004 as the (L) hand was gangrenous. Revision of (L) Below elbow amputation and split skin

grafting was done on 07.06.2004 and was discharged on 21.06.2004". Further, according to the hospital records the disability was reported as "Extent of Disability - 60 % (As per Sec. 2 of W. Comp. Act 1923)".

d) The question is whether the amputation of left hand constitutes disability entitling the complainant to an accident/disability benefit.

e) As laid down in Para 5 (b) supra, the complainant, as his left hand was amputed above the wrist, sufferred disability, which is permanent and total so far as the left hand is concerned and which is owing to an accident. It is the case of the insurer that, as spelt out in the last sentence of para 5(b) supra, there should also be amputation of one foot above the ankle to claim the benefit. But the drafting of the clause (vide para 5 (b) supra) is clumsy. The last sentence, in that para with the inclusion of the term "also" (which is underlined by me), lends support to the impression that the examples given in the sentence are only illustrative but not exhaustive. Thus there appears to be considerable ambiguity in the terms of the policy.

f) The life assured was working as operator in KPTCL. He met with the accident while he was on duty and sustained electrical burns and was hospitalized where he had amputation of his (L) hand. During the course of hearing, it was also submitted by the insured that he was not engaged in any work for his livelihood and that he spent huge amount for treatment in the hospital. Further, he stated that he had also not received any compensation from his employer/department. Since the life assured had amputation of (L) hand resulting on 60 % disability because of which the life assured can never "sufficiently do or follow" his profession to earn his wages (vide para 5 (b) supra) to do any work and earn his daily bread I am of the view that it is just and proper to meet the ends of justice to direct the insurer to make a payment of Rs. 31,700.00 only, to the life assured as ex gratia by invoking Rule 18 of the Redressal of Public Grievances Rules 1998 on humanitarian grounds and hence the insurer is directed to pay Rs. 31,700.00 (Rupees thirty one thousand and seven hundred only) as ex gratia to the complainant (Life Assured).

In the result, the complaint is not allowed. But the insurer is directed to pay a sum of Rs. 31,700.00 (Rupees thirty one thousand and seven hundred only) as ex gratia to the complainant (Life Assured).

Hyderabad Ombudsman Centre
Case No. L / 21.011.0398 / 2005 - 06
Shri U. S. S. U. Bhaskara Rao
Vs
ING VYSYA Life Insurance Co. Ltd.

Award Dated 21.03.2006

BACKGROUND

One Shri U. S. S. U. Bhaskara Rao, S/o Shri Krishna Rao, doing business and a resident of Vijayawada in Andhra Pradesh, took an insurance policy from ING Vysya Life Insurance Co. Ltd., Bangalore in 05/2005. The policy covered the ADDD Benefit and Waiver of Premiums Benefit Riders, in the event of the life assured becoming disabled by an accident, as per the policy conditions. The life assured met with an accident (train accident) on 02.07.2005, resulting in loss of left hand and right eye. The complainant and the life assured under the policy claimed Disability and Dismemberment and waiver of premiums benefits payable under the policy. But the insurer, as per the terms and conditions of the ADDD Benefit Rider, allowed only 50 % of the sum assured under the rider but repudiated/rejected the complainant's claim for

waiver of premiums benefit alleging that the disability sustained by the life assured was not total and permanent as per their disability clause defined in Waiver of premium Rider Benefit, as per terms and conditions of the policy.

DECISION :

I have carefully perused the papers placed before me including the written submissions of the complainant/insurer and also heard the arguments of both sides.

a) The life assured took a Reassuring Life Endowment Plan with Reversionary Bonus with ADDD Benefit, Term Benefit and Waiver of Premiums Benefit Riders in 05/2005. The sum Assured was Rs. 3,00,000/- (basic policy) and Rs. 2,75,000/- under the Accidental death, disability and dismemberment benefit (ADDD Benefit) along with premium waiver benefit rider. The life assured met with an accident on 02.07.2005 and, in the process, lost his left hand and his right eye. He represented/requested the insurer to consider settlement of benefits payable under the policy.

b) The insurer, while considering the claim for disability, repudiated/rejected the complainant's claim for premium waiver benefit alleging that the disability sustained by the insured was not falling under the purview of the policy terms and conditions.

c) Disability Benefit-Before discussing the facts and circumstances and the documentary evidence available on file, it is useful to know the salient features of the relevant clause governing the Disability Benefit and Premium Waiver Benefit as applicable under ADDDB of the policy in question. According to the policy conditions, in the event of dismemberment of (a) thumb and index finger on same hand (25 % of sum assured); (b) Any one limb (50 % of sum assured) and (c) two limbs or more 100 % of sum assured. Dismemberment of a limb includes severance of an arm at or above the wrist or of a leg at or above the ankle and must be out of an accident resulting from bodily injury independently of all other causes. According to the documents submitted by the complainant/insurer, the life assured met with an accident and fell from a moving train at Powerpet Station. The life assured was admitted to Vijetha Hospital. As per the Medical Certificate dated 29.07.2005, the insured fell from a moving train on 02.07.2005, was admitted there on 03.07.2005, and took treatment upto 18.07.2005. As per the records of the hospital, the insured sustained "Crush Injury to left forearm and trauma to right eye and fracture of medial malleolus and that the insured developed traumatic uveitis and became blind in the right eye". The injury sustained by the insured comes under the purview of the definition relating to ADDDB (disability) - any one limb and the amount payable was 50 % of the ADDDB sum assured. In the instant case, the ADDB sum assured was Rs. 2,75,000/- and the disability amount worked out to Rs. 1,37,500/- and the insurer already offered this amount to the complainant, which the insured rejected. According to the insured, he was affected in two limbs viz. eye and left fore arm. The insured contended that both the limbs (eye and lef foreram) were important. Allowing benefit only for one limb of left fore arm and disallowing for eye was against natural law. Unfortunately, the policy conditions did not cover for vision including eye. The terms and conditions, including the policy clauses form the basis of the contract and the same can neither be ignored nor overlooked. Therefore, the action of the insurer in allowing disability benefit under ADDDB benefit for only one limb (left fore arm) was justified and the claim of the complainant for the other limb (blind with right eye) is rightly not allowed.

