PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1)OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN– Shri.M.Vasantha Krishna
Case of MrL. Ramesh Vs Star Health and Allied Insurance Co. Ltd
REF: NO: CHN-H-044-2021-0462
Award No: IO/CHN/A/HI/0001/2021-2022

1.	**Name & Address of the Complainant**	**Mr L Ramesh** **Plot No 19&20, Kamarajar Salai, Adaikalam Pillai Colony, Iravadanallur, Selvapuram Main Road** **Madurai, Tamilnadu-625 009**
2.	**Policy (Renewal Endorsement) No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**P/121325/01/2021/000231** ***Family Health Optima Insurance Plan*** **24.05.2020 to 23.05.2021** **INR 4 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mr L Ramesh** **Mr L Ramesh**
4.	**Name of the Insurer**	**Star Health and Allied Insurance Co. Ltd**
5.	**Dates of partial settlementof the claim**	**12.08.2020 & 15.09.2020**
6.	**Reason for partial settlement**	**As per the terms & conditions of the policy**
7.	**Date of receipt of the Complaint**	**05.01.2021**
8.	**Nature of Complaint**	**Short settlement ofthe claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**20.01.2021**
10.	**Amount of Claim**	**INR 3,00,279**
11.	**Amount paid by the Insurer**	**INR 78,865 (INR 46,709+INR 32,156)**
12.	**Amount of Monetary Loss (as per Annexure VI A)**	**INR 2,21,414**
13.	**Amount of Relief sought (as per Annexure VI A)**	**INR 2,21,414**
14.a.	**Date of request for Self-contained Note (SCN)**	**06.01.2021**
14.b.	**Date of receipt of SCN**	**25.02.2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on12.03.2021**
17.	**Representation at the Hearing**	
	a) For the Complainant	**Mr L Ramesh**
	b) For the Insurer	**Dr Asiya Sahima & Ms Hemalatha**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**12.04.2021**

20. Brief facts of the Complaint: The complainant had covered himself, his spouse and child under the *Family Health Optima Insurance Plan* of the Respondent Insurer (RI) for a SI of INR 4 lakhs. The period of insurance is 24.05.2020 to 23.05.2021. He was admitted to Saravana Hospital, Madurai on 30.06.2020 after he tested positive for Covid-19 and underwent treatment. He submitted his claim for

reimbursement of treatment expenses to the extent of INR 3,00,279 to the RI. But the claim was settled for only INR 46,709. Therefore, the complainant approached the RI for a review of the settlement and payment of the balance amount of the claim. Based on the available documents, the insurer settled an additional amount of INR 32,156. Since he was still not satisfied with the settlement, the complainant has approached this Forum for relief.

21. Insurer's submission:

The complainant's claim of INR 3,00,279 for reimbursement of his treatment expenses due to Covid 19 was settled initially for an amount of INR 46,709. Later, when he approached the Ri for payment of the balance amount, an additional amount of INR 32,156 was paid. The details of the deductions made from the claim are as under:

a) The policy is subject to a limit of INR 5,000 per day towards room rent, boarding and nursing expenses, corresponding to the Sum Insured of INR 4 lakhs. Hence an amount of INR 30,000 was allowed for 6 days of hospitalization under this head and the remaining amount of INR 99,000was disallowed.
b) Since no break-up was provided for investigation charges, only 80% was allowed and INR 1,175 (20%) was deducted.
c) Injection Meropenum is not indicated for Covid 19 treatment and hence an amount of INR 23,160 (injection charges) was disallowed.
d) PPE kits were allowed @INR 1,200 per day (400 *3 per day). Hence INR 92,800 was disallowed.
e) Food charges are not payable as per policy. Hence an amount of INR 5,000 was deducted from the claim.
f) An amount of INR 279, being the discount allowed by the hospital was also deducted.

Thus, an amount of INR 221414 was deducted in all from the claimed amount and the balance was settled.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule 13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Complaint to the Ombudsman (Date of receipt 05.01.2021)
- ✓ Bill assessment sheet of the RI
- ✓ Claim form Part A dated 20.07.2020
- ✓ Claim form Part B dated 10.07.2020
- ✓ Representation dated 18.08.2020 of the Complainant to the RI

- ✓ Insurer's response to the Complainant dated 05.01.2021
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ Copy of Policy with terms and conditions
- ✓ Self-contained Note (SCN) of the RI dated25.02.2021

S No	Head of expense	Amount claimed (INR)	Amount disallowed (INR)	Amount allowed (INR)	Remarks
1	Room Rent, Boarding and nursing	1,29,000	99,000	30,000	Eligible room rent is INR 5,000 per day – allowed for 6 days
2	Professional fees	30,000	0	30,000	
3	Investigation charges	5,875	1,175	4700	(no break-up given; hence 80% allowed)
4	Medicines	30,404	23,160	7,244	Injection Meropenum disallowed
5	Misc.	1,00,000	92,800	7,200	PPE kits allowed @ INR 1200 for 6 days)
6	Others	5,000	5,000	0	Food charges - part of Room Rent paid under item 1
		3,00,279	2,21,135	79,144	

	Less Hospital discount	279	
	Amount of settlement	78,865	

✓ Discharge Summary and Final Bill dated 05.07.2020 of Saravana Multispecialty Hospital Pvt. Ltd.

24. Result of the hearing (Observations and Conclusion):

- Due to the Covid 19 pandemic, the hearing was conducted through VCon 12.03.2021 with the consent of both parties.The Complainant Mr L Ramesh, and the RI's representatives Dr Asiya Sahima and Ms Hemalatha were present during the hearing.
- The head-wise details of settlement made by the RI as under:

- Forum's observations on the settlement are as below:
  a) The Room Rent and associated expenses have rightly been limited to INR 5,000 per day and INR 30,000 overall as per eligibility. Food charges (item 6) are payable as part of Room Rent (Boarding) and since the maximum eligible amount has already been paid, no further amount is due to the complainant under this head.
  b) The Forum sees no justification for disallowing the cost of injection Meropenum amounting to INR 23,160.While the RI claimed that the injection is not indicated for Covid treatment, it finds mention in the General Insurance (GI) Council's guidelines for settlement of Covid 19 claims. The RI is therefore directed to admit the cost of injection.
  c) Cost of PPE kits may be allowed @ INR 3,040 per day as per tariff fixed by the Government of Tamil Nadu under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) for moderate cases of Covid 19. The said tariff is considered to be reasonable by the Forum. Therefore, the RI should pay an additional amount of INR 11,040 (INR 18,240 - INR 7,200 already paid) towards PPE kits.
  d) Payments and deductions under the remaining heads are in order.
  - Asa result, an additional amount of INR 34,200 (INR 23,160 + INR 11,040) becomes payable to the complainant in full and final settlement,

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum hereby directs the respondent insurer to pay an additional amount of INR 34,200 to the complainant in full and final settlement of the claim along with interest as provided in Rule 17(7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed.**

25. The attention of the insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

c) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 12th day of April 2021

(Sri M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1)OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN– Shri.M.Vasantha Krishna
Case of Mr T R JayaprakashVs Star Health and Allied Insurance Co. Ltd
REF: NO: CHN-H-044-2021-0461
Award No: IO/CHN/A/HI/0002/2021-2022

1.	**Name & Address of the Complainant**	**Mr T R Jayaprakash** **211, Chinnakadai St., Near Dhasakali Amman Temple, Madurai-625001**
2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**P/121325/01/2021/000752** ***Family Health Optima Insurance*** **04.07.2020-03.07.2021** **INR 3 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mr T R Jayaprakash** **Mr T R Jayaprakash**
4.	**Name of the Insurer**	**Star Health and Allied Insurance Co. Ltd**
5.	**Dates of partial settlement**	**21.08.2020 & 12.11.2020**
6.	**Reason for partial settlement**	**As per the terms & conditions of the policy**
7.	**Date of receipt of the Complaint**	**05.01.2021**
8.	**Nature of Complaint**	**Short settlement of the claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**19.01.2021**
10.	**Amount of Claim**	**INR 2,90,270**
11.	**Amount paid by Insurer, if any**	**INR 1,35,195 (INR 1,10,616 + INR 24,579)**
12.	**Amount of Monetary Loss (as per Annexure VI A)**	**Not mentioned**
13.	**Amount of Relief sought (as per Annexure VI A)**	**Reasonable settlement**
14.a.	**Date of request for Self-contained Note (SCN)**	**06.01.2021**
14.b.	**Date of receipt of SCN**	**25.02.2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 19.03.2021**
17.	**Representation at the Hearing**	
	c) For the Complainant	**Mr T R Jayaprakash**
	d) For the Insurer	**Dr AsiyaSahima&MsHemalatha**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**12.04.2021**

20. Brief facts of the complaint:

The complainant availed the *Family Health Optima Insurance* Plan of the Respondent Insurer (RI) covering himself, his wife and his dependent children in 2011 and the policy has been continuously

renewed to date. The period of insurance under the subject policy is 4.7.2020 to 3.07.2021and the SI isINR 3 lakhs on a floater basis. The complainant was admitted to Lakshmana Multi Speciality Hospitals, Madurai on 8.07.2020 after he tested positive for COVID-19. The claim submitted by him for reimbursement of the expenses incurred was settled for INR 1,10,616 on 21.08.2020. Subsequently, when he approached the RI for a reconsideration of the claim, a further amount of INR 24,579 was paid on 12.11.2020. The complainant is not satisfied with the settlement of the claim and has approached this Forum with a complaint of delay in settlement and disallowance of major expenses and is seeking a reasonable settlement of the claim.

21. Insurer's submission:

The RI stated that the expenses towards Room, Boarding and Nursing expenses have been limited to Rs.5,000 per day as per the policy terms and conditions. They further stated that other expenses like professional fees, procedure charges have been allowed ona proportionatebasis as perthe applicable policy provision.Deductions were also made in respect of the non-medical and non-payable items and the reimbursement for PPE kits was limited to INR 1,200 per day as per the guidelines of the General Insurance (GI) Council. The Insurer submitted a detailed, expense-wise calculation sheet showing the amount claimed, the amount allowed and the amount disallowed with reasons.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule 13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Complaint to the Ombudsman dated 05.01.2021
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ Complainant's representation dated 14.09.2020 to the RI
- ✓ Copy of Policy with terms and conditions
- ✓ Self-contained Note (SCN) of the RI dated 25.02.2021
- ✓ Bill assessment sheet of the RI
- ✓ Bills of Apollo Hospital dated 08.07.2020 for OPconsultation (2 nos.) and the test report
- ✓ Discharge summary &Invoice dated 12.07.2020 of Lakshmana MultiSpecialty Hospitals

24. Results of the hearing (Observations and Conclusion):

- Due to the COVID 19 pandemic, the hearing was conducted through VC with the consent of both parties.
- The Complainant Mr T R Jayaprakash and the representatives of the RI, Dr Asiya Sahima and Ms. Hemalatha were present during the hearing.

- The RI submitted their billing assessment sheet giving details of the claim settlement. The following are the head-wise details of the settlement made by the insurer (in consolidation of settlements made on 21.08.2020 & 12.11.2020):

S no.	Head of Expense	Amount claimed (INR)	Amount disallowed (INR)	Amount allowed (INR)	Remarks
1	Room Rent & Nursing charges	50,000	25,000	25,000	The maximum allowable room rent per day is INR 5,000 – allowed for 5 days
2	Professional fees	32,500	16,250	16,250	Allowed proportionate to the eligible room rent
3	Investigations	23,429	2,750	20,679	HIV I& II – INR 450, HCV – INR 450, HBSAG- INR 300, HBA1C- INR 1,500& Blood Sugar- INR 50 - Not payable
4	Medicines	62,571	3,705	58,866	Fabiflu- INR 3,500, Transpore- INR 125& Easyfix- INR 80 - Not payable
5	Procedure Charges – PPE Kits INR 60,000 Oxygen INR 15,000	75,000	64,500	10,500	PPE kits allowed @ INR 1,200 per day (INR 54,000deducted)Proportionate deduction –INR 10,500
6	Others	41,500	41,500	0	Registration- INR 1,500 Diet -INR 10,000 Establishment- INR 12,500& House- keeping- INR 17,500 - Not payable
7	Pre-hospitalisation Expenses – CT Chest – INR 4,870 Consultation – INR 400	5,270	1,370	3,900	
	Total	**2,90,270**	**1,55,075**	**1,35,195**	

The observations of the Forum on the above settlement are as below:

a) The RI has not cited any specific ground for disallowing investigation charges amounting to INR 2,750. The same should be allowed.

b) Similarly, the RI has not furnished any explanation for disallowing INR 3,500, the cost of Fabiflu, which may be paid.

c) In the opinion of the Forum, the indemnity towards PPE kit@ INR 1,200 per day is inadequate and an amount of INR 3,040 per day as fixed by the Government of Tamil Nadu under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) is reasonable and may be paid. Hence an amount of INR 15,200 (3,040*5)is payable (gross) and after applying the proportionate deduction of 50%, the amount payable stands reduced to INR 7,600.Since an amount of INR 3,000 (50% of INR 6,000) is already paid, the remainder of INR 4,600 is payable additionally towards PPE Kits.

d) Diet Charges, Establishment Charges and Bio-medical & House-keeping Chargeswhich have been levied on a *per diem* basis should have been considered as part of Room, Boarding & Nursing Charges. However, no amount is payable towards the same since the maximum permissible amount towards Room Rent has already been allowed.

e) Pre-hospitalization expenses of INR 5,270 should be allowed in full as the guidelines of GI Council based on which the cost of CT Chest has been limited to INR 3,900 are not binding. Hence, the disallowed amount of INR 1,370 which includes consultation charges of INR 400 should be paid.

f) The RI is therefore directed to pay an additional amount of INR 12,220 (2,750 + 3,500 + 4,600 + 1,370) in full and final settlement.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum hereby directs the respondent insurer to pay an additional amount of INR 12,220 to the complainant in full and final settlement of the claim along with interest as provided in Rule 17(7) of Insurance Ombudsman Rules 2017.

Thus, the complaint is **allowed.**

25.The attention of the insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

d) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

e) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance

Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

f) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 12th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mrs V C Sheila Devi Vs Universal Sompo General Insurance Company Ltd

COMPLAINT REF: NO: CHN-H-052-2021-0487
Award No: IO/CHN/A/HI/0003/2021-2022

1.	Name & Address of the Complainant	Mrs V C Sheila Devi 535/5, Sri Krishna, Dr Lakshmanaswamy Salai, KK Nagar, Chennai 600078
2.	Policy No: Type of Policy Duration of policy/Policy period Sum Insured (SI)	2817/59211605/01/B00 *IOB Health Care Plus* Policy 17/12/2019-16/12/2020 INR 1,00,000
3.	Name of the insured Name of the policyholder/Proposer	Mr V Suresh Babu Mrs V C Sheila Devi
4.	Name of the insurer	Universal Sompo General Insurance Company Ltd.
5.	Date of repudiation of the claim	07/03/2020
6.	Reason for repudiation	Misrepresentation by the hospital regarding the duration of Hypertension (HTN)
7.	Date of receipt of the Complaint	11/01/2021
8.	Nature of complaint	Non-settlement of the claim
9.	Date of receipt of consent (Annexure VIA)	25/01/2021
10.	Amount of Claim	Not furnished
11.	Amount of Monetary Loss (as per Annexure VIA)	Up to INR 2 Lakhs
12.	Amount paid by the insurer if any	Nil
13.	Amount of Relief sought (as per Annexure VIA)	As per eligibility
14.a.	Date of request for Self-contained Note (SCN)	12/01/2021
14.b.	Date of receipt of SCN	08/02/2021
15.	Complaint registered under	Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017
16.	Date of hearing/place	By Video Conferencing (VC) on 19/03/2021
17.	Representation at the hearing	
	e) For the Complainant	Mrs V C Sheila Devi
	f) For the insurer	Dr Ahmed Ali
18.	Disposal of Complaint	By Award
19.	Date of Award/Order	15/04/2021

20. Brief Facts of the Case:

- The complainant's spouse who is covered under the respondent insurer (RI)'s *IOB Healthcare Plus* Policy for the period from 17/12/2019 to 16/12/2020 for a SI of INR 1,00,000 was admitted to Vijaya Hospital, Chennai on 05/02/2020 and underwent treatment for Coronary Artery Disease (CAD) by way of Coronary Angiogram (CAG) and Stenting.
- A *cashless* request raised for the treatment was denied by the RI on the ground that the liability could not be ascertained in view of the chronic nature of the ailment.
- The reimbursement claim preferred by the complainant after the discharge of her husband was repudiated by the RI on the grounds of misrepresentation by the hospital who recorded in the discharge summary that the patient is a newly diagnosed case of Systemic Hypertension (HTN) whereas, in the reply given to the query raised in connection with the cashless request it was stated that the patient was a known case of (k/c/o) HTN for 1 year.
- Aggrieved by the repudiation of the claim, the complainant represented to the RI to reconsider their decision. Since there is no reply from them, she has approached this Forum for the redressal of her grievance.

21. a) Complainant's submission:

- The complainant's spouse was admitted to Vijaya Hospital, Chennai with breathing difficulty and it was diagnosed that he had suffered a cardiac arrest and must undergo a lifesaving procedure of the placement of a stent and the same was planned after informing the RI.
- During the stay in the hospital, the complainant received a call from the RI informing her that her husband had pre-existing HTN. Since she came to know that the hospital had wrongly informed the RI that he is a k/c/o HTN for 1 year, the nurse in charge at the hospital was consulted who assured her that it might be an administration error and will be clarified suitably to the RI.
- A certificate from Dr Ganesh, Consulting Cardiologist of Vijaya Hospital confirming that the complainant's spouse was a newly diagnosed case of Systemic Hypertension was submitted to the RI.
- But the RI denied both the *cashless* request and the reimbursement claim.
- Since HTN is not a pre-existing disease as certified by the treating doctor, the claim is payable and the Forum's intervention is requested for settlement of the claim.

b) Insurer's contention:

- As per the discharge summary of the hospital, the patient is a newly diagnosed case of Systemic Hypertension. But as per the reply dated 06/02/2020 of the hospital to the query raised in connection with the *cashless* request, the patient was a k/c/o HTN for 1 year and no record of

previous medication was available. The hospital has also issued another certificate with the same date stating that the patient is **not** a k/c/o HTN.

- There is clear manipulation by the hospital authorities for reasons best known to them as they have issued two certificates both dated 06/02/2020, one stating that the patient was a k/c/o HTN and the other stating that he was not a k/c/o HTN.

- The hospital has issued the discharge summary stating specifically that the patient is not a k/c/o HTN/DM/CAD/PT/BA. No hospital issues discharge summary with such a remark. If there are no past ailments, the past history section will be left blank.

- There could be several ailments that might not have been pre-existing. But the mention of only HTN, DM, CAD, PT, BA speaks volumes of the fact that the discharge summary has been prepared with malign intent to get the claim under the policy.

- The claim was rightly rejected as per the non-disclosure clause of the policy which is reproduced below.

  "*Disclosure to information norm - means the Policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation. misdescription or nondisclosure of any material facts".*

- The policy of insurance is governed by the principle of *Utmost Good Faith.* A proposer who seeks to obtain a policy of insurance is duty-bound to disclose all material facts bearing upon the issue as to whether the insurer would consider it appropriate to assume the risk which is proposed. It is with this principle in view that the proposal form requires specific disclosure of pre-existing ailments, to enable the insurer to arrive at a considered decision based on the actuarial risk.

- In the case of *Life Insurance Corporation of India Vs Asha Goel*, the apex court has held that -

  "The contracts of insurance including the contract of life assurance are contracts uberrima fides and every fact of material must be disclosed, otherwise, there is good ground for rescission of the contract. The duty to disclose material facts continues right up to the conclusion of the contract and also implies any material alteration in the character of the risk which may take place between the proposal and its acceptance. If there are any misstatements or suppression of material facts, the policy can be called into question. For determination of the question whether there has been suppression of any material facts it may be necessary to also examine whether the suppression relates to a fact which is in the exclusive knowledge of the person intending to take the policy and it could not be ascertained by reasonable enquiry by a prudent person".

- The said position has been reiterated in the judgments in the cases of *P C Chacko vs Chairman, Life Insurance Corporation of India* and *Satwant Kaur Sandhu vs New India Assurance Co. Limited*. In the latter case, the apex court has held that -

  "The upshot of the entire discussion is that in a Contract of Insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a "material fact". If the proposer has knowledge of such fact, he is obliged to disclose it particularly while answering questions in the proposal form. Needless to emphasize that any inaccurate answer will entitle the insurer to repudiate his liability because there is clear presumption that any information sought for in the proposal form is material for the purpose of entering into a Contract of Insurance".

- The aforesaid views have been elaborately discussed in the judgment dated 09/10/2020 of a three-judge bench of the Hon'ble Supreme Court (SC) of India in the case of *Branch Manager, Bajaj Allianz Life Insurance Company Ltd and Others Vs Dalbir Kaur* wherein the apex court affirmed the repudiation of a claim on account of non-disclosure of pre-existing disease.

- In view of the above-stated submissions, it is humbly submitted that the Forum may kindly dismiss the present complaint.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- Complaint dated 06/01/2021 to the Insurance Ombudsman
- RI's cashless denial letter dated 07/02/2020
- RI's claim repudiation letter dated 07/03/2020
- Complainant's representation dated 04/11/2020 to the RI
- Consent (Annexure VI A) submitted by the complainant
- Self-contained Note (SCN) of the RI
- *IOB Health Care Plus* policy with terms and conditions
- Discharge summary of Vijaya Hospital, Chennai
- Certificates (2 nos.) dated 06/02/2020 of Vijaya Health Centre
- Certificate dated 05/08/2020 of Dr Ganesh, Cardiologist of Vijaya Hospital, Chennai
- Judgment dated 09/10/2020 of the SC in the case of *Branch Manager, Bajaj Allianz Life Insurance Company Ltd and Others Vs Dalbir Kaur* in Civil Appeal No. 3397/2020

24 Result of hearing (Observations & Conclusion)

1. Because of the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 19/03/2021, with consent and participation of both the complaint and the RI.

2. The Forum records its displeasure over the RI's lack of response to the representations made by the complainant which amounts to non-compliance with the guidelines of the Insurance Regulatory & Development Authority of India (IRDAI) for redressal of customer grievances by insurance companies. It is hoped that the insurer will strengthen its customer grievance resolution mechanism and avoid such lapses in future.

3. The subject matter of the complaint is the RI's repudiation of the complainant's claim in respect of the treatment of her spouse, on the ground of misrepresentation by the hospital in respect of the complainant's history of HTN.

4. The RI stated in their repudiation letter that as per discharge summary the patient is a newly diagnosed case of HTN whereas, in response to a query raised the hospital had certified that the patient was a k/c/o of HTN for 1 year. Thus, there was a discrepancy in the provided facts and misrepresentation in providing the exact duration of HTN, leading to the repudiation of the claim. The RI cited the *disclosure to information norms* clause of the policy according to which the policy shall be void in case of misrepresentation of any material fact.

5. While the RI cited the *Disclosure to information norm* clause which is a definition clause in the repudiation letter, general condition no. 9 of the policy which deals with Misdescription reads as below.

   The Policy shall be void and premium paid shall be forfeited to Us in the event of misrepresentation, misdescription or non-disclosure of any material facts by ***you.*** *Non-disclosure shall include non-intimation of any circumstances which may affect the insurance cover granted.*

   The above condition implies that the policy is void only if there is misrepresentation by the policyholder/insured. The clause is not triggered in the case of misrepresentation by anybody other than the policyholder and in the instant case, the alleged misrepresentation was by the hospital. Hence the same cannot be a ground for repudiation of the claim by the RI.

   Moreover, the above clause applies in the event of misrepresentation at the time of taking the policy and not in the event of a claim. The thrust of the judgments cited by the RI is also on disclosures in the proposal form. But it is not the contention of the RI that there was a misrepresentation or non-disclosure by the policyholder in the proposal form.

6. Condition no. 7 of the policy deals with *Fraud* and reads as below:

All benefit under this Policy shall be forfeited and the policy shall be treated as void in case of any fraudulent claims or if any fraudulent means are used by ***You or anyone acting on Your behalf*** *to obtain any benefit under this Policy.*

The RI, however, failed to invoke the above condition to repudiate the claim.

7. It is observed that the policy of insurance first incepted on 10/12/2018 and was renewed for a further period of one year from 17/12/2019, after a gap of 7 days. Since the grace period for renewal is 30 days, the policy is deemed to have been renewed without break. Even assuming that the insured person was suffering from HTN for one year at the time of his hospitalization in February 2020, it was not a pre-existing disease at the time of inception of the policy warranting disclosure in the proposal form. Hence, the alleged misrepresentation by the hospital, even if true, is not at all material and has no bearing on the admissibility of the claim.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum concludes that the repudiation of the claim by the respondent insurer is not in order. The insurer is therefore directed to settle the claim of the complainant subject to the terms and conditions of the policy along with interest as per Rule 17 (7) of the Insurance Ombudsman Rules, 2017

Thus, the complaint is **allowed.**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

g) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

h) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

i) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 15th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mr R Senguttuvan Vs Universal Sompo General Insurance Company Ltd

COMPLAINT REF: NO: CHN-H-052-2021-0491
Award No: IO/CHN/A/HI/0004/2021-2022

1.	**Name & Address of the Complainant**	**Mr R Senguttuvan** **45/9 Nagathamman Flat, Nagathamman Koil Street,** **West Mambalam, Chennai 600033**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)**	**2817/50065335/09/000** ***IOB Health Care Plus* Policy** **29/03/2019-28/03/2020** **INR 1,00,000**
3.	**Name of the insured** **Name of the policyholder/Proposer**	**Mrs S Vijayalakshmi** **Mr R Senguttuvan**
4.	**Name of the insurer**	**Universal Sompo General Insurance Company Ltd**
5.	**Date of repudiation of the claim**	**21/01/2020**
6.	**Reason for repudiation**	**Not a covered daycare procedure**
7.	**Date of receipt of the Complaint**	**12/01/2021**
8.	**Nature of complaint**	**Non-settlement of the claim**
9.	**Date of receipt of consent (Annexure VIA)**	**22/01/2021**
10.	**Amount of Claim**	**INR 62,000**
11.	**Amount of Monetary Loss (as per Annexure VIA)**	**Not furnished**
12.	**Amount paid by the insurer if any**	**Nil**
13.	**Amount of Relief sought (as per Annexure VIA)**	**INR 62,000**
14.a.	**Date of request for Self-contained Note (SCN)**	**12/01/2021**
14.b.	**Date of receipt of SCN**	**16/02/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 19/03/2021**
17.	**Representation at the hearing**	
	g) For the Complainant	**Mr R Senguttuvan**
	h) For the insurer	**Dr Ahmed Ali**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**15/04/2021**

20. Brief Facts of the Case:

- The complainant's spouse who is covered under the respondent insurer (RI)'s *IOB Healthcare Plus* Policy for the period from 29/03/2019 to 28/03/2020 for a SI of INR 1,00,000 was admitted

to Amrit Medical Centre, Chennai on 02/01/2020 for intravitreal administration of injection Accentrix to treat her left eye CME (Cystoid Macular Edema). The treatment was repeated on 09/02/2020.

- A *Cashless* request raised by the hospital for the first admission on 02/01/2020 was initially sanctioned by the RI. Subsequently, they withdrew the sanction on the ground that administration of injection Accentrix is not covered under the policy.
- The reimbursement claim of INR 26,000 preferred by the complainant was also repudiated by the RI on the ground that the treatment undergone is not a listed daycare procedure in the policy.
- Aggrieved by the repudiation of the claim, the complainant represented to the RI to reconsider their decision. Since there is no reply from them, he has approached this Forum for relief.

21. a) Complainant's submission:

- The complainant had availed the RI's *IOB Healthcare Plus* Policy through Indian Overseas Bank 10 years ago covering himself and his spouse and has been renewing it continuously since then. The complainant has not preferred a single claim under the policy during the last 10 years.
- In the first week of January 2020, the complainant's spouse was admitted to the hospital and an intravitreal injection of Accentrix was administered to treat her left eye CME.
- The RI initially approved the *cashless r*equest raised by the hospital. But later they cancelled the approval given stating that the claim is not payable under the policy.
- The reimbursement claim made by him was also repudiated by the RI on the ground that the procedure undergone is not a listed daycare procedure in the policy. But the claim preferred was a hospitalization claim. Hence the claim is payable and Forum's intervention is requested for settlement of the same.
- The second injection of Accentrix was administered on 09/02/2020 incurring an expenditure of INR 26,000.
- The complainant is seeking the Forum's intervention for settlement of the second claim as well besides a direction to the RI to admit liability for the treatment in future.

b) Insurer's contention:

- The complainant's claim is towards the expenses for the Accentrix injection his spouse had undergone. As this procedure is not a listed daycare procedure as per the policy, the claim was rightly repudiated.
- The Forum is, therefore, requested to dismiss the complaint.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with *"Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- Complaint dated 11/02/2020 to the Insurance Ombudsman (received on 12/01/2021)
- RI's cashless denial letter 02/01/2020
- RI's claim repudiation letter dated 21/01/2020
- Complainant's representation dated 27/01/2020 to the RI
- Consent (Annexure VI A) submitted by the complainant
- Self-contained Note (SCN) of the RI
- *IOB Health Care Plus* Policy with terms and conditions
- Discharge summary & invoice (2 nos. each) of Amrit Medical Centre, Chennai.

24. Result of hearing (Observations & Conclusion)

8. Given the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 19/03/2021, with the consent and participation of both parties.

9. The Forum records its displeasure over the RI's failure to respond to the representations made by the complainant. It is hoped that they will strengthen their customer grievance redressal mechanism and avoid such lapses in future.

10. The subject matter of the grievance is the RI's repudiation of the complainant's claims in respect of the intravitreal injection of Accentrix, his spouse underwent for treatment of her left eye CME.

11. It is observed that on both occasions, the insured person was hospitalised for more than 24 hours for the treatment and hence, the repudiation of the claims by the RI on the ground that it is not a listed daycare procedure has no merit. Hence, the claim is admissible, including the pre and post-hospitalisation expenditure.

12. The Forum observes that the treatment also meets the definition of daycare procedure in the policy (although it is not a listed daycare procedure) since it is administered under local anaesthesia and the Insurance Regulatory & Development Authority of India (IRDAI) has recognised it as an advanced procedure and has instructed insurers not to exclude the same under policies issued from 01/10/2020.

13. The Forum cannot give a blanket direction to the RI to admit liability for the future claims for the treatment of the complainant's wife as desired by the complainant. He may approach the Forum with a fresh complaint if he has a grievance.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties, the respondent insurer is directed to settle the complainant's claim of INR 62,000 subject to the terms and conditions of the policy along with interest as under Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed.**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

j) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

k) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

l) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 15th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA
Case of Mr R Deepak Vs ICICI Lombard General Insurance Company Ltd
COMPLAINT REF: NO: CHN-H-020-2021-0470
Award No: IO/CHN/A/HI/0007/2021-2022

1.	**Name & Address of the Complainant**	**Mr R Deepak** **307/2, ICF North Colony, ICF, Chennai 600038**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)**	**4128i/H/85411638/06/000** **4128i/H/85406591/06/000** **I*H_1Adult_1Child_1Year Policy*** **10/12/2019 - 09/12/2020** **INR 4,00,000**
3.	**Name of the insured** **Name of the policyholder/proposer**	**Mr R Deepak & ND Tharunika** **Mr R Deepak**
4.	**Name of the insurer**	**ICICI Lombard General Insurance Company Ltd**
5.	**Date of partial settlement**	**02/09/2020**
6.	**Reason for partial settlement**	**As per COVID Package rates of the General Insurance (GI) Council applied**
7.	**Date of receipt of the Complaint**	**06/01/2021**
8.	**Nature of complaint**	**Short-settlement of the claim**
9.	**Date of receipt of consent (Annexure VIA)**	**04/03/2021**
10.	**Amount of Claim**	**INR 1,61,932 & INR 45,505**
11	**Amount of Monetary Loss (as per Annexure VIA)**	**Not furnished**
12.	**Amount paid by the Insurer**	**INR 53,803 & INR 27,570**
13.	**Amount of Relief sought (as per Annexure VIA)**	**INR 1,27,564**
14.a.	**Date of request for Self-contained Note (SCN)**	**06/01/2021**
14.b.	**Date of receipt of SCN**	**02/03/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 09/03/2021**
17.	**Representation at the hearing**	
	i) For the Complainant	**Mr R Deepak**
	j) For the insurer	**Ms Terry Nambiar**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**15/04/2021**

20. Brief Facts of the Case:

- The complainant, Mr R Deepak who is covered under the respondent insurer (RI)'s Health Insurance Policy for the period from 10/12/2019 to 09/12/2020 for a SI of INR 4,00,000 was admitted to Trauma & Orthopaedic Speciality Hospital (TOSH), Chennai on 19/07/2020 and after undergoing treatment for COVID 19 infection, he was discharged on 26/07/2020.

- The complainant's daughter Ms N D Tarunika who is also covered under the respondent insurer (RI)'s Health Insurance Policy for the period from 10/12/2019 to 09/12/2020 for a SI of INR 4,00,000 was admitted to the same hospital on 19/07/2020 for COVID 19 treatment and was discharged on 21/07/2020.
- Since the hospital did not provide the *cashless* option, reimbursement claims were preferred in respect of the expenses incurred for the treatment.
- The claim in respect of the complainant's treatment for INR 1,61,932 was settled by the RI for INR 52,303. His daughter's claim of INR 45,505 was settled for INR 27,570.
- Application of the COVID package rates prescribed by the GI Council / State Government was stated as the reason by RI for the short settlements.
- Aggrieved by the same, the complainant represented to the RI for payment of the balance amount of the claims. Since there is no reply from them, he has approached the Forum for relief.

21. a) Complainant's submission:

- ❖ The complainant had first availed the RI's health insurance policy in 2011 and since then it has been continuously renewed.
- ❖ In July 2020, the complainant and his daughter were admitted to TOSH, Chennai for treatment of COVID 19 infection. The complainant was hospitalized for 8 days and his daughter for 3 days.
- ❖ The hospital refused to accept the cashless facility and hence reimbursement claims were preferred. When the RI settled the claims there was a huge short settlement, by INR 1,09,629 in respect of the complainant and INR 17,935 in respect of his daughter. The RI cited the COVID 19 Package rates fixed by GI Council based on the usual, customary and reasonable charges prevalent in the Indian market as the reason for the short settlement and paid another INR 1,500 in respect of the complainant's claim by way of ambulance charges.
- ❖ The RI was informed immediately after the admission of the complainant and his daughter to the hospital but they never appraised the complainant about the limits applicable for settlement of COVID 19 claims.
- ❖ The complainant has contended that settlement of the claims based on the guidelines of GI Council amounts to dishonouring the policy terms and conditions. Hence Forum's intervention is requested to direct the RI to pay the amount short-settled.

b) Insurer's contention:

After receipt of a copy of the complaint made to the Forum, the RI has reviewed the claim and released an additional amount of INR 76,739 to the complainant on January 22, 2021.

The revised claim calculation is as detailed below:

Claim No.	Date of Payment	Claimed amount (INR)	Released amount	Deduction
		161,932		

1	01/09/2020		52,303	-
2	22/01/2021	-	76,739	-
			1,29,042	INR 32,890 (including ambulance charges of INR 5,000)
	Excluding ambulance charges of INR 5,000	-	-	INR 27,890 is not payable as per the non-payable list of the policy

Break-up of disallowed items:

Description	Claimed (INR)	Deduction (INR)	Remarks
Registration charges	100	100	Not payable
Medical Record Dept (MRD) charges	500	500	Not payable
Infection control charges	4,000	4,000	House Keeping – Not payable
N-95 mask	250	250	Not payable
Respirometer	640	640	Not payable
Ambulance charges	5,000	5,000	Paid the eligible amount of INR 1,500 as per the policy terms.
PPE kit charges @ INR 1,500 per day for 7 days).	10,500	4,900	Not payable but allowed as a gesture of goodwill @ INR 800 per day
DMO charges @ INR 2,500 per day	17,500	17,500	Not payable
Total		32,890	

Since the RI has settled the claim as per the policy terms and conditions, they may be absolved of the liability.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with *"Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23, Documents placed before the Forum:

- ✓ Complaint dated 04/01/2021 to the Insurance Ombudsman
- ✓ RI's claim settlement letters dated 02/09/2020 (2 nos.)
- ✓ Complainant's representations dated 06/09/2020 to the RI (2 nos.)
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ Self-Contained Notes (SCN) (2 nos.) of the RI dated 02/03/2021 & 30/03/2021
- ✓ Copy of Policies (2 nos.) with terms and conditions
- ✓ Claim forms (2 nos.) dated 26/07/2020
- ✓ Discharge summaries and invoices (2 nos. each) of TOSH, Chennai.

24. Result of hearing (Observations & Conclusion)

14. Because of the current COVID 19 pandemic situation, the hearing was conducted through VC on 09/03/2021, with the consent and participation of both the complainant and the RI.

15. The Forum records its displeasure over the delay in submission of the SCN by the insurer.

16. The Forum also expresses its disapproval over the failure of the RI to respond to the grievance representations submitted by the complainant which is in breach of the guidelines issued by the Insurance Regulatory & Development Authority of India (IRDAI) for redressal of customer grievances by insurance companies. They acted upon the grievance representation only after the policyholder approached this Forum. The RI must strengthen its customer grievance redressal mechanism and avoid such lapses in future.

17. The subject matter of the dispute is the RI's partial settlement of the claims by adhering to the GI Council /State Government guidelines for COVID 19 claims.

18. The RI stated in their SCN that after the complaint made to the Forum, they reimbursed an additional amount of INR 76,739 in respect of the hospitalization of the complainant. Thus, the amount in dispute is only INR 32,890 as shown under para 21(b) supra including the ambulance charges of INR 5,000. Since the RI had reimbursed the eligible amount of ambulance charges of INR 1500, the quantum in dispute is further reduced to INR 27,890. While the RI has rightly disallowed an amount of INR 1,490 towards non-payable items, the deduction of Infection Control charges of INR 4,000 and DMO charges of INR 17,500 is not in order since there is no clause in the policy which excludes the said items of expenditure. Hence the amount of INR 21,500 towards the same is payable to the complainant. The RI restricted the indemnity for PPE

kits to INR 800 per day as against the amount claimed of INR 1,500. The expenditure incurred is well within the limit of INR 3,040 per day allowed towards PPE kits in terms of GO MS 240 dated 05/06/2020 of the Government of Tamil Nadu under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). Hence, the disallowed amount of INR 4,900 is payable to the complainant. Thus, a total amount of INR 26,400 (INR 21,500 plus INR 4,900) is additionally payable to the complainant in settlement of the claim.

19. As regards the claim of the complainant's daughter, the RI informed the Forum post-hearing by way of an additional SCN dated 30/03/2021 that a supplementary payment of INR 17,335 was made to the complainant on 17/03/2021 and only an amount of INR 600 was denied towards Registration and MRD charges (non-payable heads). Therefore, the settlement of the claim of the complainant's daughter is in order and does not warrant any intervention by the Forum.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the respondent insurer is directed to pay an additional amount of INR 26,400 to the complainant in full and final settlement of his claim along with interest as per Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

The complaint is disposed of accordingly.

25.The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

m)According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

n) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

o) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 15th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA
Case of Mr Harish Kumar Bohra Vs Universal Sompo General Insurance Company Ltd
COMPLAINT REF: NO: CHN-H-052-2021-0516
Award No: IO/CHN/A/HI/0008/2021-2022

Award No: IO/CHN/A/HI/0008/2021-2022

1.	**Name & Address of the Complainant**	**Mr Harish Kumar Bohra 102, Sanjeevarayan Koil Street, Old Washermenpet, Chennai 600021**
2.	**Policy No: Type of Policy Duration of policy/Policy period Sum Insured (SI)**	**2850/60934083/00/000 *IOB Health Care Plus* Policy 22/02/2020-21/02/2021 INR 10,00,000**
3.	**Name of the insured Name of the policyholder/proposer**	**Mr Harish Kumar Bohra Mr Harish Kumar Bohra**
4.	**Name of the insurer**	**Universal Sompo General Insurance Company Ltd.**
5.	**Date of partial settlement**	**14/10/2020**
6.	**Reason for partial settlement**	**Exceeded the ceiling rates for COVID 19 claims**
7.	**Date of receipt of the complaint**	**21/01/2021**
8.	**Nature of complaint**	**Short-settlement of the claim**
9.	**Date of receipt of consent (Annexure VIA)**	**04/02/2021**
10.	**Amount of Claim**	**INR 79,340**
11.	**Amount of Monetary Loss (as per Annexure VIA)**	**INR 35,840**
12.	**Amount paid by the Insurer**	**INR 43,000**
13.	**Amount of Relief sought (as per Annexure VIA)**	**INR 35,840**
14.a.	**Date of request for Self-contained Note (SCN)**	**21/01/2021**
14.b.	**Date of receipt of SCN**	**18/03/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 19/03/2021**
17.	**Representation at the hearing**	
	k) For the Complainant	**Mr Harish Kumar Bohra**
	l) For the insurer	**Dr Ahmed Ali**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**15/04/2021**

20. Brief Facts of the Case:

- The complainant who is covered under the respondent insurer (RI)'s *IOB Healthcare Plus* Policy for the period from 22/02/2020 to 21/02/2021 for a SI of INR 10,00,000 was admitted to Bharathirajaa Hospital, Chennai on 27/08/2020 and was discharged on 31/08/2020 after undergoing treatment for COVID 19 infection.
- The reimbursement claim of INR 79,340 preferred by the complainant for his treatment was settled partially by the RI for INR 43,000
- Aggrieved by the short settlement of the claim, the complainant represented to the RI to reconsider their decision and the latter replied that the claim was settled as per the Government norms for COVID 19 patients. Since he is not satisfied with the reply from the RI, the complainant has approached this Forum for relief.

21. a) Complainant's submission:

- The complainant has been insured with the RI for the last 15 years. When a claim of INR 79,340 was preferred towards the expenses incurred by him for the treatment for COVID infection, the RI settled the claim for only INR 43,000 citing State Government norms.
- The policy is availed from the RI and not from any State Government agency. Hence, the claim is payable as per policy terms and conditions and the Forum's intervention is requested for settlement of the balance amount of the claim of INR 36,340.

b) Insurer's contention:

- The complainant's claim towards the hospitalization treatment for COVID 19 infection was settled for INR 43,000 after due deductions as per the terms and conditions of the policy and the ceiling rates issued by the Government of Tamilnadu vide its order GO (MS) No. 240 dated 05/06/2020.
- Details of the amount disallowed and the reasons for the same are furnished below:

S. No	Head of Expense	Amount (INR)	Reason
1	Medicines & Consumables	11,928	Excess over the ceiling rates for COVID Patients
2	Professional fee	16,000	
3	Investigations	4,020	
4	Medicines	692	Details such as Batch No. GST No. Expiry date are not available
5	Misc. Charges	3,700	Registration (INR 500) & Diet charges (INR 3,200) are not payable.

	Total	**36,340**	

- ❖ Since the claim amount has been rightly considered and approved as per the terms and conditions of the policy, the Forum is requested to dismiss the complaint.

22. Reason for Registration of Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- Complaint dated 18/01/2021 to the Insurance Ombudsman
- RI's claim settlement letter dated 14/10/2020
- Complainant's representation dated 24/10/2020 to the RI
- RI's reply dated 24/10/2020 to the complainant
- Consent (Annexure VI A) submitted by the complainant
- Self-contained Note (SCN) of the RI
- Copy of *IOB Healthcare Plus* Policy with terms & conditions
- In-Patient Bill of Bharathiraaja Hospital, Chennai
- Ceiling Rates of the Government of Tamil Nadu for settlement of Covid 19 related claims under Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)

24. Result of hearing (Observations & Conclusion):

20. Because of the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 19/03/2021 with the consent and participation of the parties.

21. The Forum registers its displeasure over the delay in submission of the SCN by the RI.

22. The subject matter of the complaint is the short- settlement of the subject claim. As against the amount claimed of INR 79,340, the RI made a payment of only INR 43,000.

23. The RI relied on the State Government guidelines for restricting the reimbursement to the complainant. However, the said guidelines are meant for the CMCHIS and do not have wider enforceability. There is nothing in the relevant GO of the Government to suggest they are binding on the hospitals. Even assuming they are so binding when the hospital has charged beyond the ceiling rates prescribed by the Government, the policyholder cannot be put to loss by limiting indemnity to him to the said rates. In the absence of any prior endorsement in the policies to the effect that the COVID 19 related claims will be settled only as per the State Government guidelines, they have no legal enforceability. Hence the RI's partial settlement of the claim based

on the ceiling rates is not justified and the claim has to be settled as per the terms & conditions of the Policy.

24. Although the RI was directed to calculate the amount payable and inform the Forum, they failed to do so. In the opinion of the Forum, Diet Charges are payable since Boarding expenses are covered by the policy. Except for Registration Charges (INR 500) and Medicines (INR 692), the deductions are not as per the terms & conditions of the Policy and therefore, an amount of INR 35,148 being the aggregate amount of the other deductions is payable to the complainant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the respondent insurer is directed to pay an additional amount of INR 35,148 to the complainant in full and final settlement of his claim along with interest as under Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed.**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

p) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

q) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

r) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 15th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA
Case of Mr V Chandramouliswaran Vs HDFC Ergo General Insurance Co. Ltd
COMPLAINT REF: NO: CHN-H-018-2021-0531
Award No: IO/CHN/A/HI/0009/2021-2022

1.	**Name & Address of the Complainant**	**Mr V Chandramouliswaran 2B Saraswathy Street, Annai Nagar, Govarthanagiri, Avadi, Chennai 600071**
2.	**Policy Nos: Type of Policy Duration of policy/Policy period Sum Insured (SI)**	**2825 2008 4568 0305 000 & 2825 2008 4568 0306 000 *my: Health Suraksha* Policy 05/09/2019-04/09/2020 05/09/2020-04/09/2021 INR 4,00,000**
3.	**Name of the insured Name of the policyholder/Proposer**	**Mr V Chandramouliswaran Mr V Chandramouliswaran**
4.	**Name of the insurer**	**HDFC Ergo General Insurance Co. Ltd**
5.	**Date of repudiation of the claim**	**21/11/2020**
6.	**Reason for repudiation**	**Hospitalization was not warranted**
7.	**Date of receipt of the Complaint**	**25/01/2021**
8.	**Nature of complaint**	**Non-settlement of the claim**
9.	**Date of receipt of consent (Annexure VIA)**	**09/02/2021**
10.	**Amount of Claim**	**INR 35,820**
11.	**Amount of Monetary Loss (as per Annexure VIA)**	**Not mentioned**
12.	**Amount paid by the insurer, if any**	**Nil**
13.	**Amount of Relief sought (as per Annexure VIA)**	**INR 35,820**
14.a.	**Date of request for Self-contained Note (SCN)**	**27/01/2021**
14.b.	**Date of receipt of SCN**	**18/03/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 19/03/2021**
17.	**Representation at the hearing**	
	m) For the Complainant	**Mr V Chandramouliswaran**
	n) For the insurer	**Ms Amala Edward**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**15/04/2021**

20. Brief Facts of the Case:

- The complainant who is covered under the respondent insurer (RI)'s *my: Health Suraksha* Policy for a SI of INR 4,00,000 had undergone institutional isolation/quarantine at Ginger Hotel, Chennai as he was found COVID positive, based on the advice of Apollo Hospitals, Chennai.
- The reimbursement claim of INR 35,820 preferred by the complainant was repudiated by the RI on the ground that the hospitalization was not warranted and the treatment could have been undertaken as an out-patient.

- Aggrieved by the repudiation of the claim, the complainant represented to the RI to reconsider their decision. Since there is no response from them, he has approached this Forum for relief.

21. a) Complainant's submission:

- ❖ The complainant was found COVID Positive on 30/08/2020 by Avadi Municipality. The next day, he contacted Apollo Hospitals, Chennai who directed him to their hospital at Vanagaram. As advised by Apollo Hospitals, Vanagaram, he underwent institutional isolation/quarantine at Ginger Hotel, Chennai.
- ❖ His claim for reimbursement of INR 35,820 towards the expenses incurred for the institutional isolation/quarantine was repudiated by the RI on the ground that the case did not warrant hospitalization.
- ❖ Since he was quarantined on medical advice, the claim is payable and the Forum's intervention is requested for settlement of the same.

b) Insurer's contention:

- The complainant had filed a claim of INR 35,820 towards hospitalization expenses incurred in respect of the institutional quarantine he had undergone for COVID 19.

- The hotel by the name "Ginger Hotel" wherein he had undergone the institutional quarantine is not in the list of the Central/ State Government approved network hotels for undergoing Covid Quarantine. Even if the said hotel is Government approved for quarantine, the liability to bear such hotel quarantine expenditure shall be on the respective Government and cannot be saddled on the RI.

- Based on the records submitted to the RI, the complainant was quarantined in a condition for which hospitalization was not required and he could have been managed on OPD (Out-patient Department) basis. Hence the claim was repudiated as per Section 9(C) xvi of the Policy terms and conditions which reads as under

  We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy:

  Conditions for which hospitalization is not required

- Further, there was no active line of treatment taken by the complainant in the instant case. He revealed no symptoms that required in-patient treatment, the oxygen levels were normal and he was afebrile throughout the institutional quarantine. The same has been recorded in the discharge summary dated 09/09/2020 as well.

- A perusal of the treatment records reveals that the complainant's daily vitals were not checked and he suffered from no difficulties that warranted in-patient treatment or institutional quarantine.

The medical advice by the concerned treating doctor was confined to dietary advice, personal hygiene and exercise instructions. The medicines administered to him as evident from the medical records were tablets and cough syrup which could have been administered on OPD Basis. Furthermore, the test results were normal and the complainant had not been undergoing any active line of treatment. The Oxygen levels were also normal. Since the complainant exhibited no symptoms that required in-patient treatment and was only a case of mild COVID, he could have been managed under home quarantine as per the guidelines of ICMR.

- For the reasons stated above, it is prayed that the Forum may be pleased to dismiss the complainant.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Complaint dated 22/01/2021 to the Insurance Ombudsman
- ✓ RI's repudiation letter dated 21/11/2020
- ✓ Complainant's representation dated 24/11/2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ RI's Self-contained Note (SCN)
- ✓ Copy of *my: Health Suraksha* policy with terms & conditions
- ✓ Claim form – Part A dated 04/10/2020
- ✓ Discharge Certificate and invoices of Apollo Hospitals
- ✓ Record of consultation at Apollo Hospitals
- ✓ Tax Invoice dated 07/09/2020 of Ginger Hotel

24. Result of hearing (Observations & Conclusion)

25. Given the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 19/03/2021, with the consent and participation of both parties.

26. The subject matter of the complaint is the RI's repudiation of the complainant's claim towards the expenses incurred of INR 35,820 for his institutional quarantine due to the COVID 19 infection.

27. As per item no. 3 of circular IRDAI / HLT/ MISC / CIR /190 / 07/ 2020 dated 16/0/2020 issued by the Insurance Regulatory & Development Authority of India (IRDAI) in connection with the processing of insurance claims for COVID 19 -

In order to ensure that the costs of treatment of COVID – 19 are covered as per the terms and conditions of policy contract, a make-shift or temporary hospital permitted by Central / State Government shall be regarded as a hospital or network provider and insurers shall settle the claims as per the following norms.

a) Where a policyholder who is diagnosed as Covid-19 positive is admitted into any such make-shift or temporary hospital on the advice of a medical practitioner or appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by insurers.

b) ***Where any network provider has set up any such make-shift or temporary hospital, such make-shift or temporary hospital shall be regarded as the extension of the network provider and cashless facility shall be made available.***

It is evident from clause (b) above that any make-shift facility set up by a network provider for COVID 19 cases shall be treated as an extension of the network provider and therefore the hotel wherein the complainant was quarantined qualifies so.

28. As per another circular IRDAI/HLT/REG/CIR/054/03/2020 dated 04/03/2020 of IRDAI, "*the costs of admissible medical expenses during the course of treatment* ***including the treatment during quarantine period*** *shall be settled in accordance to the applicable terms and conditions of policy contract and the extant regulatory framework".*

29. The RI has made some forceful arguments as to why the treatment could have been managed on an OPD basis or under home quarantine.

30. As per item 10.1 of the Clinical Management Protocol issued by the Ministry of Health and Family Welfare (MOHFW) dated 13/06/2020 which deals with Management of Mild Cases of COVID 19, "*Mild cases can be managed at Covid Care Centre, First Referral Units (FRUs), Community Health Centre (CHC), Sub District and District Hospitals or at home subject to conditions stipulated in the guidelines available under Guidelines for Home Isolation of very mild/pre-symptomatic COVID-19 cases and the relevant portion applicable for the instant case is detailed below.*

The present guidelines are in addition to guidelines on appropriate management of suspect/confirmed case of COVID-19 issued by MOHFW on 7th April 2020. All suspected (awaiting test results) and confirmed cases of COVID-19 disease are currently being isolated and managed in a hospital setting with the intent to break the chain of transmission.

As per existing guidelines, during the containment phase the patients should be clinically assigned as very mild/mild, moderate or severe and accordingly admitted to (i) COVID Care Center, (ii) Dedicated COVID Health Center or (iii) Dedicated COVID Hospital respectively.

However, very mild/presymptomatic patients having the requisite facility at his/her residence for self-isolation will have the option for home isolation"

31. Thus, home isolation for mid cases is only an option.

32. Going by the guidelines issued by MOHFW & IRDAI, the instant case warranted either home quarantine or institutional quarantine. Since home quarantine is an option and the complainant was under institutional quarantine based on medical advice, the claim is admissible.

33. The policy exclusion 9(C) xvi cited by the RI in justification of the repudiation of the claim is overruled by the circular of IRDAI dated 04/03/2020 referred to above and is of no consequence or effect so far as claims for COVID 19 are concerned.

34. The RI's stated position that in case of institutional quarantine in a Government approved hotel, the expenses have to be borne by the respective Government is not substantiated by them with evidence. On the contrary, the circulars of IRDAI referred to earlier, make it abundantly clear that expenditure on quarantine, whether institutional or at home, is admissible under a Health Insurance Policy.

35. During the hearing, the RI was advised to calculate the amount payable as per the policy and inform the Forum. It is regretted, there has been no response from them so far.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the respondent insurer is hereby directed to settle the claim of the complainant for INR 35,820 subject to the terms and conditions of the policy along with interest as under Rule 17 (7) of the Insurance Ombudsman Rules, 2017. The Forum specifically directs that the amount billed by the Hotel where the complainant was quarantined should be treated as Room charges for hospitalization.

Thus the complaint is **allowed**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

s) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

t) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance

Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

u) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 15th day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA
Case of Mr KMG Vivekanandam Vs The New India Assurance Company Ltd
COMPLAINT REF: NO: CHN-H-049-2021-0529
Award No: IO/CHN/A/HI/0010/2021-2022

1.	**Name & Address of the Complainant**	**Mr KMG Vivekanandam 57, Meenakshi Avenue, Kalai Nagar First Street, Madurai 625017**
2.	**Policy No: Type of Policy Duration of policy/Policy period Sum Insured (SI)**	**73020034190400000012 *New India Flexi Floater Group Mediclaim* Policy 27/12/2019-26/12/2020 INR 10,00,000**
3.	**Name of the insured Name of the policyholder/proposer**	**Mrs V Parvathi Mr KMG Vivekanandam**
4.	**Name of the insurer**	**The New India Assurance Company Ltd**
5.	**Date of partial settlement**	**07/12/2020**
6.	**Reason for partial settlement**	**Claim settled as per General Insurance (GI) Council approved tariff**
7.	**Date of receipt of the Complaint**	**04/12/2020**
8.	**Nature of complaint**	**Short-settlement of the claim**
9.	**Date of receipt of consent (Annexure VIA)**	**12/02/2021**
10.	**Amount of Claim**	**INR 2,02,500**
11.	**Amount of Monetary Loss (as per Annexure VIA)**	**INR 1,61.280**
12.	**Amount paid by Insurer if any**	**INR 41,220**
13.	**Amount of Relief sought (as per Annexure VIA)**	**INR 1,61,280**
14.a.	**Date of request for Self-contained Note (SCN)**	**25/01/2021**
14.b.	**Date of receipt of SCN**	**02/03/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 12/03/2021**
17.	**Representation at the hearing**	
	o) For the Complainant	**Mr KMG Vivekanandam**
	p) For the insurer	**Mr Veeraraghavan**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**16/04/2021**

20. Brief Facts of the Case:

- The complainant's spouse who is covered under the respondent insurer (RI)'s *New India Flexi Floater Group Mediclaim* Policy for the period from 27/12/2019 to 26/12/2020 for a SI of INR 10,00,000 was admitted to Sumathi Hospitals, Madurai on 11/09/2020 and was discharged on 15/09/2020 after undergoing treatment for COVID 19 infection.
- The reimbursement claim filed by the complainant for her treatment for INR 2,02,500 was settled by the RI for INR 41,220.
- Aggrieved by the short settlement of the claim, the complainant made a representation to the Customer Care Department of the RI to reconsider their decision since the SI under the Policy is INR 10,00,000. As there is no reply from them, he has approached this Forum for settlement of the balance amount of his claim of INR 1,61,280.

21. a) Complainant's submission:

- ❖ As against the reimbursement claim preferred of INR 2,02,500 towards the expenses incurred for the treatment of his spouse for COVID 19 infection, he received a settlement of only INR 41,200, although the SI was INR 10,00,000.
- ❖ The settlement by the RI is arbitrary and Forum's intervention is requested for settlement of the balance amount of INR 1,61,280.

b) Insurer's contention:

- ➢ The complainant preferred a reimbursement claim of INR 2,02,500 towards expenses incurred on hospitalization treatment of his spouse for COVID 19 infection at Sumathi Hospitals, Madurai for 4 days.
- ➢ The claim was settled for INR 41,200 as per General Insurance (GI) Council approved rates wherein INR 8,000 per day is payable in respect to treatment for moderate sickness in a Non-NABH accredited hospital as in the instant case. The amount payable was worked out as below.

Hospital Rates	INR 8,000 * 4 days = INR 32,000
Injection allowed	INR 2,200
COVID Test	INR 3,000
CT	INR 4,000
Total	**INR 41,200**

22. Reason for Registration of Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Complaint dated 22/01/2021 to the Insurance Ombudsman
- ✓ Claim settlement advice of the RI
- ✓ Complainant's representation dated 13/12/2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ Self-contained Note (SCN) of the RI dated 02/03/2021
- ✓ GI Council tariff for COVID 19 cases
- ✓ Copy of *New India Flexi Floater Group Mediclaim* Policy

- ✓ Claim form Part A dated 24/09/2020
- ✓ Discharge summary of Sumathi Hospitals, Madurai.

24. Result of hearing (Observations & Conclusion)

36. Because of the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 12/03/2021, with the consent and participation of both the complainant and the RI.

37. The subject matter of the dispute is the short-settlement of the complainant's claim of INR 2,02,500 for the treatment of his wife for COVID 19, for only INR 41,220.

38. The RI relied on the GI Council guidelines to arrive at the amount of settlement. In the considered opinion of the Forum, the GI Council tariff cannot be deemed as Government prescribed and has no statutory enforceability either on the hospitals or the insuring public. In the absence of any endorsement in the policies to the effect that the COVID 19 related claims will be settled only as per the GI Council tariff, it has no legal enforceability as well.

39. Hence, the claim merits settlement as per the policy terms and conditions. Neither party submitted a copy of the hospital invoice and other related bills to the Forum. Hence, the RI was advised during the hearing, to compute the amount payable in settlement of the claim as per terms & conditions of the Policy and inform the Forum so that the award could be issued for the said amount. However, it is regretted there has been no response from the RI so far to the Forum's directive.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both parties, the respondent Insurer is directed to reprocess the claim of the complainant, as per the terms and conditions of the policy and pay him the balance amount if any in full and final settlement of the claim, taking into consideration the amount already paid. Amount if any billed by the hospital towards PPE kits should be reimbursed subject to a maximum of INR 3,040 per day, as per the guidelines of the Government of Tamil Nadu under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). Besides, the complainant is entitled to interest as under Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed**.

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

v) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

w) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

x) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

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Dated at Chennai on this 16th day of April 2021.