d) Premium Waiver Benefit : - According to policy conditions, Waiver of Premium Rider, Total Disability refers to the disability which results from sickness or from bodily injury caused by accident; in case of disability arising from bodily injury,

results directly from the said injury and independently of all other causes and completely and continuously prevents the life assured from engaging in any work, occupation or profession to earn or obtain any wages, compensation or profit during the period of disability".

e) The life assured furnished his profession as business-finance in the proposal form submitted by him. The insurer, in the present case, obtained medical opinion from Dr. Bangaru Rao of Government General Hospital, Vijayawada. According to this doctor, the life assured "suffered from below elbow amputation (L) upper limb and Corneal opacity of ® eye with loss of vision with 50 % disability and can continue his occupation to earn without involving physical activity with some discomfort". In view of the above facts, the life assured was entitled only to the extent of 50 % of the sum assured for the benefit as already referred by me and not for waiver of premium as the disability sustained by the insured was not total and permanent as defined in the policy condition.

f) The construction of the policy bond including the relevant policy clauses, which is the basis of the contract of insurance, is a question of law and its true and correct interpretation would give jurisdiction to the Insurance Ombudsman to pronounce upon the deficiency in service, if any.

g) Therefore, the disability sustained by the life assured as enumerated above and as presented in the hospital reports and other documents did not fall within the deeming definition constituting Waiver of Premiums Benefit of the policy; the complainant is not eligible for such benefits. The insurer already expressed his acceptance to revive the policy if the complainant desired so. The complainant may approach the insurer for revival of the policy, if he desires to.

In the result, the complaint relating to waiver of premium waiver benefit is not allowed.

Hyderabad Ombudsman Centre
Case No. L / 21.001.0456 / 2005 - 06
Shri Talluru Pitchaiah
Vs
Life Insurance Corporation of India

Award Dated 31.03.2006

BACKGROUND

One Shri Talluru Pitchaiah, S/o Shri T. Subba Rao, a retired employe and resident of Ongole in Prakasam District of Andhra Pradesh, took a Nav Prabhat life insurance policy from Ongole Branch of LIC, under Nellore Division. The policy covered the risk of sickness benefits, in case event of the life assured becoming disabled due to sickness, as per the policy conditions. The life assured suffered from Coronary Artery Disease (CAD) - Heart attack and was hospitalized at Vijayawada and Hyderabad in January 2001. The hospital authorities reported that the life assured suffered from CAD-Triple Vessel Disease and Severe LV Dysfunction and therefore, advised the insured for **marked restricted physical activities.** The complainant and the life assured under the policy claimed sickness Benefits payable under the policy, as he was not in a position to earn. But the insurer (LIC) repudiated/rejected the complainant's claim for sickness benefits alleging that the insured did not suffer from any disability (partial or permanent) and that the disease Myocardial Infarction was not covered as per the terms and conditions governing the disability/sickness benefit of the policy.

DECISION :

I have carefully perused the papers placed before me including the written submissions of the complainant/insurer and also heard the arguments of both sides.

a) The life assured took a Nav prabhat Life Insurance Policy in 03/2000 for a Sum Assured of Rs. 1,00,000/-. The policy also covered the risk of Total & Permanent Disability and sickness Benefit in case of accident/disability/sickness, as per the terms and conditions of the policy. The life assured was a retired employee and resident of Ongole in Andhra Pradesh. He had chest pain and consulted hospitals at Vijayawada and Hyderabad. According to him, the sickness made him totally disable to earn, and therefore, he claimed disability/sickness benefits. But the insurer (LIC), repudiated/rejected the claim of the life assured for disability/sickness benefits on the ground that hospital reports did not mention anything relating to the disability being either partial or total and permanent and/or that the policy conditions did not provide sickness benefits for heart problem.

b) Before discussing the facts and circumstances and the documentary evidence available on file, it is useful to know the salient features of the relevant clause governing the Accidetent Benefit/Disability Benefit under a policy. According to policy condition 10.2:Sickness Beneft: "If at any time when this poilcy is in force for full sum assured and during the term of the policy, the Life Assured is involved in disability due to sickness, as laid down below and subject to clauses 10.3 to 11.9, wherever applicable the Corporation agrees to pay the under mentioned benefits. The sickness covered should be such as to result into total and permanent disability. **It should render the policyholder incapable of earning or performing the activities of daily living as defined in Clause 10.3 and 10.4.**

Event	Benefits	Conditions to be satisfied before admission of claim
F) Total and permanent disability due to sickness	**1) 10 % of the Sum Assured p.a. payable monthly till death or maturity which is earlier, and 2) Waiver of premiums for balance term**	**Earning test or ADL Test as defined in Clause 10.3 and 10.4 to be satisfied.**

10.3 : Earning Test : This has to be satisfied if the life assured is aged not over 65 years and is earning as on the date of accident or sickness.

The disability is such that there is neither then nor at any time thereafter any work, occupation or profession that the life assured can ever sufficiently do or follow to obtain any wages, compensation or profit.

10.4 : ADL Test : This test has to be satisfied if the life assured is over age 65 years or not earning as on the date of accident or sickness.

The disability is to be such that the life assured is not able to perform any four of the following five activities of daily living (i.e. failure of any four ADLs).

i. Dressing & undressing : the ability to dress and undress and to put on and take off any surgical appliances usually worn.

ii. Washing & bathing : the ability to wash in the bath or shower or by any other means to maintain personal cleanlines.

iii. Using the lavatory : the ability to do all the following : to get to and from the lavatory, to get on and off the lavatory, to maintain an adequate level of hygience.

iv. Continence : the ability to voluntary control bowel and bladder functions or to otherwise maintain an adequate level of personal hygiene with or without the use of catheters, incontinence pads or other artificial aids.

v. Mobility : the ability to walk 400 meter on the level without stopping and without severe discomfort.

c) According to the hospital records of Purna Cardiac Centre, Vijayawada, the life assured was admitted there on 04.01.2001 with complaints of severe chest pain. The diagnosis arrived by them was "CAD-Acute Anterior Wall QMI". The life assured went to Hyderabad and got himself admitted there in Mahavir Hospital & Research Centre, Hyderabad on 29.01.2001. According to the hospital authorities of this hospital, the life assured was "suffering from CAD-Tripple Vessel Disease & Severe LV dysfunction. He is advised **to be marked restricted physical activities".** The life assured was again admitted in Purna Cardiac Centre, Vijayawada on 11.03.2001and took treatment for his heart problem.

d) For getting eligibility for sickness benefits, the life assured must satisfy one of the conditions viz. Earning Test or ADL Test, as appearing in the policy conditions. According to the proposal/policy,the life assured was aged 58 years in 03/2000 and less than 65 years as on the date of illness. As per the investigation report submitted by the official of the insurer (LIC), the life assured was working as co-ordinator, in a private school and was earning accordingly. The life assured need not fulfill the conditions stipulated under ADL test since he was less than 65 years of age as on the date of illness. He should however fulfill the earning test (Vide 10.3 in para 5(b) supra). The disabiliity resulting from the disease is such that the life assured is neither at the time of the accident or sickness nor at any time thereafter any work, occupation or profession that he can ever sufficiently do or follow to obtain an wages, compensation or profit (Emphasis is supplied). The life assured, a pensioner at the inception of the policy, was co-ordinator in a private convent, as found out by the investigator of the insurer. According to the life assured, he was employed in a school. Thus there is enogh evidence to show that life assured was earning at the time of the sickness (viz. Major cardiac ailment suffering from CAD - triple Vessel and severe LV Dysfunction). Mahavir Hospital & Research Centre, a reputed charitable hospital, diagnosed the sickness and advised the life assured "marked restricted physical activities". According to life assured, he was advised complete rest and avoidance of physical and mental strain. In my opinion, in view of the medical advice, the life assured could not sufficiently do or follow his job as co-ordinator in a school. As a matter of fact, the life assured admitted that he stopped attending to the school or any other vocation or profession after the diagnosis. Thus, in my opinion, the life assured fulfills the condition laid down in 10.3 (Supra) and he qualifies for the benefit.

e) Therefore, I am of the opinion that the rejection of sickness benefits by the insurer (LIC) is not proper and justified. Therefore, I direct the insurer to consider the sickness benenfits as per the policy conditions.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre

Case No. L / 21.009.0480 / 2005 - 06
Shri Kripa Patra Nevatia
Vs
Bajaj Allianz Life Insurance Co. Ltd.

Award Dated 31.03.2006

FACTS OF THE CASE

One Shri Kripa Patra Nevatia, S/o Shri Bajrang Lal Vevatia, a resident of Mangalore in Karnataka, took a Save Care Health Insurance Policy from Bajaj Allianz Life Insurance Co. Ltd., Lucknow while he was staying there in 03/2003 for a sum assured for Rs. 1,00,000/-. The life assured was hospitalized during 06/2005 to 10/2005 and claimed for Critical Illness & Hospital Cash Benefit payable under the policy on 30.08.2005. The final diagnosis arrived by the hospital authorities was "Right frontal oligoastrocytoma Grade-III". The insurer repudiated/rejected his claim for Critical Illness & Hospital Cash Benefit on 11.11.2005, citing the reason that the life assured, while proposing for insurance, gave false answers to certain questions in the proposal form. It was also stated by the insurer that they held indisputable proof to show that even before he proposed for the above policy, the life assured was suffering from headache since 5 years and hypertension since 10 years and was on treatment for the same. He, however, did not disclose these facts in the proposal. Finding the life assured to be guilty of deliberate suppression of material facts relating to his health at the time of taking the insurance policy, insurer repudiated/rejected the claim.

DECISION :

I heard the contentions of both sides and also perused all the documents including the written submissions of both the parties.

i. The life assured took a Save Care Health Life Insurance Policy in 03/2003 for a Sum Assured of Rs. 1,00,000/-. This policy also covered Critical Illness & Hospital Cash Benefits (in the event of hospitalization). The life assured was hospitalized during the period 06/2005 to 10/2005 and claimed the above benefits from the insurer. The diagnosis arrived by the hospital authorities was **Right Frontal Oligoastrocytoma Grade - III.** The insurer arranged for investigation into the bonafides of the claim.

ii. The insurer repudiated/rejected the claim of the life assured complainant on the ground that the life assured had suppressed material facts relating to his health prior to taking the insurance policy. According to the insurer, the life assured suffered from headache since 5 years and hypertension since 10 years and was on treatment, prior to taking the insurance policy.

iii. Before discussing the facts and circumstances and the documentary evidence available on file, it is useful to refer to the provisions contanied in Sec. 45 of the Insurance Act 1938. Sec. 45 of the Insurance Act 1938 was applicable under the claim under dispute as the insurer repudiated/rejected the claim after two years from the date of commencement of the policy and treated the policy as null and void. The said provision lays down three conditions for the applicability of the 2nd part of Section 45. (1) Statement must be on a material matter or the insured must have suppressed facts which it was material to disclose (2) The suppression must be fraudulently made by the insured (3) The insured must have known at the time of making the satement that it was false or the insured suppressed facts which it was material to disclose.