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mr K Anandaraj Vs United India Insurance Company Limited
COMPLAINT REF: NO: CHN-H-051-2021-0456
Award No: IO/CHN/A/HI/0011/2021-2022

1.	**Name & Address of the Complainant**	**Mr. K Anandaraj, D-No.24, W-18, Kuppalagiri Thottam, Thirumalapuram, Bodinayakanur – 625 513.**
2.	**Policy No. Type of Policy Duration of Policy/Policy Period Sum Insured (SI)**	**0904022819P104210763 *Family Medicare Policy 2014* 05.07.2019 to 04.07.2020 INR 2,50,000**
3.	**Name of the Insured Name of the Policyholder/Proposer**	**Mr K Anandaraj Mr K Anandaraj**
4.	**Name of the Insurer**	**United India Insurance Company Limited**
5.	**Date of Repudiation / Short Settlement**	**Not Applicable**
6.	**Reason for Repudiation/ Short settlement**	**Not Applicable**
7.	**Date of receipt of the Complaint**	**04.01.2021**
8.	**Nature of Complaint**	**No Claim Discount (NCD) not allowed on policy migration**
9.	**Date of receipt of Consent (Annexure VI A)**	**25.01.2021**
10.	**Amount of Discount claimed**	**INR 3,450**
11.	**Amount of discount allowed by the Insurer**	**Nil**
12.	**Amount of Monetary Loss (as per Annexure VI A)**	**Not applicable**
13.	**Amount of Relief sought (as per Annexure VI A)**	**INR 3,450 (15% NCD)**
14. a.	**Date of request for Self-contained Note (SCN)**	**05.01.2021**
14. b.	**Date of receipt of SCN**	**29.03.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (c) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 19.03.2021**
17.	**Representation at the hearing**	
	a) For the Complainant	**Mr. K Anandaraj**
	b) For the Insurer	**Mr S Anandaraj**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**19.04.2021**

20. Brief Facts of the Case:

The complainant is the policyholder of the *Individual Health* Policy issued by the respondent insurer (RI), covering himself and his spouse since July 1990. The policy was renewed for a Sum Insured of INR 3 lakhs and INR 2.5 lakhs for the complainant and his wife respectively for the period 05.07.2018 to

04.07.2019 under which a Family Discount of INR 1,134.88 and a No Claims Discount (NCD) of INR 702.50 was allowed on renewal.

The RI revised the *Individual Health Insurance policy – Platinum/Gold/Senior Citizen* with effect from 25.03.2019 and gave notice of 90 days to the existing policyholders with the following options for renewal.

a) In case the policy is due for renewal within the notice period of 25.03.2019 to 24.06.2019, the insured have the option to either continue with the erstwhile premium rates and policy conditions (up to the date of next year renewal) or immediately opt for new premium rates and new policy conditions.

b) If the renewal falls after the notice period, the cover will be as per the revised policy terms and conditions at the revised premium.

c) The insured also has an option to migrate to other similar or closely similar products up to a SI equal to that for an individual member under the current *Individual Health Insurance* Policy. The premium will be charged as per such chosen new product and all the guidelines, terms and condition of the chosen product shall be applicable.

d) Suitable credit of continuity//waiting periods for all the previous policy years would be extended in the new policy, provided the policy has been maintained without a break.

The complainant opted for the *Family Medicare Policy 2014* of the RI for a floating SI of INR 2.50 lakhs for the period 05.07.2019 to 04.07.2020. The premium charged under the policy was INR 27,966 and no NCD was allowed.

The complainant is of the view that he is eligible for an NCD of 3% per year for the claim-free years during 2014-17 (three years), another 3% for the claim-free year 2017-2018 and a further 3% for the claim-free year 2018-2019, aggregating to 15%.

He represented to the RI at various levels for the NCD and since the reply given by them was not satisfactory, he has approached this Forum for relief.

21 (a) Complainant's Submission:

- The complainant submits that he has not made any claims from 2010-2011.
- He availed the facility of reimbursement of health check-up expenditure for the claim-free years from 2014-2017.
- He and his spouse are also covered under the Tamil Nadu New Health Insurance Scheme.

- He is of the view that although the premium may be charged as per the chosen new product and all the guidelines, terms and conditions of the chosen product shall be applicable, he is eligible for 15% NCD since on migration "*Suitable credit of continuity/waiting periods for all the previous policy years would be extended in the new policy, provided the policy has been maintained without a break*".
- His request to incorporate the original inception date of the policy and previous policy details in the new policy was effected after prolonged communication with the RI.

21 (b) Insurer's Submission:

The RI submitted their SCN dated 29.03.2021 and made the following averments

- The insured had taken *Individual Health Insurance* Policy for the period from 05.07.2018 to 04.07.2019 covering himself and his spouse with an NCD of INR 702.50.
- The product was revised with a change in premium rates w.e.f. from 25.03.2019 with the approval of the Insurance Regulatory & Development Authority of India (IRDAI).
- The revised product continues to have three plans depending upon the age at the time of entry.
- Plan A – Platinum between 18 and 35 years. Children from the age of 91 days can be covered provided either or both of the parents are covered.
- Plan B – Gold between 36 to 60 years
- Plan C – Senior Citizens between 61 and 65 years.
- A notice period of 90 days is available from the date of launch of the revised product (25.03.2019 to 24.06.2019) and if the renewal falls during the said period, the insured have the option to renew, either with the existing (pre-revision) premium rates and conditions for one more year or immediately opt for the new premium rates and policy conditions.
- Where the renewal falls after the notice period i.e. after 24.06.2019, the cover shall be as per the revised policy terms and conditions.
- The policyholders also have the option to migrate to a similar or closely similar product up to the SI under the current *Individual Health Insurance* Policy. The premium will be charged as per such chosen new product and all the guidelines and terms and conditions of the chosen product shall be applicable.
- Suitable credit of continuity/waiting periods for all the previous policy periods would be extended in the chosen new policy provided the policy is without break.

- In the present case, the renewal was due after the notice period and the complainant had opted for migration to *Family Medicare* Policy for the period 05.07.2019 to 04.07.2020.

- As per the terms & conditions of *Family Medicare* Policy, "*No Claim Discount/Cumulative Bonus, if any, under existing policy will not be carried forward".*

- Hence the claim of the complainant for NCD under the chosen *Family Medicare Policy* is not tenable.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No.13(1) (c) of the Insurance Ombudsman Rules, 2017, which concerns *"disputes over premium paid or payable in terms of insurance policy".*

23. Documents placed before the Forum:

- ✓ Complaint dated 02.01.2021 to the Insurance Ombudsman
- ✓ Complainant's representations dated 26.06.2019, 28.06.2019, 30.07.2019 & 13.09.2019 to the RI
- ✓ Complainant's representation dated 07.01.2020 to IRDAI
- ✓ RI's response dated 26.08.2019, 20.09.2019 and 01.10.2019 to the Complainant
- ✓ Consent (Annexure VI A) submitted by the Complainant
- ✓ Self-contained Note (SCN) of the RI dated 29.03.2021
- ✓ Copy of Policy with terms and conditions of *Individual Health Insurance* Policy and *Family Medicare* Policy 2014
- ✓ Internal Circular of the RI on *Revision of 'Individual Health Insurance Policy – Platinum/Gold/Senior Citizen* with effect from 25.03.2019
- ✓ Prospectus of *Family Medicare* Policy and *Individual Health Insurance* Policy – *Platinum/Gold/Senior Citizen*
- ✓ Complainant's mail dated 20.03.2021 to the Forum post-hearing

24. Result of hearing with both parties (Observations & Conclusion)

- ➢ Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 19.03.2021, with the consent and participation of both the complainant and the RI. Mr K Anandaraj, the complainant and Mr S Anandaraj, RI's representative attended the hearing.

- ➢ The Forum records its displeasure over the delayed submission of SCN by the RI which was received only on 29.03.2021, which was ten days after the hearing. It is expected that the RI will practise strict adherence to the timelines for submission of SCN, in future.

- ➢ During the hearing, the complainant submitted that he is the policyholder with the RI for several years. His *Individual Health* Policy was migrated to *Family Medicare Policy 2014* for the renewal

period 05.07.2019 to 04.07.2020. At the time of renewal/migration, he was deprived of the NCD which he was earning all along. He questioned the RI regarding the same when he was informed that the discount has to be earned afresh under the new policy. He is of the view that the provision with respect to NCD should apply only to fresh policies and not to migrated policies. He believes that the relevant clause has been drafted incorrectly and is without logic. He has pointed out that when the cost of health check-up is allowed based on claim-free experience under the policy, there is no reason why NCD should not be allowed similarly. He is also of the view that the *credits for continuity and waiting period from the previous policy years* include the benefit of NCD. Post-hearing, the complainant submitted written arguments, highlighting the above issues.

- The RI argued that as per *Family Medicare* Policy, NCD from any other previous policy will not be carried forward and the insured has to earn it afresh with three continuous claim-free years. Accordingly, no discount was allowed to the complainant during his migration from *Individual Health* Policy to *Family Medicare* Policy 2014 in the year 2019-20.
- The prospectus of the RI for the *Family Medicare Policy* has the following provisions regarding No Claim Discount (NCD)

  At renewal, the Company will review the claims experience and apply a No Claim Discount/Loading based on the claims incurred as given below:

  No Claim Discount – 3% on renewal premium after three continuous claims free ***Family Medicare Policies*** *and for every subsequent claim free year subject to a maximum of 15%.*

  If any claim is reported or if the policy is not renewed within the grace period the policy will not be eligible for any No claim discount.

  As regards the migration of *Individual Health Insurance* policyholders to *Family Medicare* Policy 2014, the prospectus provides as below:

  Existing Individual Health Policyholders of the Company can also opt for Family Medicare Policy on expiry of their current policy if there has been no claim for the preceding two years in respect of insured persons.

  No Claim discount/cumulative Bonus, if any, under existing policy will not be carried forward.

  The above provisions make it abundantly clear that the NCD is not permitted under the *Family Medicare* Policy 2014 based on the claim experience of the previously held *Individual Health Insurance* Policy.

  Although the complainant terms the provision illogical, as the product is duly approved by IRDAI with its rating and terms & conditions, it is binding on the policyholders.

- The credit for 'Continuity/Waiting Period' applies only to the coverage under the policy as per the Health Insurance Regulations of IRDAI and not to the premium or its components as argued by the complainant.
- Hence the Forum is of the view that the RI was justified in rejecting the claim of the complainant for NCD under the *Family Medicare* Policy 2014.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum is of the view that the complainant was not entitled to No Claim Discount under the Family Medicare Policy 2014 for the period 05.07.2019 to 04.07.2020.

Thus, the complaint is **not allowed**.

25. If the decision of the Forum is not acceptable to the Complainant, he is at liberty to approach any other Forum/Court as per laws of the land against the respondent insurer.

Dated at Chennai on this 19th day of April 2021.

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY

(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mr V Sathiyanarayanan Vs The New India Assurance Company Ltd

COMPLAINT REF: NO: CHN-H-049-2021-0458

Award No: IO/CHN/A/HI/0022/2021-2022

1.	**Name & Address of the Complainant**	**Mr V Sathiyanarayanan** **5/590-1, Krishnanagar, Perur, Chettipalayam, Coimbatore 641010**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)**	**72160034192700000460** ***New India Asha Kiran* Policy** **27/03/2020-26/03/2021** **INR 3,00,000**
3.	**Name of the insured** **Name of the policyholder/proposer**	**Mr V Sathiyanarayanan** **Mr V Sathiyanarayanan**
4.	**Name of the insurer**	**The New India Assurance Company Ltd**
5.	**Date of partial settlement**	**17/11/2020**
6.	**Reason for partial settlement**	**As per guideline rates of General Insurance (GI) Council for COVID 19 claims**
7.	**Date of receipt of the Complaint**	**04/01/2021**
8.	**Nature of complaint**	**Short settlement of the claim**
9.	**Date of receipt of consent** **(Annexure VIA)**	**20/01/2021**
10.	**Amount of Claim**	**INR 1,62,089**
11.	**Amount of Monetary Loss** **(as per Annexure VIA)**	**INR 22,020**
12.	**Amount paid by the insurer**	**INR 51,505**
13.	**Amount of Relief sought** **(as per Annexure VIA)**	**INR 22,020**
14.a.	**Date of request for Self-contained Note (SCN)**	**05/01/2021**
14.b.	**Date of receipt of SCN**	**18/02/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on**

		09/03//2021
17.	**Representation at the hearing**	
	q) For the Complainant	**Mr V Sathiyanarayanan**
	r) For the insurer	**Ms Aparna**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22/04/2021**

20. Brief Facts of the Case:

- The complainant, who is covered under the respondent insurer (RI)'s *New India Asha Kiran* Policy for the period from 27/03/2020 to 26/03/2021 for a SI of INR 3,00,000, was admitted to Kovai Medical Centre & Hospital (KMCH), Coimbatore on 04/10/2020 and was discharged on 10/10/2020 after undergoing treatment for COVID 19.
- The reimbursement claim preferred by him for his treatment was settled by the Third-Party Administrator (TPA) of the RI for INR 54,468 as against the actual expenses of INR 1,62,089 incurred, by restricting the amount payable as per the guidelines of GI Council for COVID 19 claims.
- According to the complainant, although the TPA arrived at the amount payable as INR 73,525, they paid only INR 51,505 after deducting INR 22,020 as excess. He, therefore, requested the RI to reimburse the amount of INR 22,020 deducted as excess but the request was not considered by them.
- Aggrieved with the response from the RI, the complainant has approached this Forum for relief.

21. a) Complainant's submission:

- The TPA arrived at the amount payable as INR 73,525 but paid only INR 51,505. When the RI was questioned why the amount of INR 22,020 was deducted as excess, they replied that as per the guidelines issued by the GI Council, INR 7,500 per day is payable for mild cases of COVID 19. As the instant case was a mild one as evidenced by the CT Scan report, the amount payable for 6 days of hospitalization was calculated as INR 45,000 and after taking into account the pre & post hospitalization expenses of INR 6,505, the claim was settled for INR 51,505.
- As per Circular no. IRDA/HLT/REG/CIR/054/03/2020 dated 04/03/2020 of the Insurance Regulatory & Development Authority of India (IRDAI), the costs of admissible medical expenses during the course of treatment for COVID 19 including the treatment during the quarantine period shall be settled in accordance to the applicable terms and conditions of policy contract and the extant regulatory framework.
- Hence the payable amount of the claim is INR 73,525 as arrived at by the TPA and the Forum's intervention is requested for settlement of the balance amount of INR 22,020.

b) Insurer's contention:

- The complainant's claim of INR 1,62,089 towards his hospitalization for treatment of COVID 19, at KMCH from 04/10/2020 to 10/10/2020, was settled for INR 51,505 as per GI Council Guidelines. On review, an additional amount of INR 2,963 was paid towards the cost of high-end drug and thus the total settlement was for an amount of INR 54,468. Subsequently, the claim was reworked as per policy terms and the

amount payable was arrived at as INR 55,816 as detailed below. Thus, an amount of INR 1,348 is additionally payable to the complainant

Item of Expense	Amount (INR)			Remarks
	Claimed	Payable	Denied	
Room Rent	72,000	18,000	54,000	Restricted to 1% of SI per day
Consultation	4,000	4,000	0	
Consultation	24,000	6,000	18,000	Proportionate clause applied*
Diet	3,920	980	2,940	
Investigation	19,300	4,825	14,475	
Pharmacy	13,899	4,915	8,984	Non-payable items - Mask, bedsheet, gloves & face shield
Misc, Registration Charge /Discharge summary	1,264	0	1,264	Non-payable items
Pre-Hospitalization	4,800	4,800	0	
Post-Hospitalization	18,906	12,296	6,610	Oxygen Stabilizer (INR 5,500) Glucometer (INR 1,110)
Total	**1,62,089**	**55,816**	**1,06,273**	

*As per policy terms, the room rent payable is 1% of the SI and works out to INR 3,000 per day in the instant case. Since the actual room rent charged was higher, the *proportionate clause* which reads as under was applied in respect of other expenses (other than medicines).

"*In case of admission to a Room Rent /ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines and implants, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day for Room Rent (including but not limited to boarding and nursing expenses)/ICU/ICCU charges".*

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Written Complaint dated 02/01/2021 to the Insurance Ombudsman
- ✓ TPA's Claim Reimbursement letter dated 17/11/2020
- ✓ Complainant's representation dated 20/11/2020 to the RI
- ✓ RI's reply dated 27/11/2020 to the complainant
- ✓ Consent (Annexure VI A) submitted by the complainant dated 18/01/2021
- ✓ Self-contained Note (SCN) of the RI
- ✓ Copy of *New India Asha Kiran* Policy with terms & conditions
- ✓ Bill dated 10/10/2020 of KMCH, Coimbatore and other invoices
- ✓ RI's claim assessment for INR 55,816
- ✓ Circular no. IRDA/HLT/REG/CIR/054/03/2020 dated 04/03/2020

24. Result of hearing (Observations & Conclusion):

a) Given the prevalent COVID 19 pandemic situation, the hearing was conducted through VC on 09/03/2021, with the consent and participation of both the complainant and the RI.

b) The Forum records its displeasure over the delay in submission of SCN by the RI.

c) Though the RI initially processed the claim by adopting the GI Council guidelines, they subsequently reprocessed the claim as per the policy terms and thereby an additional amount of INR 1,348 is payable to the complainant, over and above the amount of INR 54,468 paid already.

d) The RI disallowed INR 54,000 under the head Room Rent by restricting the reimbursement to 1% of the SI of INR 3,000 per day and the same is in order.

e) The RI disallowed INR 35,415 in respect of hospitalization expenses other than on medicines by applying the proportionate clause since the room rent availed/claimed was INR 72,000 as against the eligibility as per the policy of INR 18,000. The said disallowance is in order.

f) The RI disallowed another INR 16,858 towards non-medical/non-payable items as per policy terms & conditions. The Forum observes that out of this amount, an amount of INR 4,680 was charged by the hospital towards 6 nos. Barrier Sets @ INR 780. These are nothing but PPE kits, an essential disposable used in the treatment of COVID 19. This Forum has been allowing a reasonable cost of PPE kits as per limits fixed by the Government of Tamil Nadu under its Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). As the present case is a case of mild disease, the limit allowed under CMCHIS is INR 3,020 per day. As against the same, the total expenditure on the kits, in this case, is INR 4,680, which is very reasonable. Hence, the Forum allows the same. Since it is a pharmacy item, it shall not be subject to any further deduction under the *proportionate clause* of the Policy.

g) In conclusion, the RI shall pay an additional amount of INR 6,028 (INR 1,348 plus INR 4,680) to the complainant in settlement of his claim

h) The claim settlement letter of the TPA dated 17/11/2020 for an amount of INR 51,505 does not reflect a proper computation of the payable amount. It shows an item-wise calculation of the amount payable but the heads of expense are not as billed by the hospital. The reason for showing the head-wise calculation is also not clear when the intention of the TPA/RI was to settle the claim as per GI Council guidelines. Showing a further deduction of INR 22,020 from the amount calculated item-wise in order to match it with

the amount payable as per the Guidelines was confusing and amounted to poor communication by the TPA. This aspect is brought to the notice of the TPA and the RI so that the settlement details are communicated in a transparent and easily comprehensible manner to the claimants in future as per the regulatory mandate.

AWARD

Taking into account the facts & circumstances of the case and the submissions made, the Forum directs the respondent insurer to pay an additional amount of INR 6,028 to the complainant in full and final settlement of his claim along with interest as defined under Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

Hence, the complaint is **partly allowed**.

25. In case the complainant is dissatisfied with this order, he is at liberty to approach any other court or forum having jurisdiction against the respondent insurer.

26. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

y) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman

z) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

aa) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY

(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mrs T Banumathi Vs Star Health & Allied Insurance Company Ltd

COMPLAINT REF: NO: CHN-H-044-2021-0476

Award No: IO/CHN/A/HI/0025/2021-2022

1.	**Name & Address of the Complainant**	**Mrs T Banumathi** **6-1-72/77B, Moovendar Nagar Main Road, Viswanathapuram, Madurai 625014**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)**	**P/121312/01/2021/002100** ***Star Comprehensive Insurance* Policy** **19/09/2020-18/09/2021** **INR 7,50,000**
3.	**Name of the insured** **Name of the policyholder/Proposer**	**Mrs T Banumathi** **Mrs T Banumathi**
4.	**Name of the insurer**	**Star Health & Allied Insurance Company Limited**
5.	**Date of repudiation of the claim**	**13/12/2020**
6.	**Reason for repudiation**	**Non-Disclosure of the past medical history**
7.	**Date of receipt of the complaint**	**07/01/2021**
8.	**Nature of complaint**	**Non-settlement of the claim**
9.	**Date of receipt of consent** **(Annexure VIA)**	**21/01/2021**
10.	**Amount of Claim**	**Not furnished**
11.	**Amount of Monetary Loss** **(as per Annexure VIA)**	**Not furnished**

12.	**Amount paid by the insurer if any**	**Nil**
13.	**Amount of Relief sought** **(as per Annexure VIA)**	**INR 2,28,257**
14.a.	**Date of request for Self-contained Note (SCN)**	**07/01/2021**
14.b.	**Date of receipt of SCN**	**26/02/2021**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on** **12/03/2021**
17.	**Representation at the hearing**	
	s) For the complainant	**Mr Dilip Prasanna (Son)**
	t) For the insurer	**Dr Asiya Sahima, Ms Hemalatha**
18.	**Disposal of complaint**	**By Award**
19.	**Date of Award/Order**	**22/04/2021**

20. Brief Facts of the Case:

- The Complainant who was covered under the respondent insurer (RI)'s *Star Comprehensive Insurance* policy for the period from 19/09/2020 to 18/09/2021 for a SI of INR 7,50,000 underwent treatment of Cancer (CA) Proximal Rectum at Vadamalayan Hospital, Madurai in October & November 2020.
- The claim preferred under the policy for her treatment was repudiated by the RI on the ground that the complainant did not disclose her medical history at the time of the proposal. They also cancelled the policy under the non-disclosure clause.
- Aggrieved by the repudiation of the claim and the cancellation of the policy, the complainant represented to the Grievance Department of the RI for a reconsideration of their decision. They replied that the hospitalization was for the treatment of the non-disclosed disease which amounts to misrepresentation and hence they claimed that the rejection is in order.
- In the circumstances, the complainant has approached this Forum for relief.

21. a) Complainant's submission:

- The complainant's ailment of CA Proximal Rectum was detected only on 02/10/2020 when the colonoscopy procedure was undertaken.
- Prior to that, the complainant had consulted Dr M Kannan a couple of times for disturbed bowel movement and she was assured by the doctor that there was nothing to worry about and he had not suspected cancer.
- In the prescriptions of August & September 2020 of the doctor, there is no mention of cancer anywhere.
- Moreover, the disease in question has no specific symptoms (sic) and cannot be confirmed without undergoing necessary tests.

- Had the complainant been aware of the disease, she would have definitely disclosed and there is no need for her to hide the same.
- Therefore, the Forum's intervention is requested for the settlement of the claim.

b) **Insurer's contention**:

I. The complainant was admitted on 15/10/2020 at Vadamalayan Hospitals Pvt Ltd. Madurai for treatment of CA Proximal Rectum. The *cashless* request received from the hospital for the treatment was denied on the ground that the exact duration of CA was not clear from the available records.

II. Subsequently, the complainant submitted the claim documents for reimbursement of medical expenses. On scrutiny of the documents, it was observed (from the discharge summary) that the complainant was a known case of CA Proximal Rectum with complaints of difficulty in passing stools for the past 3 to 4 months. The prescription dated 31/08/2020 shows that she was on Tab. Orni, Colospa, VSL 3. The prescription dated 09/09/2020 shows that the insured was on Tab. VSL 3. Thus, it is confirmed that the complainant had the onset of the ailment CA Proximal Rectum before the commencement of the policy. But the same was not disclosed in the proposal at the time of taking the policy which amounts to non-disclosure of material facts. The present admission and treatment of the complainant are for the non-disclosed CA Proximal Rectum. Hence, the claim was repudiated and the decision was communicated to her vide RI's letter dated 13/12/2020.

III. An insured has a duty to disclose all material facts in the proposal while buying an insurance policy. Regulation 19(2) of IRDAI (Protection of Policyholders' Interests) Regulations 2017 reads as under:
The requirements of "disclosure of material information" regarding a proposal or policy apply, under these regulations, both to the insurer and insured.

IV. The information sought in the proposal and provided by the complainant was as below
Under the column *Health History*, for the query - *Do you have any health problems?* – she replied in the negative. Similarly, in the *Medical Declaration: Have you or any member of your family proposed to be insured, suffered or are suffering from any disease/ailment / adverse medical condition of any kind especially Heart / Stroke /* ***Cancer*** */ Renal disorder / Alzheimer's disease / Parkinson's's disease,* the proposer replied in negative, which is a clear non–disclosure of material fact, making the contract of insurance voidable as confirmed by the Supreme Court in the case of *Satwant Kaur Sandhu v. New India Assurance Co. Ltd. (2009) 8 SCC 316 (citation).*

V. At the time of commencement of the first-year policy which is from 19/09/2020 to 18/09/2021, the complainant had not disclosed her medical history/health details in the proposal which amounts to misrepresentation/non-disclosure of material facts.

VI. As per the contract of insurance, an insured is expected to declare in the proposal the details of his/her ailments/sickness – medical history which helps the insurer to evaluate the material facts and to decide whether to accept the proposal or not. In this case, the insured/complainant who has signed the proposal did not declare her pre-existing disease (PED) therein which amounts to non-disclosure of material fact.

VII. As per Condition No. 5 of the policy, "*The Company shall not be liable to make any payment under the policy in respect of any claim if information furnished at the time of proposal is found to be incorrect or false or such claim is in any manner fraudulent or supported by any fraudulent means or device,*

misrepresentation whether by the Insured Person or by any other person acting on his behalf." Hence, the claim was repudiated and the same was communicated to the insured.

VIII. *Utmost good faith* is a cardinal principle of insurance. This means that parties to an insurance contract must act in good faith, making a full declaration of all material facts in the insurance proposal. As this was not done in the present case, the insurer was deprived of an opportunity to evaluate the risk. Consequently, the Insurance contract between the parties became voidable and unenforceable.

IX. As per Condition No. 18 of the policy, *"the Company may cancel this policy on grounds of misrepresentation, fraud, moral hazard, non-disclosure of material fact as declared in the proposal form and/or claim form at the time of claim and non-co-operation of the insured by sending the Insured 30 days notice".* Hence, the policy was cancelled with effect from 19/01/2021 due to non-disclosure of the PED – CA Rectum after sending a 30 days' notice on 10/12/2020 and the premium amount of INR 36,137 was refunded.

X. It is submitted that Condition nos. 6 and 10 were erroneously mentioned in the repudiation letter and the RI confirm that the claim was repudiated under Condition no. 5 and the policy was cancelled under Condition no. 18.

22. Reason for Registration of Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Complaint to the Insurance Ombudsman
- ✓ Denial of pre-authorisation request dated 12/10/2020
- ✓ RI's claim repudiation dated 13/12/2020
- ✓ Complainant's representation dated 16/12/2020 to the RI
- ✓ RI's reply dated 21/12/2020 to the complainant
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Self-contained Note (SCN) of the RI dated 26/02/2021
- ✓ Field Visit Report of the RI
- ✓ Copy of *Star Comprehensive Insurance* Policy with the wording
- ✓ Copy of online proposal dated 19/09/2020
- ✓ RI's policy cancellation notice dated 10/12/2020
- ✓ Dr M Kannan's prescriptions dated 31/08/2020 & 09/09/2020
- ✓ CT Scan Report dated 03/10/2020
- ✓ Biopsy Report dated 06/10/2020
- ✓ Radiotherapy Discharge Summary dated 23/11/2020 of Vadamalayan Hospital
- ✓ Claim form dated 24/11/2020
- ✓ Summary Bill dated 23/11/2020 of Vadamalayan Hospital
- ✓ Dr Kannan's certificate dated 24/12/2020.

24. Result of hearing (Observations & Conclusion):

40. Given the current COVID 19 pandemic situation, the hearing was conducted through VC on 12/03/2021, with the consent and participation of both parties.

41. The subject matter of the dispute is the RI's repudiation of the complainant's claim on the ground of non-disclosure of her medical history at the time of proposing for the insurance. The medical history, which the RI refers to is the difficulty in passing motion for 3-4 months besides the consultation she had on 31/08/2020 & 09/09/2020 with Dr M Kannan of Vadamalayan Hospital, Madurai. It is the contention of the RI that by giving a negative answer to the two questions in the proposal form regarding her health condition, the complainant failed to comply with her duty of disclosure. It is observed that both the questions are regarding the general health condition of the proposer, although the second question additionally seeks information regarding certain chronic ailments, including cancer. Therefore, the argument of the complainant that she was not obligated to disclose her consultation with Dr Kannan and her treatment for altered bowel condition since her cancer was diagnosed only after taking the policy is not acceptable.

42. It is an admitted fact that the complainant had two consultations on 31/08/2020 & 09/09/2020, prior to availing the policy on 19/09/2020. As per prescription dated 31/08/2020, the diagnosis was obesity, dyspepsia and altered bowel habits for which the following medication was prescribed.

Medicine	**Property/Indication**
Tablet Orni	Antibiotic
Tablet Colospa	Irritable bowel syndrome
Capsule VSL 3	Probiotic in case of the altered microbial flora of the gut
Capsule Veloz D	Heartburn, belching, nausea

43. The Forum is of the considered opinion that while proposing for the policy on 19/09/2020, the complainant could not have been unaware of or overlooked her treatment by Dr Kannan which was of recent origin and hence her reply that she had no health problems and the declaration that she was not suffering from any disease/ailment/adverse medical condition of any kind in the proposal form amounts to incorrect information and entitles the RI to reject the claim as per condition no. 5 of the policy. The RI is also justified in cancelling the policy on the same grounds under condition no. 18 of the policy.

44. It is noted that the proposal was completed online but duly authenticated through a One Time Password (OTP) on 19/09/2020 at 3:05:03 PM. Therefore, the replies given in the proposal form are not in dispute, although the proposal is not signed.

45. While the complainant was not guilty of non-disclosure of her cancer, she is certainly at fault so far as the suppression of the other conditions she was suffering from at the time of the proposal is concerned. It also not out of place to mention that altered bowel habit is a symptom of cancer of the rectum and looking to the proximity of the diagnosis of cancer to the date of inception of the policy, the possibility of the disease being pre-existing cannot be ruled out. As per the discharge summary of the treating hospital, the condition of the complainant was highly suspicious for metastasis. This is an additional indication that the disease could be long-standing, although recently diagnosed.

46. The policy has a well defined 30 days' waiting period clause which excludes, diseases contracted during the first 30 days of the policy. In the instant case as per the available records, the disease of Carcinoma of Rectum was detected on 02/10/2020, within the first 30 days of the policy. The claim could have been repudiated under the said clause and also by invoking the waiting period clause for PED. For the reasons best known to them, the RI failed to do so.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum is of the conclusion that the repudiation of the subject claim by the respondent insurer is justified and does not warrant its intervention.

Thus, the complaint is **not allowed.**

25. In case the complainant is not satisfied with this order, she is at liberty to approach any other court or forum with necessary jurisdiction against the respondent insurer.

Dated at Chennai on the 22nd day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mrs K G Sowabhagyavathi Vs Bajaj Allianz General Insurance Co Ltd
COMPLAINT REF: NO: CHN-H-005-2021-0466
Award No: IO/CHN/A/HI/0026/2021-2022

1.	**Name & Address of the Complainant**	**Ms. K G Sowbhagyavathi,** **No.8/125, Jothy Nagar, First Street,** **Podanur,Coimbatore – 641 023.**
2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**OG-20-1503-8429-00000801** ***Health Guard Policy (Silver Plan)*** **22.01.2020 to 21.01.2021** **INR 2 lakhs plus Cumulative Bonus (CB) of INR 70,000**

3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Ms. K G Sowbhagyavathi** **Ms. K G Sowbhagyavathi**
4.	**Name of the Insurer**	**Bajaj Alliance General Insurance Co Ltd**
5.	**Date of partial settlement**	**27.11.2020**
6.	**Reason for partial settlement**	**Due to *Proportionate Clause***
7.	**Date of receipt of the Complaint**	**06.01.2021**
8.	**Nature of Complaint**	**Short settlement of the claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**25.01.2021**
10.	**Amount of Claim**	**INR 1,24,400**
11.	**Amount paid by the insurer, if any**	**INR 58,620**
12.	**Amount of Monetary Loss (as per Annexure VI A)**	**INR 65,780**
13.	**Amount of Relief sought (as per Annexure VI A)**	**INR 65,780**
14. a.	**Date of request for Self-contained Note (SCN)**	**06.01.2021**
14. b.	**Date of receipt of SCN**	**08.02.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 19.03.2021**
17.	**Representation at the hearing**	
	c) For the Complainant	**Ms. K G Sowbhagyavathi**
	d) For the Insurer	**Mr Mohammed Bilal Ali**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Case:

The complainant has taken the *Health Guard policy* issued by the respondent insurer (RI) covering herself and her two sons for an individual Sum Insured (SI) of INR 2 lakhs each. In addition, she had earned a Cumulative Bonus (CB) of 35% of the SI. She has been a policyholder of the RI since December 2008.

As per the Discharge Summary of KMCH Kovilpalayam Hospital, the complainant was admitted to the hospital on 04.09.2020 with the chief complaint of fever associated with cough and loose stools. She was diagnosed with

Covid 19 Infection – mild category and was discharged on 10.09.2020 after treatment. She is a known case of Type II Diabetes Mellitus (DM) and Dyslipidemia.

The RI settled the claim of INR 1,24,400 for her treatment partially for INR 58,620. She, therefore, represented to the Grievance Department of the RI for the payment of the balance amount INR 65,780. As per the settlement advice, an amount of INR 31,700 was disallowed since item-wise break up was not submitted for the same. Since the complainant occupied a room with a tariff of INR 5,000 per day but her eligibility was only INR 2,000 per day, a 60% proportionate deduction was also applied while arriving at the amount payable. She represented to the RI vide her letter dated 07.12.2020 stating that she had submitted the break-up for the amount of INR 31,700 and that she was admitted only in the general ward and not a separate room. However, there was no response from the RI. Aggrieved by the non-response, the complainant has approached this Forum for relief.

21 (a) Complainant's Submission:

- The complainant submits that she is the policyholder of the RI for the past 15 years with only one claim so far.
- More than 50% of her claim was disallowed citing frivolous and unacceptable reasons.
- She got admitted to the general ward and not in a private room.
- Even assuming that the claim was settled as per Clause 1(i) of the policy (*proportionate clause*), it is illogical that the RI denied the entire INR 34,080. They should have disallowed only INR12,000 and not INR 24,000.
- She also submits that she has submitted the break-up for INR 31,700 whereas the insurer took the stand that the same was not submitted, which is not acceptable.
- She has requested the Forum to direct the insurer to pay her INR 65,780 or such lawful amount to which she is entitled as per policy along with Bank interest and compensation of INR 1 lakh towards wrongful denial of her claim.

21 (b) Insurer's Submission:

The RI have submitted their SCN dated 05.02.2021 and have made the following averments

- They deny each and every allegation of the complainant, except those that are specifically admitted and submit that the amount paid was arrived after processing the claim within the precincts of the policy.
- The complainant was issued the *Health Guard policy – Silver Plan* which is live since 10.12.2008. The policy was renewed till date with frequent breaks ranging from 2 to 28 days.
- The present complaint is with respect to the complainant's hospitalization for the treatment of COVID 19 during the period 04.09.2020 to 10.09.2020. Out of the total claim of INR 1,24,400, no break-up was provided for one item of INR 31,700 and a query was raised about the same on 07.10.2020. There was

no response from the complainant till 25.11.2020 and hence the remaining claim was settled as per policy terms and conditions.

- On scrutiny and assessment of the claim, it was found that the room rent charged by the hospital was INR 5,000 per day and the total room rent for 6 days was INR 30,000. As per clause 1(i) of the policy room, boarding and nursing expenses as charged by the hospital/nursing home are covered up to 1% of the SI per day (excluding CB) or actual, whichever is lower. In case of admission to a room at rates exceeding the limits as mentioned under clause 1(i), the reimbursement of all other expenses incurred at the hospital, with the exception of the cost of medicines, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of room rent charges.
- Based on the above, the RI is liable to pay only 1% of the SI per day in respect of room rent, boarding and nursing expenses i.e. INR 2,000 per day.
- If the room rent exceeds the limits as mentioned under clause 1(i), (i.e if it exceeds 1% of the SI per day of INR 2,000), the reimbursement of all other expenses incurred at the hospital, with the exception of the cost of medicines, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of room rent charges.
- As per the summary cash bill no. 1215 dated 10.09.2020 submitted by the insured for reimbursement, the accommodation availed by the complainant was billed at INR 5,000 per day which exceeds the limit stipulated under the clause stated *supra*. Hence differential co-payment was applicable in the present case on all other expenses except the cost of medicines. Accordingly, 60% differential co-payment was applied for all the heads of expenditure, except medicines.
- After application of differential co-payment, the payable amount was INR 58,620 and since the break up for INR 31,700 was not available/not provided by the complainant, the same was disallowed and the claim was settled accordingly.
- The complainant submitted the revised services (detailed) bill after the claim amount was remitted to her account asking them to pay the remaining amount of INR 65,780. Hence, the RI reopened the claim and assessed with due diligence whether any further amount was payable as per the revised bill.
- As per the revised bill, the room rent was INR 4,000 per day and in addition, special nursing expenses were @ INR 2,500 per day. Hence the billed room, board and nursing expenses were INR 6,500 per day as against the eligible charges of INR 2,000 per day. As a result, the differential co-payment to be borne by the complainant increased to 69.23%.
- Hence the RI are not liable to pay any further amount, even as per the revised bill.
- The RI also reserved their right to amend the SCN on the revelation of new facts and circumstances and have requested the Forum to dismiss the complaint in the interest of justice.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No.13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer".*

23. Documents placed before the Forum:

- ✓ Written complaint dated 05.01.2021 to the Insurance Ombudsman
- ✓ Claim settlement letter of the RI dated 27.11.2020
- ✓ Complainant's representation dated 07.12.2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Self-contained Note (SCN) of the RI dated 05.02.2021
- ✓ Policy copy, terms and conditions
- ✓ Claim form dated 28.09.2020
- ✓ Discharge summary of KMCH Kovilpalayam Hospital, Coimbatore
- ✓ Original and revised bills of KMCH Kovilpalayam Hospital, Coimbatore
- ✓ Claim processing sheet of the RI (revised)
- ✓ Mail dated 05.04.2021 of the RI

24. Result of hearing (Observations & Conclusion)

- ➢ Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 19.03.2021, with the consent and participation of both the complainant and the RI.
- ➢ The Forum expresses its disapproval over the failure of the RI to respond to the grievance representations submitted by the complainant which is in breach of the guidelines issued by the Insurance Regulatory & Development Authority of India (IRDAI) for redressal of customer grievances by insurance companies. The RI must strengthen its customer grievance redressal mechanism and avoid such lapses in future.
- ➢ During the hearing, the complainant submitted that she was affected by COVID 19 infection and was treated in KMCH Kovilpalayam Hospital. She incurred a total expenditure of INR 1,24,400 whereas she was reimbursed only an amount of INR 58,620. The reasons stated by the RI for the deductions were not acceptable since she had submitted a revised hospital bill with item-wise details. She also questioned the proportionate deductions made as per clause 1(i).

Particulars	Amount (INR)			Remarks
	Claimed	Disallowed	Approved	
Room Charges	24,000	0	24,000	No deduction
Doctor Charges	28,000	0	28,000	No deduction

Nursing Charges	15,000	0	15,000	No deduction
Pharmacy Charges	29,875	14,646	15,229	Not payable - Swab, Gloves, Handrub, Easyfix, Thermometer, Facemask, Cap, Gloves, Faceshield. PPE kits allowed @ INR 650
Pathology Charges	10,090	1,120	8,970	Cost of Glucometer test disallowed
Radiology Charges	4,680	0	4,680	No deduction
Cardiology Charges	190	0	190	No deduction
Non-Medical Charges	65	65	0	Discharge summary registration
Miscellaneous	12,500	12,500	0	Cleaning and diet charges
Total	1,24,400	28,331	96,069	
Room rent differential co-pay (60% of all items above excluding pharmacy expenses)			46,384	Room rent restricted to INR 2,000 per day but incurred @ INR 5,000 per day. Hence 60% co-payment / proportionate deduction applicable for room rent restriction excluding consumables (sic)
Net payable			49,685	.

- During the hearing, the RI was directed to reprocess the claim based on the revised bill submitted by the complainant and submit the workings to the Forum. The RI complied with the directive of the Forum on 05.04.2021 and submitted the following calculations.

  They have, therefore, claimed that having already paid an amount of INR 58,620 which is more than the INR 49,685 as per the above calculation, they are not liable for any further payment to the complainant.

- The Forum notes the following anomalies in the calculations made by the RI.
  - Diet charges are admissible as part of the room, boarding and nursing expenses, whereas RI disallowed the same.
  - Room rent and related charges (nursing & diet charges) have not been restricted to INR 2,000 per day as per the policy provision.
  - On the other hand, proportionate deductions have been applied on the entire expenditure **including room rent and related charges** (excluding pharmacy expenses) which is incorrect.
  - The percentage of proportionate deduction applied (60%)is also incorrect. As per SCN, it should be 69.23%.
  - The disallowance of glucose testing charges using a glucometer is not justified. It is only the cost of the glucometer that is not payable under the policy.

- In the opinion of the Forum, the amount payable is as shown below.

Particulars	**Amount (INR)**			**Remarks**
	Claimed	**Disallowed**	**Approved**	

Room, nursing & diet Charges	42,500	30,500	12,000	Restricted to INR 2,000 per day
Doctor Charges	28,000	0	28,000	No deduction
Pharmacy Charges	29,875	14,646	15,229	Not payable - Swab, Gloves, Handrub, Easyfix, Thermometer, Facemask, Cap, Gloves, Faceshield. PPE kits allowed @ INR 650
Pathology Charges	10,090		10,090	No deduction
Radiology Charges	4,680	0	4,680	No deduction
Cardiology Charges	190	0	190	No deduction
Non-Medical Charges	65	65	0	Discharge summary registration
Miscellaneous	9,000	9,000	0	Cleaning charges not payable
Total	1,24,400	54,211	70,189	
Room rent differential co-pay (72% of all items above excluding room & pharmacy expenses)			30,931	Room rent restricted to INR 2,000 per day but incurred @ INR 7,083 per day. Hence 72% co-payment / proportionate deduction is applicable.
Net payable			39,258	

- Since the RI has already settled the claim for an amount higher than the above, they are justified in contending that no further amount is due to the complainant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both parties, the Forum is of the view that the settlement of the claim by the insurer is in order and does not warrant any intervention.

Thus, the complaint is **not allowed**.

25. If the decision of the Forum is not acceptable to the Complainant, she is at liberty to approach any other Forum/Court as per laws of the land against the respondent insurer.

Dated at Chennai on the 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY
(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI M VASANTHA KRISHNA
Case of Mr N Vijayan Vs Cholamandalam MS General Insurance Co. Ltd
COMPLAINT REF: NO: CHN-H-012-2021-0509
Award No: IO/CHN/A/HI/0028/2021-2022

1.	Name & Address of the Complainant	Mr N Vijayan 7/866, Mugappair West, Chennai 600037
2.	Policy No: Type of Policy Duration of policy/Policy period Sum Insured (SI)	2856/00139360/000/05 *Chola Swasth Parivar Insurance* 03/04/2019-02/04/2020 INR 5,00,000
3.	Name of the insured Name of the policyholder/proposer	Mr N Vijayan Mr N Vijayan
4.	Name of the insurer	Cholamandalam MS General Insurance Co. Ltd
5.	Date of repudiation/short settlement of the claim	Not applicable
6.	Reason for repudiation/short settlement	Not applicable
7.	Date of receipt of the Complaint	18/01/2021
8.	Nature of complaint	Non-receipt of the policy
9	Date of receipt of consent (Annexure VIA)	27/01/2021
10	Amount of Claim	Not applicable
11	Amount of Monetary Loss (as per Annexure VIA)	Nil
12.	Amount paid by the insurer, if any	Not applicable
13.	Amount of Relief sought (as per Annexure VIA)	Nil
14.a.	Date of request for Self-contained	19/01/2021

	Note (SCN)	
14.b.	**Date of receipt of SCN**	**15/04/2021**
15.	**Complaint registered under**	**Rule 13(1)(h) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 16/03/2021**
17.	**Representation at the hearing**	
	a. For the Complainant	**Mr N Vijayan**
	b. For the insurer	**Mr Srinivasan**
18.	**Disposal of complaint**	**By Award**
19.	**Date of Award/Order**	**22/04/2021**

20. Brief Facts of the Case:

- The complainant availed the respondent insurer (RI)'s *Chola Swasthya Parivar* policy for the period from 04/04/2019 to 03/04/2020. On 02/04/2020 he tried to renew the policy online but received an error message and was advised to contact the RI on its toll-free number or by e-mail.

- Accordingly, the complainant contacted the RI through e-mail for the renewal of the policy and based on their reply, transferred INR 10,870 towards the renewal premium through NEFT on 22/04/2020.

- The complainant received neither a soft nor hard copy of the policy till 13/01/2021, despite his representation to the RI. Hence, he has approached this Forum for redressal of his grievance of non-receipt of the policy.

21) **a) Complainant's submission:**

❖ The complainant's policy with the RI was due for renewal on 03/04/2020. Due to the COVID 19 pandemic situation, he attempted to renew the policy online on 02/04/2020 but received an error message reading "*This policy cannot be renewed through web. Please contact Chola MS Customer Care toll-free number: 1800-200-5544 or email at customercare@cholams.murugappa.com*.

❖ Accordingly, an e-mail was sent by the complainant on 02/04/2020 and he received a response on 16/04/2020. As advised by the RI in their response, the renewal premium of INR 10,870 was transferred to the latter through NEFT transaction no. IRL9343481 on 22/04/2020.

❖ The RI was reminded on 29/09/2020 to send the policy and they, in turn, sought the payment details and the bank account statement vide their e-mail dated 04/11/2020. The requirement of the RI was complied with vide complainant's e-mail dated 16/11/2020. Still, the policy was not received and the RI was once again reminded on 17/12/2020 to provide the same. However, there was no response.

- ❖ As it is more than 9 months since the premium for the policy was remitted and the policy is yet to be provided by the RI, Forum's intervention is requested for resolving the complainant's grievance of non-receipt of the policy.

b) Insurer's contention:

i. The complainant had taken a *Chola Swasth Parivar Insurance* Policy bearing No. 2856/00139360/000/05 for the period from 04.04.2019 to 03.04.2020.

ii. The complainant visited the RI's website for its renewal, but due to some technical issues, he could not renew the policy and thereafter as advised by the RI, he remitted the renewal premium of NR 10, 870 on 16/04/2020.

iii. Due to Covid 19 related restrictions, the RI's offices were not open during April 2020 and the payment made by the complainant was also not reflected in the RI's account. Thereafter, the payment was traced and the policy was renewed under policy no. 2856/00139360/000/05 from 22/04/2020 to 21/04/2021 with continuity benefits. The proof of delivery of the policy to the complainant on 13/02/2021 is also submitted.

iv. Hence, the Forum may be pleased to dismiss the complaint.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (h) of the Insurance Ombudsman Rules, 2017, which deals with "*non-issuance of insurance policy after receipt of premium in life insurance and general insurance including health insurance".*

23. Documents placed before the Forum:

- Complaint dated 13/01/2021 to the Insurance Ombudsman.
- Complainant's representations dated 02/04/2020, 22/04/2020, 29/09/2020, 16/11/2020 & 17/12/2020 to the RI
- RI's response dated 16/04/2020, 03/05/2020, 04/11/2020 & 11/12/2020
- Consent (Annexure VI A) submitted by the Complainant
- Self-Contained Note (SCN) of the RI
- Copy of the renewed policy dated 09/02/2021
- Proof of delivery of the policy

24) Result of hearing with both parties (Observations & Conclusion)

47. Given the current COVID 19 pandemic situation, the hearing was conducted through VC on 16/04/2021, with the consent and participation of both parties.

48. The subject matter of the complaint is the non-receipt of the renewed policy by the complainant till January 2021, although the renewal premium was remitted to the RI's bank account on 22/04/2020.

49. The RI explained in the SCN submitted as well as in the hearing that the delay in issuing the renewal policy was due to the closure of their offices on account of the COVID 19 pandemic as also their inability to trace the payment made by the complainant. However, they issued the renewal policy on 09/02/2021 and the original policy was delivered to the complainant on 13/02/2021. The RI also clarified that the policy has been renewed w.e.f 22/04/2020 with continuity benefits. The Forum is of the opinion that even after giving necessary allowance for the difficulties caused by the pandemic, the delay on the part of the RI in issuing the policy was inordinate and unreasonable. They should avoid such delays in future, at all costs.

50. Nevertheless, as the policy was already issued, there is no further relief that the Forum could provide to the complainant. Hence, the complaint is closed.

51. During the hearing on 16/04/2021, the complainant raised a concern regarding the renewal of the policy which was due during the following week. The representative of the RI assured him of all assistance in renewing the policy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum observes that the complainant's grievance of non-receipt of the policy is already resolved by the respondent insurer and there is no necessity for the Forum's intervention in the matter.

Therefore, the complaint is **closed.**

25. If the decision of the Forum is not acceptable to the complainant, he is at liberty to approach any other Forum/Court as per laws of the land against the respondent insurer.

Dated at Chennai on the 22nd day of April 2021

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY

(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mrs G Nalini Vs Max Bupa Health Insurance Company Ltd

COMPLAINT REF: NO: CHN-H-031-2021-0472

Award No: IO/CHN/A/HI/0029/2021-2022

1.	**Name & Address of the Complainant**	**Mrs G Nalini, 32, Muthukumaran Nagar, Poonamallee, Chennai 600056**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)**	**30498169202004** ***Heartbeat Gold*** **02/02/2020-01/02/2021** **INR 5,00,000**
3.	**Name of the insured** **Name of the policyholder/proposer**	**Mrs G Nalini** **Mrs G Nalini**
4.	**Name of the insurer**	**Max Bupa Health Insurance Company Limited**
5.	**Date of repudiation/short settlement of the claim**	**Not applicable**
6.	**Reason for repudiation/short settlement**	**Not applicable**
7.	**Date of receipt of the complaint**	**28/12/2020**
8.	**Nature of complaint**	**Policy declared invalid mid-term**
9.	**Date of receipt of consent** **(Annexure VIA)**	**27/01/2021**
10.	**Amount of claim**	**Not applicable**
11.	**Amount of monetary loss** **(as per Annexure VIA)**	**Unqualified**
12.	**Amount paid by the insurer if any**	**Not applicable**
13.	**Amount of relief sought** **(as per Annexure VIA)**	**INR 3,00,000**
14.a.	**Date of request for Self-contained Note (SCN)**	**07/01/2021**
14.b.	**Date of receipt of SCN**	**04/03/2021**
15.	**Complaint registered under**	**Rule 13(1)(f) of the Insurance Ombudsman Rules, 2017**

16.	**Date of hearing/place**	**By Video Conferencing (VC) on 16/04/2021**
17.	**Representation at the hearing**	
	u) For the Complainant	**Ms J Soniya (Niece)**
	v) For the insurer	**Ms Sheetal Patwa**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22/04/2021**

20. Brief Facts of the Case:

- The complainant who was covered under the respondent insurer (RI)'s *Heartbeat Gold* policy for the period from 02/02/2020 to 01/02/2021 for a SI of INR 5,00,000 visited an eye hospital in August 2020 for a check-up and was advised an operation in the eye. When the details of the insurance policy were provided to the hospital to avail the *cashless* facility for the operation, the hospital informed her that the policy is not valid.
- Thereafter, the complainant made several calls to the RI to ascertain the status of the policy but they did not respond. She also sent legal notices to the RI through her advocate and still did not receive any response. Hence, she has approached this Forum for relief.

21) **a) Complainant's submission:**

The Complainant stated as under in her complaint.

- ❖ She availed the RI's *Heartbeat Gold* policy on 02/02/2016 and has been continuously renewing it since then. The current policy is from 02/02/2020 to 01/02/2021 and the premium of INR 31,046 was debited from her bank account on 25/01/2020.

- ❖ In August 2020, when she approached the DRR Eye Care Oculoplasty Hospital to avail of the *cashless* facility to undergo eye surgery, she was informed that the policy is not valid.

- ❖ Thereafter, several calls were made to the RI and even legal notice was served on them, but the complainant's grievance remained unresolved. Hence the Forum's intervention is requested for resolving the same.

b) Insurer's contention:

The following averments were made in the SCN submitted by the RI.

- ❖ The complainant had made an online payment of renewal premium on 27/01/2020. However, the amount had been refunded to the source (*sic*) as per the *chargeback* request received from the insured's bank which is detailed below.

14-02-2020 17:56	14-02-2020	ERC227856C- CHARGEBACKDT12/02-7602316125	DIRECT BANKING- OPERATIONS MUMBAI-FC	31,046.00

- Subsequently, the renewal premium was received in the month of October 2020 through a third party NEFT as detailed below.

Pivotal ID	Insured Name	Bl Type	Bl Ref	BI Amt	BI Status	Contract No.	Upload Date	BI Realization Date
200016771	GNANASEKAR S	Internet Payment	NEFT	31046	PUSH	31415317	21-10-20	21-10-20

- Since renewal premium is not accepted after more than 90 days of the renewal date, it was refunded back to the source.
- The RI as a goodwill gesture had proposed settlement of the dispute by the reinstatement of the policy with continuity benefits and sought the complainant's consent vide e-mail dated 25/02/2021. However, the complainant, for reasons best known to her, has not provided consent for the same.
- It is, therefore, most respectfully prayed that given the facts and circumstances of the case, the complaint made by the complainant being devoid of any merits, be dismissed, in the interest of equity and justice.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (f) of the Insurance Ombudsman Rules, 2017, which deals with "*policy servicing related grievances against insurers and their agents and intermediaries".*

23. Documents placed before the Forum:

- ✓ Complaint dated 24/12/2020 to the Insurance Ombudsman
- ✓ Complainant's representation dated 19/10/2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Self-contained Note (SCN) of the RI
- ✓ Copy of *Heartbeat Gold* Certificate
- ✓ Copy of the complainant's bank account statement
- ✓ RI's e-mail dated 25/02/2021 to the complainant

24. Result of hearing (Observations & Conclusion):

52. Given the prevailing COVID 19 pandemic situation, the hearing was conducted through VC on 16/04/2021, with the consent and participation of both the complainant and the RI.

53. The Forum expresses its displeasure over the failure of the RI to respond to the grievance representations submitted by the complainant which is in breach of the guidelines issued by the Insurance Regulatory & Development Authority of India (IRDAI) for redressal of customer grievances by insurance companies. The RI must strengthen its customer grievance redressal mechanism and avoid such lapses in future.

54. The subject matter of the dispute is the RI's cancellation of the complainant's policy without even informing her of the reasons for the same.

55. The subject policy for the period from 02/02/2020 to 01/02/2021 was issued on 28/01/2020 and the premium of INR 31,046 for the same was debited from the complainant's bank account on 25/01/2020 as evidenced by the account statement submitted by her. During the hearing, there was no proper explanation from the representative of the RI of the circumstances under which the *chargeback* of the premium occurred and the amount was credited back to the complainant's bank account on 06/03/2020. The RI failed to inform the complainant about the *chargeback* and the consequent cancellation of the policy, which is a serious deficiency of service. The RI compounded the problem, by refunding the premium once again remitted by the complainant on 21/10/2020 at the behest of their *Customer Care* Department. The handling of the matter by the RI thus left a lot to be desired and the Forum places on record its strong disapproval of the same.

56. Nevertheless, as the RI has now offered to restore the policy with continuity benefits on receiving the premium from the complainant, there is no further relief to be granted by the Forum. The compensation demanded by the complainant is beyond its jurisdiction.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both parties, the respondent insurer is directed to reinstate the policy with continuity benefits, on payment of premium by the complainant.

Thus, the complaint is **allowed.**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

bb) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

cc) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on the 22nd day of April 2021.

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF TAMILNADU & PUDUCHERRY

(UNDER RULE NO: 17(1) OF THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – SHRI M VASANTHA KRISHNA

Case of Mr K Sundar Vs National Insurance Company Ltd

COMPLAINT REF: NO: CHN-H-048-2021-0481

Award No: IO/CHN/A/HI/0030/2021-2022

1.	**Name & Address of the Complainant**	**Mr K Sundar** **12/8, 2nd Street, Padmanabhanagar, Adyar, Chennai 600020**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured (SI)/ Cumulative Bonus(CB)**	**500401/50/19/10/001826** ***National Mediclaim* Policy** **12/01/2020-11/01/2021** **INR 5,00,000/ INR 45,000**
3.	**Name of the insured** **Name of the policyholder/proposer**	**Mr S Siddarth** **Mr K Sundar**
4.	**Name of the insurer**	**National Insurance Company Ltd**
5.	**Date of partial settlement of the claim**	**30/07/2020**
6.	**Reason for partial settlement**	**Settled as per PPN tariff**
7.	**Date of receipt of the complaint**	**11/01/2021**
8.	**Nature of complaint**	**Short settlement of the claim**
9.	**Date of receipt of consent** **(Annexure VIA)**	**20/01/2021**
10.	**Amount of claim**	**INR 1,30,415**
11.	**Amount of monetary loss** **(as per Annexure VIA)**	**Not furnished**
12.	**Amount paid by the insurer if any**	**INR 88,500**
13.	**Amount of relief sought** **(as per Annexure VIA)**	**INR 42,465**
14.a.	**Date of request for Self-contained Note (SCN)**	**11/01/2021**
14.b.	**Date of receipt of SCN**	**Not submitted**
15.	**Complaint registered under**	**Rule 13(1)(b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of hearing/place**	**By Video Conferencing (VC) on 09/03/2021**
17.	**Representation at the hearing**	
	w) For the Complainant	**Mr K Sundar**

	x) For the insurer	**Absent**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22/04/2021**

20. Brief Facts of the Case:

- The Complainant's son who is covered under the respondent insurer (RI)'s *National Mediclaim* Policy for the period from 12/01/2020 to 11/01/2021 for the SI of INR 5,00,000 with a CB of INR 45.000 was admitted in SRM Institutes for Medical Science (SIMS), Chennai on 29/07/2020 and underwent Diagnostic Arthroscopy, TFCC debridement, Synovectomy and 1st CMC Joint Instillation for treatment of right wrist instability, TFCC tear and Radiocarpal Synovitis.
- The *cashless* request of INR 1,15,175 raised by the hospital for the above treatment was approved by the RI's Third- Party Administrator (TPA) for INR 85,000.
- According to the complainant, the cost of Radio Frequency Wand Short Bewel 35 of INR 28,225 was denied and the pre and post-hospitalization charges of 15,240 were settled by the RI for only INR 3500.
- Aggrieved by the short settlement of the claim, the complainant represented to the RI, who explained that the claim was settled for the agreed PPN tariff of INR 70,000 for the procedure undergone. Besides, wound treatment charges of INR 15,000 were paid as also COVID test charge of INR 3,500.
- Since the complainant is not satisfied with the explanation of the RI, he has approached this Forum for relief.

21. a) Complainant's submission:

❖ As against the amount of INR 1,32,014 claimed by the hospital for the wrist arthroscopy his son underwent, the TPA of the RI had sanctioned only INR 85,000.

❖ Radio Frequency Wand Short Bewel 35 costing INR 28,225 was disallowed by the RI though the complainant has submitted a certificate dated 05/08/2020 from Dr Clement Joseph, the treating doctor who confirmed that the said device is mandatory for surgery as it is specially made for small joints and to smoothen and shape the torn cartilage.