iv. Now, The insurer in support of their repudiation action obtained and submitted treatment particulars from Manipal Hospital, Bangalore. According to the

discharge summary of the hospital, the insured was admitted there on 16.06.2005 (**after taking the insurance policy** only) had surgery on 18.06.2005 and discharged on 25.06.2005. It was reported in the discharge summary that the life assured brought there with **history of headache since 5 years.** The insurer also relied on the discharge summary obtained by them from St. John's Medical College Hospital, Bangalore. As per this discharge summary, the life assured was admitted there on 06.06.2005 (Hosp. No 1908766/670651) and the insured was admitted there with h/o of headache - on and off since 5 years and a known case of hypertension since 10 years on regular treatment. But the insurer failed to probe further and obtain treatment particulars (like details of doctors/hospitals consulted, medicines used, various pathological and other tests undertaken) to sustain their repudiation, as 2nd part of Sec. 45 was applicable. Repudiation merely on the basis of history and not supported by documentery evidences is not sufficient as the onus is on the insurer to establish fraudulent intent on the part of the insured. The insurer did not at all take this aspect into consideration before repudiating/rejecting the claim. Curiously, as per the discharge summary of Manipal Hospital, the life assured **was not a known diabetic or hypertensive.**

v. Once again the insurer relied on the discharge summary issued by Shirdi Saibaba Cancer Hospital & Research Centre, Manipal. As per this document, the life assured was admitted there on 11.07.2005 vide Hospital No. 01643980 and took treatment upto 14.07.2005. Even this admission and the treatment thereto was also only after taking the insurance policy. It was reported in the discharge summary that the life assured was a known case of HTN since 10 years (corrected as 3 years). But this too (hypertension) was not supported by documentary evidences like details of doctors/hospitals consulted and the details of medicines used. Unfortunately, the insurer could not gather any evidence relating to hypertension like **hypertension readings prior to taking the policy.** Since 2nd part of Sec. 45 of the Insurance Act 1938 was applicable and the insurer treated the policy as null and void, this aspect is very important to strengthen their repudiation action. Even the treatment relate to 09/2005 to 10/2005, which was also after taking the policy only.

vi. As could be seen from the above, the evidences gathered and submitted by the insurer all relate to after taking the policy and the insurer couldn't secure any evidence in the form of hospital reports prior to taking the policy except the history recorded in the records of the hospital, which was not sufficient. The only contention appears to be violation of the principle of utmost good faith. The insurer has not proved fraudulent intent on the part of the insured beyond doubt with sufficient evidence.

vii. Having regard to the facts and circumstaces of the case including the medical evidences as discussed above and in the absence of any supportive evidence to the effect that the life assured had fraudulently suppressed material facts relating to his health prior to taking the insurance policy and in view of the fact that the repudiation action of the insurer did not fulfill all the three ingredients required under 2nd part of Sec. 45 of the Insurance Act 1938, I am of the view that the repudiation of the claim by the insurer is not legal, correct, proper or jusfied. In view of the reasons as aforesaid, I direct the insurer to settle the claim under the above policy.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre

Case No. L / 21.004.0399 / 2005 - 06
Shri U. S. S. U. Bhaskar Rao
Vs
ICICI Prudential Life Insurance Co. Ltd.

Award Dated 31.03.2006

BACKGROUND

One Shri U. S. S. U Bhaskara Rao, S/o Shri Krishna Rao, doing business and a resident of Vijayawada in Andhra Pradesh, took insurance policies from ICICI Prudential Life Insurance Co. Ltd., Mumbai on 04/2005 and 05/2005. The policies also covered the Accident & Disability Benefit Rider, in the event of the life assured becoming disabled by an accident, as per the policy conditions. The life assured met with an accident (train accident) on 02.07.2005, resulting in loss of left hand and right eye. The complainant and the life assured under the policies claimed Disability Benefit rider benefits payable under the policies. But the insurer, repudiated/rejected the complainant's claim for disability benefit rider alleging that the disability sustained by the life assured was not total and permanent, as per their Total and Permanent Disability clause defined, as per the terms and conditions of the policies.

DECISION :

I have carefully perused the papers placed before me including the written submissions of the complainant/insurer and also heard arguments of both sides.

a) The life assured took a 16 years Smart Kid Insurance Policy in 04/2005 for a Base Sum Assured of Rs. 3,00,000/-. He also took another 16 years Invest Shield Life Insurance Policy in 05/2005 for a Base Sum Assured of Rs. 2,00,000/-. Both the policies covered Accident & Disasbility Benefit rider benefits, in the event of the life assured sustaining disability, which conform to the terms and condtions of the policies. The life assured met with an accident on 02.07.2005 and, in the process, lost his left hand and his right eye. He represented/requested the insurer to consider settlement of benefits payable under the policy.

b) But the insurer repudiated/rejected the complainant's claim for Accident & Disability benefit rider (premium waiver benefits) alleging that the disability sustained by the insured was not falling under the purview of the policy terms and conditions.

   Accident & Disability Benefit Rider: - Before discussing the facts and circumstances and the documentary evidence available on file, it is useful to know the salient features of the relevant clause governing the Accident & Disability Benefit Rider (Premium Waiver Benefit) as applicable under the policies in question. "A person shall only be regarded as "Totally and Permanently Disabled" if that person, due to accident or injury had suffered a loss such as (i) the loss by physical separation of two limbs or the complete and irremmediable loss of sight in both eyes or the loss by physical separation of one limb accompanied by the complete and irremediable loss of sight in one eye (where limb means an entire hand or foot), or (ii) has been continuously disabled for a period of six consecutive months and has been determined by the company, after consideration of the reports and other information supplied by the company's own medical practitioner, appointed to examine that person, to be incapacitated to such an extent as to render that person unlikely ever to resume work or to attend any gainful employment or occupation".

c) According to the documents submitted by the complainant/insurer, the life assured met with an accident and fell from a moving train at Powerpet Station. The life

assured was admitted to Vijetha Hospital. According to the medical certificate dated 29.07.2005, the insured fell from a moving train on 02.07.2005, was admitted there on 03.07.2005 and took treatment upto 18.07.2005. As per the Disability Certificate dated 08.08.2005 issued by Vijetha Hospital, Vijayawada (a) the life assured lost complete vision in the right eye 50 % permanent visual disabilty on total (b) below elbow forearm amputation was done for crush injury of left forearm-70 % permanent disability. Unfortunately, the policy conditions did not cover loss of sight in one eye and that it covered irremediable loss of sight in both eyes. Similarly, although the insured has had amputation at below elbow forearm, policy conditions specified one limb as entire hand or foot. With the result, this also did not conform with and fit into the policy conditions referred above.

d) The terms and conditions, including the policy clauses form the basis of the contract and the same can neither be ignored nor overlooked.

e) The construction of the policy bond including the relevant poilcy clauses, which is the basis of the contract of insurance, is a qustion of law and its true and correct interpretation would give jurisdiction to the Insurance Ombudsman to pronounce upon the deficiency in service, if any.

f) Therefore, the disability sustained by the life assured as enumerated above and as presented in the hospital reports and other documents did not fall within the deeming definition constituting Accident & Disability Rider Benefit of the policies, the complainant is not eligible for such benefits.

g) During the course of the hearing, the insurer submitted that they were prepared to reconsider their decision once again and offer to make an ex gratia payment of Rs. 2,00,000/-. The complainant also agreed and submitted his consent for the same. Now the insurer vide their letter dated 08.03.2006 confirmed of having made this payment and informed that the Accident & Disability Benefit rider under the policies stands discontinued. The insurer already expressed his acceptance to revive the policies if the complainant desired so. The complainant may approach the insurer for revival of the policies, if he desires to.

h) In view of the action initiated by the insurer vide their letter-dated 08.03.2006 referred above, the complaint stands close.

Kochi Ombudsman Centre
Case No. IO/KCH/LI/21.001.201/2005-06
Shri P. A. Assainar
Vs
Life Insurance Corporation of India

Award Dated 14.02.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules arose out of a revival repudiation of LIC policy No. 771076502 held by the complainant. It is a special policy (Asha Deep) extending certain benefits to the life assured for heart ailments etc. The policy lapsed and it was revived on the basis of a declaration of good health dated 4.3.2005. The life assured-complainant had a heart problem and he was an inpatient of the Medical Trust Hospital, Ernakulam on the date of the Declaration of good health. It was the version of the complainant that his nephew had arranged for the revival along with an LIC agent and he had not signed any form for revival. However, the declaration of good health submitted to the nsurer was not witnessed by the LIC agent, who is reportedly involved in the process of revival. The fact, however, remained that the policy was got revived on a date when the life assured was an inpatient in the hospital for angioplasty. The declaration of good health stated that the complainant was in good

health. Therefore, based on this wrong declaration, the insurer declared the policy null and void from the date of revival after the complainant submitted the claim form for benefit “B” under the disputed Asha Deep Policy. In view of the wrong statement in the declaration of good health, the action of the insurer was found justifiable. The paid up value acquired under the policy was payable on the date of maturity or it could be surrendered by the life assured if required even earlier. In this case, the complainant was prepared to wait till the date of maturity. The complaint was however, dismissed as devoid of merits.

Kochi Ombudsman Centre
Case No. IO/KCH/LI/21.001.289/2005-06
Shri C. Balan
Vs
Life Insurance Corporation of India

Award Dated 07.03.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to a dispute in relation to the Bonus payable under 3 life insurance policy (Pol. nos. 790336464, 790345902 and 45208303) held by the complainant who is a retired Policeman, Disputing the methodology of Bonus Calculation by the insurer, he had refused to receive the maturity proceeds. The complainant in his own way, computed the bonus on the total premium paid, whereas as per the Insurance regulations bonus was to be calculated on the sum assured. The insurer wrote to the complainant several times, but he refused to agree. On verification of the records, the claculation of the insurer were found correct as per the bonus regulations and the complainant was very obstinate on his own ignorant calculations. There was absolutely no merit in the complaint. Threfore the complaint was dismissed advising the complainant to receive the amounts already offered by the Insurance Company whose calculations were found correct.

Kolkata Ombudsman Centre
Case No. 189/24/003/L-TATA-AIG/06/2005-2006
Shri Subhabrata Bhaumik
Vs
Tata AIG Life Insurance Company Ltd.

Award Dated 28.12.2005

Facts & Submissions:

The complaint is regarding repudiation of claim on account of mis-representation/non-disclosure of material facts under Health First Policy issued by TATA AIG Life Insurance Co. Ltd.

Shri Subhabrata Bhaumik stated that he took a Health First Policy from TATA AIG Life Insurance Co. Ltd. on 28.05.2003 for a period of 38 years as life insurance was able to provide a complete solution for his medical needs. He renewed the policy by making payment of premium on 4.6.2004. A surgical procedure was performed on him during the confinement period of 4 days (22.4.04 to 26.4.04) at Woodlands Hospital & Medical Research, Kolkata for treatment of the covered illness under recommendation and professional care of a Registered Medical Practitioner for which investigation, diagnosis and treatment was done.

He filed the claim on hospitalisation together with relevant papers with the Insurance Company on 31.05.2004. The claim was repudiated by the Insurer on the ground that the patient had symptoms related to sub-acute appendicitis since 27.1.2003 and this

information was not disclosed in the application dt. 28.5.2003 for taking policy from the Insurer.