❖ Besides, the RI disallowed the following items

Item	Date	Amount (INR)
MRI	31/05/2020	4,000
X Ray	02/06/2020	2,200
COVID Screening (second)	29/07/2020	3,500
Consultation	29/05/2020	500
Pharmacy	Post Hospitalization	1,056
Dressing	Post Hospitalization	484
Total		**11,740**

Although certain items stated above do not fall within 30 days period prior to the hospitalization, considering the fact that the treatment was postponed due to the Covid 19 pandemic, the Forum is requested to take a lenient view and sanction the disallowed amount.

b) Insurer's contention:

- ❖ No SCN is submitted by the RI. In their reply to the representation of the complainant, they stated that the PPN tariff for the procedure undergone at SIMS Hospital is INR 70,000 and adding INR 15,000 towards wound treatment, the claim was approved for INR 85,000. As per clause no. 3.23 of the policy, reimbursement of expenses incurred in PPN hospitals for the procedures (as listed in the PPN tariff) shall be subject to the PPN tariff. The RI claimed that they also paid INR 3,500 towards the COVID test.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule13 (1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the life insurer, General insurer or the health insurer".*

23. Documents placed before the Forum:

- ✓ Written Complaint dated 04/01/2021 to the Insurance Ombudsman
- ✓ *Cashless* authorization letter dated 30/07/2020
- ✓ Complainant's representation dated 30/10/2020 to the RI
- ✓ RI's reply dated 24/12/2020 to the complainant
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Copy of *National Mediclaim* Policy with terms & conditions
- ✓ Discharge summary and bills of SIMS, Chennai.
- ✓ Treating doctor's certificate dated 05/08/2020

24. Result of hearing (Observations & Conclusion):

57. Given the current COVID 19 pandemic situation, the hearing was conducted through VC on 09/03/2021, with the consent and participation of both the complainant and the RI.

58. The Forum expresses its displeasure over the non-submission of the SCN by the RI besides their non-participation in the hearing, despite advance notice.

59. The subject matter of the complaint is the short settlement of the complainant's claim, on the basis of the PPN tariff.

60. While the RI claimed that reimbursement claims for treatment at PPN hospitals will be subject to the PPN tariff and cited clause no. 3.23 of the policy, it is incumbent upon them to ensure that the PPN hospitals honour the PPN agreements & tariffs and do not overcharge the policyholders. The policyholders cannot be penalized for the failure on the part of RI in enforcing the PPN agreement. While clause 3.23 refers to reimbursement claims, the instant case is one of *cashless settlement* and the TPA of the RI would have been aware from the estimate provided by the hospital for the *cashless* authorization that the latter were

breaching the PPN tariff. Yet, it appears, no pro-active steps were taken by the TPA to stop the hospital from doing so.

61. Therefore, the Forum directs the RI to reprocess the claim of the complainant on *open billing* basis and pay the balance amount due to him. As regards the cost of Radio Frequency Wand Short Bewel 35, the same should be reimbursed in view of the certificate given by the treating doctor. However, the RI is not bound to pay the pre-hospitalisation expenses not falling within the period of 30 days prior to admission. No such relaxation is available in the policy nor has been permitted by the Insurance Regulator due to the pandemic.

62. The RI paid for one of the two screenings for Covid 19 undergone by the insured which is reasonable. They need not reimburse the cost of the second screening which was done within 3 days from the first screening.

63. The reasons for disallowing post-hospitalisation expenses towards pharmacy (INR 1,056) are not known. The RI should pay the amount unless it consists of non-medical/non-payable items or is incurred beyond the post-hospitalisation period. The dressing charges disallowed (INR 484) consists of Tegaderm (INR 234) and dressing charges of INR 250. While, cost of Tegaderm is not payable, the dressing charges are admissible and the RI may process the claim accordingly

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, Forum directs the respondent insurer to reprocess the claim as per directions given *supra* and pay the balance amount due to the complainant together with interest as prescribed under Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed.**

25. The attention of the insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

dd) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

ee) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

ff) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)
INSURANCE OMBUDSMAN
FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
Ombudsman – Shri M Vasantha Krishna
Case of Mr Samraj Manes NapoleanVs United India Insurance Company Limited
COMPLAINT REF: NO: CHN-H-051-2021-0488
Award No: IO/CHN/A/HI/0031/2021-2022

1.	**Name & Address of the Complainant**	**Mr. Samraj Manes Napolean S** **Old No.9, New No. 15,Leela Nagar, East Tambaram,Chennai – 600 059.**
2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**0112002819P109997918** ***Family Medicare Policy 2014*** **28.10.2019 to 27.10.2020** **INR 2 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mrs PearlynChellabai** **Mr. Samraj Manes Napolean**
4.	**Name of the Insurer**	**United India Insurance Company Limited**
5.	**Date of partial settlement**	**17.09.2020**
6.	**Reason for partial settlement**	**Claim settled as per General Insurance (GI) Council Guidelines**
7.	**Date of receipt of the Complaint**	**07.01.2021**
8.	**Nature of Complaint**	**Short settlement of the claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**22.01.2021**
10.	**Amount of Claim**	**INR 1,22,487 (INR 1,13,987 Hospitalisation + INR 8,500 Pre-Hospitalisation)**
11.	**Amount paid by the insurer, if any**	**INR 52,000**
12.	**Amount of monetary loss (as per Annexure VI A)**	**INR 70,487**
13.	**Amount of relief sought (as per Annexure VI A)**	**INR 70,487**
14. a.	**Date of request for Self-contained Note (SCN)**	**12.01.2021**
14. b.	**Date of receipt of SCN**	**09.04.2021**

15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 09.04.2021**
17.	**Representation at the hearing**	
	e) For the Complainant	**Mr. Samraj Manes Napolean**
	f) For the Insurer	**MsAnitha / Mr Parthasarathy (TPA)**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Complaint:

The complainant has taken the *Family Medicare Policy 2014* issued by the respondent insurer (RI) covering himself, his spouse and his two sons for a floater Sum Insured (SI) of INR 2 lakhs. He is a policyholder of the RI since September 2004.

As per the Discharge Summary of Annai Arul Hospital, Chennai, the complainant's wife Mrs PearlynChellabai was admitted to the hospital on 29.08.2020 with the chief complaint of fever associated with cough and breathing difficulty. She was diagnosed as a case ofCovid 19 – Post-Infective Sequalae, Systemic Hypertension and was discharged on 02.09.2020 after treatment.

The RI settled the claim of INR 1,22,487 for her treatment partially for INR 52,000. He, therefore, represented to the Grievance Department of the RI for the payment of the balance amount INR 70,487. Since there is no response from the RI, the complainant has approached this Forum for relief.

21. Insurer's Submission:

The RI submitted their SCN dated 09.04.2021 and have made the following averments therein.

- The claim preferred for COVID 19 treatment was initially settled as per General Insurance (GI) Council Guidelines.
- The insured/complainant hasrepresented for payment of the balance amount.
- Therefore, the Third-party Administrator (TPA) has been advised to process the claim as per the terms and conditions of the policy and a further amount of INR 1,606 is being settled.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No.13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer".*

23. Documents placed before the Forum:

- ✓ Complaint dated 07.01.2021 to the Insurance Ombudsman

- ✓ Claim settlement letter of the TPA dated 17.09.2020
- ✓ Complainant's representation dated 28.09.2020 & 22.10.2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Self-contained Note (SCN) of the RI dated 09.04.2021
- ✓ Policy copy, terms and conditions
- ✓ Discharge summary/Bills of Annai Arul Hospital, Chennai
- ✓ Complainant's correspondence with the RI and the TPA
- ✓ Mail dated 10.04.2021 from the Insurer/TPA with the revised calculation of the claim

24. Result of hearing with both parties (Observations & Conclusion)

- ➢ Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 09.04.2021, with the consent and participation of both the complainant and the RI. Mr Samraj Manes Napolean, the complainant, Ms AnithaAlwarswamy, RI's representative and Mr Parthasarathy, representative of the TPA attended the hearing.
- ➢ There is a delay of three months in the submission of the SCN by the RI. The Forum takes a serious view of the same and expects RI's strict adherence to the timelines for submission in future.
- ➢ Similarly, the lack of response to the representations made by the complainant is a matter of concern. It is hoped that the RI will strengthen its customer grievance redressal mechanism and avoid such lapses in future.
- ➢ During the hearing, the complainant submitted that his wife tested positive for COVID 19 and was hospitalized and treated atAnnai Arul Hospital. His claim of INR 1,22,487 (inclusive of pre-hospitalisation expenses) was settled for only INR 52,000.
- ➢ The RI stated that the claim was settled as per GI Council guidelines in terms of which only INR 52,000 is payable. However, they expressed their readiness to settle the claim as per the terms & conditions of the policy and pay the balance amount due to the complainant. According to them, an additional amount of INR 1,606 was payable.
- ➢ The Forum directed the RI/TPA to process the claim on *open billing* basis subject to policy terms and conditions and to submit the calculations. They complied with the direction of the Forum vide their mail dated 10.04.2021 and submitted the revised calculation which is as below:

S. No.	Sub Group	Claimed(INR)	Disallowed (INR)	Approved (INR)	Remarks
1	CONSULTATIONS (IP)	6,000	4,261	1,739	Pro-rata deductions applied
2	LABS/BIO/MICRO/ PATHOLOGY	120	86	34	Pro-rata deductions applied

3	NURSING CHARGES	6,000	6,000	0	Pro-rata deductions applied
4	CONSULTATIONS (IP)	5,600	4,244	1,356	INR 1,600 DMO
5	LABS/BIO/MICRO/ PATHOLOGY	9,535	6,772	2,763	Pro-rata deductions applied
6	MEDICAL EQUIPMENTS	4,000	4,000	0	Monitor – not payable
7	CARDIOLOGY	250	178	72	Pro-rata deductions applied
8	PROCEDURAL CHARGES	1,250	1,250	0	Bio-medical waste charges - not payable
9	PHARMACY	61,547	24,195	37,352	NMI INR 7,395, PPE INR 1,300/day paid
10	OTHERS	20,000	12,000	8,000	Eligible INR 2,000/day, 4 Days Opted INR 6,900/day
11	FILE/ADMISSION/ REGISTRATION	500	500	0	Documentation Charges - Not payable
12	FOOD AND BEVERAGES	3,185	3,185	0	Diet Charges - Not Payable
13	LABS/BIO/MICRO/ PATHOLOGY	5,000	3,696	1,304	Pro-rata deductions applied; PPE INR 500 – Not payable
14	LABS/BIO/MICRO/ PATHOLOGY	1,500	1,065	435	Pro-rata deductions applied
15	LABS/BIO/MICRO/ PATHOLOGY	1,500	1,065	435	Pro-rata deductions applied
16	CONSULTATIONS	500	384	116	Registration INR 100 – Not payable; Pro-rata deductions applied
	TOTAL	**1,26,487**	**72,881**	**53,606**	

- It is observed that the revised calculation has been made by the RI subject to proportionate deductions since the room charges and associated expenses exceeded the eligibility (INR 2,000 per day @ 1% of the SI. On examining the relevant policy clause (Note 1 under Clause 1.2), the Forum is of the considered view that the wording employed therein does not entitle the RI to make proportionate deductions from the expenditure incurred under items 1.2 C and D, in the manner made by them. The

clause refers to the payment of expenses under items 1.2 C and D limited to the **charges applicable to the entitled room category**. However, the applicable charges have not been specified in the Policy.

- In the opinion of the Forum, the amount payable in settlement of the claim is as below.

S.No	Description	Claimed (INR)	Disallowed (INR)	Payable (INR)	Remarks
1	Professional Fees - Dr. Varun & Critical Care Consultant Charges	10,000	0	10,000	To be paid in full
2	Procedure Charges	120	0	120	To be paid in full
3	Nursing Charges/DMO/ Inpatient Service (Covid Non-critical care)/Diet Charges/Bio-medical Waste Management charges	32,035	24,035	8,000	Allowed @ 1% of the SI per day for 4 days as per Clause 1.2 A
4	Laboratory Investigations	9,535	0	9,535	To be paid in full
5	Monitor Charges - Equipment	4,000	4,000	0	Not payable
6	ECG	250	0	250	To be paid in full
7	Drugs & Disposables	61,547	17,395	44,152	Deduction for non-medical items INR 7,395; PPE kits allowed @ INR 3,000 per day for 4 days*
8	Document Charges	500	500	0	Document charges not payable
9	COVID - 19 IgG/IgM Antibody	1,500	0	1,500	Pre-Hospitalisation expenses - To be paid in full
10	COVID Test	1,500	0	1,500	Pre-Hospitalisation expenses - To be paid in full
11	Dr. Varun - Consultation fees	400	0	400	Pre-Hospitalisation expenses - To be paid in full
12	Registration fees	100	100	0	Not payable

13	CT Chest Plain – Investigation	4,500	0	4,500	To be paid in full
16	PPE & Consumable charges	500	0	500	To be paid in full
	Total	1,26,487	46,030	80,457	
	Less: Hospital Discount			4,000	
				76,457	
	Less: Amount already settled			52000	
	Amount now payable			**24,457**	

*As per Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) of the Government of Tamil Nadu taken as the benchmark.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum hereby directs the respondent insurer to pay the complainant an additional sum of INR 24,457 in full and final settlement of the claim along with interest as provided under Rule 17(7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed**.

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25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

c) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mr Mangilal B Jain Vs United India Insurance Company Limited
COMPLAINT REF: NO: CHN-H-051-2021-0480
Award No: IO/CHN/A/HI/0032/2021-2022

1.	**Name & Address of the Complainant**	**Mr Mangilal B Jain,** **New No.23, Old No.11, First Floor,** **Vadamalai Street, Sowcarpet,** **Chennai – 600 001.**
2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**0129002819P116679523** ***Individual Health Insurance Policy – Gold Plan*** **26.03.2020 to 25.03.2021** **INR 4.25 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mr Mangilal B Jain** **Mrs Bhagvanti**
4.	**Name of the Insurer**	**United India Insurance Company Limited**
5.	**Date of the partial settlement of the claim**	**25.07.2020**
6.	**Reason for partial settlement**	**Due to the application of the *Proportionate Payment Clause* and deduction of non-payable/non-medical items**
7.	**Date of receipt of the Complaint**	**16.12.2020**

8.	**Nature of Complaint**	**Short settlement of the claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**29.01.2021**
10.	**Amount of Claim**	**INR 2,00,596**
11.	**Amount paid by the Insurer, if any**	**INR 70,000**
12.	**Amount of monetary loss (as per Annexure VI A)**	**INR 1,50,111**
13.	**Amount of relief sought (as per Annexure VI A)**	**INR 1,50,111**
14. a.	**Date of request for Self-contained Note (SCN)**	**08.01.2021**
14. b.	**Date of receipt of SCN**	**20.04.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 19.03.2021**
17.	**Representation at the hearing**	
	a) For the Complainant	**Mr Mangilal B Jain**
	b) For the Insurer	**Mr V Mohan Kumar / Dr Sangeeth Raj**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Case:

The complainant's wife has taken the *Individual Health Insurance* Policy of the respondent insurer (RI) covering herself and the complainant for a Sum Insured (SI) of INR 4.25 lakhs each. She is a policyholder of the RI since March 2009.

As per the Discharge Summary of Chennai National Hospital, Chennai, the complainant was admitted to the hospital on 18.07.2020 as confirmed by Government Stanley Hospital. He was diagnosed with Covid 19 Infection, Pneumonia, old CVA and was discharged on 25.07.2020 after treatment.

The RI initially settled his claim of INR 2,17,325 for INR 70,000 and later a further sum of INR 44,001 was also paid. The deductions made from the claim were on account of the limit on room rent, application of the *Proportionate Payment Clause* and non-payable/non-medical items. The complainant represented to the Grievance Department of the RI for the payment of the balance amount INR 1,03,324. However, he did not receive any response from the RI and hence has approached this Forum for relief.

21 (a) Complainant's Submission:

- ❖ The complainant submits that he was affected by COVID 19 Pneumonia and was treated in Chennai National Hospital for a period of 7 days.

- ❖ The hospital charged him an amount of INR 2,20,111 but the Third-party Administrator (TPA) of the RI approved only INR 70,000.

- ❖ His attempt to raise a complaint with the TPA over the phone was in vain since none of the official numbers worked/responded. His correspondence with them via mail also did not yield any result. He managed to settle the hospital bill by borrowing money.
- ❖ He is seeking the Forum's intervention for the full settlement of his claim.

21 (b) Insurer's Submission:

The RI submitted their SCN dated 20.04.2021 and have made the following averments therein.

- ✧ Shri Mangilal B Jain, aged 59 Yrs, is covered under Individual Health Policy bearing no.0129002819P116679523 for the period 26.3.20 to 25.3.2021 for a SI of INR 4,25,000.

- ✧ Following complaints of high fever with cough, generalized weakness, the Covid-19 test was done outside and he was found positive.

- ✧ He was admitted to Chennai National Hospital on 18.7.2020 at 5.55 PM and discharged on 25.7.2020 at 5.05 PM.

- ✧ An amount of INR 2,00,596 was billed by the Hospital for his treatment, of which an amount of INR 1,13,174 has been settled by the TPA of the RI

- ✧ An amount of INR 87,422was disallowed as the same was found to be charged in excess by the Hospital for items that are already part of the Package charges.

- ✧ Given the above, the RI has appealed to the Forum to dismiss the complaint.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No.13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer".*

23. Documents placed before the Forum:

- ✓ Complaint dated 16.12.2020 to the Insurance Ombudsman
- ✓ Claim settlement letter of the RI dated 25.07.2020
- ✓ Complainant's representations dated 30.07.2020 and 21.09.2020 to the RI
- ✓ Consent (Annexure VI A) submitted by the complainant
- ✓ Self-contained Note (SCN) of the RI dated 20.04.2021
- ✓ Policy copy, terms and conditions
- ✓ Discharge summary/Bills of Chennai National Hospital
- ✓ Correspondence of the complainant with the RI and the TPA

- ✓ Settlement details submitted by the TPA

24. Result of hearing (Observations & Conclusion)

- Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 19.03.2021, with the consent and participation of both the complainant and the RI. Mr Mangilal B Jain, the complainant, Mr V Mohan Kumar, RI's representative and Dr Sangeeth Raj, representative of the TPA attended the hearing.
- The Forum records its displeasure over the delay of 3 months in the submission of the SCN despite continuous follow-up. The Forum expects RI's strict adherence to the timelines for submission in future.
- The Forum also expresses its disapproval over the failure of the RI to respond to the grievance representations submitted by the complainant which is in breach of the guidelines issued by the Insurance Regulatory &Development Authority of India (IRDAI) for redressal of customer grievances by insurance companies. The RI must strengthen its customer grievance redressal mechanism and avoid such lapses in future.
- During the hearing, the complainant submitted that the TPA initially assured that the claim will be settled but at the time of discharge, they stated that only INR 70,000 is payable. Therefore, he had to borrow from his friends and relatives to pay the balance amount to the hospital.
- The RI submitted that the complainant's SI is only INR 4.25 lakhs whereas he had occupied a room with a rent of INR 9,500 (including nursing charges and diet). Initially, the claim was settled for INR 70,000 based on the General Insurance (GI) Guidelines. Later, the claim was reprocessed subject to the terms & conditions of the policy including the *proportionate payment clause* and a further sum of INR 44,001 was paid.
- The Forum advised the RI to submit the calculation of the claim on *open billing* basis, based on which the further payment of INR 44,001 was made by them. They complied with the directive of the Forum post-hearing.
- The in-patient (IP) bill of the hospital is only for INR 2,00,596 and the complainant had submitted bills for a further sum of INR 16,729. However, the amount of these separate pharmacy bills submitted by him are already included in the IP bill with the same specification. Hence the complainant's claim for INR 16,729 is not entertainable.
- In the opinion of the Forum, the amount payable in settlement of the claim shall be as follows:

Item	Amount claimed (INR)	Deduction (INR)	Amount allowed (INR)	Remarks
Room rent, nursing and diet	66,500	36,750	29,750	Allowed @ INR 4,250 per day for 7 days
Investigations & X-ray	15,800	8,690	7,110	Deducted 55% as per Proportionate

				Payment Clause
Oxygen	16,800	9,240	7,560	Proportionate deduction
Pharmacy	73,796	5,878	67,918	Non-payable items
Consultation	21,000	11,550	9,450	Proportionate deduction
CT Scan	6,700	3,685	3,015	Proportionate deduction
Total	**2,00,596**	**75,793**	**1,24,803**	

Notes:

a) The complainant is eligible for a room rent (including nursing charges and diet charges) of INR 4,250 per day @ 1% of the SI of INR 4,25,000 as per the *proportionate payment clause* thereof. Hence, reimbursement of room rent and the associated charges is to be restricted accordingly.

b) The *proportionate payment clause* also provides that in case the actual room rent (including nursing and diet charges) exceeds the eligible room rent, all other expenses (except medicines), shall be paid in the same proportion. Since eligible room rent is 45% of the actuals, the remaining expenses (other than medicines) are to be paid to the extent of 45%.

c) The RI disallowed the expenditure on PPE kits amounting to INR 11,400. In the considered view of the Forum, a reasonable amount should be paid under this head for all Covid 19 related claims. As per guidelines issued by the Tamil Nadu Government for settlement of Covid 19 claims under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS), an amount of INR 3,020 is allowed per day towards PPE kits for mild cases. The expenditure incurred in the present case is well within this amount. Hence, the Forum is inclined to allow the same in full.

- Since the RI has already paid an amount of INR 114,001 in settlement of the claim, they are directed to pay the remaining amount of INR 10,802 to the complainant.

AWARD

Taking into account the facts and circumstances of the case and the submissions made by the parties, the Forum hereby directs the respondent insurer to pay an additional amount of INR 10,802 to the complainant in full and final settlement of his claim along with interest as per Rule 17(7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed.**

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

c) According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mrs S Swarnambal Vs National Insurance Company Limited
COMPLAINT REF: NO: CHN-H-048-2021-0525
Award No: IO/CHN/A/HI/0033/2021-2022

1.	**Name & Address of the Complainant**	**Mrs S Swarnambal,** **4D, Block 2, Asvini Amrisa,** **Kalasathamman Koil Street,** **Ramapuram, Chennai – 600 089.**
2.	**Policy No, Type of Policy, Duration of Policy/Policy Period and Sum Insured (SI)**	
	501700502010000005/ 501700502010000006 ***National Mediclaim / National Parivar Mediclaim*** **08.04.2020 to 07.04.2021/ 08.04.2020 to 07.04.2021** **INR 3.75 lakhs plus Cumulative Bonus (CB) INR 63,750 / Floater SI of INR 5 lakhs**	
3.	**Name of the insured** **Name of the Policyholder/Proposer**	**Master Surya** **Mr S Shankar**

4.	**Name of the Insurer**	**National Insurance Company Limited**
5.	**Date of repudiation of the claim**	**22.12.2020**
6.	**Reason for repudiation**	**Domiciliary treatment excluded in the policy**
7.	**Date of receipt of the Complaint**	**25.01.2021**
8.	**Nature of Complaint**	**Repudiation of the claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**25.01.2021**
10.	**Amount of Claim**	**INR 26,000 per month**
11.	**Amount paid by the insurer, if any**	**NIL**
12.	**Amount of monetary loss (as per Annexure VI A)**	**INR 26,000 per month**
13.	**Amount of relief sought (as per Annexure VI A)**	**INR 26,000 per month**
14. a.	**Date of request for Self-contained Note (SCN)**	**25.01.2021**
14. b.	**Date of receipt of SCN**	**16.02.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 16.04.2021**
17.	**Representation at the hearing**	
	➢ **For the Complainant**	**Mrs Swarnambal & Mr S Shankar (Policyholder)**
	➢ **For the Insurer**	**Ms Babitha Raj**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Case:

The complainant and her family comprising of her husband and two sons are covered under the *National Parivar Mediclaim* Policy issued by the respondent insurer (RI) for a floating Sum Insured (SI) of INR 5 lakhs. Their coverage incepted initially under the *Hospitalisation Benefit* Policy for the period 08.04.2010 to 07.04.2011 and later they migrated to *National Parivar Mediclaim* Policy and hence the policy is live since April 2010. They are also covered under the *National Mediclaim* Policy since April 2015.

The complainant's son is suffering from Nephrotic Syndrome from the age of 2 ½ years. In the year 2018, he underwent a Fistula operation twice for the purpose of haemodialysis which was a failure since there was protein leakage. Therefore, he has been regularly undergoing Peritoneal Dialysis since October 2018.

Her claim of INR 32,322 for Peritoneal Dialysis undertaken by her son in October 2020 was rejected by the RI vide their letter dated 22.12.2020. The repudiation is under clauses 4.18, 3.24 and 3.25 of the *National Mediclaim* Policy and clauses 3.21, 1.2.2 and 1.2.3 of the *National Parivar Mediclaim* Policy. She represented to the RI vide her letter dated 10.12.2020 to reconsider their decision but the RI reiterated their earlier stand of repudiation. Aggrieved, the complainant has approached this Forum for relief.

21 (a) Complainant's Submission:

- ✓ The complainant submits that she incurs an amount of INR 26,000 every month towards peritoneal dialysis of her son which is unaffordable.

- ✓ She has cited the circular issued by the Insurance Regulatory & Development Authority of India (IRDAI) whereby the treatment of peritoneal dialysis is covered from October 2020. In addition, since the policy is live from 2010 she is of the view that the *moratorium* period is completed thereunder and the claim should be settled.

- ✓ She also submits that based on the above, the expenditure incurred on the said treatment in October 2020 and thereafter may be considered by the RI for reimbursement.

21 (b) Insurer's Submission:

The RI submitted their SCN dated 12.02.2021 and have made the following averments therein.

- ➢ The policyholder and his family members are covered under the subject policies since 2010 without any break.

- ➢ Master S Surya, one of the insured persons is undertaking peritoneal dialysis on a regular basis and the complainant has submitted the bills for the period 03.10.2020 to 30.10.2020 for settlement. Since no Discharge Summary and hospital bills are submitted, the RI assume that the treatment was taken as out-patient.

- ➢ As per the policy terms and conditions, out-patient treatment is excluded from the policy and the submitted medical bills do not pertain to pre/post-hospitalization expenses within 30/60 days from the last hospitalization of the insured person which was from 05.12.2019 to 09.12.2019. Hence, the claim stands repudiated.

- ➢ The complainant has cited the new Health Guidelines of IRDAI wherein treatment of peritoneal dialysis is included w.e.f. October 2020. However, the subject policies were issued prior to October 2020 under which there is no provision to settle such claims.

- ➢ The complainant's request for application of the *moratorium* period is also not feasible since the same is not applicable for erstwhile policies (*sic*).

- ➢ The exclusion and coverage clauses of both the policies are as under:

Exclusion No.	National Mediclaim Policy	Exclusion No.	National Parivar Mediclaim
4.18	Out Patient Department treatment (OPD treatment)	3.8	Outpatient treatment means treatment which the insured person visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner and the insured person is not admitted as a day care patient or in-patient
3.24	Pre hospitalisation means medical expenses incurred 30 days immediately before the insured person is hospitalised, provided that: i. Such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the insurance company Pre hospitalisation will be considered as part of hospitalisation claim	1.2.2	Pre-hospitalisation - The Company shall reimburse the insured the medical expenses incurred up to thirty days immediately before the insured person is hospitalised, provided that: i. Such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the Company Pre-hospitalisation shall be considered as part of the hospitalisation claim
3.25	Post-hospitalisation means medical expenses incurred 60 days immediately after the insured person is discharged from hospital, provided that: i. Such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the insurance company Post-hospitalisation will be considered as part of hospitalisation claim	1.2.3	Post Hospitalisation - The Company shall reimburse the insured the medical expenses incurred up to sixty days immediately after the insured person is discharged from hospital, provided that: 1. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the Company Post hospitalisation shall be considered as part of the hospitalisation claim

- Based on the above, the claim is not admissible and repudiated as per the terms and conditions of the policies concerned.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No.13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer".*

23. Documents placed before the Forum:

1. Complaint dated 25.01.2021 to the Insurance Ombudsman
2. Claim repudiation letter of the RI dated 22.12.2020
3. Complainant's representation dated 10.12.2020 to the RI
4. RI's response dated 11.01.2021 to the complainant
5. Consent (Annexure VI A) submitted by the complainant
6. Self-contained Note (SCN) of the RI dated 12.02.2021
7. Copies of policies with terms and conditions
8. Claim form dated 16.11.2020 and supporting bills
9. Certificates dated 13.10.2018 and 15.01.2021 issued by MIOT Institute of Nephrology

24. Result of hearing (Observations & Conclusion)

- ✧ Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 16.04.2021, with the consent and participation of both the complainant and the RI. Mrs Swarnambal, the complainant, Mr S Shankar, the policyholder and Ms Babitha Raj, RI's representative attended the hearing.
- ✧ During the hearing, the complainant reiterated the submissions made by her in her complaint regarding coverage of peritoneal dialysis from October 2020 and the *moratorium* period introduced under Health Insurance policies.
- ✧ The RI argued that as per IRDAI's new Health Regulations, only Haemodialysis is covered both as domiciliary treatment and when undergone in a hospital as an in-patient. But peritoneal dialysis is not payable. But the argument of the RI is incorrect since IRDAI's Guidelines on Standardisation of Exclusions in Health Insurance Contracts dated 27.12.2019 provide that *insurers should not deny coverage for Oral Chemotherapy where Chemotherapy is allowed and Peritoneal Dialysis where Dialysis is allowed,* ***subject to product design*** (Item no.6 of Chapter VI of the Guidelines). Nevertheless, these guidelines apply to policies issued on or after 01.10.2020, which need to be filed with the IRDAI for approval. It is evident that the guidelines do not apply to the subject policies issued prior to October 2020 under which a claim for Peritoneal Dialysis has been made.
- ✧ It is observed that the complainant's son is under regular treatment for Peritoneal Dialysis since October 2018 and the previous claims too were rejected by the RI on the ground that Peritoneal Dialysis (domiciliary treatment) is not covered under the policy. Her request for the benefit of the *moratorium* has

no merit since the provision applies only under policies issued w.e.f 1st October 2020. In any case, it will not apply to the permanent exclusions under the policy nor to contingencies not covered such as out-patient/domiciliary treatment.

- ✧ For the above reasons, the Forum concludes that the repudiation of the claim by the RI is in order.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties, the Forum is of the view that the repudiation of the claim by the respondent insurer is justified and does not warrant any intervention.

Thus, the complaint is **not allowed.**

25. If the decision of the Forum is not acceptable to the complainant, she is at liberty to approach any other Forum/Court as per laws of the land against the respondent insurer.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF TAMIL NADU & PUDUCHERRY
(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mrs S Latha Lakshmi Vs Max Bupa Health Insurance Company Limited
COMPLAINT REF: NO: CHN-H-031-2021-0478
Award No: IO/CHN/A/HI/0034/2021-2022

1.	**Name & Address of the Complainant**	**Mrs S Latha Lakshmi,** **No. 21 B, Kattabomman 6th Street,** **Kodungaiyur, Chennai – 600 118.**

2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**30235164201906** ***Health Assurance – Criti Care Benefit*** **13.07.2019 to 12.07.2020** **INR 5.25 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mrs S Latha Lakshmi** **Mrs S Latha Lakshmi**
4.	**Name of the Insurer**	**Max Bupa Health Insurance Company Limited**
5.	**Date of repudiation of the claim**	**02.01.2021**
6.	**Reason for repudiation**	**Non-disclosure of material facts**
7.	**Date of receipt of the complaint**	**07.01.2021**
8.	**Nature of complaint**	**Repudiation of claim**
9.	**Date of receipt of Consent (Annexure VI A)**	**19.01.2021**
10.	**Amount of Claim**	**Not furnished**
11.	**Amount paid by the insurer, if any**	**NIL**
12.	**Amount of monetary loss (as per Annexure VI A)**	**Not furnished**
13.	**Amount of relief sought (as per Annexure VI A)**	**INR 5,25,000**
14. a.	**Date of request for Self-contained Note (SCN)**	**08.01.2021**
14. b.	**Date of receipt of SCN**	**22.02.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 09.04.2021**
17.	**Representation at the hearing**	
	➢ **For the Complainant**	**Mrs Latha Lakshmi**
	➢ **For the Insurer**	**Ms Sheetal Patwa**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Case:

The complainant has taken the *Health Assurance (Criti Care Benefit)* Policy issued by the respondent insurer (RI) for a Sum Insured (SI) of INR 5.25 lakhs. The policy is live since 13.07.2013.

As per the Discharge Summary of Dr Rela Institute & Medical Centre (RIMC), she was admitted to the hospital on 01.12.2019 and was diagnosed with NASH related end-stage liver disease, Meld:19, Portal Hypertension with co-morbidities of Diabetes Mellitus (DM), Hypothyroidism and Bronchial Asthma (BA). She underwent liver transplantation on 02.12.2019 and post-surgery care she was discharged on 11.12.2019.

The complainant had a history of hospitalisation as detailed below, prior to her liver transplant at RIMC:

S No	Date of Admission (DOA)	Hospital	Complaints	Medical History	Procedure performed	Final Diagnosis	Date of Discharge (DOD)
1	27.04.2013	BRS Hospital	Severe lower abdominal pain with day 2 of menstruation.	Diabetes under lift style management	IV antibiotics	Menorrhagia with severe Dysmenorrhoea with PID	30.04.2013
			History of profuse bleeding	Hypothyroid	Investigations		
				LSCS	IV Fluids		
2	23.07.2016	BRS Hospital	Profuse bleeding during periods	Type II Diabetes Mellitus (DM) on medication	D & C	Menorrhagia	24.07.2016
				Hypothyroid on treatment		DM Type 2	
				LSCS twice		Hypothyroid	
3	12.01.2017	BRS Hospital	Breathing difficulty of 1-day duration.	DM for 3 years - on treatment	Blood investigation	Hypothyroidism	21.01.2017
			Chest discomfort for 2 days	Bronchial asthma 4-5 years (takes inhalers on/off SOS)	ECG, Chest X-Ray, ECHO	Menopausal Syndrome	
			Vomiting and episodes of cough and cold	Hypothyroidism on treatment	LV Dimension, contractions, systolic and diastolic	DM -Type Ii	
			Headache	DUB - D & C done recently	HRCT Chest	Late-onset Bronchial Asthma, Acute Bronchiolitis	

The complainant submitted a claim for INR 5.25 lakhs for her transplant and the same was rejected by the RI and the grounds of rejection were as under.

"Non-disclosure - As per the submitted documents/investigation done by us, it was found that the insured has history of Bronchial Asthma since 10 years, Thyroid since 15 years and Diabetes since 27/04/2013. It was found that you have not disclosed the same at the time of taking the policy. Hence, as per the policy terms and condition, this falls under non-disclosure. Hence your claim stands repudiated as per T & C clause Def. 10".

Earlier, her admission to RIMC on 27.09.2019 was investigated by Ayu Health Allied Services and they had recommended vide their report dated 30.01.2020 that the claim be denied due to non-disclosure of DM, Asthma

& Thyroid and it was also recommended that the policy be cancelled. Accordingly, the RI served notice of cancellation of the policy vide their letter dated 04.02.2020.

Dr Vaibhav Patil, the treating doctor vide his certificate dated 27.02.2020 has certified that "*the patient was diagnosed to have non-alcoholic steatohepatitis related end-stage liver disease and underwent living donor liver transplantation on 02.12.2019. Her other co-morbidities like diabetes mellitus, hypothyroidism and bronchial asthma are not directly related to her liver disease".*

The complainant represented to the Grievance Cell of the RI by her mail dated 28.02.2020 to reconsider the case and settle her claim. However, the RI maintained their earlier stand of repudiation through their reply mail dated 17.03.2020. Aggrieved, the complainant has approached this Forum for relief.

21 (a) Complainant's Submission:

- ✓ The complainant submits that she had taken a health insurance policy from the RI during July 2013. From 2014, she was taking treatment for DM.
- ✓ At the time of taking the policy, she was taking treatment only for her Thyroid and not for any other problem.
- ✓ In March 2018 her uterus was removed and in April 2019 she fell sick. She underwent liver transplant surgery in December 2019 and her second son was the donor.
- ✓ Her claim was rejected on the ground of non-disclosure of material facts i.e. Bronchial Asthma, DM.
- ✓ She is seeking the Forum's intervention for the settlement of her claim.

21 (b) Insurer's Submission:

The RI submitted their SCN dated 17.02.2021 and have made the following averments therein.

- ✧ The policyholder/complainant, after due deliberation and pondering over the policy, submitted a duly signed proposal form to the insurer. The terms and conditions (T & C) of the policy and her obligations were duly communicated.
- ✧ The complainant has not adhered to the T & C of the policy and has suppressed the material facts about her actual health condition i.e. history of Bronchial Asthma for 10 years, Thyroid since 15 years and Diabetes since 27.04.2013 which was not disclosed at the time of policy inception and as per the policy T & C, this amounts to material non-disclosure. Hence the claim stands repudiated as per T & C - Clause Def. 10, which reads as under.

  Def.10. Disclosure of Information Norm: The policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.
- ✧ The policyholder/complainant after going through the T & C of the policy and with full knowledge thereof renewed her policy bearing no. 30235164201805 by paying the regular annual premium.

- ✧ Based on the declaration made therein *(sic)* the Company had renewed the *Health Assurance – Criti Care* Policy from 13.07.2019 to 12.07.2020 for a SI of INR 5.25 lakhs. The Company had sent a welcome letter to the policyholder which contained a Customer Information sheet, Insurance Certificate, Premium Receipt, T&C of the policy and the Product Benefit table. The policyholder does not dispute the receipt of the aforesaid documents which implies that she was in actual knowledge of the governing T & C of the policy.

- ✧ The policy T & C provide a *free-look period* whereby, if the complainant was dissatisfied with the T & C of the policy, she had the option of cancelling the same within 15 days of receipt thereof. However, no cancellation request was received from her within the *free-look period*.

- ✧ On 21.10.2019, she had filed a claim bearing No. 467491 for the reimbursement of the medical expenses of INR 5.25 lakhs incurred during her hospitalization from 01.12.2019 to 11.12.2019 in RIMC where she was diagnosed with NASH related end-stage liver disease.

- ✧ The RI, to know the veracity of the claim, appointed an investigator to investigate the same. During the investigation, it was found that she had a history of DM, Asthma, Thyroid and other ailments as mentioned in the report which was not disclosed at the time of issuance of the policy.

- ✧ After receipt of the claim documents and the investigation report, the insurer scrutinized the same carefully and repudiated the claim stating that as per the submitted documents and the investigation done, it was found that the complainant had history of Bronchial Asthma for10 years, Thyroid for 15 years and Diabetes since 27.04.2013. Therefore, it was a case of non-disclosure and hence the claim stands denied as per the policy.

- ✧ Further, it is evident from the Discharge Summary dated 27.04.2013, that the complainant was suffering from DM and Hypothyroid before the risk assessment date.

- ✧ Due to the stated non-disclosure, the policy has also been cancelled in accordance with the T & C.

- ✧ The RI concluded that based on the above facts, they have rightly repudiated the claim in accordance with the documents on record and the investigation report. Therefore, the present complaint, being devoid of merits, is liable to be dismissed.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with *"Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer".*

23. Documents placed before the Forum:

- ➢ Complaint to the Insurance Ombudsman
- ➢ Claim repudiation letter of the RI dated 02.01.2020
- ➢ Complainant's representation dated 28.02.2020 to the RI

- Insurer's response dated 17.03.2020 to the complainant
- Consent (Annexure VI A) submitted by the complainant
- Self-contained Note (SCN) of the RI dated 17.02.2021
- Policy copy, terms and conditions
- Copy of proposal form dated 10.07.2013
- Claim form dated 27.09.2019
- Discharge summaries of BRS Hospital
- Discharge summary and indoor case papers (ICP) of RIMC
- Bills of RIMC
- Other correspondence between the complainant and the RI
- Certificate of Dr Vaibhav Patel of RIMC dated 27.02.2020
- Certificate of Dr Dinesh Jothimani of RIMC dated 27.09.2019
- Investigation Report dated 30.01.2020 of Ayu Health Allied Services
- Notice of Cancellation issued by the RI dated 04.02.2020

24. Result of hearing (Observations & Conclusion):

d) Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 09.04.2021, with the consent and participation of both the complainant and the RI. Mrs Latha Lakshmi, the complainant and Ms Sheetal Patwa, RI's representative attended the hearing.

e) There is a delay of one month in the submission of the SCN by the RI. The Forum records its displeasure over the late submission of SCN and advises the RI to be prompt in complying with the Forum's requirements in future.

f) During the hearing, the complainant submitted that she had taken a Health insurance Policy with the RI for a SI of INR 5.25 lakh and she is the policyholder of the RI since 2013. At the time of taking the policy, she did not have any co-morbid issues like diabetes. She was getting treatment only for Thyroid and she had disclosed the same while taking the policy. She also submitted that she came to know of the presence of DM only when she consulted for her liver problem.

g) The RI's representative argued that the complainant was suffering from Bronchial Asthma for 10 years, Thyroid for 15 years and Diabetes since 27.04.2013 and the same was not disclosed at the time of purchasing the policy. She also pointed out that the proposal form confirms the same.

h) The Forum directed the RI to send the proposal form to check the veracity of their submission and they have, vide their mail dated 09.04.2021 forwarded the proposal form.

i) It is observed that the complainant was diagnosed with NASH related end-stage liver disease. As per the discharge summary of BRS Hospital dated 30.04.2013, which was before the inception of the policy, she was diabetic and under lifestyle management. The ICP of RIMC record that she had a history of Bronchial Asthma for 10 years, Thyroid for 15 years and that she is on medication for Diabetes for 4 years. However, on perusal of the proposal form it is observed that the complainant had replied in negative to the following question:

"Have you ever had or been told you have or been treated for any disability of medical conditions such as but not limited to high cholesterol, high blood pressure, chest pain, heart attack or any other heart condition, stroke, transient ischemic attack or any other cerebrovascular disease, diabetes or any other endocrinal disease, kidney disease, HIV/AIDS, or AIDS-related complex, any cancer or tumour, asthma or any other respiratory disease, any mental or nervous disease, hepatitis A/B or any other liver disease, blood disorder, frequent digestive and bowel disorder (approx. twice every week) paraplegia or any other disorder of the bones, spine or muscle?".

10. The Forum notes that the complainant herself admitted that she was suffering from Thyroid at the time of the inception of the policy. However, her assertion that the same was disclosed in the proposal form is incorrect.

11. The certificates issued by the treating doctors of RIMC to the effect that her co-morbidities of Diabetes, Thyroid and Bronchial Asthma are not directly related to liver disease are of no consequence as the claim is rejected on the ground of material non-disclosure.

j) Based on the above, the Forum concludes that the complainant has violated the disclosure norm and the RI has rightly rejected the claim.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties, the Forum is of the view that the repudiation of the claim by the respondent insurer is in order and does not warrant any intervention.

Thus, the complaint is **not allowed**.

25. If the decision of the Forum is not acceptable to the Complainant, she is at liberty to approach any other Forum/Court as per laws of the land against the respondent insurer.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

(UNDER RULE NO: 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri M Vasantha Krishna
Case of Mr S P Baheti Vs National Insurance Company Limited
COMPLAINT REF: NO: CHN-H-048-2021-0463
Award No: IO/CHN/A/HI/0036/2021-2022

1.	**Name & Address of the Complainant**	**Mr S P Baheti,** **No.1, 6th Cross Street,** **Shenoy Nagar, Chennai 60 0030.**
2.	**Policy No.** **Type of Policy** **Duration of Policy/Policy Period** **Sum Insured (SI)**	**500411501910000804** **National Mediclaim Policy** **12.09.2019 to 11.09.2020** **INR 5 lakhs plus Cumulative Bonus (CB) of INR 2.25 lakhs**
3.	**Name of the Insured** **Name of the Policyholder/Proposer**	**Mr S P Baheti** **Mr S P Baheti**
4.	**Name of the Insurer**	**National Insurance Company Limited**
5.	**Date of partial settlement**	**11.02.2020 & 16.03.2020**
6.	**Reason for partial settlement**	**Settled as per Preferred Provider Network (PPN) tariff**
7.	**Date of receipt of the Complaint**	**05.01.2021**
8.	**Nature of the Complaint**	**Short settlement of the claim**
9.	**Date of receipt of consent (Annexure VI A)**	**20.01.2021**
10.	**Amount of Claim**	**INR 2,09,607**
11.	**Amount paid by the insurer, if any**	**INR 1,71,949**
12.	**Amount of Monetary Loss (as per Annexure VI A)**	**INR 37,658**
13.	**Amount of Relief sought (as per Annexure VI A)**	**INR 37,658**
14. a.	**Date of request for Self-contained Note (SCN)**	**06.01.2021**
14. b.	**Date of receipt of SCN**	**10.02.2021**
15.	**Complaint registered under**	**Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017**
16.	**Date of Hearing/Place**	**By Video Conferencing (VC) on 19.03.2021**
17.	**Representation at the hearing**	

	a) For the Complainant	**Mr S P Baheti**
	b) For the Insurer	**Mr K Murugan**
18.	**Disposal of Complaint**	**By Award**
19.	**Date of Award/Order**	**22.04.2021**

20. Brief Facts of the Case:

The complainant is the policyholder with the respondent insurer (RI) since September 2014. He has availed their *National Mediclaim* Policy covering himself and his wife for the SI of INR 5 lakhs each. They have also earned a CB of INR 2.25 lakhs and INR 2.50 lakhs respectively under the subject policy for the period 2019-20.

As per the Discharge Summary of Apollo Hospitals, Chennai, the complainant was admitted with a history of slip and fall on 01.01.2020 and had sustained an injury to his left shoulder with complaints of difficulty in left shoulder movement and pain. He was diagnosed as a case of "*Left Shoulder Fracture Dislocation, Diabetes Mellitus (DM) and Hypertension (HTN)"*. He underwent the procedure of "*Left shoulder open reduction and internal fixation with Philos Plate*" on 03.01.2020 and was discharged on 06.01.2020.

The complainant incurred a total expenditure of INR 2,09,607 on his treatment. But his claim was settled as per Preferred Provider Network (PPN) tariff since the treating hospital was a signatory to the PPN agreement. An amount of INR 1,52,186 was settled as a c*ashless* claim with the hospital and INR 19,763 was paid to the complainant by way of reimbursement, aggregating to a total settlement of INR 1,71,949. The balance amount of INR 37,658 was disallowed by way of non-medicals and also due to the application of the PPN package tariff.

Mr K P Kosygan, the treating doctor has issued a certificate dated 06.01.2020 explaining the reasons for billing more than the PPN tariff which reads as under.

"The patient had complex fracture dislocation which required 4 hour long complex surgery. Unfortunately for such complex surgery it is difficult to accommodate within the exact limit of package. Patient had to be kept in ward post surgery for 2 days for pain management and mobilization. Pre surgery oral anti coagulants had to be stopped for at least 3 days to minimise bleeding and anaesthetic risk. Patient has Diabetes, Hypertension and previous pulmonary embolism and was categorized as high risk for surgery. More than average length of stay for such procedure, Medication and consumables were warranted in this case due to complexity of fracture and other medical co-morbidities".

The complainant represented to the RI through his letters dated 02.11.2020 and 16.12.2020 for payment of the unsettled amount. But the RI responded that the claim was correctly settled as per PPN package rates and that non-medical expenses were disallowed. Dissatisfied with the response of the RI, the complainant has approached this Forum for relief.

21 (a) Complainant's Submission:

- The complainant submits that he met with an accident and underwent necessary treatment for recovery.
- His claim was settled as per PPN package rates.

- He submits that it is not a pre-determined disease where the charges can be fixed for each and every disease *(sic*).

- Upon representation to the Grievance Cell of the RI, they maintained their earlier stand of settlement on the basis of PPN tariff.

- He has therefore requested the Forum to render him justice.

21 (b) Insurer's Submission:

The RI have submitted their SCN in which they have made the following averments.

- The complainant underwent left shoulder ORIF with internal fixation.

- His admission was in a PPN Hospital and the claim was processed as per PPN package rates.

- The applicable package rate, in this case, was INR 1,30,000 and in addition, INR 22,186 was settled towards the cost of the implant. The total amount of INR 1,52,186 was paid to the hospital in a *cashless* settlement.

- Pre-surgery investigations/fitness charges of INR 19,763 were settled as a reimbursement claim, post-surgery.

- The deductions from the claim were as under:

Description	**INR**
ER assessment charges not payable	1,850
HIV, HBsAg investigations not payable	4,851
Non-medical expenses (NME)	220
NME (OT Consumables)	10,461
Consultation included under package	3,300
Room Charges included under the package	6,000
Pharmacy included under the package	8,744
X-ray included under the package	1,100
NME (processing fee)	682
NME (nutritional assessment)	450
Total	**37,658**

- The complainant had claimed an amount of INR 17,293 towards pre and post hospitalization expenses, of which INR 12,413 was settled and INR 4,880 was disallowed since it was incurred beyond the *post-hospital limit (sic).*

- ❖ As per Clause No. 3.23 of the policy, *Preferred Provider Network* (PPN) means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person (*sic*). The list is available with the company/ their Third-party Administrator (TPA) and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under the PPN package) shall be subject to the rates applicable to PPN package pricing.

- ❖ The settlement of the claim as per the PPN package under Clause 3.23 is in compliance with the Policy Terms and Conditions of the *National Mediclaim* Policy.

- ❖ The PPN package rates are applicable for *cashless* and reimbursement cases of all PPN ailments. They also apply to cases of accidents as well. The PPN declaration was duly signed by the insured accepting to pay over and above the PPN tariff, if any. Hence, the settlement is in order.

- ❖ In view of the above submissions, the Forum is requested to dismiss the subject complaint.

22. Reason for Registration of the Complaint:

The complaint is registered under Rule No. 13(1) (b) of the Insurance Ombudsman Rules, 2017, which deals with "*Any partial or total repudiation of claims by the Life Insurer, General Insurer or the Health Insurer*".

23. Documents placed before the Forum:

- ✧ Complaint dated 02.01.2021 to the Insurance Ombudsman
- ✧ Claim settlement letter of the TPA dated 16.03.2020
- ✧ Complainant's representations dated 02.11.2020 &16.12.2020 to the RI
- ✧ RI's response to the complainant dated 01.12.2020 and the undated response to the representation dated 16.12.2020
- ✧ Consent (Annexure VI A) submitted by the complainant
- ✧ Self-contained Note (SCN) of the RI dated 09.02.2021
- ✧ Policy copy, terms and conditions
- ✧ Claim form- Part A
- ✧ Discharge summary/Bills of Apollo Hospital, Chennai
- ✧ PPN declaration form signed by the son of the complainant
- ✧ Complainant's other correspondence with the RI and the TPA
- ✧ Certificate of Dr K P Kosygan dated 06.01.2020
- ✧ Revised claim calculation submitted by the TPA

24. Result of hearing (Observations & Conclusion):

c) Because of the prevalent COVID 19 pandemic situation, the hearing was conducted by VC on 19.03.2021, with the consent and participation of both the complainant and the RI. Mr S P Baheti, the complainant, Mr K Murugan, representative of the RI and Dr Deepthi, representative of the TPA attended the hearing.

d) There is a delay of one month in the submission of the SCN by the RI. The Forum records its displeasure over the late submission of SCN and advises the insurer to be prompt in complying with the Forum's requirements in future.

e) During the hearing, the complainant submitted that his admission to the hospital was not a planned admission but due to an accidental fall. Hence, settlement of the claim as per the PPN Tariff is not acceptable. The treating doctor has also certified that due to the complexity of the fracture and co-morbidity factors, the patient required further stay in the hospital. However, the RI ignored the doctor's observations while settling the claim.

f) The RI argued that the claim was settled as per the PPN tariff. Though it is not a planned admission, the treatment given was one of the procedures under the PPN. Hence, the claim was settled as per the said tariff.

Item	Amount (INR)
ER assessment and treatment charges	1,850
Claim processing fees	682
Ventilator	880
CD site suction set	325
Accucheck performa	220
Surgical clipper blade	540
IV set	161
Syringes 5 ml	14
Posiflush	42
Shoulder Immobiliser	540
Gloves	240
DC underpad	180
DC wet wipes	390
Accu check safe t pro	44
DC alcohol	8
Gloves	455
3-way ext	432
Encore gloves	570
Steridrape	865
Mepilex border	743
Respirometer	640

Total	**9,821**

g) The RI also submitted that the insured had signed the PPN declaration form consenting to pay any additional amount over and above the PPN tariff. However, on perusal of the declaration form, it is noted that the same mentions the estimated cost of treatment as INR 2,50,000 and the actual cost of treatment was less than the same. There is no mention of any additional facility/provision/procedure/treatment, the cost of which is to be borne by the insured. Hence, the declaration does not serve any purpose whatsoever and is of no consequence.

h) The Forum believes that the RI cannot impose the PPN tariff on a policyholder unless the hospital too abides by it. In the present case, the treating doctor has explained the reasons for not adhering to the PPN tariff and there is no evidence that the same was disputed by the RI or the TPA. Hence, the RI is not justified in restricting the settlement to the PPN tariff. The Forum, therefore, advised the RI to recalculate the claim on an *open billing* basis as per the policy terms and conditions. They reverted vide their mail dated 26.03.2021 stating that the claim can be settled for INR 1,98,335 after disallowing the following amounts:

- ✓ Non-Medical items - INR 9,821 (as per the table below)
- ✓ Food & Beverages - INR 451
- ✓ Room rent - INR 1,000 (excess over eligibility)

k)

On a perusal of the terms & conditions of the policy, it is observed that the room charges consist of room, boarding including nursing care, RMO charges and administration charges for IV fluids/blood transfusion/injection subject to a limit of 1% of the SI per day subject to a maximum of INR 5,000. Though the patient's diet charges are payable, the per day limit is already exhausted and hence the deduction towards food & beverages is justified. In the same manner, the room rent deduction of INR 1,000 is also justified since it was more than the eligibility limit. However, the ER assessment and treatment charges are payable.

d) Hence the Forum concludes that the claim should have been settled for INR 2,00,185 (INR 198,335 + INR 1,850). Considering the payment of INR 1,71,949 already made, a further amount of INR 28,236 is due to the complainant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the parties, the Forum hereby directs the respondent insurer to pay a further sum of INR 28,236 to the complainant in full and final settlement of the claim along with interest as provided under Rule 17(7) of the Insurance Ombudsman Rules, 2017.

Thus, the complaint is **allowed**.

25. The attention of the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

- According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
- According to Rule 17(7) of the Insurance Ombudsman Rules, 2017, the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.
- According to Rule 17(8) of the Insurance Ombudsman Rules, 2017, the award of the Insurance Ombudsman shall be binding on the insurers.

Dated at Chennai on this 22nd day of April 2021.

(M Vasantha Krishna)

INSURANCE OMBUDSMAN

FOR THE STATE OF TAMIL NADU AND PUDUCHERRY

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Amit Varma V/S ICICI Lombard General Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-020-2021-0716

1.	**Name & Address of the Complainant**	Mr. Amit Varma U 26 B/6 First Floor, White Town House, DLF Phase-3, Gurugram, Haryana- 122002 Mobile NO.- 9871690731
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	4128i/iHPN/90567724/03/000 Health Policy 21-07-2020 To 20-07-2021
3.	**Name of the insured** **Name of the policyholder**	Mr. Amit Varma Mr. Amit Varma
4.	**Name of the insurer**	ICICI Lombard General Insurance Co. Ltd.
5.	**Date of Repudiation**	NA
6.	**Reason for repudiation**	NA
7.	**Date of receipt of the Complaint**	12-03-2021
8.	**Nature of complaint**	Less payment of claim
9.	**Amount of Claim**	Rs. 40555/- (10000 recd)
10.	**Date of Partial Settlement**	Not provided
11.	**Amount of relief sought**	Rs.40555+Rs.1000+Harassment charges
12.	**Complaint registered under** **Rule no: Insurance Ombudsman Rules, 2017**	Rule 13 (1)(b) – any partial or total repudiation of claim by an insurer
13.	**Date of hearing/place**	05-04-2021 / Chandigarh
14.	**Representation at the hearing**	
	For the Complainant	Mr.Amit Verma
	For the insurer	Mr.Karan Bagdai
15	**Complaint how disposed**	Award
16	**Date of Award/Order**	05.04.2021

17) Brief Facts of the Case:

On 12-03-2021, **Mr. Amit Varma** had filed a complaint that ICICI Lombard mixed two separate claims and denied his claim on flimsy grounds. His first claim was FOR Rs. 4237/- (OPD) which company didn't process stating that 10000 is the OPD limit and it can be claimed only once and kept this on hold, after which out of sheer frustration he asked for the bills to be

returned. Meanwhile COVID happened and he had sent his bills for Rs. 40555/- under normal hospitalization bill to company. Instead of treating it as a separate bill of Rs. 40555/- and reimbursing the entire amount to him (as COVID home care treatment is covered under the policy) ICICI clubbed the two claim and denied chunk of his claim of Rs. 40555/-. Both claims were different and company cannot club them without his consent. ICICI forcefully and its own accord paid Rs. 10,000/- for the first claim and denied his second claim on the pretext of OPD limit exhausted. He doesn't accept the decision of company and want Rs. 40555/- to be reimbursed to him.

On 16-03-2021, the complaint was forwarded to ICICI Lombard General Insurance Co. Ltd. Regional Office, Mohali, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 05.04.2021.

As per SCN of company, complainant filed two claims – an OPD claim was initiated on 29.10.20 amounting to Rs. 4237/- and COVID claim was initiated on November 25, 2020 amounting to Rs. 40555/- However as the OPD limit is restricted to Rs. 10000/- in the policy and it can be availed once, hence company had issued a query letter for bills of OPD claim apart from Rs. 4237/-. Complainant did not submit any further OPD bills and had filed a COVID claim. He filed COVID claim under Home health coverage of the policy. However as per terms and conditions, the complainant did not take any prior approval for the home health care treatment. As complainant not fulfilled the criteria, company settled both the claim for Rs. 10,000/- basis on the OPD limits.

However the company has reviewed the claim once again and the claim pertains to COVID as a service gesture the company has informed the complainant that the balance claim amounting to COVID will be reconsidered and settled as per terms and conditions of the policy.

18) Cause of Complaint:

- **a)** Complainant's argument: Insurance Company has not paid his COVID claim inspite of submission of all relevant documents.
- **b)** Insurers' argument: They are ready to settle the claim as per terms and conditions of the policy.

19) Reason for Registration of Complaint:- within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties(Observations & Conclusion)

On perusal of various documents and considering submissions made by complainant as well as representative of insurance company it has been observed that Mr.Amit Verma test Covid positive and filed two claims with company. First for Rs.4237/- (OPD) and second for Rs. 40555/- under normal hospitalization bill as COVID home care treatment is covered under the policy. As per company, the complainant did not take any prior approval for the home health care treatment as per terms and conditions of policy, as such they settled both the claim for Rs. 10,000/- on the OPD limits basis. However after complaint, as a goodwill gesture, company has offered to settle the balance claim amount.

In e-mail dt. 02.04.2021 to complainant, as well as during hearing, company offered to pay Rs. 34792/- detailed as under:
Total claimed amount: 44792/- (40555 + 4237)
Claim paid: 10,000
Claim to be paid: 34792/-
Balance SI left under OPD benefit; 5763/- (10000-4237)

However during hearing complainant insisted for full amount of Rs. 10,000/- under OPD claim besides normal claim of Rs. 40555/-. Complainant so far submitted bills of Rs. 4237/- only for OPD claim, as such company's decision to pay as much amount is logical. Company may consider balance amount of OPD claim as per policy terms and conditions, subject to submission of balance OPD bills by complainant within reasonable time. As company has agreed to settle the claim, and their offer is reasonable as per policy conditions, they are directed to pay balance admissible claim as per their offer to insured within 30 days of receipt of award copy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, admissible claim is hereby awarded to be paid by the Insurer to the Insured, towards full and final settlement of the claim.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 05th day of April, 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Vijay Kumar V/S Manipal Cigna Health Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-053-2021-0602

1.	Name & Address of the Complainant	Mr. Vijay Kumar S/o Sh. Gian Chand, 60/02, Shakti Vihar, Ludhiana, Punjab- 141001 Mobile No.- 9878300130
2.	Policy No: Type of Policy Duration of policy/Policy period	PROHLN000484270 Pru Health Protect 17-07-2020 to 16-07-2021
3.	Name of the insured Name of the policyholder	Mr. Vijay Kumar Mr. Vijay Kumar
4.	Name of the insurer	Manipal Cigna Health Insurance Co. Ltd.
5.	Date of Repudiation	27.11.2020
6.	Reason for repudiation	Non disclosure of Pre-existing disease
7.	Date of receipt of the Complaint	01-02-2021
8.	Nature of complaint	Rejection oh hospitalization claim
9.	Amount of Claim	Rs.173382/-
10.	Date of Partial Settlement	N.A
11.	Amount of relief sought	-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021/ online
14.	Representation at the hearing	
	For the Complainant	Mr. Javesh Arora (Son)
	For the insurer	Ms. Shweta Nair
15	Complaint how disposed	Award
16	Date of Award/Order	07.04.2021

17**)** Brief Facts of the Case:

On 01-02-2021, Mr. Vijay Kumar had filed a complaint against Manipal Cigna Health Insurance Co. Ltd for rejection of mediclaim and stated that complainant's wife was admitted in the hospital due to dengue fever on dated 04.09.2020 in Neuro City. In Neuro city complaiant was not satisfied with the treatment, No doctor visited in their room and without consent they mentioned BP as PED but complainant's wife was not suffering from any problem. After dissatisfaction the complainant's wife discharged from hospital and admitted in DMC Hospital on dated 04.09.2020. After treatment for 8 days at DMC hospital, complainant's wife was discharged on 12.09.2020 and did not face any issue regarding treatment. Manipal Cigna Health

Insurance Co. Ltd rejected complainant's claim on the basis of Neuro City's mistake. The complainant has sought the intervention of this forum for settlement of his claim.