The complainant submitted that the pain in his abdomen subsided within 2/3 days with the application of medicines prescribed by his family physician. He pointed out that appendicitis was not a confirmed diagnosis and no operation was performed on appendicitis. He contended that an illness occurred when it was investigated, diagnosed or treated or when its signs of symptoms manifested. In this case, there was no occurence of sub-acute appendicitis in future.

After relief from pain in his abdomen within 2/3 days, he took a Health First Policy from TATA AIG. It was not clear to him whether the symptoms of sub-acute appendicitis were still persistent, although surgery was performed on him for the treatment of diagnosed illness of Hernia after a lapse of more than one year from the first consultation with his family physician. The complainant stated that the Insurer terminated the policy only to avoid the genuine claim. He approached this forum for relief of Rs. 33,637/- on account of the above treatment.

TATA AIG stated that the Insured had symptom related to sub-acute appendicitis since 27th January, 2003, which was not disclosed in his application for policy signed on 28th May, 2003. Such information was relevant to the risks associated with the said application and if made known to the Company at the time of application, the underwriting consideration would not have issued the policy. They stated there was evidence of non-disclosure, suppression and mis-representation of facts while applying for the insurance coverage. Hence, the claim was declined and policy was voided from inception in accordance with Section 45 of Insurance Act 1938.

The complaint was taken up for hearing on 9.12.2005 where the persons named above were present.

At the time of hearing, Shri Subhabrata Bhoumik reiterated his submissions made earlier to the Insurance Company. He pointed out that he was under the treatment of Dr.S.Goswami who on 27.1.2003 diagnosed him as a patient of sub-acute appendicitis. He prescribed some medicines with an advice to consult a surgeon if the pain continued. He did not feel any uneasiness thereafter and he did not consult the surgeon and only took the medicines as prescibed. Subsequently, the L/A was admitted in Woodland Hospital and Medical Rasearch Centre Ltd. 22.4.2004 at 1.30 P.M. and was discharged from there on 26.4.2004 at 1P.M. The diagnosis was that he was suffering from Right Inguinal Hernia. The LA further pointed out that his father was an Agent of TATA AIG and he was supposed to adduce evidences, but due to his pre-occupation with some other job, he could not turn up for the hearing.

Dr. B.S. Powdwal, Sr. Manager (Claims) of TATA AIG submitted that the patient, Shri Bhaumik was actually suffering from Right Infuinal Hernia since January, 2003 and this fact was not disclosed in the proposal form for obtaining policy from TATA AIG. He stated that Shri Bhaumik consulted his family physician, Dr. S. Goswami who in his prescription dt.27.1.2003 diagnosed him for sub-acute appendicitis. He prescribed some medicines and advised him to consult a surgeon, if the pain continued. Dr. Powdwal pointed out that Shri Bhaumik actually consulted the surgeon, Dr. Sanjay Bakshi immediately thereafter on 30.1.2003 who also confirmed that “the patient was suffering from RIH and recommended for surgery”. This fact that the patient consulted the surgeon, was suppressed by the complainant. In this connection, Dr. Powdwal drew our attention to the prescription of Dr. Sanjay Bakshi where the date was tampered into

30.1.2004 in order to give an impression that the diagnosis of RIH was made after the policy was obtained by the complainant vide this application dt.28.5.2003.

In addition to the above discrepancies, Dr. Powdwal, a doctor himself, explained the symptoms of Sub-acute Appendicitis and RIH in this case would be similar. He referred to the Text Book on Principles of Surgery and submitted relevant extracts from the Text Book.

Decision : We note that Shri Bhaumik felt pain on right lower abdomen on 27.1.2003. He consulted his family physician, Dr. S.Goswami on the same day. Dr. Goswami prescribed some medicines and recommended that if pain continued the patient should consult a surgeon. We have reasons to believe that the patient did consult a surgeon. Dr. Sanjay Bakshi on 31.1.2003 (although the date was overwritten to look like 30.3.2004). The complainant was at pains to explain tne discrepancy in dates and could not offer any convincing arguments that he did not consult the surgeon before he took the policy from TATA AIG vide his application dt. 28.5.2003. Further, the explanation given by Dr. Powdwal regarding symptoms of the two diseases, the same is acceptable for the purpose of concluding that the disease was pre-existing prior to the commencement of the policy and that this fact was not disclosed in the proposal form for obtaining the policy.

Considering the sequence of events leading to the operation on the patient, we hold that the complainant was aware of the fact that he was suffering from Right Inguinal Hernia before he took the mediclaim policy. His explanation that earlier symptoms responded to the medicines, as prescribed by his family physician and that the symptoms of appendicitis were different from the Hernia for which he was operated upon are not acceptable in view of the records as well as the explanation and clarification given by the Insurer. We, accordingly, uphold the decision to repudiate the claim for the reasons given by them in repudiation letter.

Kolkata Ombudsman Centre
Case No. 732/21/001/L/01/2005-2006
Shri Manoj Kanti Roy
Vs
Life Insurance Corporation of India

Award Dated 20.03.2006

Facts & Submissions : The complaint is regarding non-payment of loyalty addition along with maturity value of the policy.

Shri Manoj Kanti Roy had taken one Bima Nivesh policy with LICI for which the maturity date was 10.03.2006. As per the advertisement and other communication during the time of investment in March 2000, it was assured that “Loyalty Addition” was also payable in addition to the maturity amount. But according to a communication from LICI ref. M/032006/000260 dated 19.11.2005, there was no mention of loyalty addition payable to the policyholder. The complainant wrote a letter to the Branch Manager, City Branch 5 on 30.12.05 with a reminder dated 20.01.06. He received a reply dated 04.02.06 from Manager (CRM) stating that no loyalty addition was payable for the following reasons :

“We have received your letter dated 20.01.2006 and have gone through the contents of it. We would draw your attention to the policy conditions, which states that “on the life assured surviving the stipulated date of policy, this policy may be eligible for payment of loyalty at such rate and on such terms as may be declared by the Corporation”. The

policy which was taken by you in the year 2001 could not generate any loyalty addition. Consequently the corporation has not declared any loyalty addition and on maturity only the sum assured along with the guaranteed addition is being paid to the policyholdeRs. "

Being aggrieved, he has approached this forum for relief on account of Loyalty Addition amounting to Rs. 10,000/- as per 'P' form.

LICI, CBO-5 vide their letter dated 07.03.06 stated that in this case the maturity claim has already been paid for Rs. 6,01,463/-. No loyaltyaddition was payable. Relevant extract from the letter dated 07.03.06 is reproduced below:

"In the policy document it was mentioned under heading Special Provision as :

Loyalty Addition : On the life assured surviving the stipulated date of maturity the policy may be eligible for payment of a loyalty at such rate and on such term as may be declared by the corporation. No loyalty addition has been declared by corporation. So nothing is payable as loyalty additions under this plan. Maturity value is only the total sum assured and guaranteed additions. Under this policy maturity claim has been paid for Rs. 6,01,463/- vide post dated cheque bearing no.0437659 dated 10.03.2006 on 17.02.2006. The calculation is as follows :

Sum Assured	4,00,000.00
Guaranteed addition	2,01,463.00
Net maturity value	6,01,463.00

Decision : We have gone through the publicity material issued by LICI at the time of marketing Bima Nivesh, where it was mentioned that additional incentive in the shape of Loyalty Addition was available to the policyholder. There was no mention that declaration of Loyalty Addition was subject to LICI making profit. Any policy holder unsuspecting of the intention of LICI could be misled into believing that loyalty addition was a guaranteed addition to the maturity value of the policy. But later in the policy document it was provided that the policy would be eligible for payment of Loyalty Addition only under certain circumstances and conditions. Clearly there was lack of transparency as a result of which any gullible investor is likely to be misled. We take adverse view of such practice on the part of LICI and we would expect that misleading publicity should not given at all.

However, since the Loyalty Addition is subject to the policy condition and the policy condition does not provide for automatic grant of loyalty addition, we cannot reverse the order of the LICI. Accordingly, we do not interfere in this case.

Lucknow Ombudsman Centre
Case No. L - 139 / 001 / 05 - 06
Shri Vibhuti Bhushan
Vs
Life Insurance Corporation of India

Award Dated 16.03.2006

The complainant Shri Vibhuti Bhushan Dutta had taken a Varistha Pensiion Bima Policy from LIC of India on 1.09.03 by paying a purchase price of Rs. 2,55,845/-. The annuity installment was Rs. 24,000/-. On account of his ill health he applied for the surrender value of the policy on 27.06.2005. The life assured applied for surrender value payment with the servicing Branch Rishikesh but there is no provision for payment of

S. V. under the policy. The servicing office B.O., Rishikesh therefore referred the matter to its Divisional Office which in terms referred to Zonal Office. The Zonal Office had approved surrender value payment of Rs. 2,70,980/- on 12.08.05 but the computer of servicing branch was not accepting its advice. Again a reference was made to Zonal Office and in the mean time a payment of Rs. 2,30261/- as SV was made by the Branch office on 08.10.05 to the complainant. He accepted this payment without any demur. However after accepting the payment after few days he complained for short payment of S. V. in servicing Branch. The servicing Branch paid the balance amount of Rs. 40,719/- to the complainant on 7.2.06. Further he claimed interest on delayed settlement of surrender value amount. The insurer denied the claim. He approached Insurance Ombudsman for redressal of his grievance.

However during personal hearing of the case the insurer regretted for this delay and also offered payment of interest for 3 months. This offer was not accepted by the complainant and he claimed interest on full surrender value for total delayed period.

Looking at the facts and circumstances of the case Ombudsman held that ends of justice will be met if the complainant is also paid interest on balance amount of Rs. 46,719/- for the period 12.08.05 to 07.02.06. He awarded payment of interest by the insurer for the following period 2 % above the Bank rate, as on 01.04.05 that is to say @ 8 %.

1. 20 days after receipt of application and documents for surrender value on 27.06.05 upto 08.10.05 on the amount of Rs. 2,30,261/-.
2. One week after 12.08.05. that is to say from 19.08.05 to 07.02.06 on balance amount of Rs. 40,719/- being the difference SV approved by the Zonal Office of the insurer.
3. The Insurer will further pay interest at the above rate after 30 days on the above amount if payment is delayed beyond this period. The period to be taken by the complainant in communicating its consent to the Award to the insurer shall be excluded.

   The complaint was disposed off accordingly.

Mumbai Ombudsman Centre
Case No. LI - 032 of 2005-06
Shri Chakiath Ittirakunju Joseph
Vs
TATA AIG Life Insurance Co. Ltd.

Award Dated 19.12.2005

Shri Chakiath Ittirakunju Joseph had taken a policy of Assure 20 years Security and Growth Plan under policy No. C000414858 from TATA AIG Life Insurance Company limited. Shri C. I. Joseph was hospitalized at Cardio Vascular, Medical Trust Hospital, Cochin, Kerala for Atrial Septal Defect (ASD), Ostium Secundum Type. When Shri Joseph preferred a claim under Critical Illness Rider to TATA AIG, the Company repudiated the claim stating that Shri Joseph at the time of filling in the proposal form did not disclose that he was suffering from heaviness in the chest and if he had disclosed the same, the underwriting decision would have been different. Moreover, they also stated that the heart disease which Shri Joseph suffered from, did not qualify for any of the critical illness. Not satisfied with the decision of the Company Shri

Joseph represented to the Company which was turned down by the Company. Hence aggrieved by the decision of the Company, he approached the Office of the Insurance Ombudsman. After perusal of the records parties to the dispute were called for hearing. It is evident from the records of the Medical Trust Hospital, Cochin that the Life Assured had symptoms of the illness, heaviness of chest, at the time of proposing for insurance. This has also been corroborated by the statement given by the spouse of the Life Assured which was recorded in the questionnaire Had he disclosed this fact at the time of proposing for insurance, Insurer would have taken appropriate decision in accepting the proposal and granting critical illness benefit under the policy. The second issue as per the Company's letter was about non-eligibility of this claim for consideration as A. S. D. was not one of the CRITICAL ILLNESSES as per the Critical Illness Rider (Lumpsum Benefit) of the policy. This has also been examined at this Forum and it is satisfied about the Company's stand.