On 05-02-2021, the complaint was forwarded to Manipal Cigna Health Insurance Co. Ltd. Regional Office, Mumbai, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office through e-mail on 05.03.2021. As per SCN, the complainant on 8th July 2020 had submitted a proposal form along with the portability form for porting his health insurance policy from Star Health and Allied Insurance Company Limited. Basis information provided in the proposal form and the portability form, the insurance company issued policy to the complainant covering self and wife for a period of 1 year from 17.07.2020 to 16.07.2021.That complainant on 18th September registered a reimbursement claim amounting to Rs.1,73,382/- for his wife's hospitalization at Neurocity Hospital, Ludhiana from 4th Sept.2020 to 12 Sept. 2020 with the complainant's of dengue fever(NS 1 Antigen Positive). However, as per the discharge summary, it was found that the complainant is a K/c/o hypertension since 3-4 years. However, the same was not disclosed in the proposal form, portability form or pre-policy medical examination form. That, since there was a non disclosure of material fact by the complainant while porting the policy, which is material to the policy decision, the claim was found to be non admissible. Therefore, the reimbursement claim was rejected by the company for the non disclosure material information under clause VI.1(Duty of Disclosure) of the terms and conditions and the same was intimated to the complainant vide rejection letter dated 27th November,2020 stating:

"On scrutiny of the documents it has been observed that we have received claim documents for, claimant Mrs. Veena Arora admitted at Pavasiya Hospital & Maternity home admitted from 4th Sept 2020 to 12th Sept 2020 with C/O DENGUE. Claimant is covered under Manipal Cigna Health Insurance Prohealth (protect) policy since 17 July 2020. As per available documents, patient is having history of HTN Since 3-4 years prior to policy inception which is material to the policy decision and was not disclosed in the proposal form at the time of policy inception. Hence the claim stands repudiated under clause VIII.1. We regret our inability to admit this liability under the present policy conditions. We also reserve the right to repudiate the claim under any other ground/s available to us subsequently."

The insurance company vide their mail dated 05.04.2021 informed that they re-evaluated the captioned complainant and has decided to settle reimbursement claim No.22864499 as per policy terms and conditions.

The complainant was sent Annexure VI-A for compliance, which reached this office on 15-02-2021.

18) The complainant during online hearing on 05.04.2021 agreed to accept the offer of the insurance company that they are ready to pay the claim as per policy terms and conditions.

19) In view of the above the insurance company is directed to the pay the admissible claim amount as per terms and conditions of the policy to the insured within 30 days after receipt of the copy of the award.

AWARD

Considering the facts and the submissions made by both the parties, balance admissible claim amount is hereby awarded to be paid by the insurer to the insured subject to the terms and condition of the policy, towards full and final settlement of the claim.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 16th day of March 2021

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Sanjay Kumar V/S HDFC ERGO General Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-018-2021-0591

1. On 25th January 2021, Mr. Sanjay Kumar had filed a complaint in this office against HDFC ERGO General Insurance Co. Ltd. The required documents were submitted to the insurance company but the insurance company did not settle the claim under Health Insurance Policy number 117000/11121/AA00830339-01.This office pursued the case with the insurance company to re-examine the complaint and they agreed to reconsider the claim.

2. Mr. Sanjay Kumar confirmed through mail dated 05.04.2021 that his complaint has been resolved by insurance company and hence there is no need to further pursue the matter.

3. In view of the above, no further action is required to be taken by this office and the complaint is disposed off accordingly.

Dated: 05.04.2021 **(Dr. D.K. VERMA)**

PLACE: CHANDIGARH **INSURANCE OMBUDSMAN**

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Ms. Seema Gupta V/S HDFC ERGO General Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-018-2021-0592

1.	Name & Address of the Complainant	Ms. Seema Gupta A-294, DLF Crest, DLF Phase-5, Gurugram, Haryana- 122011 Mobile No.-9319431027
2.	Policy No: Type of Policy Duration of policy/Policy period	110800/11129/AA00964683-01 Energy Silver 27-12-2019 To 26-12-2020
3.	Name of the insured Name of the policyholder	Ms. Seema Gupta Ms. Seema Gupta
4.	Name of the insurer	HDFC ERGO General Insurance Co. Ltd.
5.	Date of Repudiation	05.12.2020
6.	Reason for repudiation	Claim is under 2 years waiting period
7.	Date of receipt of the Complaint	27-01-2021
8.	Nature of complaint	Rejection of mediclaim
9.	Amount of Claim	Rs.377302/-
10.	Date of Partial Settlement	N.A
11.	Amount of relief sought	Rs.3,75,300/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021/ Online

14.	Representation at the hearing	
	For the Complainant	Ms. Seema Gupta
	For the insurer	Mr. Manoj Prajapati
15	Complaint how disposed	Agreement
16	Date of Award/Order	07.04.2021

17) Brief Facts of the Case:

On 27-01-2021, Ms. Seema Gupta had filed a complaint against HDFC ERGO General Insurance Co. Ltd. for rejection of injury claim and stated that this complainant is regarding her claim which has been repudiated by the insurance company on unjustified grounds. The complainant had fallen at home and got her shoulder injured in 12.08.2019 and had to consult a doctor in OPD for check-ups. The complainant was advised to undergo MRI. Since then complainant was on medication but was suffering from unbearable and increasing pain until her doctor took a decision to operate on accidental shoulder. On doctors advice complainant got admitted in CK Birla Hospital on 07.01.2020 and surgery was done on 08.01.2020. But the cashless facility was denied by the insurance company stating the reason that shoulder tear was not covered for 24 months after first inception whereas company's own policy wordings suggest that any accident/injury is covered from the very first day. However, the complainant paid the hospital bills of approximately Rs.375300/- out of her own pocket. Later complainant applied for claim through reimbursement but the insurance company has refused to settle the claim on the same grounds. Despite complainant's consulting doctor has given a clarification that actual cause of injury was the accident that occurred on 12.08.2019. The complainant has sought the intervention of this forum for settlement of claim.

On 02-02-2021, the complaint was forwarded to HDFC ERGO General Insurance Co. Ltd. Regional Office, Noida, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 01.04.2021. As per SCN, insurance company received a reimbursement claim from the complainant / policy holder with the date of admission on 07.01.2020 and date of discharge 09.01.2020 with claimed amount of Rs.3,77,302/- for diagnosis of SLAP/TEAR/SUPRASPINATUS TEAR(right shoulder). It is further submitted that any treatment related to any type of surgery for prolapsed inter vertebral disk comes under the waiting period of two years and policy was running on his second year, so the claim was rejected as per policy terms and conditions.

The complainant was sent Annexure VI-A for compliance, which reached this office on 22-02-2021.

18) The complainant agreed to accept the offer of the insurance company during online hearing on 05.04.2021 that they are ready to pay the claim as per policy terms and conditions. The insurance company vide their mail on 07.04.2021 offered to settle the claim for Rs 371178/-(Rupees Three Lac Seventy One Thousands One Hundred Seventy Eight only) under policy no 10800/11129/AA00964683-01, to which the complainant agreed.

Further the representative of the insurer confirmed that payment is under process.

19) Keeping in view the acceptance of offer, the complaint is closed with a direction to the insurer to pay the claim amount. The insurance company shall send a compliance report to this office within 30 the days of receipt of this order for information and record.

Dated at Chandigarh on 7th day of April 2021

(Dr. D. K. VERMA)

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Anil Kumar V/S The Oriental Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-050-2021-0590

1.	Name & Address of the Complain ant	Mr. Anil Kumar H. No.- 348, Gali No.- 04, New Suraj Nagari, Abohar, Punjab-0 Mobile No.- 9814671850
2.	Policy No: Type of Policy Duration of policy/Policy period	233203/48/2021/22 Happy Family Floater 11-04-2020 To 10-04-2021
3.	Name of the insured Name of the policyholder	Mr. Anil Kumar Mr. Anil Kumar
4.	Name of the insurer	The Oriental Insurance Co. Ltd.
5.	Date of Repudiation	12.11.2020
6.	Reason for repudiation	Not payable as per policy terms

7.	Date of receipt of the Complaint	25-01-2021
8.	Nature of complaint	Rejection of hospitalization claim
9.	Amount of Claim	Rs.32750 /-
10.	Date of Partial Settlement	N.A
11.	Amount of relief sought	Claim Amount
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021/ Online
14.	Representation at the hearing	
	For the Complainant	Mr. Anil Kumar
	For the insurer	Mr. Devinder Garg
15	Complaint how disposed	Award
16	Date of Award/Order	05.04.2021

17) Brief Facts of the Case:

On 25-01-2021, Mr. Anil Kumar had filed a complaint of against The Oriental Insurance Co. Ltd for denial of hospitalization claim and stated that complainant is taking medicalim policy of the insurer continuously for the last three years. This year policy no. is 233203/48/2021/22 and prior to 22.08.2020 all the members of his family including complainant were healthy. Due to sudden pain in the left eye on 22.08.2020, the complainant consulted Dr. Daljit Singh Eye Hospital on 24.08.2020 and on that day laser scan was done. The complainant was hospitalized on 25.08.2020 and all tests were conducted. On 26.08.2020 Inj. was administered in the left eye of the complainant and after sometime discharged from the hospital. The complainant remains admitted in the hospital for more than 24 hours. The complainant further stated that after submission of all the claim documents, insurance company rejected the claim for the reason that hospitalization was less than 24 hours where as complainant was admitted on 25.08.2020 at 11.30 to 26.08.2020 till 14.10. The complainant sought the intervention of this office for payment of claim.

On 02-02-2021, the complaint was forwarded to The Oriental Insurance Co. Ltd. Regional Office, New Delhi, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 26.02.2021. As per SCN, claim was lodged in respect of hospitalization of Sh. Anil Kumar for the period from 25.08.2020 to 26.08.2020 in Dr. Daljit Singh Eye Hospital on 26.08.2020 with the diagnosis CRVO left and underwent Inj. Accentrix Left Eye. Further information is available from hospital document that patient was hospitalized on 25.08.2020 and administration of injection Accentrix on 26.08.2020. However, there is no need of admission on 25.08.2020 as no treatment was given on 25.08.2020. Since in this claim need for 24 hours of hospitalization not required, since the patient could be treated on OPD basis, Hence, this claim is not payable.

Matter was again taken up with the concerned TPA vide mail dated 11.02.2021 to confirm whether the treatment of CRVO has been included in day care procedures or not. To whom TPA replied vide their mail dated 15.02.2021 that “The diagnosis CRVO and the injection Acentrix is not covered under day care list under appendix 1. Also

expenses on injections Lucentex/Avastain/Macugen will continue to be disallowed as the procedure involved in OPD Protocol only. Copy of the mail of health manager dated 16.08.2012 is attached hereto. Hence, the claim was repudiated as No-claim.

18) Cause of Complaint:

a) Complainant's argument: Despite hospitalization being more than 24 hours, the claim has been denied without any justification.

b) Insurers' argument: Since the patient could be treated on OPD basis, Hence claim is not payable as per policy terms and conditions.

19) Reason for Registration of Complaint: Within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company b) Copy of Policy Document

c) Annexure VI-A d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion): On going through the complaint document in the file and submission made by both the parties during online hearing, it is observed that the claim is on account of admission to hospital on 25.08.2020 for more than 24 hours. The insured Sh. Anil Kumar is covered under mediclaim insurance, diagnosed case of CRVO left eye and administered with Inj. Accentrix. As per complainant, the insurance company has denied the claim of eye treatment for which he was admitted for more than 24 hours under the advice of treating doctor The insurance company rejected the claims on the ground that the procedure underwent is outpatient procedure and in this case need for 24 hours of hospitalization not required since patient could be treated on OPD basis. In the instant case the patient is a diagnosed case of CRVO left eye and administered with Inj. Accentrix. The said injection is administered in an operation theatre under strict sterile conditions and requires post procedure observations of the patient since the same is not free from complications. On going through the various day care procedures in relation to eye surgery it is observed that due to rapid technological advancement in the medical field most of the surgical procedures on eye do not require hospitalization as it used to be few years back and even the smallest excision/incision on eyes are covered under day care procedures. Since the administration of injection Accentrix requires highly sophisticated procedures done under the supervision of a consultant eye specialist in an operation theater, in my view the case is covered under eye surgery and hence payable. The decision of the insurance company to reject the claim of the insured in respect of the said treatment taken by him at Dr. Daljit Singh Eye Hospital Amritsar is not proper and devoid of merits. The insurance company is directed to pay the admissible claim amount as per terms and conditions of the policy within 30 days after the receipt of the award's copy.

AWARD

Considering the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, admissible claim amount as per terms and condition of the policy is hereby awarded to be paid by the Insurer to the Insured, towards full and final settlement of the claim.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 5th Day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Subhash Chander Verma V/S The Oriental Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-050-2021-0603

1.	Name & Address of the Complainant	Mr. Subhash Chander Verma Kothi No.- 464, Preet City, Sector-86, S.A.S. Nagar(Mohali), Punjab-0 Mobile No.- 9815590060
2.	Policy No: Type of Policy Duration of policy/Policy period	233500/48/2020/1112 PNB-Oriental Royal Mediclaim Policy 13-06-2019 To 12-06-2020
3.	Name of the insured Name of the policyholder	Mr. Subhash Chander Verma
4.	Name of the insurer	The Oriental Insurance Co. Ltd.
5.	Date of Repudiation	17.08.2020
6.	Reason for repudiation	Pre-existing diseases excluded up to 36 months
7.	Date of receipt of the Complaint	01-02-2021
8.	Nature of complaint	Rejection of hospitalization claim
9.	Amount of Claim	Rs.53287/-
10.	Date of Partial Settlement	N.A
11.	Amount of relief sought	Rs.53287/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021/ Online
14.	Representation at the hearing	
	For the Complainant	Sh. Subhash Chander Verma
	For the insurer	Ms. Maninder Kaur
15	Complaint how disposed	Award

16	Date of Award/Order	05.04.2021

17) Brief Facts of the Case:

On 01-02-2021, Mr. Subhash Chander Verma had filed a complaint against The Oriental Insurance Co. Ltd for denial of mediclaim of his wife and stated that claim rejected by the insurance company vide ref letter dated 17.08.2020 was represented to the grievance nodal officer for reconsideration on 24.12.2020. The complainant sought the intervention of this forum as no action has been taken by the insurance company.

On 05-02-2021, the complaint was forwarded to The Oriental Insurance Co. Ltd. Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 23-02-2021.As per SCN, the insured Mr. Subash Chander Verma purchased PNB-Oriental Mediclaim policy on 10.06.2017 covering himself and spouse Mrs. Pushpa Verma with policy no. 233500/48/2018/1170. The policy is being renewed thereafter. The complainant has been filed by Mr. Verma for claim under policy no 233500/48/2020/1112.

It is submitted that the claim was duly processed by Raksha Health Insurance TPA Pvt. Ltd. and found to be non payable as per terms and conditions of the policy. Based upon the opinion and recommendations of the professionally qualified team of doctors of TPA, competent authority was of the opinion to repudiate the above said claim. Subsequently, a registered pre-repudiation letter dated 24.07.2020 was sent to the insured giving an opportunity to represent within 7 days of the receipt of the letter. As no response was received from the insured, therefore the competent authority finally repudiated the claim. The decision of the competent authority was informed to the insured through a registered repudiation letter dated 17.08.2020 citing clause 4.1 as reason of repudiation of the said claim, which is reproduced here under:

"4. General Exclusions : The company shall not be liable to make any payment under this policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 All Pre-existing Diseases (whether treated/untreated, declared or not declared in the proposal form), are excluded up to 36 months of the policy being in force and shall be covered only after the policy has been continuously in force for 36 months. For the purpose of applying this condition, the date of inception of the first PNB-Oriental Royal Mediclaim shall be considered, provided the Renewals have been continuous and without any break in the policy period. This exclusion shall also apply to any complication(s) arising from Pre-existing Diseases. Such complications will be considered as part of the Pre existing health condition or Disease."

It is further submitted that the admission in Hospital in the above claim was for LOC with diagnosis of TIA, Hyponatremia and Hypertension. It is clearly mentioned in the discharge summary that the patient Mrs. Pushpa Verma is a K/C/O-HTN on regular medication. And as per the policy clause 4.1 & 4.2, claim arising due to hypertension falls in Pre- Existing Conditions and is excluded for the initial three years from the date of first inception of the policy. As the policy was in 3rd year, therefore, the claim is non payable and was repudiated as per Clause 4.1 of the policy and complainant is not entitled for any claim amount in the present claim.

The complainant was sent Annexure VI-A for compliance, which reached this office on 26-02-2021.

18) Cause of Complaint:

a) Complainant's argument: The claim denial decision of the insurer is based on flimsy and unjustified grounds.

b) Insurers' argument: Claim is not admissible as per clause 4.1 of the policy condition related with the pre-existing health conditions

19) Reason for Registration of Complaint: Within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties(Observations & Conclusion): On perusal of the various documents available in the file including the copy of the complaint, SCN of the insurer, discharge summary and submission made by both the complainant and the insurance company during the online hearing, it has been observed that the complainant's wife was hospitalized due to sudden episode of LOC at Mayo Healthcare Super Speciality Hospital Mohali from 11.06.2020 to 13.06.2020 for the diagnosis of TIA, Hyponatremia, Hypertension. The reimbursement claim of Rs.53287/- was repudiated by the insurer under the policy clause 4.1 of the policy related to pre-existing diseases on the ground that patient was a case of hypertension.

The representative of the insurer stated that all pre existing diseases are excluded up to 36 months of the policy being in force and shall be covered only after policy has been continuously in force for 36 months. Since complainant's policy is in 3rd year of inception, so claim is inadmissible under the clause 4.1 of the policy.

The complainant submitted that his wife was hospitalized due to sudden unconscious and treated for sodium deficiency during hospitalization. The claim denial on the ground of pre-existing disease is not justified.

It is seen from the discharge summary that patient was admitted in the hospital due to sudden episode of LOC for 2-3 minutes and was diagnosed for TIA , Hyponatremia and Hypertension. The insurance company has denied the claim of complainant under clause 4.1 due to non disclosure of pre-existing diseases in proposal that patient was a case of hypertension. As per clause 4.1 under General Exclusion of the policy terms, all pre-existing diseases are excluded up to 36 months. Although it is mentioned in the discharge summary that patient is a K/C/O-HTN but there is no evidence on the record to prove that she was suffering from it prior to inception of the policy. Even as per policy clause 4.2 – Expenses on treatment of hypertension are not payable during the waiting period of 24 months only. The claim of complainant does not fall within 24 months from policy inception as the policy is in third year and is not directly related with the treatment of hypertension as the hospitalization of patient followed due to low sodium level causing Hyponatremia. Even at the time of admission the recorded BP of patient was 120/80 which is a normal value. Under the circumstances, the claim denial decision of the insurer is not justified and devoid of merits. Therefore, the insurance company is directed to pay admissible claim amount to the complainant as per policy terms and conditions within 30 days from the receipt of awards copy.

AWARD

Considering the facts & circumstances of the case and the submissions made by both the parties during online hearing, admissible claim amount per policy terms and condition is hereby awarded to be paid by the Insurer to the Insured, towards full and final settlement of the claim.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 5th day of April 2021

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Narender V/S IFFCO-TOKIO General Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-023-2021-0722

1.	Name & Address of the Complainant	Mr. Narender S/O Ved Parkash Vpo. Chaubara teh. Bhuna, Fatehabad, Haryana 125111 Mobile No.- 8199900919
2.	Policy No: Type of Policy Duration of policy/Policy period	H0499933 Corona Rakshak Policy 24-10-2020 to 05-02-2021
3.	Name of the insured Name of the policyholder	Mr. Narender Mr. Narender
4.	Name of the insurer	IFFCO-TOKIO General Insurance Co. Ltd
5.	Date of Repudiation	28-01-2021
6.	Reason for repudiation	Complainant not suffered from any illness and he is making fraud.
7.	Date of receipt of the Complaint	18-03-2021
8.	Nature of complaint	Repudiation of claim
9.	Amount of Claim	Rs 2,50,000/-
10.	Date of Partial Settlement	NA
11.	Amount of relief sought	Rs 2,50,000/- plus interest
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claim by an insurer
13.	Date of hearing/place	05-04-2021 / Chandigarh

14.	Representation at the hearing	
	For the Complainant	Mr. Narender
	For the insurer	Mr. Suraj Singh Negi
15	Complaint how disposed	Dismissed
16	Date of Award/Order	07.04.2021

17) <u>Brief Facts of the Case:</u>

On 18-03-2021, Mr. Narender had filed a complaint that he had purchased online corona Rakshak policy in Global Pandemic of Covid 19 from IFFCO-TOKIO General insurance co. Ltd on 24-10-2020. After some time on 03-01-2021, he suffered from high fever cold, cough, weakness, then he visited Sapra multispecialty hospital Hissar where primary treatment was given to me and doctor suggested for Covid 19 test due to Covid 19 symptoms. Test was given and results come with Covid 19 positive, His health condition was bad and fever was high. He approached SL Minda Memorial Hospital Bagla, Hissar where doctor observed him and prescribed for admission because his health condition was not good. He had admitted there on doctor recommendation on 3 January 2021. He was treated in SL Minda Memorial hospital for next 4 days. On 7 January as his condition became stable doctor discharged him on 7 January and suggested for next 13 days home isolation with medicines. As he had policy of company, so he claimed for it and send all relevant documents to respondent company. But company has rejected his claim with the wording that he has not suffered from any illness and he is making fraud. He contacted insurance company and asked for the proof on which ground insurance company has rejected his claim but company has not provided him any information regarding this. As his claim was genuine so he represented his case to insurer's grievance cell, with hospital's declaration and self declaration latter this was proving that he suffered from Covid 19 and was admitted in Hospital. After continuous follow up and submission of all supporting documents the claim was rejected again. According to policy wording, clause no- 4.1 Covid cover, "Lump sum benefit equal to 100 % of the sum insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of Covid 19 shall be from a government authorized diagnostic centre." Complainant stated that his claim is genuine and repudiation is unfair. His all document and bills are original and genuine, and hospital declaration letter is also showing that he is right and eligible for claim. He requested this forum to look into her case and give justice.

On 18-03-2021, the complaint was forwarded to IFFCO-TOKIO General Insurance Co. Ltd Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 01-04-2021 on email.

As per SCN submitted by insurance company submitted that they had issued a Corona Rakshak policy bearing policy No. H0499933, in the name of Mr. Narender for sum insured of Rs. 2, 50,000/- for the period from 24/10/2020 to 05/02/2021, as per terms and conditions of the policy. The insurance company received Claim documents for reimbursement under the said insurance policy with respect to patient Mr. Narender who claimed that he was admitted in S.L Minda Memorial Hospital, Hisar for the period from 03/01/2021 to 07/01/2021 with diagnosis of COVID positive. As per Discharge Summary the patient Mr. Narender was advised for home isolation for thirteen days. It is further submitted that on receipt of claim documents/medical records, an investigator was appointed by the Insurance Company for investigation. Investigator noted the following points during investigation with respect to the said claim: -

“On visit to patient home address and discuss with patient Mr. Narender and his family members we found that patient did not admit in any hospital in past 6 months. As per patient mother and his sister and his father told that no one person COVID positive in entire family. They also discussed with patient neighbours regarding patient COVID positive and his hospitalization but all patient’s neighbours denied to patient Narender admission in any hospital and also denied to COVID positive of the same. As per discussion with patient family they told that Mr. Narender not admitted in any hospital and he did not covid positive last since x 06 months. We also collected patient statement of the same”.

Considering these facts, the claim was denied on 28/01/2021 as per clause no. 8.8 of the insurance policy which states that “If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims made under the policy which are found fraudulent later under this policy shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:

(a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

On receipt of complaint from this forum, they have again examined the case and submitted that as per investigation report, neither the complainant nor his family members were admitted for treatment of Covid-19 past six months. Further, as per discharge summary under heading of physical examination on admission, **“the patient was conscious, oriented, BP 110/70 mm/Hg, Pulse 98/min, RR 20 min, SPO2 98%, temperature 101.2”F, Chest bilateral clear, P/A soft”**, all these physical examinations clearly indicate that Covid was mild category. As per guidelines issued by Ministry of Health and Family Welfare, Government of India, hospitalization is not necessitate for mild or moderate COVID 19 cases and patient could have been managed on home isolation basis. They enclosed copy of guidelines of Ministry of Health and Family Welfare, Government of India**.** They also pointed that as per Definition clause no. 3.7 (definition of hospitalization), 3.8 (Inpatient care) and 4.1 (COVID Cover) of Corona Rakshak Policy which read as under:

3.7.Hospitalisation

means admission in a hospital designated for COVID-19 treatment by Government, for a minimum period of seventy-two (72) consecutive ‘In-patient care’ hours.

3.8.In-Patient Care

means treatment for which the insured person has to stay in a hospital continuously for more than 72 hours for treatment of COVID.

4.1. COVID Cover Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.

In view of above, it is submitted that the claim of the insured was repudiated rightly as per clause no. 8.8 of the policy. The information regarding repudiation of claim has been sent to insured vide letter dated 20-01-2021. They requested for dismissal of complaint.

The complainant was sent Annexure VI-A for compliance, which reached this office on 23-03-2021.

18) Cause of Complaint:

a) **Complainant's argument:** Complainant stated that claim denial by insurance company is not justified and he requested for settlement of his claim.

b) **Insurers' argument:** Insurance Company stated that as per policy terms and conditions the hospitalization is not justified.

19) Reason for Registration of Complaint: - within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion):

I have gone through the various documents available in file and also considered the submissions made by complainant and representative of insurance company at the time of personal hearing. The claims filed by complainant under Corona Rakshak Benefit policy for his Covid-19 positive has been denied by insurance company vide repudiation letter dated 28-01-2021 due to reasons that as per clause no. 8.8 of the insurance policy which states that "If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims made under the policy which are found fraudulent later under this policy shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment.

Whereas according to complainant, as per policy condition, Lump sum benefits equal to 100% of the Sum Insured shall be payable on positive diagnosis of covid-19, requiring hospitalization for a minimum continuous period of 72 hours. There is no dispute with regard to diagnosis of Covid-19 to complainant and he was asymptomatic by either parties. Only dispute remains whether insurance company repudiation decision of complainant's claim on the basis of fraud is rational or not? I have gone through the guidelines issued by Ministry of Health and Family Welfare, Government of India dated, 13/06/2020. It is seen that the complainant was found COVID positive on 31/10/2020 and was admitted in S.L Minda Memorial Hospital, Hisar, for 5 days, from 03/01/2021 to 07/01/2021 being asymptomatic. After discharge he was advised 13 days home isolation. Further, the insurance company pointed that their investigator pointed that "On visit to patient home address and discuss with patient Mr. Narender and his family members we found that patient did not admit in any hospital in past 6 months. As per patient mother and his sister and his father told that no one person COVID positive in entire family. They also discussed with patient neighbours regarding patient COVID positive and his hospitalization but all patient's neighbours denied to patient Narender admission in any hospital and also denied to COVID positive of the same. As per discussion with patient family they told that Mr. Narender not admitted in any hospital and he did not covid positive last since x 06 months. We also collected patient statement of the same". Insurance company also annexed the

photograph of complainant holding his statement which he gave to the deputed investigator of insurance company and same matches with complainant.

Further, on going through the RT PCR report of complainant and submissions made by complainant during video conferencing wherein complainant stated and it is also evident from the documents of lab that his RTPCR sample was taken on 03-01-2021 at 2.02 pm at Nalwa Laboratories Private Limited, Hissar and his report came on same day at 4.31 pm is not logical. Since RT PCR (reverse transcription polymerase chain reaction) is a testing technique wherein RNA template is used for detection and amplification of viral RNA. The test can be completed in four to eight hours, however, the results are available in one day due to time taken in collection and in the transportation of samples to the labs. Running RT PCR machines is also expensive and that is why, labs run large batches of RT PCR tests together. This also adds to the time taken by labs to conduct this test. If the testing lab is far from the place where the sample of the person has been collected, the test result may be available after 48 hours or more, in some cases. In the instant case, the report of covid test as per the documents of Lab was available within 3 hours of taking sample (sample correction time is 2:02 pm and covid positive report time is 4:30 pm) which hints at the element of fraud also. Complainant can't be given benefit of making profit from public pool by fraudulent means by taking the cover of pandemic situation. Therefore, on the basis of above facts, the denial of claim by insurance company being totally justified and proper. Hence, complaint is hereby dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of online video conferencing, the said complaint is hereby dismissed on merits.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 07th day of April, 2021

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Jagdish Kumar Arora V/S SBI General Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-040-2021-0597

1.	Name & Address of the Complainant	Mr. Jagdish Kumar Arora S/O Sh. Puran Chand Arora, 189-Dilbagh Nagar, Basti Gujjan,

		Near Bawa Lal Ji Mandir, Jalandhar- 144002 Mobile No.- 9814905235
2.	Policy No: Type of Policy Duration of policy/Policy period	0000000013176596 Arogya Plus Insurance Policy 15-05-2019 to 14-05-2020
3.	Name of the insured Name of the policyholder	Mr. Jagdish Kumar Arora Mr. Jagdish Kumar Arora
4.	Name of the insurer	SBI General Insurance Co. Ltd.
5.	Date of Repudiation	28/04/2020
6.	Reason for repudiation	Past history of severe ulcerative colitis
7.	Date of receipt of the Complaint	02-02-2021
8.	Nature of complaint	Repudiation of claim
9.	Amount of Claim	Rs 51,669/-
10.	Date of Partial Settlement	Not applicable
11.	Amount of relief sought	Rs 51,669/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claim by an insurer
13.	Date of hearing/place	05-04-2021 / Chandigarh
14.	Representation at the hearing	
	For the Complainant	Mr. Jagdish Kumar Arora, Complainant
	For the insurer	Ms Chynikca Modie
15	Complaint how disposed	Award
16	Date of Award/Order	06-04-2021

17) Brief Facts of the Case:

On 02-02-2021, Mr Jagdish Kumar Arora informed that With reference to subject, it is submitted that he have taken a Health Insurance policy bearing number 0000000013176596 from SBI General insurance Co. Ltd. Jalandhar. The policy validity period is 15.05.2019 to 14.05.2020. His daughter got admitted in Aggarwal Liver & Gut Super Speciality Hospital Jalandhar on 15.02.2020 and was discharged on 19.02.2020. After her discharge, he submitted his bill to SBI General Insurance Co. Ltd with all the relevant forms and documents in the month of February 2020. He did not get any

information about his claim from the company till May 2020. When he personally called the TPA authorities about his claim, only then he came to know that his claim has been rejected and subsequently, on his request, rejection letter was provided to me. The base for rejection of claim, as per rejection letter dated 28.04.2020 has been termed as pre-existence of the disease from commencement of policy, which was not true. He enclosed a certificate dated 18.05.2020 from the hospital authorities which was self-explanatory, in which the doctor Sh. Manish Aggarwal clearly mentioned under his seal and signatures that the patient Miss Prerna Arora was first diagnosed to have Ulcerative Colitis on 15.02.2020 and the diagnosis of ulcerative Colitis on OPD slip dated 26.08.2017 was written retrospectively as she didn't have h/o ulcerative colitis in 2017 and hence was not on any medicine for the same. At that time (in 2017) she was treated from acute Gastroenteritis only. He submitted that his claim is genuine and can be verified by this office and also from the concerned hospital authorities. Since justice has been denied to him by the Insurance Company, hence he is moving this application to this forum so that justice can be done and his lawful claim along with penalty and interest (for unnecessary delay) can be paid to him. He requested this forum to intervene in the matter and instruct the insurance company to pay his daughter claim under the policy.

On 02-02-2021, the complaint was forwarded to SBI General Insurance Co. Ltd. Regional Office, Mumbai, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 17-02-2021 on email.

In the SCN insurance company stated that an Arogya Plus Insurance Policy Bearing No. 0000000013176596 was issued by SBI General in the name of Complainant i.e. “Mr. Jagdish Arora”, his wife “Mrs. Pooja Ahuja” and his daughter “Ms. Prerna Arora”, which was effective from 15/05/2019 to Midnight of 14/05/2020. The Insured Ms. Prerna Arora was hospitalized in Aggarwal Liver and Gut Super Speciality Hospital, Jalandhar city from 15/02/2020 to 19/02/2020 for the treatment of Ulcerative Colitis with Septicaemia and underwent medical management for the same. Accordingly, a claim bearing claim no. IP- 2260054/200619034258-01under the said policy, bearing no.0000000013176596 was registered on behalf of the Insured with SBI General towards reimbursement of the medical expenses incurred in the aforesaid Hospitalisation. Promptly thereafter, the claim file of the Insured was investigated by an internal claim investigation team, viz. Mahesh Saggar, to complete the process of evaluation of authenticity and eligibility of the claim against total claimed amount of Rs 83,000/- towards treatment of Ulcerative Colitis with Septicaemia. However, upon a close and complete scrutiny of the available documents vis-à-vis policy terms & conditions, the Insured was observed to have a history of ulcerative colitis since 2017. The patient was admitted in the “Aggarwal Liver and Gut Super Speciality Hospital” from 15/02/2020 to 19/02/2020 and the policy inception (1st Policy Issuance) date is 15/05/2019. During investigation, Dr. Munish Aggarwal confirmed that the insured had come to him for treatment of Ulcerative Collitis earlier too, which is also evident from the Consultation letter of Dr.Munish Aggarwal dated 26/08/2017. In view of the aforesaid facts and findings, the relevant policy exclusion clause 1 pertaining to pre-existing illness is reproduced hereunder for ready reference and records of Ld. Ombudsman: “EXCLUSIONS: Pre-existing diseases exclusion: Any illness/disease/injuries/health conditions which are pre-existing (treated/untreated, declared/not declared in the proposal form), when the cover incepts for the first time are excluded up to 4 years of this Policy being in force continuously. However this exclusion would not be applicable from forth continuous renewal up to minimum of sum insured and/or limit under four previous policies.”Hence as per the findings of the investigator, it was established that Insured’s symptoms were pre-existing in nature and the current ailment is a sequel of the same. Further, to substantiate their contentions, copy of all Hospital case papers including the Consultation paper of Dr. Munish Aggarwal dated 26/08/2017 were annexed by insurance company. Furthermore, the Complainant while contracting for the said Insurance policy in 2019, deliberately failed to disclose the illness history of his daughter, in Part III of the Proposal Form. It is pertinent to mention that the Complainant deliberately withheld the fact that his daughter had a history of severe ulcerative colitis, inspite of the fact that the Proposal Form had specific and individual checkboxes for past history and ailments of the proposer. Further, as per terms and conditions of the subject policy the “CONDITIONS PRECEDENT” clearly state the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of

misrepresentation, mis-description or non-disclosure of any material fact. The relevant portion of the policy condition-4 states that "Mis-description: This Policy shall be void and premium paid shall be forfeited to Insurer in the event of misrepresentation, mis-description or non-disclosure of any Materials facts pertaining to the proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy by the Insured. Nondisclosure shall include non-intimation of any circumstances which may affect the insurance cover granted. The Misrepresentation, mis-description and non-disclosure is related to the information provided by the proposer/insured to the Insurer at any point of time starting from seeking the insurance cover in the form of submitting the filled in proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy and ends only after all the Contractual obligations under the policy are exhausted for both the parties under the contract."Accordingly, the said claim was not tenable and it was appropriately repudiated by SBI General and the communication regarding the said decision was sent to the Insured through our Claim declination letter dated 28/04/2020. In the light of the aforesaid facts, they submitted that the claim of the Insured / Complainant has been denied in accordance with the terms and conditions of the said Policy. Hence, they humbly submitted that there is no error on their part in assessing the claim of the Complainant and the present Complaint is liable to be dismissed on account being meritless.

The complainant was sent Annexure VI-A for compliance, which reached this office on 12-02-2021.

18) Cause of Complaint:

a) Complainant's argument: Complainant stated that insurance company rejected his daughter's claim on flimsy ground of PED. He requested for payment of his claim.

b) Insurers' argument: Insurance Company reiterated their contents of SCN and emphasized for dismissal of complaint.

19) Reason for Registration of Complaint: - within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion)

On perusal of complaint, SCN, written brief of complainant and submission made by insurance company during personal hearing it is observed that complainant has given complaint for repudiation of his mediclaim and urge for payment of his claim. The insurance company however, was represented by their executive who reiterated the contents of the SCN and the repudiation letter dated 28.04.2020 issued to complainant for denying the claim. The insurance company plea that it was observed from the Consultation letter of Dr.Munish Aggarwal dated 26/08/201 that the insured person has Ulcerative Collitis. From the above fact it is evident that the insured was having a long standing condition which is prior to the commencement of the policy. As per documents available in the file complainant is covered under Arogya Plus Insurance Policy for the period 15/05/2019 to 14/05/2020. Insurance company pointed that during investigation, Dr. Munish Aggarwal confirmed that the insured had come to him for treatment of Ulcerative Collitis earlier too, which is also evident from the Consultation letter of Dr.Munish Aggarwal dated 26/08/2017. In the instant case, insurance company denial of claim on the basis of USG Consultation letter of Dr.Munish Aggarwal dated 26/08/2017 is not logical because same doesn't mention anything about the nature of pre existing illness, no medical records in support of the claim by insurance company about pre existing illness has been placed before this Forum by insurance company. As such insurance company has failed miserably to produce any documents in support of their contention about the pre existing Ulcerative Collitis prior to purchase of policy. Even as per the record of hospital i.e Aggarwal Liver & Gut Super Speciality Hospital Jalandhar where the complainant's daughter was admitted for the treatment of Ulcerative Colitis with Septicaemia and underwent medical management for the same is silent on any pre existing ailment. The denial of claim by insurance company being totally unjustified and arbitrary; the insurance company is directed to settle the claim subject to submission of complete documents / bills relating to treatment taken by insured within 30 days after the receipt of the award copy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, the insurance company is directed to settle the claim subject to submission of complete documents / bills relating to treatment taken by insured within 30 days after the receipt of the award copy. Hence, the complaint is treated as closed.

Dated at Chandigarh on 06th day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Arihant Jain V/S Star Health and Allied Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-044-2021-0595

1.	Name & Address of the Complainant	Mr. Arihant Jain House No.- B-III-1170, Street No.- 1, Kalyan Nagar Near Kamla Lohtia College Ludhiana Mobile No.- 9815696793
2.	Policy No: Type of Policy Duration of policy/Policy period	P/161114/02/2019/000935 Accident Care Individual Revised -2015 08-02-2019 to 07-02-2020
3.	Name of the insured Name of the policyholder	Mr. Arihant Jain Mr. Arihant Jain
4.	Name of the insurer	Star Health and Allied Insurance Co. Ltd.
5.	Date of Repudiation	Not applicable
6.	Reason for repudiation	Not applicable
7.	Date of receipt of the Complaint	02-02-2021
8.	Nature of complaint	Deduction of claim

9.	Amount of Claim	Rs 1,28,000/-
10.	Date of Partial Settlement	Paid Rs 64,000/- dated 13-01-2021
11.	Amount of relief sought	Rs 64,000/- + interest 15360/- + travelling and visit charges to ombudsman, if any + Rs 50,000/- as harassment charges
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021 Video Conferencing/ Chandigarh
14.	Representation at the hearing	
	For the Complainant	Mr. Arihant Jain, Complainant
	For the insurer	Ms. Mamta Gupta
15	Complaint how disposed	Dismissed
16	Date of Award/Order	13-04-2021

17) Brief Facts of the Case:

On 02-02-2021, Mr. Arihant Jain had filed a complained that that he met with an accident on 01/05/2019 because of slipping of his activa, as a result, he had an injury on his right knee. His knee's ACL was completely torn at that time. He gave information to the star health and allied insurance co. Ltd of that accident. He took first aid from Dr. N.D Avasthi (Ludhiana), he advised him for complete bed rest and after that he advised complainant for ACL surgery. He took second opinion from Dr. Mukesh Jain (Muzaffarnagar). He also advised complainant ACL surgery and gave him appointment for surgery after approximately 10 days because it is not a immediate surgery. This surgery take time because of swelled joint and this is a laparoscopic surgery and surgeon need a clear joint to operate. And finally complainant was operated on 09/06/2019. He got discharged after some days and took complete bed rest for a long time as advised by his doctor. After that on 18/08/2019, complainant visited his doctor for checkup on that day he asked him to put some weight on his knee and walk a little bit with the help of stick/walker. Now he told him that after some days he will able to go to office with the help of stick and work in sitting posture. The real matter is that Star health and allied insurance co ltd only pay the partial compensation amount Rs. 64000/-for only 8 weeks but his doctor advised him rest for almost 16 weeks. The insurance company not only denied the doctor's certificates issued to patient and also harassing the patient with false negotiation. The insurance company said that they paid him the amount advised by their own staff. How they judge the patient's condition sitting in their offices. If the insurance company had an issue with the patient rest days then, they had to cross check the patient's condition by visiting the hospital and patient's place too nobody can say the approx. Time of bed rest for this kind of surgery. How can star ins. Co. Doctors tell me that 8 week compensation is sufficient for ACL surgery? He have examples of many patients who are suffering from this condition and don't able to work or walk even after 6 months of surgery. He requested for resolving his issue as soon as possible. He is not satisfied with approved amount so he requested this forum to reinvestigate his claim.

On 02-02-2021, the complaint was forwarded to Star Health and Allied Insurance Co. Ltd. Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 30-03-2021 on email.

In the SCN insurance company stated that the complainant took Accident Care Individual Insurance Policy covering self (Mr. Arihant Jain) for the sum insured of Rs. 25,00,000/-vide Policy No. P/161114/02/2019/000935for the period from 08/02/2019 to 07/02/2020. The Insured made a claim vide Claim No. CLI/2020/161114/02/0000389 in the 4th month of the Medical Insurance Policy. The insured Mr. Arihant Jain, aged 26 years, was hospitalized at Vardhman Trauma & Laparoscopy Centre Pvt Ltd, Muzzaffarnagar on 07/06/2019 and was discharged on 10/06/2019. As per the Discharge Summary of the treating hospital, diagnosis was ACL Tear. The Insured submitted a claim for weekly benefits on 04/10/2019 and the same was approved for a sum of Rs. 64,000/- was settled to the insured vide NEFT Transaction No. 001130138910 dated 13/01/2020 towards 8 weeks compensation. Subsequently, the insured submitted a request for reconsideration with additional documents claiming for additional compensation for 5 weeks and the same was repudiated vide letter dated 02/03/2020. Aggrieved by the repudiation, insured submitted a request for reconsideration of repudiation and the claim was duly reviewed and repudiated vide letter dated 23/06/2020. It is observed from the documents submitted that the insured was already compensated for 8 weeks of Temporary Disablement. Hence, the same is the maximum payable has already been settled to the insured. As per the Scope of Cover Table C (3) of the Policy, "Temporary Total Disablement: If at any time during the period of insurance the insured person/s shall sustain Grievous injury arising solely and directly from an accident and resulting in hospitalization, then the insured person will be paid a sum calculated at 1% of the sum insured under Table C per completed week but not exceeding Rs.15,000/- per completed week, in all, under all Personal Accident policies, if such injury be the sole and direct cause of Temporary Total Disablement." It may be stated that, the maximum amount was already settled to the Insured as per the Terms and Conditions of the policy, there is no further amount liable for payment under the policy for the present claim. Therefore, their deductions are in order. They requested for dismissal of complaint.

The complainant was sent Annexure VI-A for compliance, which reached this office on 08-02-2021.

18) Cause of Complaint:

a) Complainant's argument: Complainant requested for balance payment of deduction from his claim.

b) Insurers' argument: Insurance Company stated that all the deductions are made as per policy terms and condition and nothing is due to payment.

19) Reason for Registration of Complaint: - within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion):

On perusal of complaint, SCN, written brief of complainant and submission made by insurance company during personal hearing it is observed that complainant has given complaint for deduction of amount and urged for payment of balance amount. Out of claim bill of Rs. 1,28,000/- as per policy terms and condition Rs. 64,000/- have been paid. The insurance company plea the maximum amount was already settled to the Insured as per the Terms and Conditions of the policy, there is no further amount liable for payment under the policy for the present claim. As per the Scope of Cover Table C (3) of the Policy, "Temporary Total Disablement: If at any time during the period of insurance the insured person/s shall sustain Grievous injury arising solely and directly from an accident and resulting in hospitalization, then the insured person will be paid a sum calculated at 1% of the sum insured under Table C per completed week but not exceeding Rs.15,000/- per completed week, in all, under all Personal Accident policies, if such injury be the sole and direct cause of Temporary Total Disablement." Insurance company further adduced medical opinion of Dr. B. Pasupathy, M.B.D (Ortho), M.S (ortho) wherein he pointed that **"the procedure done for ACL tear is ACL reconstruction. Normal protocol rehabilitation for the**

above injury-surgery is 8 weeks of physiotherapy is enough. The meniscus was not repaired only meniscectomy was done so there is no need for extra long rehabilitation to 15 weeks." It is seen that Meniscectomy is the surgical removal of all or part of a torn meniscus. A meniscus tear is a common knee joint injury. Surgeons who perform meniscectomies (orthopedic surgeons) will make surgical decisions based on the meniscus's ability to heal as well as your age, health, and activity level. In the instant case, the opinion of Dr. B. Pasupathy, M.B.D (Ortho), M.S (ortho) is sufficient to justify insurance company stand. Further, going through the medical certificate of Dr. Mukul Awasthi dated 01-05-2019 on letter head of clinic advising rest for 37 days i.e. from 01-05-2019 to 08-06-2019 is not proper because same is not supported by any documentary evidence. It is surprising that the complainant had taken treatment by getting himself admitted in hospital for ACL tear on 07.06.2019 despite the fact that the date of accident in this case was 01.05.2019. There is no evidence of any treatment have been taken by him from 01.05.2019 except the certificate advising him rest for 37 days from 01.05.2019 to 08.06.2019 which is nothing but an afterthought. The complainant has not produced any evidence that he had taken any treatment from any doctor before 07.06.2019. The treatment in this case started on 07.06.2019 after about 37 days of his getting involved in accident despite the fact that Acute ACL tear is an extremely painful condition. In view of what has been discussed above and also because of various contradictions the deduction of claim amount by insurance company is totally justified and proper. Hence, complaint is hereby dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of online video conferencing, the said complaint is hereby dismissed on merits.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 13th day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Ujwal V/S Star Health and Allied Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-044-2021-0596

1.	Name & Address of the Complainant	Mr. Ujwal, Goyal Jewellers, V& PO- Amin, Kurukshetra- 136038 Mobile No.- 9017171713

2.	Policy No: Type of Policy Duration of policy/Policy period	P/211123/01/2020/001634 Family Health Optima Insurance Plan 20/07/2019 to 19/07/2020
3.	Name of the insured Name of the policyholder	Mrs. Komal Rani Mr. Ujwal
4.	Name of the insurer	Star Health and Allied Insurance Co. Ltd.
5.	Date of Repudiation	Not applicable
6.	Reason for repudiation	Cashless Denial on PED . USG dated 11-03-2017 shows a long standing condition which is prior to the commencement of the policy
7.	Date of receipt of the Complaint	02-02-2021
8.	Nature of complaint	Repudiation of claim
9.	Amount of Claim	Rs 34,500/-
10.	Date of Partial Settlement	Not applicable
11.	Amount of relief sought	Rs 34,500/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021 Video Conferencing/ Chandigarh
14.	Representation at the hearing	
	For the Complainant	Mr. Ujwal, Complainant
	For the insurer	Ms.Mamta Gupta
15	Complaint how disposed	Award
16	Date of Award/Order	06-04-2021

17) Brief Facts of the Case:

On 02-02-2021, Mr. Ujwal had filed a complained that his spouse Mrs. Komal Rani was admitted as a case of Cholelithiasis and laparoscopy cholecystectomy was done. Insurance company has repudiated the claim on the ground of pre-existing disease. Policy was purchased on 08-07-2016. Cholelithiasis was diagnosed on 11-03-2017. He requested that insurance company may be instructed to pay his wife's claim.

On 02-02-2021, the complaint was forwarded to Star Health and Allied Insurance Co. Ltd. Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 30-03-2021 on email.

In the SCN insurance company stated that the complainant took Family Health Optima Insurance Plan covering Self (Mr.Ujwal Goyal), Spouse (Mrs. Komal Rani), Dependent Children (Mst. Purav Goel and Ms. Avni) For the sum insured of Rs. 5,00,000/- vide Policy No P/211123/01/2020/001634 for the period of 20/07/2019 to 19/07/2020. The Insured reported the claim in the 4th year of the Medical Insurance Policy. As per Pre-authorization form, the insured claimed approval for an estimated amount of Rs. 34,650/- to avail cashless facility. The Insured, Mrs. Komal Rani, aged 26 / Female, was admitted on 14/03/2020 at Cygnus Superspeciality Hospital, Kurukshetra. As per the Pre-authorization form, the insured was diagnosed with Cholelithiasis. On receipt of the Pre-authorization form, a sum of Rs. 10,000/- was initially approved. Subsequently, the insured submitted additional documents to enhance the Pre-authorization sum and on scrutiny of the same, the claim was repudiated vide letter dated 16/03/2020 for the below mentioned reason. It is observed from the USG Report dated 11/03/2017 that the insured person has Multiple Calculus. From the above fact it is evident that the insured was having a long standing condition which is prior to the commencement of the policy. The insured failed to disclose the same in proposal prior to issuance of the policy. Therefore, the cashless-authorization was rejected under Exclusion No. 3 (1) of the policy and communicated to the treating hospital as well as the insured vide copy of our letter dated 16/03/2021. Subsequently, the insured submitted a request for reconsideration of the repudiation of the claim. On receipt of the same, the claim was duly reviewed and the insured was communicated to submit the Doctor's Referral Letter for USG Report dated 11/03/2017. But the insured did not submit the same. Pre Existing Disease means, any condition, ailment or injury or related condition(s) for which the insured person had signs or symptoms and / or were diagnosed and / or were received medical advice / treatment within 48 months prior to the policy. As per Exclusion No. 3 (1) of the policy, "The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of: Pre Existing Diseases as defined in the policy until 48 consecutive months of continuous coverage have elapsed, since inception of the first policy with any Indian Insurer. However the limit of the Company's liability in respect of claim for pre-existing diseases under such portability shall be limited to the sum insured under first policy with any Indian Insurance Company". Hence, the claim is not liable under Exclusion No. 3 (1) of the policy. Insurance company pointed that cashless settlement/ facility are not a part of contractual obligation as per the terms and conditions of the insurance policy contract. It is more than the commitment given under the contract of insurance and meant for extra- comfort level for the customer. It is a facility extended to those cases where the liability of the insurance company under the policy is established beyond any doubt. In all other cases, the insured has to submit a completed claim form with all supporting treatment documents to enable the company to understand and process the claim on its merit. In this case, they have rejected only the cashless authorization and the insured has not approached for reimbursement of medical expenses. Hence, they are not aware of the exact amount spent by the insured at the time of hospitalization.

The complainant was sent Annexure VI-A for compliance, which reached this office on 08-02-2021.

18) Cause of Complaint:

a) **Complainant's argument:** Complainant stated that insurance company rejected his daughter's claim on flimsy ground of PED. He requested for payment of his claim.

b) **Insurers' argument:** Insurance Company reiterated their contents of SCN and emphasized for dismissal of complaint.

19) Reason for Registration of Complaint:- within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion):

On perusal of complaint, SCN, written brief of complainant and submission made by insurance company during personal hearing it is observed that complainant has given complaint for repudiation of his mediclaim and urged for payment of his claim. The insurance company however, was represented by their executive who reiterated the contents of the SCN and the repudiation letter dated 16.03.2020 issued to complainant for denying the cashless claim. The insurance company plea that it was observed from the USG Report dated 11/03/2017 that the insured person has Multiple Calculus. From the above fact it is evident that the insured was having a long standing condition which is prior to the commencement of the policy. As per documents available in the file complainant is covered under Family Health Optima Insurance Plan for the period 20/07/2019 to 19/07/2020. There is no dispute that complainant took Policy No. P/211114/01/2017/001491 for the period of 08/07/2016 to 07/07/2017 for the first time from insurance company and the same was subsequently renewed. In the instant case, insurance company denial of claim on the basis of USG Report dated 11/03/2017 is not logical because same is after purchasing the policy. On scrutiny of various documents it is seen that the repudiation letter doesn't mention anything about the nature of pre existing illness, no medical records in support of the claim by insurance company about pre existing illness has been placed before this Forum by insurance company. As such insurance company has failed miserably to produce any documents in support of their contention about the pre existing Multiple Calculus prior to purchase of policy. Even as per the record of hospital where the complainant was treated by laparoscopy is cholecystectomy is silent on any pre existing ailment. The denial of claim by insurance company being totally unjustified and arbitrary; the insurance company is directed to settle the claim subject to submission of complete documents / bills relating to treatment taken by insured within 30 days after the receipt of the award copy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, the insurance company is directed to settle the claim subject to submission of complete documents / bills relating to treatment taken by insured within 30 days after the receipt of the award copy.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 06th day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mr. Bhim Singh V/S Star Health and Allied Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-044-2021-0721

1.	Name & Address of the Complainant	Mr. Bhim Singh House no-40, Ward No-4, Village- Dhani Mithi, Tehsil- Siwani Mandi Distt:-Bhiwani Mobile No.- 9992365096
2.	Policy No: Type of Policy Duration of policy/Policy period	P/211125/01/2020/001862 Corona Rakshak Policy 17-10-2020 to 29-07-2021
3.	Name of the insured Name of the policyholder	Mr. Bhim Singh Mr. Bhim Singh
4.	Name of the insurer	Star Health and Allied Insurance Co. Ltd.
5.	Date of Repudiation	02-02-2021
6.	Reason for repudiation	Patient's vital and general condition are stable and within normal limits
7.	Date of receipt of the Complaint	18-03-2021
8.	Nature of complaint	Repudiation of claim
9.	Amount of Claim	Rs 2,50,000/-
10.	Date of Partial Settlement	Not applicable
11.	Amount of relief sought	Rs 2,50,000/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021 Video Conferencing/ Chandigarh
14.	Representation at the hearing	
	For the Complainant	Mr. Bhim Singh, Complainant
	For the insurer	Ms.Mamta Gupta
15	Complaint how disposed	Award
16	Date of Award/Order	07-04-2021

17) Brief Facts of the Case:

On 18-03-2021, Mr. Bhim Singh had filed a complained that that he has purchased Corona Rakshak Policy Star Health & Allied Insurance Co. Ltd for period 17-10-2020 to 29-07-2021. Unfortunately, he was admitted to in Hospital for 10 days due to Corona positive as per the advice of his treating doctor. He submitted all the documents to the insurance company. His claim has been rejected by the insurance company unlawfully on the ground that there was no requirement of admission. He stated that he was admitted on the advice of his treating doctor. He requested that insurance company may be instructed to reimburse his claim.

On 18-03-2021, the complaint was forwarded to Star Health and Allied Insurance Co. Ltd. Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 26-03-2021 on email.

In the SCN insurance company stated that the complainant took took Corona Rakshak Policy covering Self (Mr. Bhim Singh) for the Sum Insured of Rs. 2,50,000/- vide policy no. P/211125/01/2021/001862 for the period from 17/10/2020 to 29/07/2021. The Insured reported the claim in the 2nd Month of the medical insurance policy. As per Claim form, the Insured claimed an amount of Rs. 2,50,000/- towards the Lump sum benefits of COVID -19 positive. The Insured, Mr. Bhim Singh, 26 years was admitted on 27/11/2020 at Maharaja Agrasen Medical College & Hospital, Agroha (Hisar) and discharged on 07/12/2020. As per Discharge Summary from the treating hospital, the insured was diagnosed COVID-19 positive and underwent Conservative treatment. Subsequently, the insured submitted a claim for reimbursement. The Insured submitted the last necessary documents on 12/01/2021 and the claim for reimbursement of medical expenses was repudiated on 02/02/2021. On scrutiny of claim documents, it is observed from that as per indoor case records, the insured patient vital signs including Spo2 are normal throughout the period of hospitalization. As per the admission notes dated 27/11/2020 of the treating hospital, the SPO2 level of the Insured at the time of Admission was 100%. As per the Indoor Case Paper of the treating hospital, the SPO2 level and respiratory rate of the Insured was as follows:

27 /11/2020 – SPO2 - **97%**;
28/11/2020 – SPO2 - **98%**;
29/11/2020 – SPO2 – 96 to 98%
30/11/2020 – SPO2 – 94 to 96%
01/12/2020– **Vitals Stable** – SPO2 level not recorded
02/12/2020 – **Vitals Stable** – SPO2 level not recorded
03/12/2020 – **Vitals Stable** – SPO2 level not recorded
04/12/2020 – SPO2 - **SPO2- 96/%**
05/12/2020 – SPO2 - **SPO2- 100/%**

Further, as per the guidelines from All India Institute of Medical Sciences, New Delhi and Ministry of Health and Family Welfare, Government of India regarding the treatment of COVID 19 patients, the patients with SpO2 level greater than 94% on room air and respiratory rate lesser than 24/min are having only Mild Infection. The patients with Mild Infection are prescribed Home Isolation only. As per the Revised guidelines for Home isolation of very mild / pre symptomatic / asymptomatic COVID 19 cases dated 02/07/2020 issued by Ministry of Health and Family Welfare, Government of India, the COVID patients are advised to seek medical assistance only there is difficulty in breathing, Dip in oxygen saturation (SpO2 < 95%), persistent pain/pressure in the chest, mental confusion or inability to arouse, slurred speech/seizures, weakness or numbness in any limb or face and developing bluish discolorations of lips/face. It is evident that the AIIMS Guidelines are issued based on the recommendations of Ministry of Health and Family Welfare, Government of India. Hence, the hospitalization of the insured is not warranted. Hence, the claim was repudiated and communicated to the Insured vide letter dated 02/02/2021. As per Discharge card of the above hospital - tampering is noted in the period of hospitalization. Further, as per the indoor case records, the insured patient vital signs including Spo2 are normal

throughout the period of hospitalization. As per the Operative Clause of the Policy, "If during the policy period the Insured Person is diagnosed with COVID and hospitalized for more than seventy-two hours following Medical Advice of a duly qualified Medical Practitioner as per the norms specified by Ministry of Health and Family Welfare, Government of India, the Company shall pay the agreed sum insured towards the Coverage mentioned in the policy schedule." Hence, following the guidelines from All India Institute of Medical Sciences, New Delhi and Ministry of Health and Family Welfare, Government of India is justified. Therefore, for the above stated reasons, it is not possible to make the payment for the claim of the insured. They requested for dismissal of complaint.

18) Cause of Complaint:

a) **Complainant's argument:** Complainant stated that insurance company rejected his claim on flimsy grounds. He requested for payment of his claim.

b) **Insurers' argument:** Insurance Company stated that they have rightly repudiated the claim on the basis of policy terms and condition.