In view of this legal position and also in view of the fact that the illness in question does not qualify as a critical illness for lumpsum benefit under the contract, the decision of TATA AIG Insurance Company Ltd. to repudiate the claim on the ground on non-disclosure of material information regarding his health and also the heart disease suffered by him does not qualify for any of the critical illness shown in the Critical Illness Rider (Lump Sum Benefit) of the policy is held sustainable.

Mumbai Ombudsman Centre
Case No. LI - 127 of 2005-06
Smt Jasumati C. Doshi
Vs
Life Insurance Corporation of India

Award Dated 30.12.2005

Smt. Jasumati C. Doshi approached the Insurance Ombudsman by complaint dated 03.10.2005 against rejection of Double Accident Benefit (DAB) claim under policy nos. 91005450 and 904356596 on the life of her late husband Shri Chandulal J. Doshi, by Life Insurance Corporation of India. It is seen that Shri Doshi was insured under the above two policies with effect from 14.11.1988 and 28.03.1998 for Rs. 1,00,000/- and Rs. 2,00,000/- under Plan and Term 5-29 and 88-20 respectively. Shri Chandulal J. Doshi died on 21.06.2004 due to accident that took place at Bhavnagar Tarapore Highway between truck and motor car. LIC of India settled the claim for basic sum assured + double Accident Benefit (DAB) of Rs. 42,500/- under policy no. 904356596 and rejected Double Accident Benefit under policy no. 910054500 as the policies were not eligible for DAB.

While proposing for policy no. 904356596 for Rs. 2,00,000/- in the proposal form dated 10.12.1997, the deceased life assured had declared that his then exisitng policy numbers 73625604, 910048807 and 910054500 for Rs. 2 Lakh each were without DAB cover. Based on this information LIC granted DAB cover in the new policy since the aggregate DAB cover in his existing and new policies did not exceed the prevailing limit of Rs. 5 lakhs. As a matter of fact at that time he had DAB cover of Rs. 4,57,500/- and LIC could have granted Rs. 42,500 DAB cover under this new policy had he disclosed the correct information. Again while proposing for insurance under policy no. 910054500 for Rs. 1,00,000/- sum assured, the life assured in his proposal form dated 17.01.1988 mentioned that his previous policy nos. 73625323, 73625324, 73625604,

910048807 for Rs. 1 lakh each and policy no. 71301849 for Sum Assured 50,000/- were without DAB cover and based on this information LIC granted DAB cover under this policy. The deceased life assured was fully aware of the rules of LIC granting DAB as is evident from the fact that he applied for extension of this cover under his policy nos. 71301848 and 71301849 for Rs. 50,000/- each consequent on the increase in limit of accident benefit cover by LIC. Here again he suppressed the information about DAB cover in respect of all his existing policies and as a result LIC granted him DAB cover of Rs. 1 lakh against the balance limit of Rs. 5,000/- resulting in excess DAB cover of Rs. 95,000/-. The fact that the deceased life assured suppressed the information about accident cover on each occasion leads to the conclusion that he acted with a malafide intention to get additional benefits under the policies.

It is pertinent to note that LIC collected the additional premium for the accident cover under policy nos. 910054500 and 904356596 based on the reply to the relevant proposal form regarding the accident cover he had already under the existing policies and decided to grant policy with accident cover after ensuring the total limit of the total accident cover not exceeding the then prevailing limit as per their guidelines. Based on the above analysis it is observed that the decision taken by LIC to reject payment of Double Accident Benefit under the two policies cannot be faulted and this Forum therefore cannot interfere with their decision.

Mumbai Ombudsman Centre
Case No. LI - 021 of 2005-06
Smt. Sandhybai Bhaskarrao Patil
Vs
Life Insurance Corporation of India

Award Dated 25.01.2006

Smt. Sandhayabai B. Patil took Ashadeep Policy no. 968100725 for Rs. 50,000/- and other four endowment policy nos. 967619184 & 967621457 for Rs. 1,00,000/- each and Rs. 50,000/- each under policy nos. 958105003 & 968094347 from Life Insurance Corporation of India from Chalisgaon Branch Office of Nashik Division of Life Insurance Corporation of India. As per statement, Smt. Patil was travelling as a pillion rider on motorcycle when she fell down and was admitted in an unconscious condition at Jalgaon Neurology and Trauma Centre under care of Dr. Rajesh Jain from 12.07.2003 to 19.07.2003. Smt. Patil preferred a claim to LIC of India and also applied for Extended Permanent Disability Benefit (EPDB) under all the policies. Life Insurance Corporation of India referred the matter to its Divisional Medical Referee for his opinion and accordigly after getting his opinion they admitted the claim for Contingent Benefit under Ashadeep policy but EPDB was not given under all the policies.

In the facts and circumstances, I set aside the rejection of EPDB claim of the complainant by LIC in full and direct them to settle the EPDB claim of Smt. Sandhyabai Bhaskarrao Patil under policy nos. 968100725, 967619184, 967621457, 968105003 and 968094347. The case is disposed of accordingly.