19) Reason for Registration of Complaint: - within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company
b) Copy of Policy Document
c) Annexure VI-A
d) Reply of the Insurance Company

21) Result of video conferencing with both parties (Observations & Conclusion):

On examination of various documents available in file including the copy of complaint, SCN filed by insurance company, discharge summary of hospital and submissions made by both complainant and insurance company at the time of video conferencing, it is seen that the complainant claim for covid-19 has been denied by insurance company vide letter dated 02-02-2021. The denial has been done due to reasons "as per the indoor case records, the insured patient vital signs including Spo2 are normal throughout the period of hospitalization." It is seen that there is no dispute that complainant was tested positive for Covid-19 by either parties. There is also no dispute that complainant was tested for covid-19 in Maharaja Agrasen Medical College & Hospital, Agroha (Hisar) on 27-11-2020 and thereafter he remained admitted in the above hospital form 27-11-2020 and got discharged on 07-12-2020. The plea of insurance company that tampering is noted in the period of hospitalization is immaterial since the complainant was a referred case and he has no role in it. Further, the complainant was admitted as per advice of the treating doctor in which complainant has no role. Therefore, the repudiation of the insurance company is not in order and insurance company is directed to pay the admissible claim amount subject to terms and condition of the policy after completion of claim related formalities within 30 days after the receipt of award copy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of video conferencing, insurance company is directed to pay the admissible claim amount subject to terms and condition of the policy after completion of claim related formalities.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 07th day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Ms. Padma Bhatia V/S Star Health and Allied Insurance Co. Ltd.
COMPLAINT REF. NO: CHD-H-044-2021-0723

1.	Name & Address of the Complainant	Ms. Padma Bhatia 2013, St No-2, Jaswant Nagar Near Karma Hospital, Samrala Chowk,Ludhiana Mobile No.- 7009546477
2.	Policy No: Type of Policy Duration of policy/Policy period	P/211200/01/2021/001287 Medi-classic Insurance Policy 22-05-2020 to 21-05-2021
3.	Name of the insured Name of the policyholder	Ms. Padma Bhatia Ms. Padma Bhatia
4.	Name of the insurer	Star Health and Allied Insurance Co. Ltd.
5.	Date of Repudiation	04-12-2020
6.	Reason for repudiation	Patient was symptomatic 4 days prior from the date of admission and it falls under 30 days waiting period.
7.	Date of receipt of the Complaint	18-03-2021
8.	Nature of complaint	Repudiation of claim
9.	Amount of Claim	Rs 2,22,249/-
10.	Date of Partial Settlement	Not applicable
11.	Amount of relief sought	Rs 2,22,249/-
12.	Complaint registered under Rule no: Insurance Ombudsman Rules, 2017	Rule 13 (1)(b) – any partial or total repudiation of claims by an insurer
13.	Date of hearing/place	05.04.2021 Video Conferencing/ Chandigarh
14.	Representation at the hearing	
	For the Complainant	Ms. Padma Bhatia, Complainant
	For the insurer	Ms.Mamta Gupta
15	Complaint how disposed	Dismissed

16	Date of Award/Order	07-04-2021

17) Brief Facts of the Case:

On 18-03-2021, Ms. Padma Bhatia had filed a complained that that she is insured from Star Health & Allied Insurance Co. Ltd. under Medi Classic Insurance policy No. P/211200/01/2021/001287 for period 22-05-2020 to 21-05-2021. Unfortunately on 24-June-2020, her condition worsened with fever and she was admitted to "Mohan Dai Oswal Hospital Ludhiana". Doctor recommended Covid-19 test on 25-June-2020 and report came positive on 26-June-2020 at around 12 PM. Her claim has been rejected by the insurance company unlawfully. She requested this forum to kindly look into the matter and arrange for the payment of the claim.

On 18-03-2021, the complaint was forwarded to Star Health and Allied Insurance Co. Ltd. Regional Office, Chandigarh, for Para-wise comments and submission of a self-contained note about facts of the case, which was made available to this office on 26-03-2021 on email. In the SCN insurance company stated that the complainant took Medi-classic Insurance Policy (Individual) covering Self (Mrs.Padma Bhatia) for the Sum Insured of Rs. 3,00,000/- vide policy no. P/211200/01/2021/001287 from 22/05/2020 to 21/05/2021. The Insured reported the claim in the 33rd day of the medical insurance policy. As per Claim form, the Insured claimed an amount of Rs. 1,07,600/- towards the treatment of Acute Infective Viral Pneumonia, Covid 19 Positive , T2 DM. The insured Mrs. Padma Bhatia, 63 years 7 months / Female was admitted on 24/06/2020 at Mohandai Oswal Hospital - Ludhiana and discharged on 07/07/2020. As per Discharge Summary from the treating hospital, the insured was diagnosed for Acute Infective Viral Pneumonia,Covid 19 Positive , T2 DM. The Insured raised Pre-authorization request to avail cashless facility. It is observed from the Pre-authorization Form duly filled and signed by the treating doctor that the insured has a history of symptoms since 4 days. It is observed from the documents submitted that the patient is admitted in the hospital for treatment during the first 30 days from the date of commencement of the policy. As per waiting period/exclusion no. 3(i) of the policy, the claim is not admissible. Hence cashless request was repudiated on 25.06.2020. The Insured submitted claim documents for reimbursement of medical expenses on 19/11/2020 and the same was repudiated on 04/12/2020. On scrutiny of claim documents, it is observed from the Pre-authorization request form duly completed and signed by the doctor and with the seal of the above hospital that the insured patient has shortness of breath for 4 days prior to the date of admission. Which confirms that insured patient was symptomatic of above diagnosis during the first 30 days from the date of commencement of the policy. From the above mentioned facts, it is evident that the insured was symptomatic of the diagnosis and the onset of the diagnosed disease was during the first 30 days from the commencement of the policy. As per 3 Exclusion No. 3. 30 days waiting period - Code Excl. 03(A) of the above policy, the company is not liable to pay any claim pertaining to expenses related to the treatment of any illness within 30 days from the first policy commencement date. "30-day waiting period - Code Excl 03

A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered
B. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently".
Hence, the claim was repudiated and the same was communicated to the insured vide letter dated 04/12/2020. Therefore, for the above stated reasons, it is not possible to make the payment for the claim of the insured. They requested for dismissal of complaint.
The complainant was sent Annexure VI-A for compliance, which reached this office on 25-03-2021.

18) Cause of Complaint:

a) **Complainant's argument:** Complainant stated that repudiation of claim by insurance company is not based on logical grounds. Her claim is very much payable and genuine.
b) **Insurers' argument:** Insurance Company stated that their repudiation is made as per policy terms and condition.

19) Reason for Registration of Complaint:- within the scope of the Insurance Ombudsman Rules, 2017.

20) The following documents were placed for perusal.

a) Complaint to the Company b) Copy of Policy Document

c) Annexure VI-A d) Reply of the Insurance Company

21) Result of Personal hearing with both parties (Observations & Conclusion):

I have gone through the various documents available in file including the copy of complaint, copy of policy and submissions made by both parties during video conferencing. It is observed that complainant has given complaint for denial of his health claim lodged under the policy and urged for payment of his claim. As per insurance company their decision is justified. In the instant case, it is seen that the there is no dispute that complainant was admitted on 24/06/2020 at Mohandai Oswal Hospital - Ludhiana and discharged on 07/07/2020. As per Discharge summary from the treating hospital, the insured was diagnosed for Acute Infective Viral Pneumonia,Covid 19 Positive and T2 DM. Insurance company mainly relied upon their exclusion clause of waiting period. It is seen that as per waiting period clause "Any disease contracted by the insured person during the first 30 days from the commencement date of the policy." In the instant case, it is seen that complainant policy inception date is 22-05-2020 and he was admitted for Covid 19 +ve on 24-06-2020. The admission is due to illness and same falls under the waiting period. As such, there is no deficiency of service noticed on the part of insurance company. On perusal of various documents submitted by insurance company it is also seen that the Pre-authorization Form dated 24-06-2020 duly filled and signed by the treating doctor of Mohandai Oswal Hospital - Ludhiana where complainant was admitted clearly indicates that she had symptoms for last 04 days. As such the stand taken by insurance company that complainant had contracted the illness within waiting period and as per waiting period clause is applicable the claim is not payable**.** As such, there is no deficiency of service noticed on the part of insurance company. Hence, the decision of the insurance is in order and complaint is dismissed accordingly.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of online hearing, the said complaint is hereby dismissed on merits.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 07th day of April 2021.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORETHE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
INSURANCE OMBUDSMAN- Dr. D.K. VERMA

Case of Mrs. Tarlochan Rani V/S Bajaj Allianz General Insurance Co. Ltd
COMPLAINT REF. NO: CHD-H-005-2021-0625

1. On 11.02.2021, Mrs. Tarlochan Rani had filed a complaint in this office against Bajaj Allianz General Insurance Co. Ltd for not settling the health claim. The required documents were submitted to the insurance company but the insurance company did not settle the health claim under policy no. OG-21-1203-8430-00000662.

2. This office pursued the case with the insurance company to re-examine the complaint and they agreed to reconsider the claim.

3. Mrs. Tarlochan Rani confirmed telephonically that her complaint has been resolved by insurance company and she has received payment of her claim and wants to withdraw her complaint from this forum.

4. In view of the above, no further action is required to be taken by this office and the complaint is disposed off accordingly.

Dated: 05-04-2021 **(Dr. D.K. VERMA)**

PLACE: CHANDIGARH **INSURANCE OMBUDSMAN**

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF WESTERN U.P. & UTTARAKHAND
UNDER INSURANCE OMBUDSMAN RULES, 2017
OMBUDSMAN –SH. C.S. PRASAD
CASE OF SH. ANIL KUMAR GUPTA V/S HDFC ERGO GEN. INSURANCE CO.
COMPLAINT REF. NO. : NOI-H-018-2021-0237

AWARD NO:

1.	**Name & Address of the Complainant**	**Sh. Anil Kumar Gupta** **163, Patiyali Gate, Etah,** **Uttar Pradesh-207001.** **Phone No.09410834281**
2.	**Policy No:** **Type of Policy** **Policy period** **Sum Insured**	**2857 2015 8351 8003 000** **Health Medisure Classic Insurance Policy** **18.12.2019 to 17.12.2020** **Rs.3,00,000/-**
3.	**Name of the insured** **Name of the policyholder**	**Sh. Anil Kumar Gupta** **Sh. Anil Kumar Gupta**
4.	**Name of the insurer**	**HDFC Ergo Gen. Insurance Co.**
5.	**Date of Repudiation**	**16.08.2020**
6.	**Reason for repudiation**	**Claim repudiated on the basis of treatment is not covered**
7.	**Date of receipt of the Complaint**	**15.01.2021**
8.	**Nature of complaint**	**Individual Mediclaim**
9.	**Amount of Claim**	**--**
10.	**Date of Partial Settlement**	**--**
11.	**Amount of relief sought**	**Rs.1,41,572/- as per Annex VI A**
12.	**Complaint registered under Rule of IOB rules,2017**	**13 (1) (b)**
13.	**Date of hearing/place**	**12.04.2021 /NOIDA**
14.	**Representation at the hearing**	

	a) For the Complainant	**Sh. Anil Kumar Gupta**
	b) For the insurer	**Ms. Khushmani Kaur, Asstt. Manager**
15	**Complaint how disposed**	**Award**
16	**Date of Award/Order**	**22.04.2021**

17. Brief Facts of the Case : Sh. Anil Kumar Gupta, the complainant had taken Health Medisure Classic Insurance Policy No. 2857 2015 8351 8003 000 commencing from 18.12.2019 to 17.12.2020 was issued for a S.I. of Rs.3,00,000/-. The Insurance Company had repudiated his claim on the ground that experimental treatment was not covered. Aggrieved, he requested the insurer including its GRO to reconsider the claim but failed to get any relief. Thereafter, he has preferred a complaint to this office for resolution of his grievance.

18. Cause of Complaint:

a) Complainant's argument: The complainant Sh. Anil Kumar Gupta stated in his complaint that he was diagnosed with coronary artery disease (CAD) and get treatment at Saaol Heart Center under the supervision of Dr. Bimal Chhajer, MBBS, MD from 11.02.2020 to 02.06.2020 for the same. His claim has been rejected by the Insurance Company on 16.08.2020 which is unjustified.

b) Insurers' argument: The Company in their SCN stated that :

1. That through the present complaint, the complainant is seeking the reimbursement of the expenditure incurred during his hospitalization from 11/02/2020 to 02/06/2020.

2. That as per the Discharge Summary submitted by the complainant, the complainant was suffering from Coronary Artery Disease. He had taken EECP (Natural Bypass)- 35 sittings and Cardio Detox/Biochemical Angioplasty (BCA)- 20 sittings. Further, the Discharge Summary also mentions that the complainant was hospitalized for 24 hours on 11/02/2020 and thereafter only 4-5 hours of daily hospitalization was required.

3. That EECP, as per the Discharge Summary, is a procedure wherein the machine supplies more blood to the heart muscles during diastole. Further, as per the Lifeline Multispeciality Hospital, EECP is a no risk, non-surgical and non-invasive safe treatment. Further, it is totally an OPD procedure where no hospitalization is required.

4. The respondent would further like to submit that another treatment taken by the complainant was Biochemical Angioplasty/Cardio Detox. That the same is also called Chelation Therapy. As per the Discharge Summary, Biochemical Angioplasty/Cardio Detox is a procedure wherein certain chemicals are injected in the patient through intravenous route for a period of two hours to obtain softening of blockage and gradual reduction of blockage. That as per the US Department of Health and Human Services the use of EDTA chelation has not been approved by the FDA. It also states that a large scale study of EDTA Chelation is currently in progress and when the study is completed, the results of the study shall be used to determine whether approve the use of EDTA chelation therapy.

   Further, as per the paper titled "*Role of EDTA chelation therapy in cardiovascular diseases"* published in the National Medical Journal of India, "*The available data do not support the use of chelation in cardiovascular diseases".*

5. That as per the terms and conditions of the policy, treatment taken as an outpatient is excluded from the policy. Relevant condition is quoted herein below for your reference:

   "Day Care treatment: *refers to medical treatment and/or surgical procedure which is*
   - *undertaken under……, and*

- *which would have……..24 hours*
- *Treatment taken as an outpatient is not included under the Policy."*

That EECP is an OPD procedure and so any expenditure incurred during this procedure is excluded from the scope of the policy.

6. Further, as per the Exclusion clause of the policy, treatment that is not scientifically recognized or experimental or unproven is excluded from the policy. Relevant condition is quoted below for your reference:

"D. EXCLUSIONS
The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:
17. Certification / Diagnosis / Treatment by a family member or from persons not registered as Medical Practitioners under the respective Medical Councils, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven."

That the policy defines the terms Experimental/Unproven in the following manner:

"Unproven/Experimental treatment: *Treatment including drug experimental therapy which is not based on established medical practice in India and is a treatment experimental or unproven."*

That in view of the aforementioned information, since chelation therapy is an experimental treatment, the same is excluded from the scope of policy.

7. That the claim of the complainant was processed as per the terms and conditions of the policy and the same was repudiated vide letter dated 16/08/2020.

19) <u>Reason for Registration of Complaint</u>:-Repudiation of Mediclaim

20) The following documents were placed for perusal:-
a) Annex VI A
b) Complaint copy
c) Policy copy
d) SCN

21) <u>Observations and Conclusion :-</u>

Both the parties appeared for personal hearing through video call and reiterated their submissions. Sh. Anil Kumar Gupta, the Complainant has reiterated that he is patient of Saaol Heart Center. His claim has been wrongly rejected by the Insurance Company.

The Insurance Company reiterated that the patient was managed with EECP and Biochemical Angioplasty which is not covered under the policy. The EECP is a procedure wherein the machine supplies more blood to the heart muscles during diastole. Further, as per the Lifeline Multispeciality Hospital, EECP is a no risk, non-surgical and non-invasive safe treatment. Further, it is totally an OPD procedure where no hospitalization is required. As per the terms and conditions of the policy, treatment taken as an outpatient is excluded from the policy. Moreover, as per the Exclusion clause of the policy, treatment that is not scientifically recognized or experimental or unproven is excluded from the policy.

I have examined the documents exhibited as evidence and oral submissions made by both the parties. The Insurer seems to have taken a very narrow and technical view of the case with the intention to repudiate

the claim. There is no dispute about the fact that the complainant was admitted and treated in Saaol Heart Centre for his heart ailments. It is evident from the documents submitted that Saaol Heart Centre is a well established institution run by well known medical practitioners nursing staff and is engaged in providing treatment to the patients.

The ground of rejection is that the complainant was managed by EECP and Bio chemical Angioplasty which is not covered under the policy. It is observed from the discharge summary dated 02.06.2020 signed by Dr. Bimal Chhajer that the complainant "has been suffering from Coronary Artery Disease (CAD) and was treated under his supervision." He has explained the line of treatment and the beneficial impact it had on the patient. It is also pertinent to mention that Saaol Heart Centre is a well known institution run by qualified doctors including Dr. Bimal Chhajer who is known for applying unconventional and unorthodox methods to treat heart ailments.

There are other orders passed by the other Insurance Ombudsmens e.g. judgments of Sh.Vijay Kumar Data Vs. New India Assurance Co. Award No.IO/CHD/A/GI/0136/2016-2017 passed by Chandigarh Ombudsman, Sh. Pradeep Kumar Pawar vs. National Insurance Co. Award No. IO/DEL/A/GI/0257/2016-17 passed by Delhi Ombudsman and Sh. Prabhu Dayal Vs. Star Health and Allied Ins. Co. Award No.IO/JPR/A/GI/0032/2015-16 passed by Jaipur Ombudsman in the similar cases in Saaol Heart Center (Chandigarh, Delhi and Jaipur) in respect of similarly placed patients who underwent similar treatment at Saaol Heart Centre. They have awarded relief to the above complainants whose claims were also repudiated by the Insurance Companies. It is also mentioned that the policy taken by the instant complainant does not say anything about not entertaining the cost of treatment taken in such hospitals like Saaol Heart Centre. Following the judicial discipline, I feel that the ends of justice will be met if the complainant's claim is settled by the Insurance Company.

AWARD

Taking into account the facts and circumstances of the case and the submissions made by both the parties during the course of hearing, the Insurance Company is directed to settle the claim and pay the admissible amount to the complainant as per terms and conditions of the policy.

The complaint is treated as disposed off accordingly.

22. The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

a) According to Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Place: Noida.
Dated: 22.04.2021

C.S. PRASAD
INSURANCE OMBUDSMAN
(WESTERN U.P. & UTTARAKHAND)

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OFWESTERN U.P AND UTTARAKHAND
UNDER THE INSURANCE OMBUDSMAN RULES, 2017
OMBUDSMAN – SH. C.S. PRASAD
CASE OF MR. INSAD ALI V/S. ICICI LOMBARD GEN. INS. CO.
COMPLAINT REF. NO.: NOI- H- 020- 2021 - 0240

AWARD NO:

1.	**Name & Address of the Complainant**	**Mr. Insad Ali,** **H.No.12, Water Tank** **Compound – 12, Sector-53,** **Gautam Budh Nagar** **Uttar Pradesh-201301.** **Ph. No.08448026787**
2.	**Policy No:** **Type of Policy** **Policy period**	**4150/192720539/00/000** **Hospifund Insurance Policy** **29.01.2020 to 27.01.2021**
3.	**Name of the insured** **Name of the policyholder**	**Mr. Insad Ali** **Mr. Insad Ali**
4.	**Name of the insurer**	**ICICI Lombard Gen. Insurance**
5.	**Date of Repudiation**	**10.10.2020**
6.	**Reason for repudiation**	**Misrepresentation**
7.	**Date of receipt of the Complaint**	**27.01.2021**
8.	**Nature of complaint**	**Individual Mediclaim**
9.	**Amount of Claim**	**N.A.**
10.	**Date of Partial Settlement**	**N.A.**
11.	**Amount of relief sought**	**Rs.1,00,000/- as per Annexure VI A**
12.	**Complaint registered under IOB Rules, 2017**	**13 (1) B**
13.	**Date of hearing/place**	**12.04.2021 /Noida**
14.	**Representation at the hearing**	
	a) For the Complainant	**Mr. Insad Ali**
	b) For the insurer	**Ms. Terry Nambiar- Manager- Legal**
15	**Complaint how disposed**	**Dismissed**
16	**Date of Award/Order**	**22.04.2021**

17) **Brief Facts of the Case :** Mr. Insad Ali, the complainant had taken Hospifund Insurance Policy No. 4150/192720539/00/000 commencing from 29.01.2020 to 27.01.2021 was issued to the complainant. The Insurance Company rejected his claim on the ground of Misrepresentation / Fraudulent Claims. Aggrieved, he requested the insurer including its GRO to reconsider the claim but failed to get any relief. Thereafter, he has preferred a complaint to this office for resolution of his grievance.1

18) **Cause of Complaint:**

a) **Complainants argument :** The Complainant Mr. Insad Ali stated in his complaint that his wife Ms. Shabana begum was hospitalized for the period from 12.08.2020 to 17.08.2020. He claimed for Daily Cash Benefits which was rejected by the Insurer on the ground of misrepresentation.

b) Insurers' argument: The Insurer stated in their SCN that Mr. Inshad Ali had opted for Hospifund Insurance Policy no. 4150/192720205/00/000 Covering his wife i.e. Shabana (herein after called as **Insured**).

Further, they would like to highlight what are the standard exclusions and the terms and conditions were displayed while opting for the said policy to the Proposer and it was clearly mentioned that if any fraud or mis-representation is given by the Insured then the policy will be null and void no benefit is payable to the Insured. The Proposer agreed upon the terms and conditions of the policy and paid the premium amount. As per the policy wording the standard exclusions is as follows:-

PART III OF SCHEDULE
Standard terms and conditions:-
12. Fraudulent Claims
If any Claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by You or anyone acting on Your behalf to obtain any benefit under this Policy, or if a Claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

13.Cancellation/ termination
(a) Disclosure to information norm
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

(b) You may cancel the Policy during free look period (15 days from the date you receive the Policy) in which case we will refund the premium paid subject only to a deduction of the expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges.

It is clearly mentioned in the risk assumption letter that incase of any inconsistency the Proposer should approach the Company to rectify such inconsistency within 15 days of issue of such letter. The relevant clause for ready reference:

"*The policy has been issued on the details furnished by the policyholder. Please review the details furnished in the policy certificate and confirm the same are in order. In case of any discrepancy/variation you are requested to call us immediately at our toll free no. 1800 2666 within 15 days of issue of this letter*"

The complainant had submitted the claim reimbursement in the month of November, 2020 for hospitalization from August 12, 2020 to August 17, 2020 at Chandra Hospital towards treatment of fever, vomiting and pain in abdomen wherein the Company registered the claim and provided the claim no. SCM040611168.

Along with claim intimation, they had received the discharge summary through Complainant which was *handwritten discharge summary*. Along with claim intimation, the Company have received the pathology reports from Dr. Y K Goora and the complainant claimed the bill for an amount of Rs.6,700/- for the current hospitalisation. Further we have attached one sample pathology report of the doctor which we were in receipt along with the claim intimation. ***The company would like to state basis on the pathology reports the recommended 5 days hospitalization*** which is to be noted by your good office.

It is pertinent to highlight that along with claim intimation the complainant had submitted the fever chart which shows the fever was not more than 98F temperature but still the Complainant was admitted for 5 days. We would like to state that looking at the pandemic situation of COVID-19 with the normal temperature and with the body pain people were taking treatment at home and the Complainant decided

to stay at for 5 days in the hospital only for the fever and vomiting. Therefore, the company understood that there is fraud involved in the said matter. We hereby enclose herewith the fever chart as **Annexure-'G'** for your perusal.

After looking at the claim intimation form, discharge summary and all other documents, the company appointed the investigator in the said matter and the investigator met with the Applicant and Insured along with their daughter. If the Insured was suffering from malaria then her fever chart should show continue for 2 days at least 100 temperature but it was not showing in the fever chart. Therefore, the Investigator visited the Hospital for verification. The Complainant had submitted the documents wherein all the pathology reports are signed by Dr. Y.K Goorah and Company's investigator visited the pathologist Dr. Y. K Goorah wherein he clearly informed them that he is not associated with Chandra Hospital nor he has done any test with regard to the said patient. Further he clearly stated that the stamp and signature which are used on the pathology reports are forged by the hospital they are not his stamp and signature. The original stamp and signature he gave to the company after rejecting all the pathology reports.

Based on the pathology reports, the Hospitalization was mandatory but the pathology reports are only not original then the hospitalization for 5 days is not true of the Insured. After the Investigation, they have procured the above documents from the pathologist and found that there is fraud involved by the Applicant and the Hospital. The Company repudiated the claim as per the policy terms and conditions.

Further, the Company would like to state that the complainant is alleging that Oriental General Insurance has paid the claim amount of Rs. 39,000/- approx amount they were not aware of the fraud which the Complainant and Hospital conducted. The Company has shared the feedback to the Oriental Insurance; they may recover the amount from the Complainant soon for the fraudulent activity which they are conducting investigation.

In the pandemic situation of COVID-19, the hospital and applicants and few people who are running the fraudulent rackets trying to take undue advantage of the Insurance Money. In the said activity the Hospitals are also earning out of Insurance money as well as Applicants are also taking undue advantage of the Insurance money.

19) <u>Reason for Registration of Complaint</u>:- Rejection of Hospifund Cash Benefit

20) The following documents were placed for perusal:-

a) Annexure VI A
b) Complaint copy
c) Rejection letter
d) SCN

21) <u>Observations and Conclusion</u> :- Both the parties appeared for personal hearing through video call and reiterated their submissions. The Complainant Mr. Insad Ali reiterated that his wife Ms. Shabana begum was hospitalized for the period from 12.08.2020 to 17.08.2020. He claimed for Daily Cash Benefits which was rejected by the Insurer on the ground of misrepresentation.

The Insurance Company reiterated that the complainant had submitted the claim reimbursement in the month of November, 2020 for hospitalization of his wife from August 12, 2020 to August 17, 2020 at Chandra Hospital towards treatment of fever, vomiting and pain in abdomen. Based on the pathology reports from Dr. Y K Goora, the Hospitalization was mandatory. After investigation, it was found that the pathology reports are forged by the hospital; they are not his stamp and signature. The original stamp and signature have been provided by Dr. Y K Goora to the company after rejecting all the pathology reports. When it was found that the pathology reports are forged, then the hospitalization for 5 days is also not true of the Insured. After the Investigation, they have procured the above documents from the pathologist and

found that there is fraud involved by the Applicant and the Hospital. The Company repudiated the claim as per the policy terms and conditions.

During the course of hearing, the Insurance Company has confirmed that they are in the process of filing an FIR against the complainant regarding these misrepresentations.

It is observed that the claim papers have many discrepancies. The Insurer is in the process of filing an FIR as they have reasonable grounds of suspicion to fraud. Since, it will require deeper investigations to reveal the truth of such claim; such investigation is beyond the jurisdiction of this forum. The complaint is dismissed.

Recommendation

Taking into account the facts and circumstances of the case and the submissions made by both the parties during the course of hearing, the Insurer is in the process of filing an FIR as they have reasonable grounds of suspicions to suspect fraud. Since, it will require deeper investigations to reveal the truth of such claim; such investigation is beyond the jurisdiction of this forum.

The complaint is dismissed.

Place: Noida.
Dated: 22.04.2021

C.S. PRASAD
INSURANCE OMBUDSMAN
(WESTERN U.P. & UTTARAKHAND)

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF WESTERN U.P. & UTTRAKHAND
UNDER INSURANCE OMBUDSMAN RULE 2017
OMBUDSMAN: SH. C.S. PRASAD
CASE OF SH. ANIRUDH BHAGAT V/S. NATIONAL INSURANCE CO. LTD.
COMPLAINT REF. NO.: NOI-H-048-2021-0253

AWARD NO:

1.	**Name & Address of the Complainant**	**Sh. Anirudh Bhagat** **12/17 B, Nagla Balchand,** **Nunhai Road, Agra,** **Uttar Pradesh-282006** **Phone No. 9897007070**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period** **Sum Insured**	**461400/50/20/10000098** **National Mediclaim Plus Policy** **16.05.2020 to 15.05.2021** **Rs.10,00,000/- + C.B. Rs.2,00,000/-**
3.	**Name of the insured** **Name of the policyholder**	**Sh. Anirudh Bhagat** **Sh. Anirudh Bhagat**
4.	**Name of the insurer**	**National Insurance Company Ltd.**
5.	**Date of Repudiation**	**--**
6.	**Reason for repudiation**	**--**
7.	**Date of receipt of the Complaint**	**09.02.2021**
8.	**Nature of complaint**	**Individual Mediclaim**
9.	**Amount of Claim**	**N.A.**
10.	**Date of Partial Settlement**	**N.A.**

11.	**Amount of relief sought**	**Rs.1,45,465/- as per Annex. VI A**
12.	**Complaint registered under Insurance Ombudsman Rule 2017**	**13 (1)b**
13.	**Date of hearing/place**	**12.04.2021 / NOIDA**
14.	**Representation at the hearing**	
	y) For the Complainant	**Sh. Anirudh Bhagat**
	z) For the insurer	**Sh. Rajeev Kumar Satsangi, Sr. D.M.**
15	**Complaint how disposed**	**Award**
16	**Date of Award/Order**	**22.04.2021**

17. **Brief Facts of the Case**:- The Complainant Sh. Anirudh Bhagat had taken National Mediclaim Plus Policy No. 461400/50/20/10000098 for the period from 16.05.2020 to 15.05.2021 for the Sum Insured of Rs.10,00,000/- + C.B. Rs.2,00,000/-. The Complainant lodged the claim which was partially settled by the Insurance Company. Aggrieved, he requested the Insurer including its GRO to reconsider the settled claim amount but failed to get any relief. Thereafter, he has preferred a complaint to this office for resolution of his grievance.

18. **Cause of Complaint:-**

a) **Complainant's argument:-** Sh. Anirudh Bhagat, the Complainant stated in his complaint that :

He has a Mediclaim policy with National Insurance Company Ltd., Agra (Insurance policy no. 461400/50/20/10000098) for the sum insured of Rs. 10 Lac with bonus of Rs. 2 Lac. He has had this policy without break for the last 20 years.

He had repeated exchanges and arguments with the Insurance Company & TPA (MD India) and the Hospital (Max Saket, New Delhi). The summary of the exchange is -

- On 18th November 2020, he got admitted for Covid-19 treatment in Max Saket Hospital, New Delhi.
- He was charged by full amount by the Hospital (Bill No. SCIC96955; Rs. 5,12,217). This rate is without any subsidy given on account of Covid-19 treatment and there was no mention of the subsidy during the time he was admitted at the hospital.
- He got a cashless remittance of his insurance from TPA, MD India (appointed by National Insurance), who deducted a major amount of Rs. 1,45,465 stating that it is deducted under "As per Covid State GR package". TPA has completed the remittance on the basis of a subsidized rate, but that is not something he was originally charged by the hospital.
- Despite constantly talking to both parties, he has not received a satisfactory response from either.

b) **Insurers' argument:**- The Insurance Company provided the point-wise reply in their SCN and stated that :

Policy details :

NIC underwritten National Mediclaim Plus Policy
Policy number: 461400/50/20/10000098
Insured person: Shri Anirudh Bhagat
Policy period: 16.05.2020 TO 15.05.2021
Policy coverage/inception dt. : 16.05.2020
sum insured : 10,00,000- CB amt. 2,00,000 [applicable SI : 12,00,000]

Hospitalisation details :

TPA claim no. : MDI5952889
Patient Name :Shri Anirudh Bhagat
Patient age : 57
Hospital details : Max Smart Super Speciality Hospital, Delhi
D O A :18.11.2020
Diagnosis - COVID-19 PNEUMONIA
Claim request date : 01.12.2020

Case Details

As per their TPA M D India and papers provided the case details are as under:-
A 57 years old male patient Shri Anirudh Bhagat admitted in Max Smart Super Specialty Hospital, Delhi for date of D. O. A. 18.11.2020 to 01.12.2020. The Patient was admitted in hospital with complaining of sore throat and admitted with COVID-19 positive and patient treated with and outside HRCT Chest Corads 6 (CT severity score 5/25). The Patient was treated with Inj. COVIFOR,IV STEROIDS, Inj. Ulinafic and SPO2 and other supportive treatment .

Point Wise Reply

The Claimant (Patient) admitted with complaining of sore throat and admitted with COVID 19 positive and patient treated with and outside HRCT Chest Corads 6(CT severity score 5/25). The Patient was treated with Inj COVIFOR, IV steroids, Inj Ulinafic and SPO2 and other supportive treatment.

As per Delhi GR clause-2 : The rates for private hospitals beds would be all inclusive as a package. This will include, but not limited to: bed, food and other amenities, monitoring, nursing care, doctors' visits/ consults, investigations including imaging, treatment as per the national protocol for COVID care and standard care for co-morbidities, oxygen, blood transfusion etc.

As per Delhi GR clause-3: The package rates would include costs of medical care of underlying co-morbid conditions including supportive care and cost of medications thereof, for the duration of care for COVID. Since many of the COVID patients have conditions such as hypertension, diabetes, cardiovascular problems, etc., the charges for medical care of such co-morbidities will be a part of the package

As per Delhi GR clause-4 : The rates would apply to standard care of COVID-19 patients as per the National Guidelines. But these would not cover experimental therapies (e.g. Ramdesivir etc. Patient admitted in single room hence MDINDIA TPA issued Authorization as per Delhi GR moderate sickness i. e. NABH accredited hospital rate of Rs 10000/- per day. Patient was admitted for 13 days hence 10000* 13 = Rs 130000/-

As per their Head Office instruction, cost of Inj Remdesivir can be allowed as per approved protocol hence Cost of Inj Remdisir of Rs.32400/- Paid separately, Inj Ulinafic Cost of Rs.77300/- paid extra and IL, COVID test and CT angio paid extra.

Hence, subject claim has been settled and paid as per DELHI GR, U.P.

Calculation details as per below:-

RalNo	Particulars	As_claimed	As_Auth	Deduction Reason(PM)
1	Bed/Nursing harges	141000	130000	As per COVID State GR package(10000*13)
2	Visit Charges	27050	0	(IL6+ Covid test paid) as per GR
3	Medicines	140280	109700	As per Delhi GR
4	Investigations - ANALYSIS	114115	37480	(IL6+ Covid test paid+ CT angio) as per GR

5	Consumables	8158	0	Non-medical expenses are not payable. - Examination Gloves
6	PPE Kit	61000		included in Delhi GR
7	IV Cannulation	520	0	IV Cannulation
8	RMO, DIATECIAN	9400	0	RMO, DIATECIAN
9	Non-medical	2924	0	Non-Payable
10	Others	7770	0	Misc Common Items, ASSESMENT,TPA, Diet
15	Total	512217	277180	

The captioned claim has been settled and paid as per above mentioned Delhi GR and UP GR with the purview of the policy terms & conditions.

19) <u>Reason for Registration of Complaint</u>: - Partial settlement of Mediclaim

20) The following documents were placed for perusal.

a) Customer complaint
b) Annexure vi and vi (a)
c) Policy Copy
d) SCN

21) <u>Observations & Conclusions:</u>

The complainant and the representatives of the insurance company were present for online hearing on 12.04.021. The complainant reiterated that he was admitted in Max Smart Super Speciality Hospital, Delhi hospital for treatment of COVID-19. He was charged by full amount by the Hospital for Rs.5,12,217/-. This rate is without any subsidy given on account of Covid-19 treatment and there was no mention of the subsidy during the time he was admitted at the hospital. He got a cashless remittance of his insurance from TPA, MD India (appointed by National Insurance), who deducted a major amount of Rs. 1,45,465 stating that it is deducted under "As per Covid State GR package".

The insurance company reiterated that the claim was settled as per the policy terms and conditions and as per the guidelines of Government of National Capital Territory of Delhi's Order dated 20.06.2020 to settle the COVID-19 cases.

Ongoing through the documents exhibited and the oral submissions made by both the parties, it is observed that the complainant was admitted in Max Smart Super Speciality Hospital, Delhi. The hospital bill was raised for Rs.5,12,217/- which was settled by the insurance company for Rs.2,77,180/- only. The Delhi government vide their Order dated 20.06.2020 fixed the cost of treatment of Covid patients in private hospitals. It is also notified that "This will include, but not limited to: bed, food and other amenities, monitoring, nursing care, doctors' visits/ consults, investigations including imaging, treatment as per the national protocol for COVID care and standard care for co-morbidities, oxygen, blood transfusion etc.". As per Delhi Government's GR Clause No.5 adding that the charges will not include the cost of Covid-19 diagnostic test(s) as well as IL-6 levels.

In this case, the said hospital is NABH accredited, hence, the applicable package rate applicable as per Delhi Govt. guidelines and as per GIC guidelines is Rs.10,000/- a day. The complainant was admitted in the hospital for 13 days. The approved amount of package charges was rightly settled for Rs. 1,30,000/- out of Rs.1,41,000/-. Further, the deduction for Visit Charges for Rs. 27,050/- is also justified as doctors' visits/ consults are already included. Further, Rs.37,480/- out of Rs.1,14,115/- has paid (IL6+ Covid test paid+ CT angio) as per GR of Delhi Govt. The deduction of Rs.61,000/- for PPE Kit is also as per GR because it is clearly mentioned that Rs.10,000/- per day charge includes cost of PPE. Other deductions are appropriate as per

policy terms and conditions. I find that the insurance company has settled the claim as per the terms, conditions of the policy and also as per the guidelines issued by the Delhi Govt and General Insurance Council/IRDAI Circulars. I see no reason to interfere with the decision of the insurance company to partially pay the claim. The complaint is closed.

AWARD

Taking into account the facts and circumstances of the case and the submissions made by both the parties, I see no reason to interfere with the decision of the insurance company to partially pay the claim.

The complaint is closed.

Place: Noida.
Dated: 22.04.2021

C.S. PRASAD
INSURANCE OMBUDSMAN
(WESTERN U.P. & UTTARAKHAND)

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. ANUBHA GOYAL VS HDFC ERGO GENERAL INSURANCE CO.LTD

COMPLAINT REF. NO: GUW-H-018-21-22-0012 : Award No

1.	**Name & Address of the Complainant**	**MRS.ANUBHA GOYAL**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**1506001119/AA01048065-01** **MEDICLAIM** **30/03/2019 TO 29/03/2020**
3.	**Name of the insured** **Name of the policyholder**	**MR.ABIR GOYAL** **MR.ABIR GOYAL**
4.	**Name of the insurer**	**HDFC ERGO GENERAL INSURANCE CO.LTD**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**05/11/2020**
6.	**DETAILS OF LOSS**	**Rs.1011954/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**

8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**REPUDIATION OF CLAIM** **28/01/2021**
9.	**Amount of Claim**	**Rs.1011954/-**
10.	**Date & Amount of Partial Settlement**	**NIL**
11	**Amount of relief sought**	**Rs.1011954/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **28/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MRS ANUBHA GOYAL**
	• **For the insurer**	**MS.SASWATA BANERJEE**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**28/04/2021**

17) Brief Facts of the Case: Late Shri Abir Goyal, husband of the complainant Mrs Anubha Goyal had an Optima Restore Individual policy with HDFC ERGO General Insurance Company Ltd. Late Shri Goyal was insured with Oriental Insurance Co. Ltd. from 30/03/2016 for a sum insured of Rs.500000/- and ported his health insurance policy to HDFC Ergo Health Insurance on 30/03/2019 for a Sum-Insured of Rs. 1500000/-. On 13/10/2020 Abir Goyal was tested Covid Positive and was admitted to Excelcare Hospitals, Guwahati on 14/10/2020. After he was tested Covid negative, patient was shifted to non COVID ICU for further care on 25/10/2020. After that he continued to develop multi-organ inflammatory syndrome and finally succumbed to his ailments on 05/11/2020. In the Death Certificate also it is mentioned that Death is due to POST Covid Multi-organ inflammatory syndrome. On 06/11/2020 insurance co. repudiated the claim on the ground of 'Non-Disclosure of material information'. The complainant Mrs. Anubha Goyal is not satisfied with insurance co.'s decision. So she approached this forum for reconsideration of the claim.

18 a) Complainant's Argument: - The Complainant Mrs. Anubha Goyal stated that it was grossly unfair to repudiate the claim as the insured paid a premium of more than Rs.175000 & had been continuing the policy since 2016. She also mentioned that while taking the first policy in 2016 her husband had all the medical examination before issuance of the policy & it was renewed twice before porting with the respondent and the fact of coronary artery disease was well informed to the agent at the time of porting in 2019 for which the agent said no need to tell that as it belongs to 2013 and now all your PED will be covered.

She also mentioned that her husband died of COVID and its complications and the said PED is not directly related with the present ailment. She also stated that its being more than 6 years of claim free continuous

coverage & when 1st time she has filed the claim against the said health insurance policy that too for COVID the same cannot be rejected on the basis of Non-disclosure of facts.

18b) Insurers' argument: Insurance co. stated the following points in their SCN:-

1. That the complainant's husband submitted a proposal form vide proposal number 93DRLPAXQP dated 07/03/2019 proposing the issuance of 'Optima Restore Individual'for the sum insured of Rs. 10 lacs.

2.Insurance co.also produced us the first paragraph of the proposal form in which there is a column written as PLEASE PROVIDE US WITH INFORMATION ON MEDICAL STORY AND LIFE STYLE OF ALL MEMBERS INCLUDED IN THIS POLICY. In this column the proposer ticked N against each & every question.

3. That in the portability form as well, the deceased insured stated that he had not lodged any claims with the previous insurer and stated that he had no pre-existing disease. Insurer submitted copy of the pre policy checkup document and the previous year policy with other insurer. It is furthermore submitted that the portability form which was duly signed and submitted by the deceased clearly sought claims history and past treatment papers but no such document was submitted by the deceased.

4. That believing the declarations, information and details provided by the Complainant in the Proposal Form to be true, correct and complete in all respect, policy was issued for the Sum Insured as opted in the Enrolment Form for the complainant .The policy was renewed for the next terms i.e from 30/03/2019 to 29/03/2020 and then 30/03/2020 to 29/03/2021.

5. That a claim was registered for the hospitalization of the deceased/insured at Excelcare Hospital for the period of 14/10/2020 to 05/11/2020 for the treatment of Covid 19.

6.That post receipt of the claim intimation, and as per initial patient evaluation form it was found that the insured was a known case of CAD and as such a query letter was issued vide letters dated 29/10/2020 and 05/11/2020 for furnishing the below details;1.Treating doctor's certificate for exact duration of CAD along with past consultation papers and treatment records.2.provide all investigation, treatment and follow up records pertaining tp CAD including first consultation papers since first diagnosis.

8.That treatment papers of Medanta for 31/12/2013 were received which showed that the insured had been suffering from CAD,CAG and had undergone PTCA but the same was not revealed at the time of opting for the policy from oriental insurance and also while porting the policy to erstwhile Apollo Munich Health Insurance Company.

9. Based on the fact that there was non-disclosure of material fact the claim of the complainant was denied and the same was informed through repudiation letter.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 28/04/2021 The complainant was represented by MRS.ANUBHA GOYAL and the insurer was represented by Ms Saswata Banerjee.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records.

Insurance Co. repudiated the claim on account of non-disclosure of material facts. During the course of hearing ,insurance co. submitted the proposal form of complainant's husband where he clearly denied that he was a heart patient .insurance company submitted a portability form also where the deceased insured stated that he had no pre-existing disease. Insurance co. also submitted the treatment papers of Medanta for 31/12/2013 which showed that the insured had been suffering from CAD,CAG and had undergone PTCA but the same was not revealed at the time of opting for the policy from oriental insurance and also while porting the policy to Apollo Munich Health Insurance Co.

So, it is a clear case of suppression of material fact by insured and hence the policy becomes null and void as per terms and conditions of insurance.

Considering all the facts the Forum also agrees that as per policy terms & conditions, the claim is not payable. The decision of repudiation of claim taken by the insurance company is upheld and accordingly, no relief is provided to the complainant against her complainant lodged with this Forum.

Hence the complaint is treated as closed.

Dated at Guwahati, the 28th Day Of April, 2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. ARUN CHOUDHARY VS STAR HEALTH AND ALLIED INSURANCE CO.LTD

COMPLAINT REF. NO: GUW-H-044-2122-0007 Award No

1.	**Name & Address of the Complainant**	**MR.ARUN CHOUDHARY**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**P/191311012020008130** **MEDICLAIM** **31/12/2019 TO 30/12/2020**
3.	**Name of the insured** **Name of the policyholder**	**MR.ARUN CHAUDHURY**

4.	**Name of the insurer**	**STAR HEALTH AND ALLIED INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**13/08/2020**
6.	**DETAILS OF LOSS**	**RS.219294/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**PARTIAL PAYMENT** **17/02/2021**
9.	**Amount of Claim**	**RS.219294/-**
10.	**Date & Amount of Partial Settlement**	**RS.149240/-**
11	**Amount of relief sought**	**RS.70054/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **27/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MR.ARUN CHOUDHURY**
	• **For the insurer**	**MS.SUDESHNA BHATTACHARJEE**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**27/04/2021**

17) Brief Facts of the Case: The complainant Mr. Arun Choudury had a mediclaim policy with STAR HEALTH AND ALLIED INSURANCE CO.LTD. On 13/08/2020 he took admission to Marwari Hospitals with the complaints of COVID 19 POSITIVE. Conservative treatment was given & discharged from hospital on 22/08/2020. After that Mr.Choudhury submitted a) Reimbursement of Rs. 11610/- b) Cashless settlement of Rs.219294/- to the insurance co. But the insurance co. settled only Rs.10290/- out of Rs.11610 deducting an amount of Rs.1320 & Rs.149240/- out of Rs.219294 deducting an amount of Rs.70054/-. Mr. Choudhury is unhappy with the settlement of insurance co. So he approached to us for reconsideration of his claim.

18 a) Complainant's Argument: - The complainant Mr. Choudhury stated that the supreme court has given notice for reimbursing full cost of Covid treatment. So he should get full amount of claim amount.

18b) Insurers' argument: Insurance co. given in their SCN the deduction details as follows:

DEDUCTION DETAILS OF UNDER REIMBURSEMENT

1. An amount of Rs.200/- was deducted from Investigation & diagnostics within Hospitalization stating that Collection charges are not payable.

2.An amount of Rs.1120 was deducted from Investigation & diagnostics(pre-Hospitalization) stating that As Per GI Council, the charges pertaining to D-DIMER is capped at Rs.800/-

3. Thus from the claimed amount of Rs.11610/-an amount of Rs.10290/ the maximum payable amount was already allowed.

4. The Insurer highlighted the fact that the claimed amount by the Insured in the claim is duly settled by the Insurer.

DEDUCTION DETAILS UNDER CASHLESS SETTLEMENT:

1. An amount of Rs.1740/-was deducted from Professional fees as RMO charges not payable.

2. An amount of Rs.1603/- was deducted from Investigation and diagnostics stating that the maximum payable for covid test is capped at Rs.2200/- per unit as per the State Government orders .

3. An amount of Rs.31140/- was deducted from Medicines within Hospital stating that disposable kit,,ec fix,thermometer,cannula and betadine are not payable as per the other excluded expenses of the policy.

4. An amount of Rs.35571/- was deducted from others stating that Bio-medical waste,Diet,sanitization,mrd (medical record document),tpa charges are not payable as per Other Excluded Expenses of the policy.

5. An amount of Rs.145488/- was duly settled by the insured.

Considering the Insured was admitted for Covid treatment the Insurer proposes to allow an amount of Rs. 1200 per day as per GI council guidelines for charging of PPE KIT AT Hospital.Rs.1200*9(days admitted)= Rs.10800/-

Further, an amount Rs.8100/- may be allowed towards diet charges of the Insured during Hospitalization. Thus, Insurer offers to pay an amount of Rs. 18900/- towards full and final settlement of the claim upon submission of the money receipt of payment to hospital.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27/04/2021 The complainant was represented by Mr.Arun Choudhury himself and the insurer was represented by Ms.Sudeshna Bhattacharjee.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records. From the list of deductions submitted by the Company few items have been rightly deducted as per policy condition. However,the Insurer's contention that RMO charges are not reimbursable because RMO's full time employees on role of the Hospital has charged it to the insured, reimbursement of the same cannot be denied. Insurance co. further agreed to pay an amount of Rs.1200 per day as per GI council guidelines for PPE Kit at Hospital. Total payable amount for PPE kit is Rs.10800/-.Insurer also agreed to pay an amount of Rs.8100/- towards diet charges of the insured during Hospitalization. So balance amount payable to the insured is Rs.(1740+10800+8100)=20640 upon submission of the money receipt of payment to hospital.

Under the above circumstances and in order to ensure fairness to the policy holder, the forum directs the insurance co. to pay an amount of Rs.20640/- inclusive of RMO charges as full and final settlement of the claim to the insured upon submission of the money receipt of payment to the insurance co.

Hence the complaint is treated as closed.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Guwahati, the 27th Day Of April, 2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. JAHARLAL PURKAYASTHA VS NATIONAL INSURANCE CO.LTD.

COMPLAINT REF. NO:GUW-H-048-2122-0020 : Award No

1.	**Name & Address of the Complainant**	**MR.JAHARLAL PURKAYASTHA**
2.	**Policy No:** **Type of Policy**	**200600502010000421** **MEDICLAIM POLICY**

	Duration of policy/Policy period	**01/02/2021 TO 31/01/2022**
3.	**Name of the insured** **Name of the policyholder**	**JAHARLAL PURKAYASTHA** **JAHARLAL PURKAYASTHA**
4.	**Name of the insurer**	**NATIONAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**N/A**
6.	**DETAILS OF LOSS**	**Rs.27009/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**PREMIUM DISPUTE** **08/04/2021**
9.	**Amount of Claim**	**N/A**
10.	**Date & Amount of Partial Settlement**	**NIL**
11	**Amount of relief sought**	**27009/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **30/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MR.JAHARLAL PURKAYASTHA**
	• **For the insurer**	**MR.SUJIT CHAKRAVARTY**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**30/04/2021**

17) Brief Facts of the Case: Mr. Jaharlal Purkayastha had a National Mediclaim policy with National Insurance co. since 2006. As stated by Mr. Purkayastha, he is continuing this policy without any break and without any claim. But this year i.e., during the year 2021-2022, suddenly insurance co. increased the premium by nearly 150% i.e., from Rs.19833/- to Rs.46842/-upon same sum insured. Though Mr. Purkayastha made the payment, he made query to insurance co. about the premium hike. But insurance co. did not respond. So he has appealed to this forum for redressal of his grievance.

18 a) Complainant's Argument: - Mr. Purkayastha stated he made the payment because if he don't pay policy will stand cancelled. He stated that he is paying premium since last 15 years without taking any benefit of the policy. But without showing any reason they have increased the premium.

18b) Insurers' argument: Insurance co. stated in their SCN the following points:-

1) Insurance co. issued Policy No 200600205010000421 having Mr. Jaharlal Purakayastha (Male,75) and Spouse Saswati Purakayastha (Female,63) as Insured members with Premium Rs. 46842.

2) The expiring policy No 200600195010000435 having same Insured members was issued for the period 01.02.2020 to 31.01.2021 at the prevailing premium rate for Rs.19833.

3) While Feb.2020 Policy has SI 150000 each insured, Feb 2021 Policy has SI 200000 for each. Besides the MMC Policy is revised twice effective 15.05.2020 and 01.07.2020 by NIC Head office Technical (him) Dept. The existing Insured's were given same renewal rates within 90 days (plus 30 days standard grace for break in cover) from above dates and Policy renewal date of Mr. Jaharlal is found not eligible for this benefit.

4) Premium revision effective from 15.05.2020 is due to price correction and higher SI option as mentioned in HO advice dt.27.04.2020 and revision effected from 01.07.2020 is due to 'inclusion of criteria laid down as per IRDA health regulations and standardization guidelines 2019' mentioned in HO advice dt.23.06.2020.

5) Insured Mr. Jaharlal has earlier raised Greivance no GR1210147914 WHICH IS ATTENDED WITH ADEQUATE CLARIFICATION.

6) Premium revision is commensurate with coverage expansion by inclusion of 12 modern technology in treatment,HIV/AIDS,Mental illness,Morbid Obesity, Pre hospitalization for 45 days, ICU per day limit up to Rs. 20000,Ayurveda & Homeopathy treatment expense covered up to SI,

140+ daycare procedures, Age band in rate chart converted to 5 years from earlier 10 years.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) Complaint letter b) Annexure – VI A

c) Copy o the policy d) Annexure VII A e) S C N

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 30/04/2021. The complainant was represented by Mr.Jaharlal Purkayasta and the insurer was represented by Mr.Sujit Ckakravorty.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records. During the course of hearing the representative of the insurance co. explained the reason of hike under the following points:

1. **From 2013-2020 same rate was prevailed for same product. But after 7 years i.e from 2021 insurance co. made various change & inserted new regulations under the guidelines of IRDA.**
2. **As the overall claim experience was not good, IRDA had to bring some changes in the NMP policy.**
3. **The rate has been approved by IRDA so they have to abide by the rates.**
4. **In the old policy Sum Insured was Rs.1,50,000 for each insured person. But in the New rate chart there is no option of taking sum insured Rs.150000/-.So automatically Sum Insured has been changed to Rs.200000/-each.Insurance Co. also clarified that during this policy period Though Cover Is for**

Rs.200000/-,in case of hospitalization Rs75000/- extra cover will be approved to each insured. i.e,total cover Rs.550000/-.

Under the above circumstances the forum is in the opinion that as the rate has been approved by IRDA ,insurance co. has to follow the Rate Chart. As per policy terms and conditions, the rate is correct . The decision of charging new rate is upheld and accordingly, no relief is provided to the complainant.

Hence the complaint is closed.

Dated at Guwahati, the 30th Day Of April, 2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. MANISH KUMAR BHOWMICK VS CARE HEALTH INSURANCE CO.

COMPLAINT REF. NO:GUW-H-037-2122-0016 : Award No

1.	**Name & Address of the Complainant**	**MANISH KUMAR BHOWMICK**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**19594454** **PERSONAL ACCIDENT** **09/01/2021 TO 08/01/2024**
3.	**Name of the insured** **Name of the policyholder**	**MANISH KUMAR BHOWMICK** **MANISH KUMAR BHOWMICK**
4.	**Name of the insurer**	**CARE HEALTH INSURANCE CO.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**DOES NOT ARISE**
6.	**DETAILS OF LOSS**	**(RS.4273/-+ Rs.6834/-)=11107/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**DISPUTE REGARDING PREMIUM** **02/04/2021**
9.	**Amount of Claim**	**RS.11107/-**
10.	**Date & Amount of Partial Settlement**	**NIL**

11	**Amount of relief sought**	**RS.11107/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati 29/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MR.MANISH KUMAR BHOWMICK**
	• **For the insurer**	**MR.NEELANJAN CHATTERJEE**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**29/04/2021**

17) Brief Facts of the Case: Mr. Manish Kumar Bhowmick remitted an amount of Rs.6834/- & 4273/- for insurance premium against his two staff housing loans. (Rs.4273/- was paid on 7/1/2021 by cash & policy was not issued & amount not refunded. Rs.6834/- policy issued but submitted for cancellation to the insurer. But not cancelled yet.) At the time of purchasing the policy, the care health insurance officials assured him that these policies will cover normal death along with accidental death. But after receiving the policy he could know that the said policy covers only the accidental death. So he requested Care Health Insurance co. to cancel the policy immediately. Accordingly he had submitted all the documents like original policy, KYC documents, and cancelled cheque. Insurance co. after several correspondences informed him to wait for ten working days and again they sent him a message that your request has been processed. But they have not cancelled the policy yet and on 14th March 2021 they sent him a mail that your request cannot be processed.

Mr. Bhowmick also mentioned that after one and half month insurance co. verbally informed that one of his proposal for Rs.4272 had been rejected and the amount will be credited in his account. But till date no amount has been credited in his account.

18 a) Complainant's Argument: - Same as Point No. 17.

18b) Insurers' argument: Insurance Co. stated in the SCN that the complainant is contending that at the time of the purchasing the policy it was assured that the policy would cover normal death and policy was purchased accordingly by him. The insurance co. denied the contentions of the complainant. The Complainant had filled the Proposal Form with due knowledge of the intent and purpose of getting health insurance coverage. Insurance co. mentioned that in the proposal form under the head of 'benefit column' in the terms and condition section it is clearly specified that coverage pertaining to Accidental Death would be given only.

Insurer also stated that the Complainant was entitled to 'Free Look period of 15 days" to review the policy after receiving the policy certificate along with the Proposal form and policy Terms and conditions. On receipt of the policy documents, the complainant had the option to raise the objection of Mis-Selling to the respondent company but no communication to that effect was made within 15 days or thereafter.

Insurance Company stated that Complainant has raised a cancellation request to cancel the policy on 21st February,2021.The request for cancellation was duly registered with the respondent company. Upon verification of the KYC documents submitted by the complainant it was observed by the respondent company

that there was a Mis-match in the signature and no justification was provided regarding the same by the complainant. Due to mismatch in the signature Insurance Company was not able to cancel the policy.

Insurance co also stated that Complainant had applied for another policy (product Group Care 360) having proposal no 1100402664935. Due to discrepancies found the Transaction ID provided by the bank, policy of the complainant was not processed by the insurance co.

Insurance co. stated that ,the co.is willing to initiate cancellation of the policy from 21st February,2021 as per policy terms and conditions and also return the premium of Rs.4272 of the declined proposal no 1100402664935.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) Complaint letter b) Annexure – VI A

c) Copy o the policy d) Annexure VII A e) S C N

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 29/04/2021. The complainant was represented by Mr.Manish Kumar Bhowmick and the insurer was represented by Mr.Neelanjan Chatterjee.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records.

During the course of hearing Mr. Bhowmick, the complainant stated that after several correspondences, insurance co. not yet cancelled the policy No.19594454 for an amount of Rs.6834 /-and not refunded the money to him & insurance co. not yet refunded a premium of Rs.4273 /- for which policy was not issued. During the course of hearing insurance co. agreed to refund an amount of Rs.5692/- after deducting premium on pro-rata basis against policy No.19594454.Insurance Co. also agreed to refund Rs.4272/- for which policy was not issued.

Under the circumstances & in order to ensure fairness to the policy holder, the forum directs the insurance co. to pay an amount of Rs.9964/-(5692+4272) to the policy holder.

Hence the complaint is treated as closed.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Guwahati, the 29thth Day Of April, 2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR DIPEN KALITA VS THE ORIENTAL INSURANCE CO.LTD.

COMPLAINT REF NO: GUW-H-050-2122-0005: Award No

1.	**Name & Address of the Complainant**	**MR DIPEN KALITA** **House no.17, Nabagraha Road, Silpukhuri, Guwahati- 7.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**32110/48/2020/575** **Happy Family Floater Policy-2015.** **12 MONTHS, From 10.10.2019 to 09.10.2020**
3.	**Name of the insured** **Name of the policyholder**	**MR DIPEN KALITA** **MR DIPEN KALITA**
4.	**Name of the insurer**	**THE ORIENTAL INSURANCE CO.LTD**
5.	**Date OF OCCURANCE OF CLAIM**	**07.07.2020**
6.	**DETAILS OF LOSS**	**The Insured was admitted to Guwahati Medical College & Hospital on 08.07.2020 with Chest complaint and discharged on 17.07.2020. He had incurred medical expenses for Rs 80,796/-.**
7.	**REASON FOR GRIEVANCES**	**The Insurer repudiated the claim under clause no. 4.8 of the policy. Insured was aggrieved with the decision and raised his grievance at this forum.**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**Complaint for rejection of claim.** **05.04.2021**
9.	**Amount of Claim**	**Rs 80,796/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs 80,796/=**
12.	**Complaint registered under Rules of Ins. Ombudsman 2017.**	**13(1)(b)**
13.	**Date of hearing/place**	**27.04.2021/At O/O Ins Ombudsman , Guwahati.**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr Dipen Kalita**
	• **For the insurer**	**Mr. Arnab Sengupta.**
15	**Complaint how disposed**	**Through personal hearing.**
16	**Date of Award/Order**	**27.04.2021**

17) Brief Facts of the Case: The Insured was admitted to Guwahati Medical College & Hospital on 08.07.2020 with complaint of chest pain. He was evaluated and treated with CAU plus R PTCA 'S' to LAD. After the treatment patient was stable and discharged on 17.07.2020 with advice to take medicine regularly and stop smoking. The insurer stated that as per GMCH's in its outpatient slip dt.30.09.2020 clarified that smoking is a risk factor for CAD and increases the risk of CAD. Therefore, the claim was repudiated under policy Clause 4.8.The Insured was aggrieved with the Insurer for alleged ground of repudiation of his claim.

18)Complainant's argument: The Insured stated due to sudden chest complaint he was admitted to Guwahati Medical College & Hospital on 08.07.2020 and after full checkup & treatment he was discharged from the hospital on17.07.2020. He stated that the Discharge Certificate issued by the hospital dtd.17.07.2020 reflects his checkup & treatment taken in the hospital. The Insured had stated that the treatment taken by him was on genuine ground covered by the policy and hence, he had prayed for proper justice.

18 b) Insurers' argument: The Insured was admitted to the hospital for complaint of chest pain on 08.07.2020. The patient was evaluated and treated with CAU plus R PTCA 'S' to LAD. He was discharged from the Hospital on 17.07.2020 with advice to take medicine regularly and stop smoking. The Insurer stated that the TPA vide query dtd.25.8.2020 asked the Insured clarification regarding the period since he was suffering from Hypertention/CDA certified by treating Doctor and supported by past treatment papers and a certificate from the treating Doctor regarding relation of present ailment with smoking. The Insurer also had stated that GMC in its outpatient Slip dtd.30.09.2020 has certified in relation to the query that smoking is a risk factor for CAD and increases the risk of CAD. In view of Doctor's certificate the claim was repudiated under policy clause no.4.8. The policy Clause 4.8 states that Convalescence ,general debility ,run down condition or rest cure, congenital external disease or defects or anomalies, sterility, any fertility ,sub fertility or assisted conception procedure, venereal disease ,intentional self injury /suicide, all psychiatric and psychosomatic disorder and disease /accident due to ,and or use ,misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc, any disease or injury as a result of committing or attempting to commit a breach of Law with criminal intent

In the above circumstances, Insurer was unable to settle and hence, repudiated the claim.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27.04.2021.The complainant Mr Dipen Kalita was present through online hearing and the insurer was represented by Mr. Arnab Sengupta through on line hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary evidence submitted by the claimant as well as representative of the Insurance Company.

As per discharge certificate complainant was advised to stop smoking, which means that he was a regular smoker. Hence insurer has rightly repudiated the claim under 4.8 .

Moreover as per 4.3(xvii) of policy clause, for ailment due to hypertension waiting period is 2 years and this treatment was done during first year of policy. So, the claim comes under waiting period of the policy and is not payable.

Hence, this forum upholds the decision of insurer to repudiate the claim by insurer.

The complaint is treated as closed.

Dated at- Guwahati 27th Day of April, 2021.

K.B.Saha

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR MANABENDRA GOSWAMI VS SBI GENERAL INSURANCE.

COMPLAINT REF NO: GUW-H-040-2122-0009: Award No

1.	**Name & Address of the Complainant**	**MR MANABENDRA GOSWAMI HOUSE NO.22,USHANAGAR, DISPUR, GUWAHATI-6.**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**6988346-03 AROGYA PLUS POLICY 12 MONTHS, From 04.09.2020 to 03.09.2021**
3.	**Name of the insured Name of the policyholder**	**SHRI RITAM GOSWAMI MR MANABENDRA GOSWAMI**
4.	**Name of the insurer**	**SBI GENERAL INSURANCE**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**14.10.2020**
6.	**DETAILS OF LOSS**	**The complainant along with his family was covered by the policy. His son Mr Ritam Goswami was admitted to Down Towan Hospital Ltd , Guwahati on 14.10.2020. He was diagnosed with Microscopic Hematuria, Proteinuria .His USG guided renal biopsy was done on 15.10.2020and sent for EM/IF/LM. He**

		was discharged on 16.10.2020 with necessary advices. The Insured had incurred medical expenses for Rs44,265/- .
7.	**REASON FOR GRIEVANCES**	**The Insured had lodged a claim with the Insurance company for Rs 44,265/- . The Insurer repudiated the claim on the ground that the admission was basically for USG guided renal biopsy i.e. the Insured was hospitalized for microscopic hematuria and proteinuria under evaluation, IgA nephropathy ,query tubercular for which renal biopsy was done. The expenses incurred at Hospital were primarily for evaluation purpose only, which is excluded under the policy terms and conditions. Insured was aggrieved with the decision and put his grievance at this forum.**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**Unsatisfied for rejection of claim.** **05.04.2021**
9.	**Amount of Claim**	**Rs 44,265/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs44,265 /=**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017.**	**13(1)(b)**
13.	**Date of hearing/place**	**29.04.2021/At O/O Ins Ombudsman Office, Guwahati.**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr Manabendra Goswami**
	• **For the insurer**	**Mr.Sanjiv Tripathi**
15	**Complaint how disposed**	**Through personal and online hearing.**
16	**Date of Award/Order**	**29.04.2021**

17) Brief Facts of the Case: The complainant's son Shri Ritam Goswami was admitted to Down Towan Hospital Ltd , Guwahati on 14.10.2020. He was diagnosed with Microscopic Hematuria, Proteinuria under Evaluation IGA Nephropathy. .His USG guided renal biopsy was done on 15.10.2020and sent for EM/IF/LM. He was discharged on 16.10.2020 with necessary advices. The Insured incurred medical expenses for Rs44,265/-. The Insurer repudiated the claim on the ground that the admission was basically for renal biopsy post which the Insured was under observation and not for treatment .The expenses incurred at Hospital were primarily for evaluation purpose only , which excludes under the policy terms and conditions. Insured was aggrieved with the decision of Insurer.

18) Complainant's argument: The Insured stated that his son Shri Ritam Goswami was suffering from Proteinuria and Hematuria since Nov.2019 and in emergency condition he was admitted to Down Town Hospital on 14.10.2020 and UGS guided renal biopsy was done on 15.10.2020 and was sent for Electron Microcpy. The patient was under treatment for pain management with hemodynamic monitoring for 2 days in the hospital. He was discharged from hospital on 16.10.2020 in Hemodynamic Status with the advice of taking rest with medications. The Insured stated that the Insurer asked for so many documents and in spite of submission of the same, the Insurer repudiated the claim. The Insured also stated that as per clause 3.2 of the policy states that " Expenses incurred not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease ,illness or injury, for which confinement is required at a hospital or nursing home or at home under domiciliary hospitalization as defined" are not excluded. He stated that in the instant case, the UGS guided renal biopsy is primarily associated with the positive existence of IQA Nephropathy.

In the circumstances, the Insured had prayed for justified with payment of his claim.

18 b) Insurers' argument: The Insured patient was admitted to the hospital for treatment of Microscopic hematuria and proteinuria under evaluation and investigation purpose only. A Nephropathy, query tuberculin brain abscess for which medical management was done. The Insurer stated that as per submitted documents of the claim, it was observed that the line of treatment does not need hospitalization. As per policy terms and conditions, expenses incurred at hospital or nursing home primarily for diagnosis irrespective of 24 hours hospitalization. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the medical practitioner, which ordinarily can be given without hospitalization. This claim for hospitalization falls beyond purview of policy coverage as per exclusion clause no.32 of the policy and hence, not payable.

Hence, the claim was repudiated.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 29.04.2021.

The complainant Mr Mananbendra Goswami present and the insurer was represented by Mr.Sanjiv Tripathi through online hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary evidence submitted by the claimant as well as representative of the Insurance Company.

During hearing the complainant informed that his son was suffering from 15/11/2019 and being treated at the same hospital in OPD under Nephrology Dept. He also produced the OPD Sheet of continuous treatment at that Hospital. He also submitted proof of continuation of same treatment in March'2021. Hence it is clear that the boy is a serious patient of Kidney and he was hospitalized relating to this ailment as per advice of the Dr. A. Barkataky, M.D.,D.M.(Nephro) on 14/10/2020 after examining at OPD of Down Town Hospital Ltd. Hence, active line of treatment was followed in course of Hospitalization and on discharged as per discharge certificate with advices for taking medicine as revealed from hospital bills.

Hence, this forum set aside the decision of the Insurer to repudiate the claim and the Insurer is directed to pay the claim of Rs.37,812/- as under:

1.	**Room rent**	**Rs 5060/-**
2.	**Nursing charge**	**Rs 500/-**
3.	**Laboratory**	**Rs 3840/-**
4.	**Renal Biopsy Procedure charge**	**Rs 4500/-**
5.	**Electro Microscopy etc. charge**	**Rs 10,080/-**
6.	**Pharmacy excluding refund & non payable**	**Rs 4432/-**
7.	**Consultant fees**	**Rs 9400/-**
TOTAL		**Rs 37,812/-**

Hence, the complaint is treated as closed.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017.

- **As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**

Dated at- Guwahati 29th Day of April 2021.

K.B.Saha

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR RAJESH KUMAR SINGH VS THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF NO: GUW –H- 050-2122-0001: Award No:

1.	**Name & Address of the Complainant**	**MR RAJESH KUMAR SINGH C/O VRS AGRITECH PVT LTD,ONKAR PLAZA A.T.ROAD,GUWAHATI-1.**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**321200/48/2021/3654,SI Rs 50,000/--, CORONA RAKSHAK POLICY. From 17.08.2020 to 28.05.2021.**
3.	**Name of the insured Name of the policyholder**	**MR RAJESH KUMAR SINGH MR RAJESH KUMAR SINGH**
4.	**Name of the insurer**	**THE ORIENTAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**14.09.2020**
6.	**DETAILS OF LOSS**	**The Insured was covered under the Corona Rakshak policy. He was detected Covid -19 positive on 14.09.2020 and admitted to Nehru Satdium Covid Care Centre ,Guwahati on 14.09.2020. He was discharged from the Covid Centre on 23.09.2020 on being tested negative result. He had lodged claim for total SI for Rs 50,000/- to the Insurer.**
7.	**REASON FOR GRIEVANCES**	**The claim was repudiated by the Insurer on the ground that in spite of several reminder/ request letters the Insured had not submitted requisite documents and also Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy. Insured was aggrieved with the decision of Insurer and hence, he had put up his grievance at this Forum.**
8.a 8.b	**Nature of complaint Date of receipt of the complain**	**Complaint against rejection of claim. 05.04.2021**
9.	**Amount of Claim**	**Rs 50,000/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs 50,000/=**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**

13.	**Date of hearing/place**	**27.04.2021,At O/O Insurance Ombudsman Office, Guwahati.**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr. Rajesh Kumar Singh**
	• **For the insurer**	**Mr. Ranbir Ganguli**
15	**Complaint how disposed**	**Through personal hearing.**
16	**Date of Award/Order**	**27.04.2021**

17) Brief Facts of the Case: The Insured was covered under the Corona Rakshak policy. He was detected Covid -19 positive on 14.09.2020 and admitted to Nehru Stadium Covid Care Centre, Guwahati on 14.09.2020 as per direction of the Health Deptt. Govt. of Assam. He was discharged from the Covid Centre on 23.09.2020 on being tested negative. He had lodged claim for total SI for Rs 50,000/- to the Insurer.
The claim was repudiated by the Insurer on the ground that in spite of several reminder/ requests letters the Insured had not submitted requisite documents. Moreover, Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy i.e. the Insured had not followed the criteria of the policy terms and conditions that on being tested COVID positive, the patient has to stay in a hospital continuously for more than 72 hours for treatment of COVID, instead he had stayed in Covid Care Centre for care and isolation.

18 (a) Complainant's argument: The complainant stated that he was detected Covid -19 positive on 14.09.2020 and as per direction of Health Department, Govt. of Assam, he was referred and admitted to Nehru Stadum Covid Care Centre, Guwahati on 14.09.2020 for treatment and he was discharged on 28.09.2020 on being tested negative result i.e. after 9 days isolation and treatment. The Insured stated that his claim was rejected by the Company on alleged ground of non submission requisite documents and also bacuse of 'the patient has to stay in a hospital continuously for more than 72 hours for treatment of Covid', instead he had stayed in Covid Care Centre. The Insured stated that decision of the Insurer was not acceptable, since in brochure of policy it is mentioned that the patient should do Covid test in Govt. authorized centre and if test result is positive should be admitted for minimum 72 hours in Govt. authorized centre or hospital. He stated that he had fulfilled both the criteria as he had done test in Govt. Hospital and he was taken to Govt. Covid Centre by the Assam Govt. for his treatment. Moreover, he had submitted all the supporting documents. He had also stated that as per IRDAI guideline patient admitted in Govt. authorized Covid Centre also eligible for getting Corona Rakshak claim.
Hence, he had prayed for payment of his claim.

18 (b) Insurers' argument:The Insurer stated that the Insured was seeking reimbursement of expenses for treatment of Covid -19 positive claim. But, as per the 3.6 coverage of the policy, Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of the Covid -19 , requiring hospitalization for a minimum continuous period of 72 hours. Corona Rakshak claim shall be made payable only on Hospitalization and the hospital must be as per definition of hospital, the Insured had stayed in a Govt Quarantine Centre for 9 days. The Insurer stated that the patient had stayed at Covid Care Centre throughout the period for care and isolation only. Moreover, the Inured had not submitted all the requisite documents as asked for.
Therefore, the claim was not admitted as per terms and conditions of the policy.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) **Complaint letter**
b) **Annexure – VI A**
c) **Copy o the policy**
d) **Annexure VII A**
e) **S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27.04.2021.

The complainant Mr. Rajesh Kumar Singh was presented and the insurer was represented by Mr. Ranbir Ganguli through online hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary as well as verbal submission made by the claimant as well as representative of the Insurance company.

On perusal of claim papers, policy documents and arguments of Insured and Insurer, it is noted that the claimant was admitted in a make shift covid care center at Nehru Stadium, Guwahati. As per discharge certificate, the Insured was detected Covid positive on 14.09.2020 and he was admitted to Covid Care Centre i.e. he was isolated in a makeshift covid care center only.

Hence, insurer had rightly repudiated the claim on the ground that the criteria of Minimum 72In-patient care consecutive hours of hospitalization was not met by the Insured and also for non submission of requisite documents as asked for.

However, as per Guidelines on settlement of Covid -19 claims vide IRDAI Circular Ref no. IRDAI/HLT/MISC/CIR/190/07/2020 DTD.16.07.2020, it is clarified as below: -

(a) Where a policy holder who is diagnosed as Covid -19 positive is admitted into any make –shift or temporary hospital on the advice of a medical practitioner or any appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by the Insurers.

In the instant case, the Insured had not submitted any bill/cash memo against cost of treatment as full treatment cost was born by Govt. So, no claim is payable.

Hence, this forum upholds the decision of insurer to repudiate the claim on valid ground.

Hence, the complaint is treated as closed.

Dated at- Guwahati 27th Day of April. 2021.

K.B.Saha
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR RAJKISHOR PANDY VS THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF NO: GUW –H- 050-2122-0003: Award No:

1.	**Name & Address of the Complainant**	**MR RAJKISHOR PANDY C/O VRS COMMERCIALS, COMMERCIAL BUILDINING, A.T.ROAD,GUWAHATI-1.**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**321200/48/2021/3388,SI Rs 1,00,000/--, CORONA RAKSHAK POLICY. From 13.08.2020 to 24.05.2021.**
3.	**Name of the insured Name of the policyholder**	**MR RAJKISHOR PANDEY MR RAJKISHOR PANDEY**
4.	**Name of the insurer**	**THE ORIENTAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**12.09.2020**
6.	**DETAILS OF LOSS**	**The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 12.09.2020 and admitted to Nehru Satdium Covid Care Centre ,Guwahati on 12.09.2020. He was discharged from the Covid Centre on 20.09.2020 on being tested negative result. He had lodged claim for total SI for Rs 1,00,000/- to the Insurer.**
7.	**REASON FOR GRIEVANCES**	**The claim was repudiated by the Insurer on the ground that in spite of reminders/ requests the Insured had not submitted requisite documents and also because of Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy Insured was aggrieved with the decision of Insurer and hence, he had put up his grievance at this Forum.**
8.a 8.b	**Nature of complaint Date of receipt of the complain**	**Complaint against rejection of claim. 05.04.2021**
9.	**Amount of Claim**	**Rs 1,00,000/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs 1,00,000/=**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**27.04.2021,At O/O Insurance Ombudsman Office, Guwahati.**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr. Rajkishor Pandey**
	• **For the insurer**	**Mr. Ranbir Ganguli**
15	**Complaint how disposed**	**Through personal hearing.**
16	**Date of Award/Order**	**27.04.2021**

17) Brief Facts of the Case: The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 12.09.2020. He was admitted to Nehru Stadium Covid Care Centre, Guwahati on 12.09.2020,as per direction of the Health Deptt. Govt. of Assam.He was discharged from the Covid Centre on 20.09.2020 on being tested negative. He had lodged claim for total SI for Rs 1,00,000/- to the Insurer.
The claim was repudiated by the Insurer on the ground that in spite of several reminders/ requests the Insured had not submitted the requisite documents and also because of Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy i.e. the Insured had not followed the criteria of the policy terms and conditions that on being tested COVID positive, the patient had to stay in a hospital continuously for more than 72 hours for treatment of COVID, instead he had stayed in Covid Care Centre for care and isolation.

18 (a) Complainant's argument: The complainant stated that he was detected Covid -19 positive on 14.09.2020. He stated that as per direction of Health Department, Govt. of Assam, he was referred and admitted to Nehru Stadum Covid Care Centre, Guwahati on 12.09.2020 for treatment and he was discharged on 20.09.2020, after 9 days isolation and treatment. The Insured stated that his claim was rejected by the Company on alleged ground of non submission of documents and also on the ground as alleged that 'the patient has to stay in a hospital continuously for more than 72 hours for treatment of Covid', instead he had stayed in Covid Care Centre. The Insured stated that decision of the Insurer was not acceptable as he has submitted all the requisite documents and in brochure of the policy it is mentioned that, the patient should do Covid test in Govt. authorized centre and on being tested positive result should be admitted for minimum 72 hours in Govt. authorized centre or hospital. The Insured stated that he had fulfilled both the criteria as he had done test in Govt. Hospital and he was taken to Govt. Covid centre by the Assam Govt. for his treatment. The Insured had stated that he had submitted all the documents to the Insurer. He had also stated that as per IRDAI guideline patient admitted in Govt. authorized Covid centre also eligible for getting Corona Rakshak claim. Hence, he had prayed for settlement of his claim.

18 (b) Insurers' argument: The Insurer stated that the Insured was seeking reimbursement of expenses for treatment of Covid -19 positive claim. But, as per the 3.6 coverage of the policy, Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of the Covid -19 , requiring hospitalization for a minimum continuous period of 72 hours. Corona Rakshak claim shall be made only on Hospitalization and the hospital must be as per definition of hospital, the Insured had stayed in a Govt quarantine Centre for 9 days. The Insurer stated that the patient had stayed at Covid Care Centre throughout the period for care and isolation only. Moreover, in spite of several reminders/ requests the Insured had not submitted requisite documents.
Therefore, the claim was repudiated.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.
- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27.04.2021.

The complainant Mr. Rajkishor Pandy was presented and the insurer was represented by Mr. Ranbir Ganguli through online hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary as well as verbal submission made by the claimant as well as representative of the Insurance company.

On perusal of claim papers, policy documents and arguments of Insured and Insurer, it is noted that the Insured had not submitted requisite documents. Moreover, the claimant was admitted in a make shift covid care center at Nehru

Stadium, Guwahati. As per discharge certificate, the patient he was detected Covid positive on 12.09.2020 and he was admitted at Covid Care Centre i.e. he was isolated in a makeshift covid care center only.

Hence, insurer has rightly repudiated the claim on the ground that the criteria of Minimum 72In-patient care consecutive hours of hospitalization was not met by the Insured. Moreover, the Insured had not complied with requisite documents/ clarifications as asked by the Insurer.

However, as per Guidelines on settlement of Covid -19 claims vide IRDAI Circular Ref no. IRDAI/HLT/MISC/CIR/190/07/2020 DTD.16.07.2020, it is clarified as below: -

(b) Where a policy holder who is diagnosed as Covid -19 positive is admitted into any make –shift or temporary hospital on the advice of a medical practitioner or any appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by the Insurers.

In the instant case, the Insured had not submitted any bill/cash memo against cost of treatment as full treatment cost was born by Govt. So, no claim is payable.

Hence, this forum upholds the decision of insurer to repudiate the claim on valid ground.

Hence, the complaint is treated as closed.

Dated at- Guwahati 27th Day of April. 2021.

K.B.Saha

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR SUMAN DEB VS THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF NO: GUW –H- 050-2122-0010: Award No:

1.	**Name & Address of the Complainant**	**MR SUMAN DEB ANANDAPARA,PO.ANANDAPARA,DULIAJAN ,DIST. DIBRUGARH,ASSAM.**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**322502/48/2021/121 ,SI Rs 2,50,000/--, CORONA RAKSHAK POLICY. From 14.08.2020 to 25.05.2021.**
3.	**Name of the insured Name of the policyholder**	**MR SUMAN DEB MR SUMAN DEB**
4.	**Name of the insurer**	**THE ORIENTAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**25.09.2020**
6.	**DETAILS OF LOSS**	**The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 19.09.2020. and was admitted to Khanipur Covid Care Centre , Dibrugarh on 19.09.2020. He was discharged from the Covid Centre on 28.09.2020 on being tested negative result. He had lodged claim for total SI for Rs 2,50,000/- to the Insurer.**
7.	**REASON FOR GRIEVANCES**	**The claim was repudiated by the Insurer on the ground that Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy and also for non submission of requisite documents. Insured was aggrieved with the decision of Insurer and hence, he had put up his grievance at this Forum.**

8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**Complaint against rejection of claim.** **05.04.2021**
9.	**Amount of Claim**	**Rs 2,50,000/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs 2,50,000/=**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**27.04.2021,At O/O Insurance Ombudsman Office, Guwahati.**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr. Suman Deb**
	• **For the insurer**	**Mr. Ranbir Ganguli**
15	**Complaint how disposed**	**Through personal and online hearing.**
16	**Date of Award/Order**	**27.04.2021**

17) Brief Facts of the Case: The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 19.09.2020. He was admitted to Khanipur Covid Care Centre, Dibrugarh, as per direction of the Health Deptt. Govt. of Assam.He was discharged from the Covid Centre on 28.09.2020 on being tested negative. He had lodged claim for total SI for Rs 2,50,000/- to the Insurer.
The claim was repudiated by the Insurer on the ground that Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy i.e. the Insured had not followed the criteria of the policy terms and conditions that on being tested COVID positive, the patient has to stay in a hospital continuously for more than 72 hours for treatment of COVID, instead he had stayed in Covid Centre for care and isolation and also because of non submission of documents.

18 (a) Complainant's argument: The complainant stated that he was detected Covid -19 positive on 19.09.2020. He stated that as per direction of Health Department, Govt. of Assam, he was referred and admitted to Khanipur Covid Care Centre, Dibrugarh on 19.09.2020 for care and treatment. He was discharged on 28.09.2020 i.e. after 9 days isolation and treatment. The Insured stated that his claim was rejected by the Company on alleged ground non submission of documents and also that of 'the patient has to stay in a hospital continuously for more than 72 hours for treatment of Covid', instead he had stayed in Covid Care Centre. The Insured stated that decision of the Insurer was not acceptable, since, in brochure of policy it was mentioned that, the patient should do Covid test in Govt. authorized centre and if test result is positive should be admitted for minimum 72 hours in Govt. authorized centre or hospital. He stated that he had fulfilled both the criteria as he had done test in Govt. Hospital and he was taken to Govt. Covid centre by the Assam Govt. for his care and treatment. He had submitted all documents. He had also stated that as per IRDAI guideline patient admitted in Govt. authorized Covid Care Centre also eligible for getting Corona Rakshak claim.

18 (b) Insurers' argument: The Insurer stated that the Insured was seeking reimbursement of expenses for treatment of Covid -19 positive claim. But, as per the 3.6 coverage of the policy, Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of the Covid -19 , requiring hospitalization for a minimum continuous period of 72 hours. Corona Rakshak claim shall be made only on Hospitalization and the hospital must be as per definition of hospital ,instead the Insured had stayed in a Govt quarantine Centre for 9 days. The Insurer also stated that the patient had

stayed in the covid Care Cantre for care and isolation only. Moreover , the Insured had not submitted requisite documents in spite of several reminders.
Therefore, the claim was not admitted as per terms and conditions of the policy and hence, repudiated the claim.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) **Complaint letter**
b) **Annexure – VI A**
c) **Copy o the policy**
d) **Annexure VII A**
e) **S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27.04.2021.

The complainant Mr.Suman Deb was presented through online and the insurer was represented by Mr. Ranbir Ganguli through online hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary as well as verbal submission made by the claimant as well as representative of the Insurance company.

On perusal of claim papers, policy documents and arguments of Insured and Insurer, it is noted that the claimant was admitted in a make shift covid care center at Khanipur , Dibrugarh. As per discharge certificate, the patient he was detected Covid positive on 19.09.2020 and he was admitted at Covid Care Centre i.e. he was isolated in a makeshift covid care center for 9 days.
Hence, insurer has rightly repudiated the claim on the ground that the criteria of Minimum 72In-patient care consecutive hours of hospitalization was not met by the Insured. Moreover, the Insured had not submitted requisite documents as asked for.
However,as per Guidelines on settlement of Covid -19 claims vide IRDAI Circular Ref no. IRDAI/HLT/MISC/CIR/190/07/2020 DTD.16.07.2020, it is clarified as below: -

(c) **Where a policy holder who is diagnosed as Covid -19 positive is admitted into any make –shift or temporary hospital on the advice of a medical practitioner or any appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by the Insurers.**

In the instant case, the Insured had not submitted any bill/cash memo against cost of treatment as full treatment cost was born by Govt. So, no claim is payable.

Hence, this forum upholds the decision of insurer to repudiate the claim on valid ground.

Hence, the complaint is treated as closed.

Dated at- Guwahati 27th Day of April. 2021.

K.B.Saha
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR UDAY THAKUR VS THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF NO: GUW –H- 050-2122-0002: Award No:

1.	**Name & Address of the Complainant**	**MR UDAY THAKUR C/O PAN GOPAL DAS,AMBARI FATASHIL,MILANPUR ,HOUSE NO.03, GUWAHATI-781025.**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**321200/48/2021/3396,SI Rs 1,00,000/--, CORONA RAKSHAK POLICY. From 13.08.2020 to 24.05.2021.**
3.	**Name of the insured Name of the policyholder**	**MR UDAY THAKUR MR UDAY THAKUR**
4.	**Name of the insurer**	**THE ORIENTAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**14.09.2020**
6.	**DETAILS OF LOSS**	**The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 14.09.2020. He was admitted to Nehru Satdium Covid Care Centre ,Guwahati on 14.09.2020. He was discharged from the Covid Centre on 23.09.2020 on being tested negative result. He had lodged claim for total SI for Rs 1,00,000/- to the Insurer.**
7.	**REASON FOR GRIEVANCES**	**The claim was repudiated by the Insurer on the ground of non submission of requisite documents and that of Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy. Insured was aggrieved with the decision of Insurer and hence, he had put up his grievance at this Forum.**
8.a 8.b	**Nature of complaint Date of receipt of the complain**	**Complaint against rejection of claim. 05.04.2021**
9.	**Amount of Claim**	**Rs1,00,000/=.**
10.	**Date & Amount of Partial Settlement**	**N/A.**
11	**Amount of relief sought**	**Rs 1,00,000/=**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**27.04.2021,At O/O Insurance Ombudsman Office, Guwahati.**
14.	**Representation at the hearing**	

	• For the Complainant	Mr. Uday Thakur
	• For the insurer	Mr. Ranbir Ganguli
15	Complaint how disposed	Through personal hearing.
16	Date of Award/Order	27.04.2021

17) Brief Facts of the Case: The Insured was covered by the Corona Rakshak policy. He was detected Covid -19 positive on 14.09.2020. He was admitted to Nehru Stadium Covid Care Centre, Guwahati on 14.09.2020 as per direction of the Health Deptt. Govt.of Assam. He was discharged from the Covid Centre on 23.09.2020 on being tested negative. He had lodged claim for total SI for Rs1,00,000/- to the Insurer.
The claim was repudiated by the Insurer on the ground of non submission of requisite documents also that of Covid Care Centre does not fall under definition of Hospital as per clause no.3.6 of the policy i.e. the Insured had not followed the criteria of the policy terms and conditions that on being tested COVID positive, the patient had to stay in a hospital continuously for more than 72 hours for treatment of COVID, instead he had stayed in Covid Care Centre for care & treatment as well as isolation.

18 (a) Complainant's argument: The complainant stated that he was detected Covid -19 positive on 14.09.2020. He stated that as per direction of Health Department, Govt. of Assam, he was referred and admitted to Nehru Stadum Covid Care Centre, Guwahati on 14.09.2020 for treatment. He was discharged on 28.09.2020, after 9 days isolation and treatment. The Insured stated that his claim was rejected by the Company on alleged ground non submission of documents and also that of 'the patient has to stay in a hospital continuously for more than 72 hours for treatment of Covid', instead he had stayed in Covid Care Centre. The Insured stated that decision of the Insurer was not acceptable, since in the brochure of policy it was mentioned that, the patient should do Covid test in Govt. authorized centre and if test result is positive should be admitted for minimum 72 hours in Govt. authorized centre or hospital. He stated that he had fulfilled both the criteria as he had done test in Govt. Hospital and he was taken to Govt. Covid centre as per directive of Govt. of Assam for his treatment. He had also stated that as per IRDAI guideline patient admitted in Govt. authorized Covid centre also eligible for getting Corona Rakshak claim. Moreover, he had submitted all documents to the Insurer.
In the circumstances, the Insured had prayed for natural justice.

18 (b) Insurers' argument: The Insurer stated that the Insured was seeking reimbursement of expenses for treatment of Covid -19 positive claim. But, as per the 3.6 coverage of the policy, Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of the Covid -19 , requiring hospitalization for a minimum continuous period of 72 hours. Corona Rakshak claim shall be made only on Hospitalization and the hospital must be as per definition of hospital as stated in the policy clause 3.6.The Insured had stayed in a Govt quarantine Centre for 9 days. The Insurer stated that the patient had stayed at Covid Care Centre throughout the period for care and isolation only. Moreover, In spite of several reminder/request letters the Insured had not submitted requisite documents.
Therefore, the claim was not admitted as per terms and conditions of the policy and hence, repudiated the claim.

19) Reason for Registration of Complaint: - Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) Complaint letter
b) Annexure – VI A
c) Copy o the policy
d) Annexure VII A
e) S C N

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27.04.2021.

The complainant Mr.Uday Thakur was presented and the insurer was represented by Mr. Ranbir Ganguli through online hearing.

DECISION

We have taken in to consideration the facts and circumstances of the case from the documentary as well as verbal submission made by the claimant as well as representative of the Insurance company.

On perusal of claim papers, policy documents and arguments of Insured and Insurer, it is noted that the claimant was admitted in a make shift covid care center at Nehru Stadium, Guwahati. As per discharge certificate, the patient had been detected Covid positive on 14.09.2020 and he was admitted to Covid Care Centre i.e. in a makeshift covid care center for care and isolation.

Hence, insurer has rightly repudiated the claim on the ground that the criteria of Minimum 72 In-patient care consecutive hours of hospitalization was not met by the Insured. Moreover, the Insured had not submitted requisite documents as asked for.

However, as per Guidelines on settlement of Covid -19 claims vide IRDAI Circular Ref no. IRDAI/HLT/MISC/CIR/190/07/2020 DTD.16.07.2020, it is clarified as below: -

(d) Where a policy holder who is diagnosed as Covid -19 positive is admitted into any make –shift or temporary hospital on the advice of a medical practitioner or any appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by the Insurers.

In the instant case, the Insured had not submitted any bill/cash memo against cost of treatment as full treatment cost was born by Govt. So, no claim is payable.

Hence, this forum upholds the decision of insurer to repudiate the claim on valid ground.

Hence, the complaint is treated as closed.

Dated at- Guwahati 27th Day of April. 2021.

K.B.Saha
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. ROSHAN DHAKAL VS CHOLA MS GENERAL INSURANCE CO.LTD

COMPLAINT REF. NO:GUW-H-012-21-22-0008 : Award No

1.	**Name & Address of the Complainant**	**ROSHAN DHAKAL**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**2894/00053352/000/00** **CORONA RAKSHAK POLICY** **19/10/2020 TO 15/07/2021**
3.	**Name of the insured** **Name of the policyholder**	**ROSHAN DHAKAL**
4.	**Name of the insurer**	**CHOLA MS GENERAL INSURANCE CO LTD**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**22/10/2020**

6.	**DETAILS OF LOSS**	**NIL**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**REPUDIATION OF HEALTH CLAIM** **15/02/2021**
9.	**Amount of Claim**	**RS.170000/-**
10.	**Date & Amount of Partial Settlement**	**NIL**
11	**Amount of relief sought**	**Rs.170000/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **29/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**Mr.ROSHAN DHAKAL**
	• **For the insurer**	**MR.SUBIR AHMED CHOUDHURY**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**29/04/2021**

17) Brief Facts of the Case: Mr. Roshan Dhakal, the complainant, had a Corona Rakshak Policy with Chola MS General Insurance Co. Ltd. On 22/10/20 Mr. Dhakal went to Tolaram Bafna Civil Hospital, Amingaon, Kamrup, with complaints of cough & breathing . There he was tested Covid 19 positive. Doctor referred him to Palasbari Covid Care Centre & sent by An Ambulence to palasbari ccc. He was admitted there for 9 days i.e., from 22/10/2020 to 30/10/2020. Last Test Result on 29/10/2020 was Negative. He was released from Covid Care Centre on 30/10/2020 & advised for Home Quarantine from 30/10/2020 to 05/11/2020. After follow up at the treatment centre, Mr. Dhakal submitted his claim on 05/11/2020 to the insurance co. But Insurance Co. repudiated the claim. Mr. Dhakal is not happy with the decision of repudiation by the insurance co. So, he approached to this forum for reconsideration of the claim.

18 a) Complainant's Argument: - The complainant Mr Choudhury stated that the supreme court has given notice for reimbursing full cost of Covid treatment. So he should get full amount of claim. The complainant also raised a question againt insurance co. that insurance co. has made payment to another person on same claim and same documents.

18b) Insurers' argument: Insurance company stated in their SCN that,

After receiving claim intimation and after scrutinizing all relevant documents ,it was found that condition of health of the complainant was not suggesting for hospitalization rather complainant was taken to COVID CARE CENTRE(NOT HOSPITAL) as per local Government norms and guidelines for Covid-19 management and was given oral medications only and no active line of management for treatment was given.

As there was no need of hospitalization of complainant ,he was not hospitalized. As per government protocol for Covid-19 management complainant was sent to Covid Care Centre only which is not a hospital but was sent there only for breaking the chain of spread of corona virus as per government norms.

Keeping in view the above points the claim was repudiated .

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

a) **Complaint letter**
b) **Annexure – VI A**
c) **Copy o the policy**
d) **Annexure VII A**
e) **S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 29/04/2021. The complainant was represented by Mr.Roshan dhakal himself and the insurer was represented by Mr.Subir Ahmed Choudhury.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records.

On perusal of claim papers, policy documents and arguments of Insured and Insurer, it is noted that the claimant was admitted in a make shift covid care center at Covid Care Centre, Palasbari. As per discharge certificate patient had no comorbid symptoms or diseases. Complainant was an asymptomatic covid patient and was admitted to covid care centre to isolate him from spreading the disease. Though he was detected covid positive, he was not hospitalized, he was isolated in a makeshift covid care center only.

Hence, Insurer has rightly repudiated the claim on the ground that the criterion of Minimum 72 In-patient care consecutive hours of hospitalization was not met by the Insured.

As per Guidelines on settlement of Covid -19 claims vide IRDAI Circular Ref no. IRDAI/HLT/MISC/CIR/190/07/2020 DTD.16.07.2020, it is clarified as below: -

(e) Where a policy holder who is diagnosed as Covid -19 positive is admitted into any make –shift or temporary hospital on the advice of a medical practitioner or any appropriate Government authorities, notwithstanding the definition of hospital specified in the terms and conditions of policy contract, the treatment costs shall be settled by the Insurers.

The Insured had not submitted any bill/cash memo against cost of treatment as full treatment cost was born by Govt. So, no claim is payable.

In this case, the complainant raised a question during the course of hearing that the same insurer has approved the claim with same complaint with same documents. He submitted the details of that claim. After that this Forum asked the insurer to clarify the issue. The insurance co. admitted that they had settled that specific claim by mistake.

Under these circumstances the Forum is in the opinion that it will not be appropriate to advice the insurer to repeat the same mistake. As per policy terms & conditions, the claim is not payable. The decision of repudiation of claim taken by the insurance co. is upheld and accordingly, no relief is provided to the complainant against his complaint lodged with this Forum.

Hence the complaint is treated as closed.

Dated at Guwahati, the 29th Day Of April,2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. SURESH KUMAR AGARWALA VS STAR HEALTH AND ALLIED INSURANCE CO.LTD

COMPLAINT REF. NO:GUW-H-044-2122-0006: Award No

1.	**Name & Address of the Complainant**	**MR. SURESH KUMAR AGARWALA**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**P/191312/01/2020/002132** **MEDICLAIM** **03/02/2020 TO 02/02/2021**
3.	**Name of the insured** **Name of the policyholder**	**MR.SURESH AGARWALA** **MR.SURESH AGARWALA**
4.	**Name of the insurer**	**STAR HEALTH AND ALLIED INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**18/10/2020**
6.	**DETAILS OF LOSS**	**RS.328833/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**REPUDIATION OF CLAIM** **22/02/2021**
9.	**Amount of Claim**	**RS.328833/-**
10.	**Date & Amount of Partial Settlement**	**NIL**
11	**Amount of relief sought**	**RS.328833/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **27/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MR.SURESH KUMAR AGARWAL**
	• **For the insurer**	**MS.SUDESHNA BHATTACHARJEE**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**27/04/2021**

17) Brief Facts of the Case: The complainant Mr. Suresh Kumar Agarwala had a Family Health Optima Insurance Plan with a sum insured of Rs.1000000/- with Star Health and Allied Ins. Co.Ltd. Earlier he had insurance policy with National Insurance Co.Ltd . Mr. Agarwala was hospitalized at Srimanta Sankardeva Hospital & Research Institute, Dibrugarh on 18/10/2020 and diagnosed as papilloma urothelial carcinoma. Immunotherapy was given. On 19/10/2020 he was discharged from hospital. After that Mr. Agarwal submitted claim for immunotherapy. But the insurance co. repudiated the claim stating that as per IRDA guidelines, the sublimit for immunotherapy is Rs.400000/- per policy period for sum insured Rs.1000000/-.Insurance co. already reimbursed an amount of Rs.660444/- in the same policy period. So sum insured has been exhausted in the current policy period in previous claim. The complainant Mr. Agarwal is not happy with the reason of repudiation. So he approached to us for reconsideration of his claim.

18 a) Complainant's Argument: - The complainant stated that under policy no.P191312/01/2020/002132,he had been reimbursed an amount of Rs.660444/- towards hospitalization expenses, against the policy for various claims earlier during the same period of insurance. According to him as insurance policy covers claim up to Rs.10 lacs whereas he had received claim against his hospitalization Rs.6.60 lacs approx, so balance of Rs.3.40 lacs remained unclaimed, which still he is eligible to claim against his treatment bills during the policy period.

18b) Insurers' argument:

Insurance co. stated the following points in their SCN:-

1.The Insured preferred a claim for reimbursement for Rs.325383/- for admission at Srimanta Sankardeva Hospital & Research Institute for Immunotherapy treatment from 18/10/2020 to 19/10/2020.

2. On 02/12/2020 the Insurance Co communicated the Repudiation letter to the Insured stating that as per sub limit incorporated in the said policy, the maximum amount payable for treatment related to the diagnosis is Rs. 400000/- as per new guidelines but insurance co. already settled an amount of Rs. 660444/- towards hospitalization expenses vide their various claim numbers which is the maximum admissible amount under the policy issued.

3. As per the new guidelines issued by IRDAI since 01st October 2020 there is capping for treatment of Immunotherapy based on Sum Insured of the Insured and as the guidelines were in force from 1st October'2021, the above claim was repudiated as the Insurer already settled two previous claims of the Insured amounting Rs.660444/- in that Policy year.

4. As per the Terms and Conditions of the policy, for the Sum Insured of Rs.1000000/- the sub limit for Immunotherapy is Rs. 400000/- which was already exhausted thus, the Insurer repudiated the claim.

5. As per coverage clause Y of the policy issued to the Insured it is stated that, Coverage for Modern Treatments: The expenses payable during the entire policy period for the following treatment/procedure (either as a day care or as in-patient exceeding 24 hrs of admission in the hospital) is limited to the amount mentioned in table below; For Sum Insured of Rs.1000000/- (Ten Lakhs) the sub-limit for Immunotherapy-Monoclonal Antibody to be given as Injection is Rs. 400000/-(four lakhs).

The Insurer has already settled to the insured as follows:

a) CLI/2021/191312/0041520-IMMUNOTHERAPY - RS.329821/-

b) CLI/2020/191312/2005743 –IMMUNOTHERAPY - RS.330623/-

The Insurance Company stated that, the maximum amount was already settled to the Insured as per the Terms and Conditions of the policy, there is no further amount liable for payment under the policy for the present claim.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 27/04/2021.The complainant was represented by Mr.Suresh kumar Agarwal and the insurer was represented by Ms.Sudeshna Bhattacharjee.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records.

During the course of hearing insurance co. submitted Policy Terms & conditions 2017-18 where it is clearly written that immunotherapy was not payable under this policy. Exclusion no 23 states that, "The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of Oral Chemotherapy, Immunotherapy and Biologicals, except when administered as an in patient, when clinically indicated and hospitalization warranted." They submitted that Policy Plan 2017-18 was issued to the Insured.

However, Insurance co. admitted during the course of hearing that, initially Immunotherapy was not payable but due to some internal mistake the Insured was paid Rs.660444/-.They submitted that ,based on the recent changes incorporated in the current year policy effective from 1st October 2020 with due approval of IRDAI they incorporated sub-limit for Immunotherapy based on sum insured.

Based on the sum insured of insured Rs.1000000/- (Ten lakh SI) Rs.400000/- is made admissible every policy period. So, as per policy terms and conditions of the policy, the sub-limit for Immunotherapy is Rs. 400000/- which was already exhausted.

So, the decision of repudiation of claim taken by the insurance company is upheld and accordingly, no relief is provided to the complainant against his complaint lodged with this Forum.

Hence the complaint is treated as closed.

Dated at Guwahati, the 27th Day Of April, 2021

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, GUWAHATI
(UNDER RULE NO: 16(1)/17 of INSURANCE OMBUDSMAN RULES 2017)
OMBUDSMAN – K.B. SAHA
CASE OF: : Complainant MR. YOGENDRA TIWARI VS HDFC ERGO GENERAL INSURANCE CO.LTD

COMPLAINT REF. NO:GUW-H-018-21-22-0011 : Award No

1.	**Name & Address of the Complainant**	**YOGENDRA TIWARI**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**150600/11129/AA01174965** **MEDICLAIM**
3.	**Name of the insured** **Name of the policyholder**	**YOGENDRA TIWARI** **YOGENDRA TIWARI**
4.	**Name of the insurer**	**HDFC ERGO GENERAL INSURANCE CO.LTD.**
5.	**Date OF OCCURANCE OF LOSS/CLAIM**	**04/01/2020**
6.	**DETAILS OF LOSS**	**Rs.10236/-**
7.	**REASON FOR GRIEVANCES**	**Rules 17(6) of the Insurance ombudsman Rule 2017**
8.a **8.b**	**Nature of complaint** **Date of receipt of the complain**	**REPUDIATION OF CLAIM** **02/04/2021**
9.	**Amount of Claim**	**RS.10236/-**
10.	**Date & Amount of Partial Settlement**	**NIL**
11	**Amount of relief sought**	**Rs.10236/-**
12.	**Complaint registered under Rules of Insurance Ombudsman 2017**	**13(1)(b)**
13.	**Date of hearing/place**	**O/o Insurance Ombudsman Guwahati** **28/04/2021**
14.	**Representation at the hearing**	
	• **For the Complainant**	**MR.YOGENDRA TIWARI**
	• **For the insurer**	**MS.SASWATA BANERJEE**
15	**Complaint how disposed**	**Through personal Hearing**
16	**Date of Award/Order**	**28/04/2021**

17) Brief Facts of the Case: Mr.Yogendra Tiwari had Energy Silver Insurance policy with APOLLO MUNICH HEALTH INSURANCE which is renamed as HDFC ERGO GENERAL INSURANCE CO.LTD. On 04/01/2020 while going for morning walk at about 8 A.M., a street dog had bitten him. He was wounded by the dog bite on his right leg and scratches on the left leg. Mr. Yogendra Tiwari immediately rushed to the Marwari Hospitals , Athgaon, Guwahati. After two hours, Mr. Tiwari was released from hospital on Day Care Medical treatment basis. After that he submitted claim of Rs.10236/- to the insurance co. for reimbursement. But the Insurance Co. repudiated his claim as treatment was done on OPD basis. Mr. Tiwari was not happy with the decision of the insurance co. So he approached to this forum for reconsideration of his claim.

18 a) Complainant's Argument: - The insurer viewed the claim as an accidental claim of biting by a street dog. Complainant also stated that though treatment was done on Day Care Basis, he was badly injured & needed hospitalization.

18b) Insurers' argument: Insurance co. in their SCN stated the following reasons for their repudiation of the claim.

1. **That since the Claim was for the wound treatment of the Insured Member on OPD basis, hence the claim stood repudiated.**

2. Insurance co. also pointed out that mandatory 24 hrs hospitalization was also not completed.

3. Based on the medical documents the claim was rejected as per policy terms & conditions.

The policy wordings defines day care treatment as under:

Day Care treatments refers to medical treatment, and/or surgical procedure listed in Annexure I which is

i) undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and, ii) which would have otherwise required a hospitalization of more than 24 hours, Treatment normally taken on an Out-patient basis is not included in the scope of this definition.

19) Reason for Registration of Complaint: -: Scope of the Insurance Ombudsman Rules 2017 (Rule after proper approval from honorable ombudsman13 (1) (b).

20) The following documents were placed for perusal.

- **a) Complaint letter**
- **b) Annexure – VI A**
- **c) Copy o the policy**
- **d) Annexure VII A**
- **e) S C N**

Result of hearing with both parties (Observations & Conclusion):- Both the parties were called for hearing on 28/04/2021 The complainant was represented by Mr.Yogendra Tiwari himself and the insurer was represented by ms.Saswata Banerjee.

DECISION

We have taken into consideration the facts & circumstances of the case from the documentary as well as verbal submission made by the claimant and representative of Insurance co. We have also gone through the records.

Insurance co. repudiated the claim on the ground that treatment was done on out-patient basis without any hospitalization. The discharge certificate from Marwari Hospitals clearly proves that, the mandatory 24 hours hospitalization was also not completed.

Expenses of Medical treatment as outpatient are not payable as per terms and conditions of the policy.

Hence, the forum decides to upheld the decision of repudiation of claim taken by the insurance company and accordingly, no relief is provided to the complainant against his complaint lodged with this Forum.

Hence the complaint is treated as closed.

Dated at Guwahati, the 17th Day Of December, 2020

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF ASSAM MEGHALAYA, MANIPUR, MIZORAM, ARUNACHAL PRADESH, NAGALAND AND TRIPURA

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – Shri K. B. Saha

- ***CASE OF JAGADISH SHILL V/S LIFE INSURANCE CORPORATION OF INDIA***

COMPLAINT REF: NO: 1) GUW-L-029-2122-0002

AWARD NO: IO/GUW/A/LI/ /2021-2022

1.	**Name & Address of the Complainant**	**Mr. Jagadish Shill** P.O. & PS Gouripur, Ward No-3. Near Jaiguru Hotel Dist- Dhubri Assam 783331 Mobile 9435123939
2.	**Policy No:** **Policy Type/Duration/Period**	**488936682** **DETAILS ARE IN THE TABLE**
3.	**Name of the Insured/LA** **Name of the proposer**	Jagadish Shill Self
4.	**Name of the insurer**	• **LIC of INDIA** (Bongaigaon Division)
5.	**Date of Repudiation**	Not known
6.	**Reason for repudiation**	Not Known
7.	**Date of receipt of the Complaint**	07.04.2021
8.	**Nature of complaint**	**For reimbursement of Hospital expenses**
9.	**Amount of Claim**	Not known
10.	**Date of Partial Settlement**	Not applicable
11.	**Amount of relief sought**	N/A
12.	**Complaint registered under** **Insurance Ombudsman Rules' 2017**	13 (2)
13.	**Date of hearing/place**	28.04.2021 At O/O Insurance Ombudsman Guwahati
14.	**Representation at the hearing**	
	• **For the Complainant**	Mr. Gautam Shill
	• **For the insurer**	Mr. Dulal Basu Manager CRM
15	**Complaint how disposed**	BY CONDUCTING HEARING
16	**Date of Award/Order**	28.04.2021

17) Brief Facts of the Case:

Life Insurance Corporation of India

Pol No	L.A.	PLAN	DOC	Premium (yly)	Mode	1ST Comp /Representation to GRO of Ins. Co
488936682	Jagadish Shill	LIC's Health Plus	31/01/2008	10,000/-	Yearly	

Period of hospitalization: From 05.06.2020 at 01.20 A.M to 15.06.2020 at GNRC Guwahati.

The complainant has alleged the following:-

i) That he had purchased the above mentioned health policy in the year 2008 from LIC of India.
ii) That, he was admitted at GNRC, Guwahati on 05.06.2020 due to sudden attack of brain stroke and was under treatment in the said hospital and was discharged from there on 15.06.2020. .
iii) At present, he is still under treatment of the said hospital due to the effect of paralysis..
iv) He submitted the claim papers to the LICI , Barpeta Branch in the month of July 2020.
v) The complainant further stated that till date , the insurance company has not responded
vi) Being dissatisfied with the attitude of insurer's service, the complainant has now approached this Forum for redressal of his grievance.

18) Cause of Complaint: Due to delay in settlement claim of Health insurance policy.

- **Complainant's argument:** In point No. 17 it is mentioned categorically.
- **Insurers' argument:** As per SCN received from the insurer :-
  - A) The above Insurance policy on the life of Principal insurer, Mr. Jagadish Shill was taken on 31.01.2008 under table 901/15/15 with yearly mode at their Barpeta Branch .
  - B) The Principal Insurer Mr. Jagadish Shill made a claim against her hospitalisation from 05.06.2020 to 15.06.2020 at GNRC Guwahati,
  - C) On receipt of the claim form, the matter was referred to their TPA (Heritage Health Insurance) for processing the claim as per rule of the corporation. TPA has processed the claim at their end and recommended for repudiation vide their mail dated 05.04.2021 on the ground of exclusions applicable to Hospital cash benefit (under the rejection code (H1 and H 12).
  - D) The discharge summary of GNRC , Guwahati reflects that there is a history of Hypertension and Type –ll DM for 10 years with regular medication. Left knee joint pain (Arthritic) for many years. No h/o CAD/Thyroid disorder, He is non veg having good appetite. Bowel/bladder habit normal. He is an alcoholic.
  - E) They further informed that claim along with TPA's recommendation had been placed to DODRC on 20.04.2021. DODRC decided to call discrete evidence from the TPA in support of their findings
  - F) On receipt of reply from the TPA , the case will be placed before the DODRC for their decision.
  - G) Thus, the insurer requests the forum to allow them 1 month time for disposal of the claim.

19) Reason for Registration of Complaint:- Scope of Insurance Ombudsman rule 2017

Repudiation of Claim.

20) The following documents were placed for perusal.

i) Complaint letter ii) P – form iii) SCN

21) Result of hearing with both parties (Observations & Conclusion) :

Both the parties were called for hearing on 28.04.2021. Complainant Mr. Jagadish Shill informed this forum about his inability to attend hearing because of his health ground but authorised his brother Mr. Gautam Shill to attend hearing on his behalf and insurer was represented by Mr Dulal Saha ,Manager CRM LICI, Bongaigaon .

During the course on hearing the representative of insurer pointed out that as per the Discharge summary the Life Assured was patient of HTN and Type II DM for 10 years and also history of Left Knee joint pain for many years. On the other hand representative of the complainant mentioned h/o of hypertensive and type II DM was not prior to the commencement of the policy.

Decision

We have taken in to consideration the facts and circumstances of the case from the documentary as well as verbal submissions made by the authorised person of the claimant and also from the representative of the Insurance Company. The following points stand out.

1 .As per discharge summary dated 15.06.2020 the history of past illness was with regular medication for 10 years, which is after the commencement of policy.

2. Insurer should not dispute a claim for past illness which developed after commencement of policy. Since, the TPA's ground for repudiation was clearly untenable, it is pointless to call for further evidence. It would only serve to further delay which has already delayed 9 without any valid ground.

Considering above the Insurance Company is directed to settle the claim immediately as per rules of the corporation with interest @2% above the prevailing Bank rate from the date of submission of papers to the date of payment

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

Hence the complaint is treated as closed.

Dated at Guwahati, the 28th day of April 2021.

K.B.Saha

Insurance Ombudsman

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. SURESH BABU IRS

Case between: MR. B. CHINNI ……The Complainant

Vs

M/s Star Health And Allied Insurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .044 .2122.0008 **Award No.: I.O.(HYD)/A/HI/ 0002 /2021-22**		
1.	Name & address of the complainant	Mr. B. Chinni 1-128, Iruvaram Palli HW, Irala Mandal,Chittoor Andhra Pradesh- 517 130 (Cell No. 77994-89256)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	P/111119/01/2021/002809 Corona Rakshak Policy 01.09.2020 to 15.12.2020
3.	Name of the insured Name of the Policyholder	Mr. Bandapalle Chinni Mr. Bandapalle Chinni
4.	Name of the insurer	*M/s Star Health and Allied Insurance Co. Ltd.*
5.	Date of Repudiation	*24.12.2020*
6.	Reason for repudiation	*Treatment did not warrant admission in hospital*
7.	Date of receipt of the Complaint	19.03.2021
8.	Nature of complaint	*Claim pertaining to medical insurance policy*
9.	Amount of Claim	Rs. 2,50,000/-
10.	Date of Partial Settlement	------
11.	Amount of Relief sought	Rs. 2,50,000/-
12.	Complaint registered under Rule No.13 (b) of Ins. Ombudsman Rules, 2017	Rule 13 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Complaint how disposed	Allowed (Statistical Purpose)
14.	Date of Order/Award	20.04.2021

15)Brief Facts of the Case:

The complainant had purchased a Corona Rakshak Policy from respondent which was effective from 01.09.2020. During the policy period of insurance, he was admitted in S V R R Govt. general hospital, Tirupati with

complaints of cough. He was diagnosed with COVID positive because of which he was treated with oral medicines until he was discharged in a stable condition from hospital on 28.09.2020. He had filed a claim against the insurance policy with respondent but was denied by them. Unhappy with his claim being repudiated by respondent, he had approached this Forum to seek justice.

16) Cause of Complaint: Non settlement of Mediclaim.

17) Reason for Registration of Complaint:

The claim preferred by the complainant was non - settlement of Mediclaim by the insurer. As the complaint fell under Rule 13(b) of Insurance Ombudsman Rules, 2017, it was registered.

After registration of complaint by this Forum and before hearing, the insurer further reviewed the claim , processed it and agreed to settle the claim for Rs.2,50,000/- . The Complainant accepted the settlement and vide mail dated 16.04.2021 requested the Forum to withdraw the complaint. (Two lakhs fifty thousand only).

AWARD

The complaint is treated as resolved and closed.

Dated at **Hyderabad** on the **20th** day of **April 2021.**

(I.SURESH BABU)

INSURANCE OMBUDSMAN
FOR THE STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. Suresh Babu

Case between: Mrs. Rohini Deepthi Natti ……The Complainant

Vs

M/s MAX Bupa Health Insurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .031 .2122.0007

Award No.: I.O.(HYD)/A/HI/ 0003 /2021-22

1.	Name & address of the complainant	Mrs. Rohini Deepthi Natti 402, Dwaraka Nilayam, Road #19, Cooperative Bank Colony, Nagole, Hyderabad, Telengana State- 500 068 (Cell No. 73823-12323)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	30689720201902 Family First Gold medical insurance policy 04.08.2019 to 03.08.2020
3.	Name of the insured Name of the Policyholder	Mrs. Rohini Deepthi Natti Mrs. Rohini Deepthi Natti
4.	Name of the insurer	*M/s MAX Bupa Health Insurance Co. Ltd.*
5.	Date of Repudiation	*28.01.2021*
6.	Reason for repudiation	*Claim falls outside the scope of policy clause No. 2.1 & 2.9*

7.	Date of receipt of the Complaint	22.03.2021
8.	Nature of complaint	*Claim pertaining to medical insurance policy*
9.	Amount of Claim	Rs. 6,91,913/-
10.	Date of Partial Settlement	------
11.	Amount of Relief sought	Rs. 6,91,913/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	20.04.2021, online, Hyderabad
14.	Representation at the hearing	
	a) For the complainant	Self
	b) For the insurer	Ms.Bhuvan Bhaskar, Manager
15.	Complaint how disposed	Dismissed
16.	Date of Order/Award	20.04.2021

17) Brief Facts of the Case:

The complainant had purchased an annual medical insurance policy from respondent in which she had covered the hospitalization cost of her, her spouse and her son. During the period of insurance, she got admitted in Apollo Hospitals between 04.12.2019 and 12.12.2019 to donate her liver to her father for which she had undergone Donor hepatectomy on 06.12.2019. The total hospitalization cost incurred towards her treatment alone was Rs. 5,92,745/- excluding the pre surgery evaluation cost. Subsequently, she had filed her claim with respondent company against the insurance policy. The respondent had denied her claim on grounds being mentioned in the exclusion clause of policy. Since her representation given to Grievance department of respondent too had not yielded fruitful result, the complainant had therefore approached this forum to seek justice.

18) Cause of Complaint: Repudiation of claim made against the medical Insurance policy.

a) Complainant's argument:

In her letter addressed to this Forum, the complainant had submitted that the respondent company had confirmed to her on multiple no. of occasions that the donor's medical expenses shall be covered and she was also informed by respondent as to the eligible room rent under her policy of insurance. Upon filing her claim for reimbursement, she was given an oral assurance by respondent that her claim processing would not take much time because of its simplistic nature. However, her claim was rejected after a month without assigning a clear reason. Further, none of the officials of respondent had come forward to explain the exact reason for the denial of her claim. She had even expressed her displeasure regarding the unprofessional attitude of respondent in handling her claim which had furthered her stress even before she could recover completely from the surgery.

b) Insurer's argument:

Self contained note was submitted by the respondent on 15.04.2021. They had issued a Family Floater First Gold policy commencing from 04/08/2017 to 03/08/2018 in the name of the complainant for herself, spouse and her child for a floater sum insured of Rs.3 Lakhs, individual sum insured of Rs.1 Lakh each for spouse & Child and Rs.5 Lakhs for the complainant. They received a claim on 08/02/2020 towards reimbursement of medical expenses

incurred for hospitalization of the complainant in Apollo Hospitals, Jubilee hills from 04.12.2019 to 12.12.2019. As per their investigation The Complainant had donated a part of her liver to her father Sri N.Siva Prasad Rao who was suffering from CAD(CABG) and liver cancer accidently detected in October 2019. As per policy document the father of the complainant is not insured under the policy hence as per section 2.9(c) living organ transplant claim stands denied.

19) Reason for Registration of Complaint:
The insurer rejected the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:
   a. Policy copy
   b. Discharge summary
   c. Rejection letter
   d. Correspondence with insurer
   e. Self contained note with enclosures.

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the online hearing at Hyderabad on 20.04.2021.
The complainant stated her father needed liver transplantation and she had been the donor. The hospitalization expenses as a donor was initially accepted over phone by the staff of respondent insurer and later it was rejected stating her father should also be covered under the policy for her claim to become payable. As per clause 2.1 she was eligible for her the cost of her hospitalization she reiterated. She also stated that clause 2.9 was not applicable to her.

The Respondent insurer stated that a per Section 2.1(a) Inpatient care reads:"We will indemnify the medical expenses incurred on the insured person's hospitalization during the policy period following an illness or injury that occurs during the policy period, provided that the hospitalization is medically necessary and advised and follows evidence based clinical practices and standard treatment guidelines". In the instant case the complainant was hospitalized not due to illness or injury but was hospitalized as a willing donor of her liver to her father who was not insured in the complainant's policy or any other policy with their company.

Section 2.9 of the policy Living Organ donor transplant specifies that medical expenses incurred for a living organ donor inpatient treatment for harvesting the organ donated is indemnified provided as per section 2.9 (C) the recipient insured person claim is accepted under section 2.1 (inpatient care). This means that the insured who is the recipient should have been insured under the policy; whereas, in the instant case the recipient being the father is not covered under her policy or under any other Policy with the respondent company.

As regards the recoded telephonic call the complainant mentioned during the hearing, as proof of confirmation that the donor expenses would also be covered, the Forum feels that officials of the respondent insurer could have assumed that her father would have also been covered under one policy along with the complainant.

Since the Policy issued is a contract between the Complainant and the Respondent Insurer, the Policy terms and conditions of the Contract in the printed form is a binding agreement in the Court of Law. The denial clause 2.9 (c) applied by the respondent insurer is therefore correct and policy clause 2.1 which the complainant dwells upon is not applicable in her case. This Forum does not see any infirmity in the decision taken by the respondent insurer to repudiate her claim.

A W A R D

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing and the information/documents placed on record, the complaint devoid of any merit is dismissed without costs.

Dated at **Hyderabad** on the **20th** day of **April , 2021.**

(I. SURESH BABU)

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. Suresh Babu

Case between: MR. SIGHAKOLLI L N S PRASAD……The Complainant

Vs

M/s STAR Health and Allied Insurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .044 .2122.0022

Award No.: I.O.(HYD)/A/HI/ 0005 /2021-22

1.	Name & address of the complainant	Mr. Sighakolli L N S Prasad 28-4-3, Peddaveedhi, Jampeta, Rajahmundry,Andhra Pradesh- 533 103 (Cell No. 98661-83486)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	P/131124/01/2020/002695 Family Health Optima Insurance-2017 28.10.2019 to 27.10.2020
3.	Name of the insured Name of the Policyholder	Mr. Sighakolli L N S Prasad Mr. Sighakolli L N S Prasad
4.	Name of the insurer	*M/s STAR Health and Allied Insurance Co. Ltd.*
5.	Date of Repudiation	------
6.	Reason for repudiation	*Claim settled as per policy terms and conditions*
7.	Date of receipt of the Complaint	01.04.2021
8.	Nature of complaint	*Claim pertaining to medical insurance policy*
9.	Amount of Claim	Rs. 4,69,197/-
10.	Date of Partial Settlement	04.01.2021
11.	Amount of Relief sought	Rs. 4,16,697/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	23.04.2021, online, Hyderabad
14.	Representation at the hearing	
	a) For the complainant	Self
	b) For the insurer	Mr.M.Ravi Kumar, AGM, Legal
15.	Complaint how disposed	Allowed partially
16.	Date of Order/Award	23.04.2021

17) Brief Facts of the Case:

The complainant had renewed an annual medical insurance policy from respondent company to cover the hospitalization cost of his spouse and him with a sum insured of Rs. 5 Lakhs. He was admitted on 01.09.2020 to Ascent hospitals to undergo treatment for COVID-19 infection and was discharged on 08.09.2020. He had filed his hospitalization claim with respondent. However, his claim was settled for a partial sum of Rs. 52,500/- Unhappy with the major portion of his claim having been disallowed by respondent; the complainant has approached this Forum to seek justice after his representation given to the grievance department to reconsider his entire claim too had proved futile.

18) Cause of Complaint: Partial settlement of claim by respondent under the medical Insurance policy.

a) Complainant's argument:

In his letter addressed to this Forum, the complainant had stated that he was not satisfied with the reply given by respondent. He had submitted all the documents in support of his claim and yet the respondent had disallowed a major sum of Rs. 4,16,697/- as against his claim amount of Rs. 4,69,197/-.

b) Insurer's argument:

Self contained note was submitted by the respondent over mail dated 21.04.2021. They had partially settled the claim and have now reviewed the complaint and claim documents, and decided to settle the claim for an additional amount of Rs. 1,17,000/- . Work sheet has been enclosed.

Total Claim amount Rs 4,69,197/-
NON-payables Rs 1,91,136/-

Total Payable Rs 2,78,061/-

Amounts already paid : Rs 1,61,061/- (Rs 52,500 + 1,08,561)

Balance Rs 1,17,000/-

List of Non-payable amounts: Room rent payable Rs.5000/- per day and ICU Rs.10,000/- per day.

	Claimed Rs.	Disallowed Rs.	
Room rent	1,90,000	1,30,000	
Investigation and diagnostic	12,000	2,400	80% paid
Medication with hospital	57,197	13,736	urobag, respirometer, mask, diapers, disposables not payable)
Others	55,000	45,000	Vido con, equipment not paid, oxygen allowed

19) Reason for Registration of Complaint:

The insurer partially settled the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:

a. Policy copy
b. Discharge summary
c. Correspondence with insurer
d. Self contained note with enclosures.

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the online hearing at Hyderabad on 23.04.2021.

The complainant stated his covid-19 hospitalisation claim was partially paid. Out of total amount spent for treatment of Rs.4,69,197/- he was paid initially Rs.52,500/-, and Rs.108561/-. Therefore total amount received by him was Rs.161061/-. He informed the forum that respondent insurer was harassing him to submit original claim documents every time they make a part payment which was not fair he reiterated.

The respondent insurer have initially paid Rs.52,500/- as per grid rate of Rs.7500/- per day. They had reviewed and paid Rs.1,08,561/- . During the hearing they expressed their willingness to review and pay Rs.1,17,000/-. However, amount of Rs.1,91,136/- was disallowed as non-payable as per terms and conditions of the Policy.

The amount Claimed by the respondent was Rs.4,69,197/- and the respondent insurer has partially settled Rs.1,61,061/- and were willing to settle a further amount of Rs.1,17,000/-. The total amount comes to Rs.2,78,061/-. The Forum observed that room rent charges applicable for a sum insured of Rs.4 Lakhs was Rs.5000/- maximum per day as per policy 1 A Coverage. Under the Dis-allowed amount of Rs.1,91,136/-, the major amount pertains to excess room rent billed over and above the eligible room rent hence disallowed .

	Claimed Rs.	Disallowed Rs.	Remarks/ reasons
Room rent	1,90,000	1,30,000	Rs.5000/- per day for 2 days and Rs.10,000/- ICU for 5 days
Investigation and diagnostic	12,000	2,400	80% paid due to lack of breakup
Medication with hospital	57,197	13,736	urobag, respirometer, mask, diapers, disposables not payable)
Others	55,000	45,000	Vido con, equipment not paid, oxygen allowed

The Forum finds the non-allowable items are as per the policy terms and conditions and IRDAI list of non payable items. Therefore the respondent insurer is directed to release the balance amount of Rs.117000/- as agreed as per Policy terms and conditions without further delay.

A W A R D

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing and the information/documents placed on record, the insurer is directed to settle the claim for Rs.1,17,000/- .

The complaint is *Allowed partially.*

22) The attention of the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

a) *According to Rule 17(6), the insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance to the same to the Ombudsman.*
b) *According to Rule 17(7), the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory & Development Authority of India Act from the date the claim ought to have been settled under the Regulations till the date of payment of the amount awarded by the Ombudsman.*
c) *According to Rule 17 (8), the award of Insurance Ombudsman shall be binding on the Insurers.*

Dated at **Hyderabad** on the **23rd** day of **April , 2021.**

(I. SURESH BABU)

OMBUDSMAN FOR THE
STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE **THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM** **(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)**
Ombudsman - Shri I. Suresh Babu
Case between: MRS. PULI BALAMMA……The Complainant **Vs** **M/s Chola MS General Insurance Co. Ltd……The Respondent** **Complaint Ref. No. I.O.(HYD).H .012 .2122.0011**

Award No.: I.O.(HYD)/A/HI/ 0006 /2021-22		
1.	Name & address of the complainant	Mrs. Puli Balamma W/o Puli Pitchireddy H.No. 7-82/1, VipparlareddyPalem (Vill), Vipparla (PO), Rompicherla (Mandal), Guntur District,Andhra Pradesh- 522 617 (Cell No. 91600-86008)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	2894/00032771/000/00 Corona Rakshak Policy 23.08.2020 to 05.03.2021
3.	Name of the insured Name of the Policyholder	Mrs. Puli Balamma Mr. Puli Pitchireddy
4.	Name of the insurer	*M/s Cholamandalam MS General insurance Co. Ltd.*
5.	Date of Repudiation	*03.02.2021*
6.	Reason for repudiation	*Treatment does not warrant hospitalization*
7.	Date of receipt of the Complaint	30.03.2021
8.	Nature of complaint	*Claim pertaining to medical benefit insurance policy*
9.	Amount of Claim	Rs. 150,000/-
10.	Date of Partial Settlement	------
11.	Amount of Relief sought	Rs. 150,000/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	22.04.2021
14.	Representation at the hearing	
	a) For the complainant	Mrs. P. Balamma
	b) For the insurer	Dr.Prabhu
15.	Complaint how disposed	ALLOWED
16.	Date of Order/Award	26/04/2021

17) Brief Facts of the Case:

The complainant's spouse had procured a Corona Rakshak insurance policy from respondent to include him and the complainant, for a sum insured cover of Rs. 1.5 Lakhs each. On 10.09.2020, the complainant was admitted in

a COVID care center, Chilakaluripet, Guntur to undergo treatment for a COVID infection. Subsequently, she had filed a claim under the policy with respondent. Since the respondent had denied her claim, the complainant had filed a complaint against respondent in this forum.

18) Cause of Complaint: Repudiation of claim by respondent under the benefit Insurance policy.

a) Complainant's argument:

In her letter addressed to this Forum, the complainant had submitted that she had consulted a doctor on outpatient basis on 08.09.2020 when she had developed fever, running nose, headache, body pains, reddish eyes, tiredness etc. However, her health had started to deteriorate on 09.09.2020 when she suffered from palpitation and cough, loss of smell and taste. She was shown to a doctor at Palnadu Hospitals who had provisionally diagnosed her with COVID and which was confirmed through an RT-PCR test. She could not undergo scanning test as advised by doctor owing to the severity of her health. The hospital had the facility to treat COVID patients but since she was unable to afford the cost for her treatment, she was therefore referred to AP Government COVID field surveillance medical officer and upon his direction; she was admitted to COVID care center after the duty doctor had confirmed the need for her admission in hospital. Her submission was that the center which had treated her for COVID was in line with the main hospital and had followed the guidelines laid down by the central government with all the necessary equipments, treating doctors, nursing staff, and a nodal officer on duty being made available round the clock. In support of her claim, she had submitted all the medical records to this Forum to examine and do justice to her.

b) Insurer's argument:

As per the self contained note submitted by the respondent claim of complainant could not be honored because the treatment given to her during her hospitalization did not warrant her inpatient admission since she was administered oral medicines. Further, her medical parameters were within the normal limits and did not require treatment in hospital as per the guidelines laid down by the Ministry of Health & Family welfare. They has also stated that the Covid Care Centre, Chilakaluripet is an isolation centre and cannot be treated as an hospital. Hence they have justified their rejection of the claim on the said grounds.

19) Reason for Registration of Complaint:

The insurer rejected the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:

a. Policy copy
b. ICMR Specimen Referral Form for COVID_19 and Discharge Card
c. Rejection letter
d. Correspondence with insurer
e. SCN

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the OnLine hearing at Hyderabad on 22/04/2021. The complainant reiterated the same submissions made in 18(a) and pleaded for the settlement of her claim since she has complied all the policy conditions. She has further stated that she was referred to the Covid Care Centre, Chilakaluripet by the local surveillance health team after she was diagnosed as Covid Positive. She was treated in the Covid Care Centre from 10/09/2020 with oral medication and discharged on 16/09/2020 with an advice of 14 days home quarantine. Since all the policy conditions were complied, she has lodged the claim for the settlement of her claim under the policy. However, her claim was rejected stating that her medical condition was normal and does not require any hospitalization.

The Respondent has reiterated the same pleadings mentioned in their SCN and justified their rejection of the claim. They have also stated that the Covid Care Centre is meant for isolation and not qualified as hospital for the admissibility of the claim.

Upon perusing the arguments of the parties, the Forum has observed that the policy was a benefit policy and the Lump sum benefit equal to 100% of the sum insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. For the purpose of hospitalization the policy has made it very clear that any set-up designated by the government as hospital for the treatment of Covid-19 shall also be considered as hospital. The Positive diagnosis of COVID shall be from a government authorized diagnostic centre. Keeping in view of the above observations the forum has observed that the complainant has underwent Covid test from a government designated authorized diagnostic centre and diagnosed COVID POSITIVE. She was admitted in Covid Care Centre which was set-up by the Government for the treatment of Covid-19 patient on the advice of the local health team and the insured was continuously treated for more than 72 hours. The Covid Care Centres are the temporary set-ups established by the state governments as per the guidelines of the MoH&FW for treating the mild cases. Hence the Covid Care Centres qualifies the definition of hospital defined in the Policy Definitions No.3.9(vi) and the treatment in the Covid Care Centre should be treated as valid hospitalization for the admissibility of the claim under the policy. In view of the aforementioned discussions the forum has felt that the claim is tenable under the policy since the complainant has fulfilled all the conditions precedent and eligible for all the benefits under the policy. Hence the Forum direct the respondent insurer to admit the claim and pay the agreed sum insured mentioned in the policy schedule.

Accordingly the complainant is allowed.

A W A R D

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the Online Hearing and the information/documents placed on record, the insurer is directed to settle the claim for Rs.150,000/- as mentioned in the policy schedule.

The complaint is ALLOWED.

22) The attention of the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

d) *According to Rule 17(6), the insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance to the same to the Ombudsman.*
e) *According to Rule 17(7), the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory & Development Authority of India Act from the date*

the claim ought to have been settled under the Regulations till the date of payment of the amount awarded by the Ombudsman.

f) *According to Rule 17 (8), the award of Insurance Ombudsman shall be binding on the Insurers.*

Dated at **Hyderabad** on the26 th day of APRIL **, 2021.**

(I. SURESH BABU)

INSURANCE OMBUDSMAN

FOR THE STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. Suresh Babu

Case between: MR.P.VENKATA REDDY……The Complainant

Vs

M/s HDFC ERGO Generao Insurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .018 .2122.0012

Award No.: I.O.(HYD)/A/HI/ 0007 /2021-22

1.	Name & address of the complainant	Mr.P.Venkata Reddy H.No.8-3-222/8/42 (F-69) Madhuranagar, HYDERABAD TELANAGA STATE—500 038 Mobile No.92468 75614
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	2804 2037 5456 9800 000 Optima Senior Medical Insurance 21.10.2020 to 20.10.2021
3.	Name of the insured Name of the Policyholder	Mrs.Pamireddy Surya Prabha Mr.Pamireddy Venkata Reddy
4.	Name of the insurer	*M/s HDFC ERGO HEALTH Insurance Co.Ltd.,*
5.	Date of Repudiation	*10.02.2021*
6.	Reason for repudiation	*Non-Disclosure of facts*
7.	Date of receipt of the Complaint	31.03.2021
8.	Nature of complaint	*Claim pertaining to medical Insurance Policy*
9.	Amount of Claim	Rs.508,200/-
10.	Date of Partial Settlement	------
11.	Amount of Relief sought	R508,200/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	22.04.2021
14.	Representation at the hearing	
	a) For the complainant	Mr.P.Venkata Reddy
	b) For the insurer	Ms.Amala Edward
15.	Complaint how disposed	DISALLOWED
16.	Date of Order/Award	26/04/2021

17) Brief Facts of the Case:

The complainant had procured a medical insurance policy from respondent to cover the hospitalization benefits for his spouse. On 09.12.2020, his spouse was admitted to Yashoda Hospitals where she was diagnosed with pulmonary edema, exacerbation of allergic airway disease, DM. Since her cashless claim was rejected by respondent, she had filed a reimbursement claim with respondent company. Since the respondent had denied her reimbursement claim too, the complainant had therefore filed a complaint against respondent in this Forum to seek justice.

18) Cause of Complaint: Repudiation of claim by respondent under the benefit Insurance policy.

a) Complainant's argument:

In his letter addressed to this Forum, the complainant had submitted that at the time of purchasing a medical insurance policy for his spouse, he had submitted the supporting documents to respondent to show that she was suffering from Pulmonary Edema. The respondent had verified the documents submitted and then an amount of Rs. 36,249/- was remitted towards premium as computed by them. Later, as advised by respondent, she underwent certain medical tests at the center authorized by respondent and thereafter was asked to pay an additional premium of Rs. 5,438/- towards loading and GST charges and the policy was issued thereafter. When cashless claim was rejected, she had filed reimbursement claim which too was rejected by respondent and her policy too was cancelled. In this regard, the complainant had pleaded that the copies of all documents pertaining to his spouse's ailments were furnished to respondent before the issuance of policy of insurance. A certificate from doctor was also provided to respondent at the time of processing of claim. The complainant had therefore asserted that no facts pertaining to his wife's ailments were concealed and denial of her claim and termination of policy of insurance by respondent was unfair.

b) Insurer's argument:

As per the self contained note submitted by the respondent the claim of complainant was repudiated and the policy was cancelled due to non-disclosure and concealment of facts on the medical history details of the insured who was a known case of Obstructive Sleep Apnea (OSA) and Pulmonary Hypertension (PAH) which were there in her prior to inception of policy. The decision was taken in accordance with Section VI of policy terms and conditions and justified their repudiation of claim and cancellation of the policy.

19) Reason for Registration of Complaint:

The insurer rejected the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:

a. Policy copy
b. Discharge Summary
c. Rejection letter
d. Correspondence with insurer
e. SCN
f.Proposal Form and Pre-investigation reports

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the online hearing at Hyderabad on 22.04.2021. The complainant has reiterated their earlier submissions and sought relief from the forum. The insured has also stated that he was an insurance advisor in the respondent insurance company and submitted all the requirements sought by the respondent. He has further stated that he has disclosed all the pre-existing diseases of his wife at the time of proposing for insurance and she underwent pre-health investigations as suggested by the respondent insurer. The respondent insurer has accepted the proposal after loading the premium basing on the pre-investigation reports. The complainant has stated that he has complied all the policy conditions and request for the settlement of the claim.

The Respondent Insurer has stated that the policy was issued basing on the proposal form submitted by the proposer Mr.P.Venkata Reddy to cover his wife Mrs.P.Surya Prabha under Health Insurance policy. The insured person was referred to the panel doctor for medical examination and during the course of the investigations it was revealed that the proposer has been suffering from hypertension for 6 years. Since it was not disclosed in

the proposal, they have loaded the premium for the said pre-existing condition and issued the policy from 21/10/2020 to 20/20/2021 with a sum insured of Rs.500,000/-.

During the policy period i.e. on 09.12.2020, the insured Mrs.P.Surya Prabha was admitted in the Yashoda hospitals and submitted her claim for the reimbursement of the medical expenses of Rs.488,904/-. After perusing the claim documents the Respondent insurer has observed that the insured was diagnosed with Pulmonary Edema, Exacerbation of Allergic Airway Disease, Diabetes Mellitus, Obstructive Sleep Apnea with Pulmonary Arterial Hypertension and Systemic Hypertension. They have noted from the Discharge Summary that the insured was a k/c/o DM, Hypertension and OSA. They have also noted that the insured was hospitalized prior to the inception of the policy in 2018 and 2019 for the treatment of the same complications. However the insured has not disclosed all these known facts which are material for underwriting the risk, at the time of proposing the insurance. Since the insured has violated policy condition No. (j) of Section IV they have rightly repudiated the claim and cancelled the policy on the grounds of non-disclosure and suppression of material facts.

Upon hearing arguments and examination of the documents submitted the parties it was noted that the proposer has submitted the proposal for covering his wife under Optima Senior Medical insurance policy for the first time. The duly completed proposal form was signed by the proposer Mr.P.Venkata Reddy and witnessed by the Insured Mrs.P.Surya Prabha. It has been observed from the information furnished in the proposal form against question No.7, the proposer has mentioned NO for all the questions mentioned in the Sections of A,B and C under the MEDICAL AND LIFE STYLE INFORMATION. For the pointed question of whether the proposer had ever suffered from/are currently suffering from any of the diseases mentioned in Section A (i) to (xiii) under the MEDICAL AND LIFE STYLE INFORMATION the proposer has declared NO for all the diseases. The proposer has also declared NO for all the questions relating to regular medications, lab tests, scans, previous surgeries, diseases suffered under Section B of the MEDICAL AND LIFE STYLE INFORMATION. The proposer has furnished NO for all the questions mentioned in Section C which are related to details of illnesses/medications/tests/surgery undergone earlier.

The insured person was referred for medical examination and during the examination it was revealed that she was suffering from hypertension for six years. Basing on the revelations from the pre- medical examination reports the respondent insurer had accepted the proposal after loading the premium. During the policy period the insured was admitted in Yashoda Hospitals for the treatment of Pulmonary Edema, Excerbation of Allergic Airway Disease and Diabetes Mellitus and applied for the reimbursement of the medical expenses incurred. On examination of the Discharge summary it was noted that the insured has a past history of Diabetes Mellitus hypertension and OSA. It was further noted from the previous medical records that the insured was admitted in M/s.St.Theresa's Hospital in November,2018 for the treatment of COPD with mild PAH,T2DM with HTN and Hypothyroidism. She was also admitted in Yashoda Hospitals for the treatment of OSA,Allergic Airway Disease,Severe PAH,Type II DM,Hypertension from 17/8/2019 to 23/8/2018. On the close examination of the information furnished in the Hospital Records issued by the Yashoda Hopitals and St.Theresa's Hospital it was noted that the insured was suffering from DM,OSA,COPD,PAH,Allergic Airway Disease and Hypertension prior to the applying for insurance but failed to disclose the same in the proposal form. The proposer and the insured who are both well aware of the pre-existing conditions chose not to disclose them tantamount to suppression of material facts. The Forum has also observed that the proposer was an agent of the respondent insurer and aware of the duties of an agent while furnishing the material information as required by the insurer in respect of the risk, in order to take informed decision by the insurer for acceptance of the proposal.

It is pertinent to quote the General Principles laid down in 19(4) of IRDAI(Protection of Policy Holders Interests) which states:

"the Policyholder shall furnish all information that is sought from him by the insurer, either directly or through the distribution channels, which the insurer considers as having a bearing on the risk to enable the insurer to assess properly the risk covered *under a proposal for insurance*".

In the present instance the distribution channel is none other than the proposer himself. The proposer who is also acting as an agent while proposing the insurance of his wife should be aware of the importance of the material information sought by the insurer. The proposer who is having knowledge of the pre-existing conditions of his wife, preferred not to disclose them will be construed as breach of trust. He has also breached the duty as an agent and approached the forum without clean hands.

The Forum would like to quote the decision of the hon'ble Supreme Court in the case of Satwant Kaur Sandhu Vs. The New India Asssurance Co.Ltd., in Civil Appeal No.2776 of 2002 which states:

''That in a Contract of insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a MATERIAL FACT. If the proposer has knowledge of such fact, he is obliged to disclose it particularly while answering questions in the proposal form. Needless to emphasize that any inaccurate answer will entitle the insurer to repudiate his liability because there is clear presumption that any information sought for in the proposal form is material for the purpose of entering into a Contract of Insurance".

In view of the above discussions the Forum concludes that this is a clear case of non-disclosure of material facts with regard to the pre-existing diseases/ailments at the time of proposing the insurance. Therefore, the Respondent Insurer was justified in repudiating the claim and the complaint deserves to be rejected accordingly.

A W A R D

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the online hearing and the information/documents placed on record, the forum upheld the repudiation of the claim and cancellation of the policy on the grounds of non-disclosure of material facts.
The complaint is DISALLOWED.

22) The attention of the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017

g) *According to Rule 17(6), the insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance to the same to the Ombudsman.*

h)

i) *According to Rule 17(7), the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory & Development Authority of India Act from the date the claim ought to have been settled under the Regulations till the date of payment of the amount awarded by the Ombudsman.*

j)

k) *According to Rule 17 (8), the award of Insurance Ombudsman shall be binding on the Insurers.*

Dated at **Hyderabad** on the26 **th** day of APRIL **, 2021.**

(I. SURESH BABU)

INSURANCE OMBUDSMAN

FOR THE STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. Suresh Babu

Case between: MR. SHARAD SINHA……The Complainant

Vs

M/s The New India Assurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .050 .2122.0023

Award No.: I.O.(HYD)/A/HI/ 0008 /2021-22

1.	Name & address of the complainant	Mr. Sharad Sinha #401, Aditya Classic, Hotel Katriya Lane, Somajiguda,Hyderabad Telengana State- 500 082 (Cell No. 98490-21401)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	61380034192800000231 New India Floater Mediclaim Policy 25.08.2019 to 24.08.2020
3.	Name of the insured Name of the Policyholder	Master Sameer Sinha Mr Sharad Sinha
4.	Name of the insurer	*M/s The New India Assurance Company Limited*
5.	Date of Repudiation	*22.03.2021*

6.	Reason for repudiation	*Claim falls under the exclusion clause 4.4 of policy*
7.	Date of receipt of the Complaint	01.04.2021
8.	Nature of complaint	*Claim pertaining to medical insurance policy*
9.	Amount of Claim	Rs. 44,618/-
10.	Date of Partial Settlement	-----
11.	Amount of Relief sought	Rs. 44,618/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	23.04.2021, online, Hyderabad
14.	Representation at the hearing	
	a) For the complainant	Self
	b) For the insurer	Dr.J.Shyam
15.	Complaint how disposed	Claim Dismissed, policy to be renewed as per IRDAI guidelines
16.	Date of Order/Award	27.04.2021

17) Brief Facts of the Case:

The complainant had purchased an annual medical insurance policy from respondent to cover the health of his spouse, son, and him which carried a total sum insured of Rs. 8 Lakhs. On 18.02.2020, his son was admitted to National Institute of Mental Health And Neuro Sciences (NIMHANS) to undergo treatment for his ADHD, ODD etc. and was discharged on 24.03.2020. Subsequently, the complainant had filed a claim with the respondent company towards the expenses paid to hospital for treatment of his son. The respondent however had denied the claim on grounds of exclusion clause applicable under the policy. Aggrieved by the repudiation of claim, the complainant had approached this forum to seek justice.

18) Cause of Complaint: Repudiation of claim by respondent under the medical Insurance policy.

a) Complainant's argument:

In his letter addressed to this Forum, the complainant had stated that he had been a policy holder for several years with the respondent. The TPA of respondent to whom the claim papers were submitted had not acted on his claim even after 8 months of his long wait. He had therefore approached the respondent only to get a response from them that his claim was denied once after he had fulfilled the process of filing a complaint in their portal. He had pointed out at the unprofessional manner in which his claim was treated both by the TPA and respondent. His submission was that the IRDAI being a regulator for all the insurers had issued a circular in the year 2018 which had directed the insurers to make provision for medical insurance in respect of treatment of mental illness as per section 21 sub sections 4 of the Mental Healthcare Act, 2017. The complainant was of the firm belief that an insurer was not supposed to defy the law of land especially the directions given by IRDAI by issuing policies in conflict with such directions and the Act. The complainant had made a claim only on the basis of knowledge of such a law which was binding upon the respondent like any other commercial contract would be. He had also pointed out at the IRDAI's failure to check if the insurers abide by the Act as well as such compliance on the basis of circular issued to them. The complainant was also aggrieved because the respondent had failed to address the circular issued by IRDAI and the provisions of Act in spite of his submitting the same to respondent for their reconsideration of claim on the basis of such provision.

b) Insurer's argument:

Self contained note was submitted by the respondent over mail dated 22.04.2021.The complainant's son Mr. Sameer Sinha was suffering from psychosomatic disorder; at the "National lnstitute of Mental Health & Neuro Sciences, Bengaluru during the period 08.02.2020 to 24.03.2020. But, the claim was rejected based on the following grounds. The claim was for treatment of ADHD (Attention deficit hyperactivity disorder), ODD (opposition defiant disorder), Conduct disorder and gaming disorder which is a psychiatric & psychosomatic disorder falling under the Policy Exclusion 4'4 Permanent- Any medical expenses incurred for or arising out of 4.4.6 convalescence, general debility, Run-down condition or rest cure, obesity treatment and its complications, congenital external disease/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders , infertility, sterility, use of intoxicating druts/alcohot, use of tobacco leading to cancer. Misrepresentation about mental health disorders of dependent child and insured.

As per the discharge summary of the hospital, lnsured son was suffering with ADHD, ADS and NDS in insured. Insured had to declare about mental disorders in policy. This comes under the policy Exclusion 5.1 This Policy is issued on the basis of the truth and accuracy of statements in the Proposal' lf there is a misrepresentation or non-disclosure we will be entitled to treat the Policy as void ab- initio . As per 5.8 The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, mis-description or nondisclosure of any material fact/particular if such claim be in any manner fraudulent or supported by any fraudulent ,by the insured Person or by any other person acting on his/her behalf. The coverage of mental health disorders was not an automatic choice for the existing policy. As the IRDAI circular about the inclusion of mental health disorders is issued on 01.10.2020 and claim occurred policy is effective from 25.08.2019 to 24.08.2020. Hence, there was no coverage for the above said disease. Coverage for mental health disorders cannot be applicable to before the issue of the circular. lt would have be covered by loading 5% premium at the time of renewal ,on receipt of request from the insured for inclusion of mental health disorders coverage under the policy. Since no such request for inclusion was made and no additional paid the current policy exclusion applied squarely.

19) Reason for Registration of Complaint:

The insurer rejected the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:
   a. Policy copy
   b. Discharge summary
   c. Rejection letter
   d. Correspondence with insurer
   e. Self contained note with enclosures.

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the online hearing at Hyderabad on 23.04.2021.

The complainant stated that as per IRDAI circular dated 16.08.2018 mental disorders are payable as per the provisions laid down by the Medical Health care Act 2017 with immediate effect. Besides what he had reiterated in his complaint letter, he had also stated that the Act of respondent insurance company in not complying with the provisions laid down in the Act was ultravires.

The Respondent insurer have expressed that as per the Standardization of exclusions of IRDAI dated 27.09.2019 for all existing products, mental diseases need to be covered from 1.10.2020 renewals, subject to payment of 5%

loading premium on the current premium and upto the limits of the policy. As per this guideline, all New India products for renewal from 1.10.2020 were charged with 5% additional premium to include mental health illness.

The Forum on examination of the Mental Healthcare Act observes that The Mental Healthcare Act 2017 aims to provide mental healthcare services for persons with mental illness. It ensures that these persons have a right to live life with dignity by not being discriminated against or harassed. Based upon this Act, IRDAI had directed all the Insurance Companies to comply with the provisions laid down in the Mental Healthcare Act 2017 with immediate effect. However, IRDAI has not laid down any specific guideline to be followed by the insurance companies while incorporating such provisions with immediate effect under their Health Insurance Products vide their circular dated 16.08.2018. In the absence of such guidelines, it is not fair to expect from the Insurer to incorporate such provision arbitrarily.

However, the Guidelines laid down by the IRDAI under Health Insurance circular no IRDAI/HLT/REG/CIR/193/07/2020 dated 22.07.2020 Guidelines on standardization of exclusions Chapter II of the Circular shows the list of exclusions not allowed in Health Insurance Policies 1 (a to l). Under 1(e) Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders are payable. The effective date mentioned under chapter I section 5- Effective date reads " The provision of these guidelines shall be applicable in respect of all health insurance products (other than Personal Accident, Domestic and overseas travel policies) (both individual and group) referred in clause 2 filed on or after 1st October 2019. All existing health insurance products that are not in compliance with these guidelines shall not be offered and promoted from 1st October 2020 onwards."

This Guideline laid down by IRDAI dated 27.09.2019 was issued based upon the working group constituted by IRDAI vide order reference no IRDAI/HLT/ORD/MISC/113/07/2018 dated 24.07.2018 to review the extant practices and make appropriate recommendations to meet the said objective.

As per the aforementioned guidelines, it is very clear that the effective date for incorporation of the Mental Health illness under the health insurance policy is effective from 1.10.2019 for policies issued afresh. In case of already existing polices, such policies cannot be issued without incorporating "exclusions not allowed in health insurance policies" after 01.10.2020. Whereas, in the instant case, the complainant's renewal policy was effective from 25.08.2019 which is prior to the effective date mentioned in the aforementioned circular, such incorporation can only be made effective after the expiry of the policy or on or before 1.10.2020, whichever is earlier. Hence, the respondent insurance company is justified in denying the claim which was reported during the policy period commencing from 25.08.2019 to 24.08.2020.

The existing renewal policy under which the claim was reported did not carry 5% additional premium towards inclusion of mental health illness. Since all Insurance contracts are agreements entered into between both the parties, no insurance claim is payable in the absence of the requisite premium.

Since the policy terms and conditions were made available to the complainant, it was equally the duty of the complainant to have verified the policy exclusions and brought it to the notice of the respondent insurer as to why mental health illness was not included in that renewal policy. The Circular submitted by the Complainant is therefore infructuous owing to the guideline not specified by IRDAI to the Insurance Companies.

The Forum therefore takes cognizance of the IRDAI circular IRDAI/HLT/REG/CIR/177/09/2019 dated 27.09.2019 which is very comprehensive and unambiguous. Hence the present claim is not tenable as per aforementioned circular which is effective from 1.10.2020 for existing policies. Since the Respondent insurer too has failed to

communicate the loading of 5% premium for exiting policy holders, they are hereby directed to seek a fresh proposal form at the time of renewal and follow the IRDAI guidelines suitably incorporating the mental health illness cover on par with any other physical illness.

A W A R D
Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing and the information/documents placed on record, the claim of the complaint is dismissed. However, the respondent insurer is directed to seek a fresh proposal form at the time of renewal and follow IRDAI guideline suitably.

Dated at **Hyderabad** on the **27th** day of **April , 2021.**

(I. SURESH BABU)

INSURANCE OMBUDSMAN

FOR THE STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATES OF A.P., TELANGANA & YANAM

(Under Rule 16(1)/17 of The Insurance Ombudsman Rules, 2017)

Ombudsman - Shri I. Suresh Babu

Case between: MR. B HEMA KUMAR……The Complainant

Vs

M/s Future Generali India Insurance Co. Ltd……The Respondent

Complaint Ref. No. I.O.(HYD).H .016.2122.0035

Award No.: I.O.(HYD)/A/HI/ 0009 /2021-22

1.	Name & address of the complainant	Mr. B. Hema Kumar House #3-147-87-301, Sri Krishna Nilayam, Road #4, Balaji Nagar,

		Nizampet,Telengana State - 500 090 (Cell No. 97046-65656)
2.	Policy No./Collection No. Type of Policy Duration of Policy/Policy period	CRP-95-20-7031675-00-000 Corona Rakshak Policy- Individual 01.08.2020 to 27.04.2021
3.	Name of the insured Name of the Policyholder	Mr. B. Bhoovan Chandra Mr. Hemakumar Bondalapati
4.	Name of the insurer	*M/s Future Generali India Insurance Co. ltd*
5.	Date of Repudiation	*18.12.2020*
6.	Reason for repudiation	*Claim falls outside the scope of policy*
7.	Date of receipt of the Complaint	24.03.2021
8.	Nature of complaint	*Claim pertaining to medical benefit insurance policy*
9.	Amount of Claim	Rs. 250,000/-
10.	Date of Partial Settlement	------
11.	Amount of Relief sought	Rs. 250,000/-
12.	Complaint registered under Rule No.13.1 (b) of Ins. Ombudsman Rules, 2017	Rule 13.1 (b) – any partial or total repudiation of claims by the Life insurer, General Insurer or the Health insurer
13.	Date of hearing/place	28.04.2021
14.	Representation at the hearing	
	a) For the complainant	Mr.B.Hema Kumar
	b) For the insurer	Dr.Akanksha Saxena
15.	Complaint how disposed	ALLOWED
16.	Date of Order/Award	30.04.2021

17) Brief Facts of the Case:

The complainant had purchased a Corona Rakshak medical Benefit insurance policy from the respondent in which his family comprising of him, his spouse, daughter and son were covered individually for a sum insured of Rs. 250,000/-. On 04.09.2020, his son was treated in Mamata Academy of Medical Sciences Hospital for his mild COVID-19 infection and was discharged on 08.09.2020. He had filed a claim under the insurance policy with respondent. However, the respondent had denied his claim on grounds of exclusion clause cited by them. Unhappy with his son's claim having been repudiated by respondent, the complainant had therefore filed a complaint against respondent in this Forum to seek justice.

18) Cause of Complaint: Repudiation of claim by respondent under the medical benefit Insurance policy.

a) Complainant's argument:

In his letter addressed to this Forum, the complainant had stated that his son had shown symptoms of COVID-19 and was therefore admitted in hospital as per the suggestion given by the consultant doctor. When he had filed a claim, the respondent had initially denied the claim by stating that his son had not fulfilled the policy criteria

which required him to be treated in hospital for continuous 72 hours. When he had submitted the required clarification, the respondent had rejected the claim by mentioning that the treatment given to his son did not warrant inpatient admission in hospital. In support of his son's hospitalization claim, the complainant had submitted the Antigen test report to show that he was afflicted with COVID-19.

b) Insurer's argument:

As per the Self Contained Note submitted by the respondent the respondent had stated that the insured did not receive any active line of treatment during his admission in hospital. As per the Discharge Summary there was no clinical features that necessitated hospitalization. They have quoted the Circular issued by Govt. of India MOHFW dated 17/03/2020 which states that Mild Symptoms does not require hospitalization. They have submitted the opinion received from an independent Forensic Expert Dr.C.H.Asrani, who has confirmed that the hospitalization is meant for isolation/evaluation and could easily be managed on domiciliary basis. Taking cognizance of all the factors and Govt. Guidelines they have rightly repudiated the claim.

19) Reason for Registration of Complaint:

The insurer rejected the claim preferred by the complainant. As the complaint falls under Rule 13.1(b) of Insurance Ombudsman Rules, 2017, it was registered.

20) The following copies of documents were placed for perusal:
- a. Policy copy
- b. Discharge summary
- c. Rejection letter
- d. Correspondence with insurer
- e. Expert Opinion
- f. SCN

21) Result of the personal hearing with both the parties:

Pursuant to the notices given by this Forum both parties attended the ONLINE hearing at Hyderabad on 28.04.2021. The complainant stated that his son was covered under the Corona Rakshak policy issued by the insurer for Rs.250,000/-. During the policy period his son was diagnosed with Corona positive and admitted in the hospital on the advice of the Attending Doctors. He was treated in the hospital from 04/09/2020 To 08/09/2020 and incurred an amount of Rs.125,000/- towards the hospitalization expenses. Since he was eligible for the benefits under the Policy he has applied for the settlement of his claim under the policy. However his claim was rejected stating that the patient could be treated at home and does not require hospitalization.

The Respondent insurer has reiterated the submissions made in their SCN. On the pointed question of who will decide the admission in hospital the respondent has accepted that the attending doctor is the right person to decide the admission. However they have quoted the guidelines issued by the MoH & FW on the management of Covid-19 and justified the rejection of the claim.

Upon hearing the arguments of both parties and on the perusal of the documents made available to this forum, it has been noted that the insured person covered under the Corona Rakshak Policy from 17/07/2020 to 27/04/2021 for Rs.250,000/-. The Corona Rakshak policy was a benefit policy intended to cover the COVID Cover and Lump Sum Benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID requiring hospitalization for a minimum period of 72 hours. The OPERATIVE CLAUSE of the policy states "*If during the policy period the insured person is diagnosed with COVID and hospitalized for more than seventy two hours following Medical Advice of duly qualified Medical Practitioner as per the norms specified by Ministry of Health and Family Welfare, Government of India, the Company shall pay the agreed sum insured towards the Coverage mentioned in the policy schedule*". On scrutiny of the Guidelines issued by the Ministry of Health & Family Welfare, it is noted that the Guidelines are intended for the clinicians taking care of hospitalized adult and pediatric patients of COVID-19. It is not meant to replace clinical judgement or specialist consultation but rather to strengthen clinical management of these patients and provide to up-to-date guidance. Thus the guidelines are suggestive in nature and the actual line of treatment and admission in the hospital will be decided

by the qualified medical practitioner. Keeping in view of the aforementioned discussions the Forum has observed that the insured person admitted in the hospital on the advice of the Medical practitioner, who is well aware of the MOHFW guidelines and treated for more than 72 hours. If the insurer has any objection on the decision of the attending doctor/Hospital for violating the guidelines of the Ministry of Health & Family Welfare they can initiate action on the Medical Practioner/Hospital but cannot deny the claim interpreting the guidelines in their own way. It is also to be noted that there is no specific protocol for Covid treatment and the best person to decide the line of treatment is the attending doctor. As such, the Forum has felt that the Respondent Insurer has denied the claim arbitrarily without taking cognizance of the guidelines in the right perspective. In view of the above, the forum has of the opinion that the insured person has fulfilled all the conditions precedent as stated in the Operative clause of their policy and eligible for the Lump sum benefit equal to 100% of the Sum insured mentioned in the policy schedule.
According the complaint was allowed.

A W A R D

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the online hearing and the information/documents placed on record, the insurer is directed to settle the claim for Rs.2,50,000/-.

The complaint is ALLOWED.

22) The attention of the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

l) *According to Rule 17(6), the insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance to the same to the Ombudsman.*

m) *According to Rule 17(7), the complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory & Development Authority of India Act from the date the claim ought to have been settled under the Regulations till the date of payment of the amount awarded by the Ombudsman.*

n) *According to Rule 17 (8), the award of Insurance Ombudsman shall be binding on the Insurers.*

Dated at **Hyderabad** on the 30th day of APRIL **, 2021.**

(I. SURESH BABU)

INSURANCE OMBUDSMAN

FOR THE STATES OF A.P.,

TELANGANA AND YANAM CITY

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata

(States of West Bengal, Sikkim andUnion Territories of Andaman & Nicobar Islands)

(UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name:P.K.RATH

CASE OF COMPLAINANT– SHRI RAJIB BHATTACHARYYA

VS

RESPONDENT: STAR HEALTH & ALLIED INSURANCE CO. LTD.COMPLAINT REF: NO: KOL-044-2021-0464

AWARD NO:IO/KOL/A/HI/0028/2021-2022

1.	**Name &Address OfThe Complainant**	Shri Rajib Bhattacharyya 7B, Bijoy Nagar, P.O : Naihati,24-Parganas (North), Pin : 743 165.
2.	**Type Of Policy:** Life / Health / General **Policy Details:**	
3.	**Name of insured**	Shri Rajib Bhattacharyya
4.	**Name of the insurer**	M/s. Star Health & Allied Insurance Co. Ltd.
5.	**Date of receipt of the Complaint**	23-Jan-2021
6.	**Nature of Complaint**	Repudiation of claim
7.	**Amount of Claim**	8,15,000
8.	**Date of Partial Settlement**	
9.	**Amount of relief sought**	8,15,000
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	13 (1) (b)
11.	**Date of hearing** **Place of hearing**	19-Apr-2021 Kolkata
12.	**Representation at the hearing**	
	a)For the Complainant	Shri Rajib Bhattacharyya- Complainant
	b)For the Insurer	Ms. Sudeshna Bhattacharya – Representative of Star Health & Allied Insurance Co.
13.	**Complaint how disposed**	By conducting online hearing
14.	**Date of Award**	26-Apr-2021

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
P/191116/01/ 2020/007577	500000	04-10-2019	03-10-2020		17635	One year	One time

Brief Facts of the Case:

The complainant-cum-insured, Shri Rajib Bhattacharyya has stated that his son, Shri Rohit Bhattacharyya who is covered under the Floater Health Policy since 04-10-2019 was admitted in the hospital on 26-12-2019 for treatment of Crohn's disease along with other complications and discharged on 10-01-2020. The Insurance Company denied the approval of cashless treatment. The insured, after discharge from the hospital, lodged claim for Rs.8,15,000/- for reimbursement of treatment expenses but the Insurance Company

repudiated the claim and cancelled the policy of the insured patient on the ground of misrepresentation / non-disclosure of material facts at the time taking the policy.

As per self-contained note, the Insurance Company has repudiated the claim vide repudiation letter stating that "*we have processed the claim records relating to the above insured patient seeking reimbursement of hospitalization expenses for treatment of spontaneous ileal perforation with peritonitis, ulcerative lesions with polypoid lesions on preoperative enteroscopy, Crohn's disease. It is observed from the medical records, the insured patient has acute abdomen due to perforation, laparotomy revealed ileal perforation with extensive ileal ulcers with transmural extension associate3d with multiple polypoid lesions. All these findingsconfirms insured patient has fistulising type of Crohn's disease. HPE Report dated 02-01-2020 shows many serpentine ulcers extending transmurally producing perforation confirms* well established Crohn's disease with transmural extension and perforation of serpentine ulcers. **Based on these findings, our medical teamis of the opinion that the insured patient has advanced Crohn's disease present prior to date of commencement of first year policy."** The Insurance Company did not submit any document in respect of pre-existing disease.

Contention of the complainant:

The complainant has stated in the hearing that the insured patient was admitted in the hospital with complaint of vomiting and abdominal pain. During the hospitalization period, the present disease was detected and there was no past history of Crohn's disease as per treating doctor's statement. Therefore, submission of previous history document to the Insurance Company does not arise

Contention of the Respondent:

The representative of the Insurance Company stated that as per submitted medical records, the insured patient had acute abdominal pain and the insured patient is suffering from Crohn's disease. The Medical Team of the Insurance Company has opined that the patient was suffering from Crohn's disease prior to the date of commencement of the first year policy. Hence, the claim has been repudiated and the policy cancelled.

Observation and conclusions:

It is observed that the complainant has attended the hearing physically at this office premises whereas the representative of the Insurance Company has attended the hearing online. The complainant has stated in the hearing what he already stated in his written complaint submitted to this office. The representative of the Insurance Company has stated that the claim has been repudiated as the Insured had not disclosed about his pre existing disease.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record, it is observed that the Insurance Company has repudiated the claim and cancelled the policy of the insured patient based on findings of their internal Medical Team. They are of the opinion that the insured patient was suffering from advanced Crohn's disease prior to the date of commencement of the first policy. But the Insurance Company could not submit any documentary evidence pertaining to period prior to the date of commencement of the policy, with regard to the present ailment. Hence, the decision of the Insurance

Company is set aside and the Insurer is hereby directed to admit the claim of Rs 8,15,000/-, subject to applicable deductions towards exclusion/non-payables/ceilings/limitations as specified under the policy terms and conditions. The Insurance Company is also directed to reinstate the policy of the Insured patient with all continuity benefits. The complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the acceptance letter of the Complainant and shall intimate the compliance of the same to the

Ombudsman.

PRADEEP KUMAR RATH

Digitally signed by PRADEEP KUMAR RATH

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATH CASE OF
COMPLAINANT - Siddhartha RayVS

RESPONDENT: The National Insurance Co. Ltd.
COMPLAINT REF: NO: KOL-H-048-2021-0482

AWARD NO:IO/KOL/A/HI/0024/2021-2022

1.	**Name & Address Of The Complainant**	Siddhartha Ray AL-215, Sector -II, Salt Lake City, Kolkata -700091.
2.	**Type Of Policy:** Health **Policy Details:**	
3.	**Name of Insured** **Name of the Policy Holder**	Siddhartha Ray Siddhartha Ray
4.	**Name of insurer**	The National Insurance Co. Ltd.
5.	**Date of Repudiation**	
6.	**Reason For Repudiation**	As per SCN of National Insurance Co., the insured lodged the claim for the previous hospitalisation (14-02-2020 - for 7 hours) amounting to Rs.4,841/- only as pre & post hospitalisation claim. As per policy terms and conditions, pre & post hospitalisation will be considered as a part of hospitalisation claim. Hence, the claim repudiated.
7.	**Date of Receipt of the complaint**	05-Feb-2021
8.	**Nature of Complaint**	Repudiation of claim
9.	**Amount of Claim**	0.00
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	4841
12.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) — any partial or total repudiation of claims by an insurer
13.	**Date of Hearing**	19-Apr-2021
14.	**Representation at the hearing**	
	a)For the Complainant	ABSENT
	b)For the Insurer	Mr Tirthankar Marik – Representative of The National Insurance Co.
15.	**Complaint how disposed**	By conducting hearing and issuance of award.
16.	**Date of Award**	27-04-2021

Policy Number	Sum Assured/Insured	FromDate	To Date	DOC	Premiun	Policy Term/Mode	Paying Term
154400/50/19/1000/4876	50000	28-Nov-2019	29-Nov-2020		9056	one year	one time

Brief Facts of the Case:

The complainant-cum-insured was covered under (i) Varistha Mediclaim Policy, (ii) National Mediclaim Policy and

(iii) Group Mediclaim Policy of Bajaj Allianz Insurance Company. The insured was admitted in the hospital on 14-02-2020 for replacement of pacemaker but unfortunately the same was cancelled. The charges for hospitalization was borne by the insured. The insured was again admitted for the same treatment and the hospitalization expenses reimbursed by Bajaj Allianz Insurance Co. The insured lodged claim for Rs.4,841/- (pre & post exp.) to National Insurance against National Mediclaim Policy. As per Self Contained Note (SCN) of National Insurance Co., the

Insured lodged the claim for the previous hospitalization (14-02-2020 - for 7 hours) amounting to Rs.4,841/- only as pre & post hospitalization claim which was rejected by the National Insurance Company on the ground that it needs to be considered with the main hospitalization claim, which has been submitted / lodged with another Insurer.

Contention of the complainant:

The complainant has informed over telephone as well as through letter dated 15-04-2021 that he cannot attend the hearing as he is suffering from fever and cough.

Contention of the Respondent:

The representative of the Insurance Company has stated in the hearing that the insured was admitted in the hospital on 14-02-2020 for permanent Pacemaker replacement surgery but unfortunately, the same was cancelled due to non-compatibility of pacing leads and hence, the insured was discharged on the same day within 7 hours. The same surgery was conducted on 17-02-2020 and the hospitalization claim reimbursed from Bajaj Allianz Insurance Company. The insured lodged claim for the previous hospitalization for 7 hours amounting to Rs.4,841/- only as pre & post hospitalization claim. The insured did not submit the settlement sheet of Bajaj Allianz Insurance Company.

Observation and conclusions:

It is observed that the complainant has intimated in writing about his decision to not participate in the hearing due to illness whereas the representative of the Insurance Company has attended the hearing online. The representative of the Insurance Company has stated in the hearing that the insured lodged claim only for pre and post hospitalization claim. The Insurance Company is not in a position to settle the claim for only pre and post hospitalization expenses without knowing about details of the main hospitalization claim. He added that the Insured has not provided the detailed calculation sheet of his main claim submitted with Bajaj Allianz and without the same they are unable to assess whether or not the Sum Insured limit with the other Insurer has been exhausted or not.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by the Insurance Company during the hearing and after going through the documents on record, it is observed that the Insured cum complainant had lodged claim for the previous hospitalization (14-02-2020 – for 7 hours) amounting to Rs.4,841/- only as pre and post-hospitalization claim with National insurance Co. As per policy terms and conditions, no pre and post hospitalization claim can be entertained without the main hospitalization claim. Pre and post hospitalization claim are to be considered as a part of hospitalization claim. The complainant should have submitted the pre and post claim with the other Insurer –Bajaj Allianz with whom he had lodged the main hospitalization claim. Hence, this instant complaint does not merit consideration and the same is dismissed without any relief to the complainant.

Dated at Kolkata, this 27th day of April, 2021

PRADEEP KUMAR RATH

Digitally signed PRADEEP KUMAR RATH
Date: 2021.04.27 16:22:10 +05'30

Shree P K Rath
Insurance Ombudsman

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATH CASE
OF COMPLAINANT - Monotosh SahaVS

RESPONDENT: The New India Assurance Co. Ltd.COMPLAINT REF: NO: KOL-H-049-2021-0459

AWARD NO:IO/KOL/AHI/0027/2021-20220

<table>
<tr><td>1.</td><td colspan="2">Name & Address Of The Complainant</td><td colspan="7">Monotosh Saha
Dhara Para Bye Lane, P.O. Chandan Nagar, Dist. Hooghly, Pin - 712136</td></tr>
<tr><td>2.</td><td colspan="9">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured/Insured</th><th>FromDate</th><th>To Date</th><th>DOC</th><th>Premiun</th><th>Policy Term/Mode</th><th>Paying Term</th></tr>
<tr><td>512500/34/20/28/00000013</td><td>200000</td><td>29-Apr-2020</td><td>28-Apr-2021</td><td></td><td>0</td><td>one year</td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td colspan="2">Name of Insured
Name of the Policy Holder</td><td colspan="7">Monotosh Saha
Monotosh Saha</td></tr>
<tr><td>4.</td><td colspan="2">Name of insurer</td><td colspan="7">The New India Assurance Co. Ltd.</td></tr>
<tr><td>5.</td><td colspan="2">Date of Repudiation</td><td colspan="7">07-Oct-2020</td></tr>
<tr><td>6.</td><td colspan="2">Reason For Repudiation</td><td colspan="7">The patient was treated for Chronic Kidney Disease. As per claim documents received, it is observed that the patient was diagnosed as having multiple Corticle Cyst, Pneumonia and as per USG Abdomen Report dated 06-04-2014, the patient was diagnosed Poly Cystic Kidney Disease which is a genetic disorder and the expenses incurred towards genetic disorders are not payable. Hence, the claim has been repudiated. Clause - 2.15 : Treatment usually done in outpatient department are not payable under the Policy even if converted as an inpatient in the hospital for more than 24 hours.</td></tr>
<tr><td>7.</td><td colspan="2">Date of Receipt of the complaint</td><td colspan="7">25-Jan-2021</td></tr>
<tr><td>8.</td><td colspan="2">Nature of Complaint</td><td colspan="7">Repudiation of claim</td></tr>
<tr><td>9.</td><td colspan="2">Amount of Claim</td><td colspan="7">0.00</td></tr>
<tr><td>10.</td><td colspan="2">Date of Partial Settlement</td><td colspan="7"></td></tr>
<tr><td>11.</td><td colspan="2">Amount of relief sought</td><td colspan="7">0</td></tr>
<tr><td>12.</td><td colspan="2">Complaint registered under Insurance Ombudsman Rules 2017</td><td colspan="7">Rule 13(1)(b) — any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>13.</td><td colspan="2">Date of Hearing</td><td colspan="7">19-Apr-2021</td></tr>
<tr><td>14.</td><td colspan="2">Representation at the hearing</td><td colspan="7"></td></tr>
<tr><td></td><td colspan="2">a)For the Complainant</td><td colspan="7">Ms. Sumita Saha - daughter of the complainant</td></tr>
<tr><td></td><td colspan="2">b)For the Insurer</td><td colspan="7">Shri Basavjeet Ghatak – representative of New India</td></tr>
<tr><td>15.</td><td colspan="2">Complaint how disposed</td><td colspan="7">By conducting hearing</td></tr>
<tr><td>16.</td><td colspan="2">Date of Award</td><td colspan="7">26th April, 2021</td></tr>
</table>

Brief Facts of the Case:

As per the complaint, Shri Manotosh Kumar Saha, covered under New India Floater Mediclaim Policy, is suffering from Polycystic Kidney Disease along with other ailments since April, 2015. Since then, the Insured patient is taking Dialysis at regular intervals and on more than one occasions, the cost of Dialysis has been reimbursed by the Insurer. During the year 2020, total 28 Haemodialysis (as per Doctor Certificate) was received by the patient under Day Care and the said claims have been repudiated by the Insurance Company. The Insurer has stated that as per USG Abdomen Report dated 06-04-2014, the patient was diagnosed with Poly Cystic Kidney Disease which is a genetic disorder and the expenses incurred towards genetic disorders are not payable.-Hence, the claim has been repudiated under Policy Clause - 2.15 : Treatment usually done in outpatient department are not payable under the Policy even if converted as an inpatient in the hospital for more than 24 hours.

Contention of the complainant:

The complainant has stated in the hearing that the insured patient is suffering from Polycystic Kidney Disease and some other ailments since April, 2015. The insured lodged claim earlier for the same ailment and the Insurance Company had settled the claims. The complainant has submitted the Bank details for payment of claims as proof. The Insurance Company has denied all claims submitted during 2020 on the ground of genetic disorder.

Contention of the Respondent:

The representative of the Insurance Company has stated in the hearing that the TPA had settled the claims and made payment earlier by mistake. The insured patient was admitted in the hospital in 2020 and diagnosed with Polycystic Kidney Disease which is a genetic disorder and the expenses incurred for genetic disorders are not payable as per policy conditions. Hence, the claim has been repudiated.

Observation and conclusions:

It is observed that Ms. Sumita Saha, daughter of the Complainant has attended the hearing on behalf of the complainant online whereas the representative of the Insurance Company has attended the hearing physically at this office premises. Ms. Saha repeated in the hearing what has been already stated in the written complaint submitted to this office. She added that previously the TPA was Mediassist and the current TPA is MD India. The representative of the Insurance Company has stated that the claim has been repudiated as per policy terms and conditions pertaining to genetic diseases.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record, it is observed that the Insurance Company has repudiated the claim showing the reason that the insured patient was admitted in the hospital in 2020 and diagnosed with Polycystic Kidney Disease which is a genetic disorder and the expenses incurred for genetic disorders are not payable as per policy terms and conditions. As per submitted documents, it is observed that the insured patient is suffering from Polycystic Kidney Disease and some other ailments since April, 2015. The insured had lodged claim earlier for the same ailment and the Insurance Company has settled the claims. So, the Insurance Company cannot avoid the responsibility for payment of claims for the same ailment under the same policy which is continuing with the same Insurer. Hence, the decision of repudiation made by the Insurance Company is set aside and the Insurance Company is directed to admit the claims subject to applicable deductions such as, exclusions/non-payables/ceilings/limitations as specified under the policy terms and conditions. Thus the **complaint is disposed of in favour of the complainant.**

Shree P K Rath

Insurance Ombudsman

Dated at Kolkata, this 26th day of April, 2021

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATHCASE
OF COMPLAINANT - Darshi DuttaVS

RESPONDENT: The New India Assurance Co. Ltd.
COMPLAINT REF: NO: KOL-H-049-2021-0478
AWARD NO:IO/KOL/A/HI/0030/2021/2022

1.	**Name & Address Of The Complainant**	Darshi Dutta 127B, Motilal Nehru Road, 3rd floor, Near Sishu Mangal Hospital, Kolkata - 700029.
2.	**Type Of Policy:** Health **Policy Details:**	

Policy Number	Sum Assured/Insured	FromDate	To Date	DOC	Premiun	Policy Term/Mode	Paying Term
512700/34/16/04/00000001	500000				0		

3.	**Name of Insured** **Name of the Policy Holder**	Darshi Dutta Darshi Dutta
4.	**Name of insurer**	The New India Assurance Co. Ltd.

5.	**Date of Repudiation**	
6.	**Reason For Repudiation**	As per complaint, Shri Prosenjit Dutta covered under Family (Floater) Group Mediclaim Policy was admitted in the hospital on 31-03-2017 and undergone surgery for Larynx: Glottis and after discharge from the hospital, the insured lodged claim for Rs.2,32,969/- but the Insurance Company did not settle the claim. The Insurance Company did not submit the self-contained note.
7.	**Date of Receipt of the complaint**	03-Feb-2021
8.	**Nature of Complaint**	
9.	**Amount of Claim**	0.00
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	0
12.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(a) - delay in settlement of claims
13.	**Date of Hearing**	19-Apr-2021
14.	**Representation at the hearing**	
	a)For the Complainant	Ms. Darshi Dutta - Complainant
	b)For the Insurer	Shri Satyen Ghosh – Representative of The New India Assurance Co.
15.	**Complaint how disposed**	By conducting hearing
16.	**Date of Award**	27-Apr-2021

Brief Facts of the Case:

As per the complainant, Shri Prosenjit Dutta, covered under Family (Floater) Group Mediclaim Policy, was admitted in the hospital on 31-03-2017 and undergone surgery for Larynx: Glottis. After discharge from the hospital, the insured lodged claim for Rs.2,32,969/- but the Insurance Company did not settle the claim. The Insurance Company has submitted the self-contained note on 16-04-2021 which states that the Insurance Company did not receive (1) In-patient Discharge Bill for Rs.1,20,975.23 and (2) 2nos. of receipts for payment for surgery of Rs.70,000/- and Rs.50,975/-. They have also stated that on receipt of notice from the Hon'ble Ombudsman Office, Kolkata on 15-02-2021, they have taken up the matter with concerned TPA.

Contention of the complainant:

The complainant has stated in the hearing that the Insured had lodged claim in 2017 to the Insurance Company for reimbursement and reminded them several times. But the Insurance Company did not settle the claim and has also not any information either.

Contention of the Respondent:

The representative of the Insurance Company has stated that the insured patient was admitted in the hospital for treatment of Larynx Glottis. The Insurance Company did not receive some documents till 15-02-2021. The Insurance Company has already taken up the matter with TPA for further course of action. The representative further stated that the policy has not been renewed after 2018 and at present there is no interaction with the concerned TPA Medi Assist with whom the Insured had deposited all

documents in the year 2017. He added that they have contacted the TPA and obtained the relevant Bills, Money Receipts and Investigation Reports, which are now being evaluated.

Observation and conclusions:

The complainant has attended the hearing physically at this office premises whereas the representative of the Insurance Company has attended the hearing online. The complainant repeated what she has already stated in her written complaint submitted to this office. She stressed on the fact that in spite of taking up the issue of the pending claim repeatedly over the last three years with the Insurance Company, they have been kept completely in the dark about the fate of their claim. The representative of the Insurance Company stated that they have already taken up the matter with the concerned TPA for further course of action.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record, it is observed that the Insured had lodged claim in 2017 and reminded the Insurance Company several times for settlement of the claim. It is observed that though the insured had submitted the claim documents within the stipulated time frame, the Insurance Company has not settled the claim till date. Hence, the Insurance Company is directed to settle the claim for Rs. 2,32,969/- subject to applicable deductions towards exclusions/non-payables/ceilings/limitations and co-pay (if any), as specified under the policy terms and conditions along with interest at the rate of 2 percent above the Bank Rate prevalent at the beginning of the financial year 2017-18, on the admissible claim amount, for the period from the date of submission of claim documents to the TPA / Insurer to the date of making actual payment, as full and final settlement of the claim. Thus the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata, this 27th day of April, 2021

Shree P K Rath

Insurance Ombudsman

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata
(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATH
CASE OF COMPLAINANT - Raman Agarwal
VS
RESPONDENT: The Oriental Insurance Co. Ltd.
COMPLAINT REF: NO: KOL-H-050-2021-0479
AWARD : IO/KOL/A/HI/0025/2021/2022

1.	**Name & Address Of The Complainant**	Raman Agarwal 156/96/1A, B.T.Road, Dunlop, Kolkata - 700108.
2.	**Type Of Policy:** Health **Policy Details:**	

Policy Number	Sum Assured/Insured	FromDate	To Date	DOC	Premiun	Policy Term/Mode	Paying Term
311101/48/2020/505	500000	23-Aug-2019	22-Aug-2020		22866	one year	one time

3.	**Name of Insured** **Name of the Policy Holder**	Raman Agarwal Raman Agarwal
4.	**Name of insurer**	The Oriental Insurance Co. Ltd.
5.	**Date of Repudiation**	
6.	**Reason For Repudiation**	As per SCN as well as repudiation letter, the insured patient has history of surgery sleeve gastrectomy (Bariatric Surgery) and this Incisional Hernia due to obesity related, which is not payable as per policy conditions. As per SCN, Clause No.4.20 - treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme and similar services or supplies are not payable.
7.	**Date of Receipt of the complaint**	03-Feb-2021
8.	**Nature of Complaint**	Repudiation of claim
9.	**Amount of Claim**	0.00
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	566742
12.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) — any partial or total repudiation of claims by an insurer
13.	**Date of Hearing**	19-Apr-2021
14.	**Representation at the hearing**	
	a)For the Complainant	Shri Raman Agarwal - Complainant
	b)For the Insurer	Shri Anindya Sengupta – Representative of The Oriental Insurance Co
15.	**Complaint how disposed**	By conducting Hearing
16.	**Date of Award**	27-Apr-2021

Brief Facts of the Case:

The complainant, Shri Raman Agarwal has stated that the insured and his mother, Smt. Sarala Agarwal underwent a Bariatric Surgery in 2017 for weight management. In February' 2020, the insured patient was admitted in the hospital for treatment of Incisional Hernia and after discharge from the hospital, the insured lodgedreimbursement claim for Rs.5,66,742/- but the Insurance Company has repudiated the claim.

Contention of the complainant:

The complainant has stated in the hearing that the insured patient was earlier admitted in the hospital in June 2017 for bariatric surgery for weight management and no medical insurance claim was paid at that time. In February, 2020, the insured patient was admitted in the hospital for treatment of Incisional Hernia and after discharge from the hospital, the insured lodged claim for Rs.5,66,741/- but the Insurance Company has repudiated the claim. He also stated that according to doctor incisional hernia is not due to obesity.

Contention of the Respondent:

The representative of the Insurance Company has stated in the hearing that the insured patient has history of Bariatric Surgery and was admitted in the hospital in the year 2017 for Bariatric Surgery, which does not come under the scope of cover under the policy. The insured patient was admitted in the hospital on 21-02-2020 for Incisional Hernia due to Sleeve Gastrectomy (Bariatric Surgery) which is not covered as per policy conditions.

Observation and conclusions:

It is observed that the complainant has joined the hearing physically at this office premises and the representative of the Insurance Company has attended the hearing online. The complainant repeated what he already stated in his written complaint submitted to this office. The representative of the Insurance Company has stated that the claim has been repudiated as per policy terms and conditions as the current operation has resulted asa consequence of the previous bariatric surgery undergone by the insured three years ago.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by both the parties during the course of hearing and after going through the documents on record, it is observed that the insured patient was admitted in the hospital in February, 2018 for Sleeve Gastrectomy (as per the relevant Hospital Discharge Summary). She was again admitted to hospital on 21-02-2020 for treatment of Obstructed Incisional Hernia. The Insurance Company has repudiated the claim on the ground that the Hernia is only due to “bariatric surgery” which is not covered under the policy. Prima facie, it appears that the proximate cause of hernia surgery is the bariatric surgery undergone earlier by the Insured. As such, the decision of repudiation made by the Insurance Company is not unjustified. Hence, the complaint is dismissed without any relief to the complainant.

Dated at Kolkata, this 27th day of April, 2021

Shree P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata
(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATH
CASE OF COMPLAINANT - Sukdeb Mukherjee
VS

RESPONDENT: The United India Insurance Co. Ltd.
COMPLAINT REF: NO: KOL-H-051-2021-0457
AWARD NO:IO/KOL/A/HI/0026/2021-2022

<table>
<tr><td>1.</td><td>Name & Address Of The Complainant</td><td colspan="8">Sukdeb Mukherjee
IB 61, Sector - III, Salt Lake City, Kolkata - 700106.</td></tr>
<tr><td>2.</td><td colspan="9">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured/Insured</th><th>FromDate</th><th>ToDate</th><th>DOC</th><th>Premium</th><th>Policy Term/Mode</th><th>Paying Term</th></tr>
<tr><td>030600/28/18/P1/11/95241</td><td>100000</td><td>04-Dec-2018</td><td>03-Dec-2019</td><td></td><td>0</td><td></td><td></td></tr>
<tr><td>0306</td><td>0</td><td></td><td></td><td></td><td>0</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td colspan="2">Name of Insured
Name of the Policy Holder</td><td colspan="7">Sukdeb Mukherjee
Sukdeb Mukherjee</td></tr>
<tr><td>4.</td><td colspan="2">Name of insurer</td><td colspan="7">The United India Insurance Co. Ltd.</td></tr>
<tr><td>5.</td><td colspan="2">Date of Repudiation</td><td colspan="7"></td></tr>
<tr><td>6.</td><td colspan="2">Reason For Repudiation</td><td colspan="7">The patient is suffering from Carcinoma of Prostate and during hospitalisation, Pamoreline Injection was given. As, this drug is not a Chemotherapy drug and this drug belongs to Hormone Replacement Therapy. So, this claim is not admissible under Clause No.2 - this treatment is not covered under day care and Clause No.3.16 - admission means for a minimum period of 24 hours inpatient care consecutive hours for specified procedures/treatment.</td></tr>
<tr><td>7.</td><td colspan="2">Date of Receipt of the complaint</td><td colspan="7">28-Jan-2021</td></tr>
<tr><td>8.</td><td colspan="2">Nature of Complaint</td><td colspan="7">Repudiation of claim</td></tr>
<tr><td>9.</td><td colspan="2">Amount of Claim</td><td colspan="7">0.00</td></tr>
<tr><td>10.</td><td colspan="2">Date of Partial Settlement</td><td colspan="7"></td></tr>
<tr><td>11.</td><td colspan="2">Amount of relief sought</td><td colspan="7">60204</td></tr>
<tr><td>12.</td><td colspan="2">Complaint registered under Insurance Ombudsman Rules 2017</td><td colspan="7">Rule 13(1)(b) — any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>13.</td><td colspan="2">Date of Hearing</td><td colspan="7">19-Apr-2021</td></tr>
<tr><td>14.</td><td colspan="2">Representation at the hearing</td><td colspan="7"></td></tr>
<tr><td></td><td colspan="2">a)For the Complainant</td><td colspan="7">Shri Sukdeb Mukherjee - Complainant</td></tr>
<tr><td></td><td colspan="2">b)For the Insurer</td><td colspan="7">Ms. Lipika Das – Representative of The United India Insurance Co</td></tr>
<tr><td>15.</td><td colspan="2">Complaint how disposed</td><td colspan="7">By conducting hearing</td></tr>
<tr><td>16.</td><td colspan="2">Date of Award</td><td colspan="7">26-Apr. 2021</td></tr>
</table>

Brief Facts of the Case:

The complainant-cum-insured has stated in the complaint that the he is suffering from Carcinoma of Prostate and was admitted in the hospital for administering Pamoreline Injection. After discharge from the hospital, the insured lodged

claims for Rs.60,204/- against three injections but the Insurance Company has repudiated the claims.The complainant lodged complaint to this office earlier for the same treatment and the same was awarded in favourof the complainant.

Contention of the complainant:

The complainant has stated in the hearing that as per Doctor's advice, he was admitted in the hospital and during the hospitalization, Pamoreline injection was given and he was released on the same day. The insured lodged claim for administering Pamoreline injection three times but the Insurance Company repudiated the claims. The complainant further stated that earlier the Insurance Company has settled the claims for the same ailment and for the same treatment, as per Ombudsman Order and the present claim is a follow-up claim for the next three injections administered at the same hospital.

Contention of the Respondent:

The representative of the Insurance Company stated in the hearing that the insured patient is suffering from Carcinoma of Prostate and during hospitalization, Pamoreline injection was given. He submitted that the Pamoreline injection is not a Chemotherapy drug and this drug pertains to Hormone Replacement Therapy which is not payable as per policy terms and conditions.

Observation and conclusions:

It is observed that the complainant has attended the hearing physically at this office whereas the representative of the Insurance Company has attended the hearing online. The complainant has stated what he has already stated in his written complaint submitted to this office. The representative of the Insurance Company has stated that the claim has been repudiated as per policy terms and conditions on the ground that treatments pertaining to Hormone Therapy are not payable. She added that immunotherapy drug injection was not included earlier but the same is now covered with effect from October' 2020.

AWARD

Taking into account the facts and circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record, it is observed that since the treatment undergone by the complainant is akin to the chemotherapy, repudiation of the claims are not justified. In view of the above, the decision of repudiation made by the Insurer is set aside and the Insurance Company is directed to admit the claim and pay the complainant Rs. 60,204/- towards full and final settlement of the claim, subject to applicable deductions towards exclusions/non-payables/ limitations/ ceilings as specified under the policy terms and conditions. Hence, the complaint is disposed of in favour of the complainant.

Dated at Kolkata, this 26th day of April, 2021

Shree P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,Kolkata
(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)
(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : SHRI P. K. RATH

CASE OF COMPLAINANT - Ujjal Kumar ChatterjeeVS
RESPONDENT: The United India Insurance Co. Ltd.
COMPLAINT REF: NO: KOL-H-051-2021-0461
AWARD NO:IO/KOL/A/HI/0029/2021/2022

1.	**Name & Address Of The Complainant**	Ujjal Kumar Chatterjee S/o, Late Anadi Mohan Chatterjee, 26A, Bakultala Lane, Konnagar, Hooghly -
2.	**Type Of Policy:** Health **Policy Details:**	
3.	**Name of Insured** **Name of the Policy Holder**	Ujjal Kumar Chatterjee Ujjal Kumar Chatterjee
4.	**Name of insurer**	The United India Insurance Co. Ltd.
5.	**Date of Repudiation**	
6.	**Reason For Repudiation**	
7.	**Date of Receipt of the complaint**	25-Jan-2021
8.	**Nature of Complaint**	Delay in settlement
9.	**Amount of Claim**	0.00
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	633258
12.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) — any partial or total repudiation of claims by an insurer

Policy Number	Sum Assured/Insured	FromDate	To Date	DOC	Premiun	Policy Term/Mode	Paying Term
030704/28/18/P1/10820979	125000	01-Dec-2018	30-Nov-2019		11474		

13.	**Date of Hearing**	19-Apr-2021
14.	**Representation at the hearing**	
	a)For the Complainant	Shri Ujjal Kumar Chatterjee - Complainant
	b)For the Insurer	Shri Arun Kumar Singh – Representative of United India Insurance Company
15.	**Complaint how disposed**	By conducting hearing
16.	**Date of Award**	27-Apr-2021

Brief Facts of the Case:

As per the complainant, the Insured, Shri Ujjal Kumar Chatterjee is covered under Mediclaim Policy with sum insured of Rs.1,25,000/-. As per advice of treating doctor, the insured was admitted in hospital on 07-04-2019. During hospitalization, the old AICD (Automatic Implantable Cardioverter Defibrillator) was explanted and a new AICD was implanted on 10-04-2019. After being discharged from the hospital, the insured lodged claim for Rs.6,33,258/- forreimbursement of treatment expenses but the Insurance Company did not settle the claim till date. The Insurance Company did not submit their self-contained note till the date of hearing.

Contention of the complainant:

The complainant has stated in the hearing that the insured had submitted the claim documents well in advance andcomplied with all queries that had been raised by the Insurer's TPA MD India. Besides, they had also asked for the

original Tax Invoice of the implanted device. The complainant stated that the operation had taken place as Apollo Hospital and the hospital authorities have stated that as they are making bulk purchase of the device it is not possible to provide individual Tax Invoice to each patient party. He further stated that even though the aforementioned facts were made known to the TPA and the Insurer the claim has not been settled till date, in spite of several reminders.

Contention of the Respondent:

The representative of the Insurance Company stated during the hearing that they have received all the claim documents. He added that the insured had enhanced the Sum Insured (SI) to Rs.5,00,000/- with effect from 01-12-2018 but as the present ailment was detected in 2012. Hence it is a pre-existing disease and the applicableSI is Rs.1,25,000/- as there is a three year waiting period for the enhanced SI to take effect, as per policy terms and conditions. The representative further stated that the TPA has completed review of the claim and they are ready to settle the claim and have already requested the Insurer to re-open the claim as its current status is closed.

Observation and conclusions:

It is observed that the complainant has attended the hearing physically at this office premises whereas the representative of the Insurance Company has attended the hearing online. The complainant repeated what he has already stated in his written complaint submitted to this office. The representative of the Insurance Company has stated that the Insurance Company has received all relevant claim documents and the claim is under process. From relevant documents it is observed that the claim papers have been submitted by the complainant in April' 2019.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record, it is observed that though nearly two years have passed since the complainant has submitted his claim documents, the Insurance Company has not settled the claim till date. The reason for the complainant's inability to submit the original Tax Invoice of the implanted device is totally justified and the TPA / Insurer has not acted prudently in this aspect. Hence, the Insurance Company is directed to settle the claim after effecting deductions as per policy terms and conditions, along with interest on the admissible amount, for the period from the date of submission of claim documents to the date of actual payment, at the rate which is 2 percent above the Bank Rate prevalent at the beginning of the financial year 2019-2020. Thus the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman. Dated at Kolkata, this 27th day of April, 2021

Shree P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASEOFCOMPLAINANT– Debrup Banerjee

VS

RESPONDENT: Max Bupa Health Insurance Co. Ltd

COMPLAINT REF: NO: KOL-H-031-2021-0410

AWARD NO: IO/KOL/A/HI/0004/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td>Debrup Banerjee
Eden Windsor Park, BL-D, FL-4B, 4th Floor, 3191 Nayabad , Kolkata- 700094</td></tr>
<tr><td>2.</td><td colspan="2">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>31041464201900</td><td>2500000</td><td>29.10.2019</td><td>28.10.2020</td><td>26.02.2020</td><td>120322</td><td>Critical care</td><td>annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>Tushar Kanti Banerjee</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>Max Bupa Health Insurance Co. Ltd</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>11.02.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>Rejection of claim</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>2500000</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>NA</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>2500000</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td>Rule 13(1)(b) any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td>12.04.2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td></td></tr>
<tr><td></td><td>a)For the Complainant</td><td>Debrup Banerjee</td></tr>
<tr><td></td><td>b)For the Insurer</td><td>Dr Janardhan & Sri Bhuban bhaskar</td></tr>
</table>

13.	**Complaint how disposed**	By conducting on line hearing.
14.	**Date of Award**	19.04.2021

Brief Facts of the Case:

This is a claim under critical care health Insurance Policy of late Sri Tushar Kanti Banerjee (65 years old). Insured was admitted to Sterling Hospital on 26.02.2020 with a complaint of watery stool, nausea, vomiting and with low urine output & respiratory distress. He was discharged on 08.03.2020. The patient was diagnosed as AGE with dehydration, diffuse cerebral Atrophy, Plural effusion, HTN. Finally the patient died due to LRTI, Sepsis, & LVE with anaemia. The Insurance Company has rejected the claim on the ground that sufferings are not within the scope of Critical Illness cover. Sum Insured (SI) is Rs. 25 lakh. The complainant cum nominee, Debrup Banerjee is claiming the cause of death as CABG & claimed that after CABG, patient survived for 30 days afterwards. Hence claim is to be considered.

Contention of the complainant:-

During the hearing the complainant stated that the Patient cum Insured is covered under the policy for having CABG. As such the Insurance Company has to consider the claim. He added that his father was suffering from Cerebral Atrophy and the treating Doctors had advised for CABG.

Contention of the Respondant:-

The representative of the Insurance Company submitted that there is no document to prove that the patient had CABG. He stressed on the fact that Death was for other reason. Suffering also had no relation with heart ailment. The Insurer's representative stressed on the fact the disease from which the Insured was suffering is not included in the list of 20 specified diseases covered under this Critical care policy. As such, claim is not admissible under the subject policy.

Observation and conclusions:

1) The Policy is a Critical Illness policy and the specified diseases covered are listed in the policy documents. The ailment of the deceased Insured is not included in the list.

2) There are no documents pertaining to CABG having being undergone by the deceased Insured. During the hearing the complainant stated that they were planning for CABG and trying to arrange for the same but the condition of the Insured deteriorated and he died before the procedure could be carried out.

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the decision of Insurer towards rejection of claim is just & proper since the claim is not coming under the purview of policy coverage, as per policy terms and conditions. Therefore, the Complaint is dismissed without any relief to the Complainant. Hence, the Complaint is closed without further reference and the same is treated as disposed of.

Dated at Kolkata on 19th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT– Pradyumna Agarwal

VS

RESPONDENT: Manipal Cigna Health Insurance Company Ltd.

COMPLAINT REF: NO: KOL-H-053-2021-0417

AWARD NO: IO/KOL/A/HI/0012/2021-2022

1.	**Name &Address OfThe Complainant**	Sri Pradyumna Agarwal 519A, Rabindra Sarani, Baghbazar, Kolkata-700003.
2.	**Type Of Policy:** Health **Policy Details:**	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
PROHLN000248502	2500000	06.07.2019	05.07.2020	01.03.2020	44086	Mediclaim	Annual

3.	**Name of insured**	Sri Pradyumna Agarwal
4.	**Name of the insurer**	Manipal Cigna Health Insurance Company Ltd.
5.	**Date of receipt of the Complaint**	22.12.2020
6.	**Nature of Complaint**	Repudiation of claim.
7.	**Amount of Claim**	79516
8.	**Date of Partial Settlement**	NA
9.	**Amount of relief sought**	79516
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) any partial or total repudiation of claims by an insurer
11.	**Date of hearing** **Place of hearing**	12.04.2021 Kolkata
12.	**Representation at the hearing**	---
	a)For the Complainant	Sri Pradyumna Agarwal
	b)For the Insurer	Sri Jaswinder Singh Shekhawat
13.	**Complaint how disposed**	By conducting on line hearing.
14.	**Date of Award**	19.04.2021

Brief Facts of the Case:

The complainant cum patient Sri Pradyumna Agarwal was initially admitted to Institute of Neuroscience, Kolkata during the period from 01.03.2020 to 03.03.2020 for Bell's Palsy & the relevant claim has been admitted by the Insurer. On subsequent submission of pre & post hospitalization claim for Rs 79,516/-, the Insurer denied the Claim with the plea that the claim documents are manipulated. In spite of asking for details of it by Insured, the Insurer denied revealing the same to the representative of Insured and stuck to their decision of denial of claim.

Contention of the complainant:-

During the hearing the complainant stated that in spite of asking several times about reasons for rejection of claim, it was not disclosed by the Insurer. He stated that because of spread of COVID Infection & restriction of movement by Govt. authority, there was variation of dates in respect of payments of Doctor & other fees. The complainant also added that the earlier claim during Hospitalization, for the same treatment, was approved but here the Insurer never gave him any chance to clarify the matter before rejection of the claim.

Contention of the Respondant:

The Insurers representative stated that by seeing the variation of dates & varying quantum of amount against fees of the same doctor on different dates and further because of variation in

other charges on different dates, it has been presumed that the bills have been fabricated and hence the claim for pre & post hospitalization has been rejected .

Observation and conclusions:

1) No chance given to Complainant to explain about various bills before rejection of claim.

2) No documents are available with the Insurer to prove any fabrication of documents as provided by the Complainant.

3) Rejection of claim was based on assumption of certain facts by the Insurer from their own end.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties in hearing and after going through the documents on record it is observed that the rejection of pre & post hospitalization claim of the Complainant, alleging the bills as fabricated and false, is not based on documentary evidences & also without giving any chance to the insured for explaining the detailed facts. Thus the Principle of Natural Justice has been violated. Therefore, the Insurance Company is directed to admit the claim for an amount of Rs 79,516/- as claimed by complainant subject to terms, conditions, limitations, sublimit & other provisions of the policy. The complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)(Under Rule No.16/17 of Insurance Ombudsman Rules 2017)

Ombudsman Name : Shri P. K. Rath

CASE OF COMPLAINANT - Kamal Kumar BanerjeeVS

RESPONDENT: The National Insurance Co. Ltd.COMPLAINT REF: NO: KOL-H-048-2021-0405 AWARD NO: IO/KOL/A/HI//0016/2021-2022

<table>
<tr><td>1.</td><td colspan="2">Name & Address Of The Complainant</td><td colspan="6">Kamal Kumar Banerjee
Arun Apartment, A/48, Nandan Kanan, Survey Park, Santoshpur, Kolkata - 700075.</td></tr>
<tr><td>2.</td><td colspan="8">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured/Insured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term/Mode</th><th>Paying Term</th></tr>
<tr><td>100301/50/18/10007343</td><td>250000</td><td>04-Mar-2019</td><td>03-Mar-2020</td><td></td><td>0</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td colspan="2">Name of Insured
Name of the Policy Holder</td><td colspan="6">Kamal Kumar Banerjee
Kamal Kumar Banerjee</td></tr>
<tr><td>4.</td><td colspan="2">Name of insurer</td><td colspan="6">The National Insurance Co. Ltd.</td></tr>
<tr><td>5.</td><td colspan="2">Date of Repudiation</td><td colspan="6"></td></tr>
<tr><td>6.</td><td colspan="2">Reason For Repudiation</td><td colspan="6"></td></tr>
<tr><td>7.</td><td colspan="2">Date of Receipt of the complaint</td><td colspan="6">10-Dec-2020</td></tr>
<tr><td>8.</td><td colspan="2">Nature of Complaint</td><td colspan="6">Partial Settlement of Claim</td></tr>
<tr><td>9.</td><td colspan="2">Amount of Claim</td><td colspan="6">0.00</td></tr>
<tr><td>10.</td><td colspan="2">Date of Partial Settlement</td><td colspan="6"></td></tr>
<tr><td>11.</td><td colspan="2">Amount of relief sought</td><td colspan="6">120500</td></tr>
<tr><td>12.</td><td colspan="2">Complaint registered under InsuranceOmbudsman Rules 2017</td><td colspan="6">Rule 13(1)(b) — any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>13.</td><td colspan="2">Date of Hearing</td><td colspan="6">10-Mar-2021</td></tr>
<tr><td>14.</td><td colspan="2">Representation at the hearing</td><td colspan="6"></td></tr>
<tr><td></td><td colspan="2">a)For the Complainant</td><td colspan="6">Mr. Kamal Kumar Banerjee</td></tr>
<tr><td></td><td colspan="2">b)For the Insurer</td><td colspan="6">Mr. Bharat Pratap Singh</td></tr>
<tr><td>15.</td><td colspan="2">Complaint how disposed</td><td colspan="6">By Conduction Hearing</td></tr>
<tr><td>16.</td><td colspan="2">Date of Award</td><td colspan="6">26th April, 2021</td></tr>
</table>

Brief Facts of the Case:

Policy Name :: National Mediclaim Policy,
Policy Type :: Health Insurance,
Period of Insurance :: 04/03/2019 to 03/03/2020,
Sum Insured :: Rs.2,50,000/- + Rs.67,500/- (CB)
Hospitalisation date/s:: 23/06/2019 & Expired on 07/07/2019.

The complainant lodged complaints against the Insurance Company in connection with Partial settlement of hospitalisation claim of his wife Late Nibedita Banerjee. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

Cause of Complaint: Partial Settlement of Claim.

Complainant's Argument: The complainant stated that:

(i) his wife admitted at Apollo Glenegales Hospital, Kolkata for Hernia operation on 23/06/2020 and expired on 07/07/2019 and incurred expenses Rs.8,63,882/- + Pre-hospitalisation Expense Rs.80,992/- at Medica Super Speciality Hospital on 22/06/2019 (Total Expenses Rs.9,44,000/-).

(ii) But company settled Rs.1,89,000/- + Rs.33,000/- total Rs.2,22,000/-.

(iii) His Basic Sum Insured is Rs.2,50,000/- + Rs.92,500/-(CB) = Rs.3,4,500/-

(iv) Hence, claim stands for due is Rs.1,20,500/- (3,42,500 – 2,22,000).

Being aggrieved and dissatisfied with the Partial-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company has not submitted their SCN (Self Contained Note). However, the Representative of the Insurance Company, during the course of hearing submitted that since all the limits are exhausted under the policy, no further amount is available for settlement of the main claim i.e. for the hospitalisation period 23/06/2019 to 07/07/2019. However, the hospitalisation Expense Rs.80,992/- at Medica Super Speciality Hospital on 22/06/2019 can be settled for as per terms & conditions of the policy, by treating the expenses as Pre-Hospitalisation expenses.

The Representative of the Insurance Company was directed to produce the settlement details of the claim for examination and taking a decision. The Company vide their mail dated 10th March, 2021 submitted their SCN: -

Brief details of the claim:

Patient Mrs Nibedita Banerjee – 49 years old Female patient was admitted to Medica Super Speciality on 22/06/2019 with Complain of abdomen pain and vomiting.
Doctors had explained the Patients relative regarding the need of urgent surgery and also further complication due to delay in surgery which may have led to further complications. However consent was not provided and the Patient was discharged against Medical advice.

Total Bill Claimed – Rs 80992/-
DOA- 22/06/2019 04:03
DOD- 22/06/2019 22:14

Since the period of Hospitalisation was less than 24 Hrs – and the patient was discharged against medical advice – the claim was repudiated as per clause Nos- **3.12 Hospitalisation** means admission in a hospital as an inpatient for a minimum period of 24 consecutive hours except for specified procedure/ treatment, where such admission could be for a period of less than 24 consecutive hours.

The Patient was then shifted to Appolo Gleaneagles and cashless claim was approved: details of which is mentioned below:

NIBEDITA BANERJEEPol. NO				Sum Insured	Cumulative Bonus
100301501810007343				250000	67500
		CLAIMED		APPROVED	CALCULATING SI Rs-250000/-
191300072748023001	A HEAD	342629		50000	
	B HEAD	14000		14000	
	C HEAD	507254		125000	C HEAD EXHAUSTED AS SI 250000/-
191300072748 (MAIN CLAIM CASHLESS)	TOTAL	863883		189000	
		CLAIMED		APPROVED	
191300072748025401 (191300072748) PRE POST	A HEAD				CALCULATING CB OF 67500

	B HEAD				
	C HEAD	90000		33750	C HEAD EXHAUSTED
	REMAINING IN A HEAD-29375/- AS SI (250000)+ CB (67500)= 317500, C HEAD MAX 158750 EXHAUSTED IN CASHLESS AND IN ANOTHER REIUMBURSEMENT PRE POST CLAIM , REMAINING IN A HEAD IS 29375 (79375-50000)				

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

The Insurance Company vide their Foot Note of the SCN stated: **"REMAINING IN A HEAD-29375/- AS SI (250000)+ CB (67500)= 317500, C HEAD MAX 158750 EXHAUSTED IN CASHLESS AND IN ANOTHER REIUMBURSEMENT PRE POST CLAIM , REMAINING IN A HEAD IS 29375 (79375-50000)"**

From the above remark, it is not clear whether Rs.29,375/- still remains under **A Head**. Hence, the insurance company vide mail dated 11/03/2021 & 15/03/2021 asked to submit settlement details of the previous claim settled during the policy period, to ascertain whether Rs.29,375/- is exhausted or still available. But till date Company has not responded till date.

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A & (d) Self Contained Note from the insurer.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the Company has failed to submit the settlement details of the previous claims settled during the policy period.

In view of the above, the Insurance Company is directed to

1. **Pay the claim amount of Rs.29,375/- to the Complainant towards full and final settlement of the main claim &**
2. **Settle the expenses of Rs 80992/- incurred for the admission dated 22/06/2019 towards Pre-Hospitalization, subject to deductions, limitations, cappings, non-payables, Co-payment (if any) as per Policy Terms & Conditions.**

Hence, the complaint is treated as disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules-2017:

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the AWARD and shall intimate the compliance to the Ombudsman.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant: Ms. Sampurna Dhar
VS
Respondent: HDFC ERGO General Insurance Company Ltd.

COMPLAINT REF NO: KOL-H-018-2021-0490

AWARD NO:IO/KOL/A /HI/0017/ 2021-2022

1.	Name & Address of the Complainant	**Ms. Sampurna Dhar, GC-220/6, Sector-III, Salt Lake City, Kolkata,** West Bengal, 700 106 Mobile No**:82405-05142**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
2950201300216600000	CSI 1,00,000	20/01/2016	19/01/2021				

3.	Name of the insured	**Ms. Nipa Dhar**
4.	Name of the insurer	**HDFC ERGO General Insurance Company Ltd.**
5.	Date of Receipt of the Complaint	12-Feb-2021
6.	Nature of Complaint	Non-Settlement of Claim
7.	Amount of Claim	Rs.1,00,000/-
8.	Date of Partial Settlement	

9.	Amount of relief sought	**Rs.1,00,000/-**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing Place of hearing	**21-Apr-2021** **Kolkata**
12.	Representation at the hearing a) For the Complainant	
	b) For the insurer	
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26-Apr-2021**

Brief Facts of the Case:

Policy Name :: Sarv Suraksha Policy,
Policy Type :: Personal Accident Insurance,
Period of Insurance :: 20/01/2016 to 19/01/2021
Sum Insured :: Capital Sum Insured Rs.1,00,000/-

The complainant lodged complaints against the Insurance Company in connection with Non-settlement of his Critical Illness claim of her mother Mrs. Nipa Dhar. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) Her mother had this policy against car loan.

(ii) After her demise on 27/07/2019, they remitted EMis on request of HDFC Bank.

(iii) They have submitted all the documents proving that the insured died because of organ transplantation and subsequently kidney failure.

(iv) Till date the claim is not settled.

Being aggrieved and dissatisfied with the Non-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their Mail dated 05/04/2021 has stated that they have already settled the claim and the payment details furnished as below:

Cheque In Fav Of	SAMPURNA DHAR	Cheque Amount	**Rs.1,00,000/-**
Bank A/C No. (Account No of the Payee)	67297036869	Bank Name (Insured)	STATE BANK OF INDIA
Cheque/NEFT Number	**3001036969**	Cheque Date	01/04/2021

Payment Mode	NEFT	Payment Status	Payment Confirmed
		IFSC Code	SBIN0070682

Observation and conclusions:

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A & (d) Self Contained Note from the insurer.

AWARD
Taking into account the facts & circumstances of the case and the submissions made by both the parties after going through the documents on record it is observed that the claim has been settled for Rs.1,00,000/- towards full and final settlement of the claim.
Hence, the complaint is treated as disposed of.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mrs. Sumita Basu Mallick
VS
Respondent : HDFC ERGO General Insurance Company Ltd. (Mumbai)

COMPLAINT REF NO: KOL-H-018-2021-0506

AWARD NO:IO/KOL/A /HI/0018/ 2021-2022

1.	Name & Address of the Complainant	**Mrs. Sumita Basu Mallick** **2nd floor, 40/1C Gopal Mallick Lane, Kolkata - 700012.** Mobile No: **98746-02750**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
2825/100445540200		23/04/2019	22/04/2020				

3.	Name of the insured	**Mrs. Sumita Basu Mallick**

4.	Name of the insurer	HDFC ERGO General Insurance Company Ltd. (Mumbai)
5.	Date of Receipt of the Complaint	15-Feb-2021
6.	Nature of Complaint	Repudiation of Claim
7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.88,296/-**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing	**21-Apr-2021**
	Place of hearing	**Kolkata**
12.	Representation at the hearing	
	a) For the Complainant	**Mr. Dipankar Basu Mallick**
	b) For the insurer	**Ms. Saswata Banerjee**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26-Apr-2021**

Brief Facts of the Case:

Policy Name :: Health Suraksha Silver Plan,
Policy Type :: Health Insurance,
Period of Insurance :: 23/04/2019 to 22/04/2020,
Sum Insured :: Rs.3,00.000/-
Hospitalisation date/s:: 16/12/2019 to 21/12/2019.

The complainant lodged complaints against the Insurance Company in connection with repudiation of her hospitalisation claim. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) She was holding a group medical policy of Apollo Munich since August 2017 and was paying the premium but there was no claim from her side.

(ii) in April, 2019, he received a phone call from the sales representative of HDFC ERGO who briefed her over phone about the group Mediclaim policy of HDFC ERGO and enticed her to leave her earlier policy and take the policy from them with additional benefits.

(iii) It was also told to her that switching over from Apollo Munich t HDFC will be treated as continuation of her group medical policy. Believing him, she switched to this company.

(iv) In the month of November, 2019, she was detected some severe health issue and has undergone operation.

(v) When lodged her claim with supporting documents which was well within the scope of the policy. But her claim was rejected illegally.

Being aggrieved and dissatisfied with the Partial-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of her grievance. The complainant has

also given her unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) dated 25/03/2021 has stated that:

(i) Prior to the aforementioned policy, there was no insurance coverage with them.

(ii) The Complainant was diagnosed to be suffering from Bulky uterus with large fibroid and had undergone treatment for fibroid at Uma Medical Realted Institute.

(iii) The post hospitalisation and cashless claim was lodged is denied as there is a waiting period of 2 years as per waiting period clause 9. A.ii a and 9 a ii b of the policy Exclusion Clause.

(iv) The claim of the complainant is denied on the ground of waiting period of 2 years which are applicable for the ailment and not on the ground of any pre-existing ailment.

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

Discharge Summary:
Diagnosis: Fibroid Uterus / Menorrhagia / Servive Anemia
Clinical Summary: TAH + BSO done under SA on 18/12/2019.
Specimen of Uterus + B/L Adnexae 9315 gms) handed over to Husband for HPE.

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A, (d) Self Contained Note from the insurer, (e) Discharge Summery & (f) Repudiation Letter.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the repudiation is in consonance with the policy issued to the Complainant.

Hence, the complaint is dismissed without any relief to the complaint.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mrs. Savita Bajaj
VS
Respondent : National Insurance Company Ltd.

COMPLAINT REF NO: KOL-H-048-2021-0491

AWARD NO:IO/KOL/A /HI/0020/ 2021-2022

1.	Name & Address of the Complainant	**Mrs. Savita Bajaj, Flower Valley, Block-C-1, Flat No.201, 493 B, G. T. Road, South Shibpur, Howrah,** West Bengal, 711 102. Mobile No**: 93397-68133**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
100501/50/17/10000531	3,00,000	14/05/2017	13/05/2018				
100501/50/18/10000480	3,00,000	14/05/2018	13/05/2019				

3.	Name of the insured	**Mrs. Savita Bajaj**
4.	Name of the insurer	**National Insurance Company Ltd.**
5.	Date of Receipt of the Complaint	12-Feb-2021
6.	Nature of Complaint	Repudiation of Claim
7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.1,85,561/- + Interest**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing	**21-Apr-2021**
	Place of hearing	**Kolkata**
12.	Representation at the hearing	
	c) For the Complainant	**Mr. Vinod Bajaj**
	d) For the insurer	**Ms. Mary Minz**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26 -Apr-2021**

Brief Facts of the Case:

Policy Name :: National Mediclaim Policy,
Policy Type :: Health Insurance,
Period of Insurance ::

Policy Number	Sum Assured	From Date	To Date
100501/50/17/10000531	3,00,000	14/05/2017	13/05/2018
100501/50/18/10000480	3,00,000	14/05/2018	13/05/2019

Hospitalisation date/s::
21/05/2018, 11/06/2018, 02/07/2018, 23/07/2018, 13/08/2018, 03/09/2018, 24/09/2018 & 15/10/2018 (all same day discharge).

The complainant lodged complaints against the Insurance Company in connection with repudiation of her hospitalisation claim. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) She is taking this policy since 2013 without any break.

(ii) She is suffering from breast cancer since. 03/07/2017 and submitted total 8 claimsfor rs.1,85,561/-.

(iii) Previous claim for the year 2017-2018 were settled after a long follow up.

(iv) Despite the certificate of Dr. P. N. Mahapatra wherein it is stated that the treatment cannot be done in OPD procedure, the insurance company is reluctant to accept the same.

Being aggrieved and dissatisfied with the Non-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of her grievance. The complainant has also given her unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) dated 05/03/2021 has stated that:

(i) The insured has lodged 8 reimbursement claims. In all the cases patient was admitted for only administration of TRASTUZUMAB injection only.

(ii) The claims are repudiated due to:

1. The administration of Trastuzumab injection is not included in the list of treatments under Day Care Procedure of the policy. Hence, considered as Out Patient Department (OPD) Treatment which is not payable under exclusion clause 4.18.

2. The Adjuvant Therapies taken were also not within the period of post hospitalisation under the definition clause 3.25.

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A & (d) Self Contained Note from the insurer.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the injection has been administered on different days for the treatment of breast cancer by following inpatient procedures. Hence, rejection of the claim on the ground of OPD treatment is not justified.

In view of the above, the Insurer's repudiation of claims are set aside and the Insurance Company is directed to admit the claims and pay the claimed amount of Rs.1,85,561/- to the Complainant towards full and final settlement of the claim subject to deductions, limitations, cappings, non-payables, Co-payment (if any) as per Policy Terms & Conditions.

Hence, the complaint is treated as disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules-2017:

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the AWARD and shall intimate the compliance to the Ombudsman.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mr. Santu Dutta
VS
Respondent : National Insurance Company Ltd., KOL BC Hub

COMPLAINT REF NO: KOL-H-048-2021-0554

AWARD NO:IO/KOL/A /HI/0019/ 2021-2022

1.	Name & Address of the Complainant	**Mr. Santu Dutta, C/O Sri Jagajyoti Dutta, Vill-Jagolgori, BO-Betai, Amta, Howrah** West Bengal, 711 401 Mobile No**: 94343-73483**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term

156012/50/17/10000564		3,00,000	11/01/2018	10/01/2019				
3.	Name of the insured		**Mr. Santu Dutta**					
4.	Name of the insurer		**National Insurance Company Ltd., KOL BC Hub**					
5.	Date of Receipt of the Complaint		03-Mar-2021					
6.	Nature of Complaint		Repudiation of Claim					
7.	Amount of Claim							
8.	Date of Partial Settlement							
9.	Amount of relief sought							
10.	Complaint registered under IOR-2017		13 (1) (b)					
11.	Date of hearing		**21-Apr-2021**					
	Place of hearing		**Kolkata**					
12.	Representation at the hearing							
	e) For the Complainant		**Mr. Santu Dutta**					
	f) For the insurer		**Mr. Goutam Ghosh**					
13.	Complaint how disposed		By Conducting online Hearing					
14.	Date of Award/Order		**26-Apr-2021**					

Brief Facts of the Case:

Policy Name :: National Parivar Mediclaim Policy,
Policy Type :: Health Insurance,
Period of Insurance :: 11/01/2018 to 10/01/2019,
Sum Insured :: Rs.3,00,000/-
Hospitalisation date/s:: 03/07/2019 to 10/07/2019.

The complainant lodged complaints against the Insurance Company in connection with repudiation of his hospitalisation claim. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) He was admitted in Hare Krishna Nursing Home for the treatment of HTN, DM, TIA.

(ii) He had complied all the query raised by the TPA and submitted all the required papers with them.

(iii) But on 09/01/2020 they repudiated his claim mentioning a cause that he has modified the date of the Amta Rural Hospital Prescription.

(iv) That was a mistake of the concerned medical officer, and he rectified it on later with proper date and seal (Company may go through the hospital register to verify it).

Being aggrieved and dissatisfied with the Non-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) dated has stated that:

(i) As per the submitted documents patient was admitted for treatment of HTN, DM & TIA in 3rd year of Policy Period.

(ii) Policy was 1st incepted on 11-01-2016 where the patient has no declaration towards existing HTN or DM.

(iii) In the 3rd year the insured was admitted on 3rd Jul 2018 for the above treatment where the doctor certifies that HTN & DM are diagnosed after admission in the hospital.

(iv) Another prescription dated 29th Jun 2018 from Amta Rural Hospital that is prior to the admission date shows the patient is having past history of HTN & DM

(v) The date in prescription mentioned in point is found to be modified.

(vi) From the submitted documents under claim, it is inferred that the patient was a known case of HTN.

(vii) Hence claim is repudiated under the following clauses:

a. Clause 5.1 (The policy shall be void and all premium paid hereon shall be forfeited to the company, in the event of mis-representation, mis-description or non-disclosure of any material fact.)

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A, (d) Self Contained Note from the insurer, (e) Discharge Summery & (f) Repudiation Letter.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the repudiation is in consonance with the policy issued to the Complainant.

Hence, the complaint is dismissed without any relief to the complaint.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant: Mr. Suresh Kumar Choudhary
VS
Respondent: The New India Assurance Co. Ltd. Kolkata

COMPLAINT REF NO: KOL-H-049-2021-0509

AWARD NO:IO/KOL/A /HI/0021/ 2021-2022

1.	Name & Address of the Complainant	**Mr. Suresh Kumar Choudhary, C/o Om Prakash Duli Chand 71, Burtola Street, 2nd Floor, Kolkata,** West Bengal, 700 007 Mobile No**: 93312-30936**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
510500/34/17/28/00000230	5,00,000	29/07/2017	28/07/2018				
510500/34/18/28/00000260	5,00,000	29/07/2018	28/07/2019				

3.	Name of the insured	**Mrs. Anita Choudhary, C/o Om Prakash Duli Chand, 71 Burtalla Street, 2nd Floor, Kolkata-700 007. Mobile – 93312-30936**
4.	Name of the insurer	**The New India Assurance Co. Ltd. Kolkata**
5.	Date of Receipt of the Complaint	15-Feb-2021
6.	Nature of Complaint	Partial Settlement of Claim
7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.5,00.000/- + Rs.2,00,000/- for harassment.**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing	**21-Apr-2021**
	Place of hearing	**Kolkata**
12.	Representation at the hearing	
	a) For the Complainant	**Mr. Suresh Kumar Choudhary**
	b) For the insurer	**Ms. Rinku Mondal**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26 -Apr-2021**

Brief Facts of the Case:

Policy Name :: New India Floater Mediclaim Policy,
Policy Type :: Health Insurance,
Period of Insurance ::

Policy Number	Sum Assured	From Date	To Date
510500/34/16/25/00001424	2,50,000	29/07/2016	28/07/2017
510500/34/17/28/00000230	5,00,000	29/07/2017	28/07/2018
510500/34/18/28/00000260	5,00,000	29/07/2018	28/07/2019

Hospitalisation date/s:: 24/07/2018 to 31/07/2018

The complainant lodged complaints against the Insurance Company in connection with Pending hospitalisation claim of his spouse Mrs. Anita Choudhary. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) The patient was diagnosed with a non-functional valve which was to be replaced immediately. After her medical examination doctors opined that open-heart surgery can't be taken up as there was minimal chances of patient survival. Thus, doctor advised for Transcatheter Aortic Valve Implantation (TAVI) which is a minimum invasive technology and it has 50% more chance of patient survival.

(ii) As their case fell in 2 policy periods, they raised a claim with the Health Insurance TPA. The policy was to be renewed on 28/07/2018 and the premium was paid well in advance.

(iii) The Company paid them only Rs.5,00,000/- only being Rs.2,50,000/- for each policy period. But the sum insured for the policy is Rs.5,00,000/- for each policy period. Hence, residual claim of Rs.5,00,000/- is still lying unpaid.

(iv) He raised a query to the treating doctor and as per the opinion of the treating doctor, the disease is not Rheumatism. He has the recording of the conversation with the doctor. Hence, his wife was not diagnosed with Rheumatism. He is ready to produce the recording evidence before the Ombudsman.

Being aggrieved and dissatisfied with the Partial-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) dated 26/02/2021 has stated that:

(i) Patient Smt. Anita Choudhary, 44 years female admitted at Narayana Institute of Cardiac Sciences, Bangaluru and diagnosed as Aortic Valve Disease, Severe Aortic Stenosis, Reduced LV Systolic Function, LVEF – 40%, Diabetes Mellitus, Systemic Hypertension, Anaemia, Ulcerative Colitis, Allergic Rhinitis.

(ii) Patient is a known case of Diabetes Mellitus and Hypertension admitted for surgical management of complications arising out of same.

(iii) As per Policy Exclusion Clause No.4.3.1 – There is a watiting period of 24 months for Diabetes Melitus and Hypertension. Hence, the complications arising out of same are also subject to waiting period of 24 months.

(iv) Application Sum Insured for claim under current policy is Rs.2.5 lacs as per 2016-2017.

(v) Hospitalisation falls under 2 policy periods i.e. 2017-18 & 2018-19.

(vi) A claim under policy period 2017-18 has been settled under cashless facility for 2.5 lacs as per previous sum Insured.

(vii) Later on under policy period 2018-19 another claim settled for Rs.2.5 lacs as per 2016-17 sum insured. No amount is payable further.

(viii) Hence, the Sum Insured has been exhausted under Policy Exclusion Cl.No.4.3: Unless the Insured Person has Continuous Coverage in excess of 24 months, expenses on treatment of the disease is not payable. & Enhancement of Sum Insured will not be considered under clause No.5.11: Enhancement of Sum Insured.

(ix) In respect of any increase in Sum Insured, exclusion 4.1, 4.2, 4.3.1 and 4.3.2 would apply to the additional Sum Insured from the date of such increase.

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A, (d) Self Contained Note from the insure & (e) Discharge Summery.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the settlement of the claim is in consonance with the policy issued to the complainant.

Hence, the complaint is dismissed without any relief to the complaint.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mr. Rajendra Kumar Somani
VS
Respondent : The United India Insurance Company Ltd.

COMPLAINT REF NO: KOL-H-051-2021-0511

AWARD NO:IO/KOL/A /HI/0022/ 2021-2022

1.	Name & Address of the Complainant	**Flat No.1C, First Floor, Jashoda Apartment, Najrul Sarani Exrension, Halderpara, Siliguri, Dist - Jalpaiguri** West Bengal, 734 006 Mobile No**: 98320-23567**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
0319002819P113860131	4,00,000	29/01/2020	28/01/2021				

3.	Name of the insured	**Mr. Rajendra Kumar Somani**
4.	Name of the insurer	**The United India Insurance Company Ltd**
5.	Date of Receipt of the Complaint	08-Feb-2021
6.	Nature of Complaint	Partial Settlement of Claim
7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.1,24,409/-**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing	**21-Apr-2021**
	Place of hearing	**Kolkata**
12.	Representation at the hearing	
	a) For the Complainant	**Absent**
	b) For the insurer	**Mr. Tapan Bhandari**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26 -Apr-2021**

Brief Facts of the Case:

Policy Name :: Family Medicare Policy - 2014
Policy Type :: Health Insurance,
Period of Insurance :: 29/01/2020 to 28/01/2021,
Sum Insured :: Rs.4,00,000/-,
Hospitalisation date/s:: 30/08/2020 to 01/09/2020.

The complainant lodged complaints against the Insurance Company in connection with Partial Settlement of his hospitalisation claim. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) He was admitted in North Bengal Neuro Centre Private Ltd., Siliguri for undergoing PTCA with double stenting to LAD on 30/08/2020.

(ii) MD India Health Insurance TPA settled for Rs.2,10,700/- against the bill raised for Rs.3,35,109/-.

(iii) He had to pay an additional amount of Rs.1,24,409/- from his pocket.

(iv) An additional claim was lodged with the TPA. The reasons which are stated by the TPA for non-settlement is not acceptable.

Being aggrieved and dissatisfied with the Partial-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) dated 10/03/2021 has stated that:

(i) Hospital Total Bill amount Rs.3,35,109/-

(ii) Total Authorised amount Rs.2,10,700/- (Cashless)

(iii) Hospital Discount 20% on Total Bill Rs.67,022/- (TPA vide authorisation letter dated 08/03/2021 stated "Please do not collect the hospital discount amount from patient/Insured.

(iv) Deduction (Agreed Tariff) Rs.53,500/- (deducted as per agreed tariff by TPA from Hospital Bill. As per authorisation letter dated 08/03/2021 T & C – Network provider shall not collect any additional amount from the individual in excess of agreed package rate).

(v) Amount to be paid by Insured Rs.3,887/- (as per TPA authorisation letter dated 08/03/2021).

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

The Complainant was not present at the time of hearing. However, he has requested to take a decision on the basis of the details he submitted vide his complaint letter. Following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A, (d) Self Contained Note from the insurer & (e) Discharge Summery.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties & after going through the documents on record it is observed that a sum of Rs.67,022/- has been deducted just because TPA has instructed the hospital not to deduct the amount towards discount, as per their agreement they have with the hospital. Since, the hospital has not honoured the instruction/agreement, the Complaint should not be penalised.

In view of the above, the Insurance Company is directed to ensure that the TPA should take all necessary steps to recover the amount from the hospital, so that the amount Rs.67,022/- is refunded to the Complainant towards full and final settlement of the claim.

Hence, the complaint is treated as disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules-2017:

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the AWARD and shall intimate the compliance to the Ombudsman.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mr. Abhiroop Shaw
VS
Respondent : Maanipal Cigna Health Insurance Company Ltd.

COMPLAINT REF NO: KOL-H-053-2021-0487

AWARD NO:IO/KOL/A /HI/0023/ 2021-2022

1.	Name & Address of the Complainant	**Mr. Abhiroop Shaw, 245/2, Katadange Road, PO-Finga Para, Bhatpara, Kankinara, 24 Pgs (N),** West Bengal, 743 129 Mobile No**:98367-77044**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
PROHL.N980567616	10,00,000/-	04/04/2019	03/04/2019				

3.	Name of the insured	**Mr. Abhiroop Shaw**
4.	Name of the insurer	**Maanipal Cigna Health Insurance Company Ltd.**
5.	Date of Receipt of the Complaint	11-Feb-2021
6.	Nature of Complaint	Repudiation of Claim
7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.82,000/-**
10.	Complaint registered under IOR-2017	13 (1) (b)
11.	Date of hearing	**21-Apr-2021**
	Place of hearing	**Kolkata**
12.	Representation at the hearing	
	a) For the Complainant	**Mr. Ahiroop Shaw**
	b) For the insurer	**Mr. Jaswinder Shekhawat**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**26 -Apr-2021**

Brief Facts of the Case:

Policy Name :: Cigna TTK ProHealth Insurance,
Policy Type :: Health Insurance,
Period of Insurance :: 04/04/2019 to 03/04/2020,
Previous Insurance :: Since and ported from
Sum Insured :: Rs.10,00,000
Hospitalisation date/s:: 15/02/2020 to 16/02/2020.

The complainant lodged complaints against the Insurance Company in connection with repudiation of his hospitalisation claim. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) He was hospitalised at Apollo Gleneagles Hospital for sudden and severe explosive headache with multiple episodes of vomiting from 14/02/2020.

(ii) The TPA has initially denied the cashless as the patient admitted for diagnostic purposes and then rejected reimbursement claim as patient does not warrant hospitalisation.

(iii) The hospital diagnosed the case of Thunderclap Headache which is an extremely painful headache that comes suddenly.

(iv) It was extremely necessary to seek the medical attention to rule out any life threatening causes. Clinically, there was no other sign or system therefore investigations such as CT etc. was necessary as per the treating doctor and accordingly hospital treated him conservatively as some bacterial infection seen in the MRI.

Being aggrieved and dissatisfied with the Non-settlement of claim by the Insurance Company, the complainant has approached this office for redressal of his grievance. The complainant has also given his unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company vide their SCN (Self Contained Note) has stated that:

(i) That the Complainant on 19th February 2020 had registered a reimbursement claim bearing claim no.- 21715518 amounting Rs.80,909/- for his hospitalization at Apollo Hospitals, Kolkata from 15th February 2020 to 16th February 2020 with the complaints of Thunderclap Headache.

(ii) From the perusal of the discharge summary, it appeared that the Complainant had not received any active treatment at the hospital, however, was kept under conservative management only which could have been done on OPD basis as well.

(iii) The insured can claim the hospitalization benefit under the policy only when there is an active treatment being to him. However, in the present case, the Complainant had not received any active treatment during his hospitalization & it was just a conservative management which could have been done on OPD basis. Hence, the claim shall not be admissible as per Clause VI.19 (Permanent Exclusions) of the policy terms. The claim was thus rejected by the Company vide repudiation letter dated 29th February 2020 stating:

"On scrutiny of the documents it has been observed that We have received claim documents for, claimant Mr Abhiroop Shaw admitted at Apollo Hospitals - Kolkatafrom 15-February-2020 to 16-February-2020 with the complaints of Thunderclap Headache. Claimant is covered under ManipalCigna Health Insurance Pro Health Plus V3 insurance policy since 04-April-2019. As per available documents, the said treatment does not warrant hospitalization and the treatment could have been done on the OPD basis, hence the claim stands repudiated under Policy Clause VI.19. We regret our inability to admit this liability under the present policy conditions. We also reserve the right to repudiate the claim under any other ground/s available to us subsequently."

(iv) Reference is drawn to Clause- VI.19 (Permanent Exclusions) of Policy terms & conditions:

"VI. PERMANENT EXCLUSIONS:

19. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital. "

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

Both the parties were present and participated in the hearing and following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A, (d) Self Contained Note from the insurer, (e) Discharge Summery & (f) Repudiation Letter.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing & after going through the documents on record it is observed that the repudiation Is in consonance with the policy issued to the Complainant.

Hence, the complaint is dismissed without any relief to the complaint.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
STATES OF WEST BENGAL, SIKKIM AND UT OF ANDAMAN & NICOBER ISLANDS
(Under Rule No.16(1)/17 of The Insurance Ombudsman Rules -2017)

OMBUDSMAN–SHRI P. K. RATH

Case of Complainant : Mrs. Pausali Chattopadhyay Mitra
VS
Respondent : GODIGIT General Insurance Co. Ltd

COMPLAINT REF NO: KOL-H-059-2021-0505

AWARD NO:IO/KOL/A /HI/0031/2021-2022

1.	Name & Address of the Complainant	**Flat 3B, Block - A, 32, Central Park, Bansdroni, Kolkata - 700070.** Mobile No: **98314-44449**
2.	Type of Policy: Life / Health / General	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
D011075748	15,00,000	24/12/2019	23/12/2020				

3.	Name of the insured	**Mrs. Pausali Chattopadhyay Mitra**
4.	Name of the insurer	GODIGIT General Insurance Co. Ltd (Bangalore)
5.	Date of Receipt of the Complaint	05-Feb-2021
6.	Nature of Complaint	Undue loading of Premium at the time of renewal

7.	Amount of Claim	
8.	Date of Partial Settlement	
9.	Amount of relief sought	**Rs.39,617/-**
10.	Complaint registered under IOR-2017	Rule 13(1)(c)
11.	Date of hearing Place of hearing	**21-Apr-2021** **Kolkata**
12.	Representation at the hearing	
	a) For the Complainant b) For the insurer	**Ms. Pausali Chattopadhyay Mitra** **Absent**
13.	Complaint how disposed	By Conducting online Hearing
14.	Date of Award/Order	**29 -Apr-2021**

Brief Facts of the Case:

Policy Name :: Digit Health Care Plus Policy (Family Floater)
Policy Type :: Health Insurance,
Period of Insurance :: 24/12/2019 to 23/12/2020,
Sum Insured :: Rs.15,00,000/-
Nature of Complaint :: Undue loading of premium.

The complainant lodged complaints against the Insurance Company in connection with undue loading of premium at the time of renewal. Hence, this complaint lodged with this office for settlement of claim.

Contention of the complainant:

The complainant stated that:

(i) Policy issued to her on 24/12/2019 without any medical u/w surcharge and or loading after duly uploading past medical records and other documents, underwriting requirements and the entire payment and policy documentation was done through Digit Portal online on 07/12/2019.

(ii) There was no intimation sent to her registered mobile number on any loading amount but in the first year the Renewal with an undue loading of Rs.1,688/- loaded suddenly without any written, electronic or verbal communication.

(iii) There was no loading in the last year and on the basis of utmost good faith she has provided and shared all the medical information during the tele-conversation and online digital proposal documentation and she was neither informed on any loading amount.

(iv) In spite of her being in good health with no diseases and with no medical history, dangerous job or a hazardous pastime and PED of 2 years exclusion, was loaded unfairly which is highly unfair.

(v) Although renewal quote was issued on 19/10/2020, she neither got an email/call on her policy. On 16/12/2020, just before 7 days she got the renewal intimation with under loading. She immediately informed about the unfair loading but they failed to address her concern until 17/12/2020. The policy expired on 23/12/2020.

(vi) This is gross and intentional mistake from Insurer of keeping the medical underwriting loading amount concealed in the issued policy schedule and completely keeping the customer uninformed and under the above, she fully expect and would appreciate

immediate processing of the premium refund of Rs.39,617/- so that she can purchase health insurance policy immediately in this COVID-19 pandemic environment.

Being aggrieved and dissatisfied with the Non-refund of loaded of premium loaded at the time of renewal by the Insurance Company, the complainant has approached this office for redressal of her grievance. The complainant has also given her unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per consent form.

Contention of the Respondent:

The Insurance Company not yet submitted their SCN.

The Insurance Company vide their SCN (Self Contained Note) dated 19/04/2020 has stated that:

(i) There is no kind of deficiency of services or unfair trade practices on the part of opponent Insurance Company. There is only a nominal communication gap and system glitch. However, the same was reasonably explained to the Complainant herein.

(ii) The Complainant submitted a proposal to the opponent insurance company in the year 2019. Based on the proposal form, it was noted that, complainant is suffering from "hypothyroidism". So considering this aspect, the opponent after considering the loading of 5% issued policy bearing No. D011075748, which is valid from 24-Dec-19 to 23-Dec-2020.

(iii) Due to the glitch in the system, the loading amount is not reflecting in the PDF version of the Policy shared with the Complainant. However, it is pertinent to note that, same is considered and is reflecting in our system at backend. The Copy of the screen shot is attached herewith the SCN.

(iv) After the expiry of the first policy, the complainant came for renewal and accordingly, the Company issued the renewal quote in which the loading amount is clearly reflecting. Since the error in system was resolved by the Company.

(v) After receipt of renewal quote, the complainant started disputing the loading charge and regarding the rise in the premium. However, it is stated that, as mentioned above loading was there in the policy since its inception but same was not reflecting due to system error which was fixed later and regarding the rise in the premium is concerned, the same is due to increase in the age of the Complainant from 44 to 45. Further during the renewal, the complainant had opted for increase in the sum insured to an extent of Rs.50,000. Therefore, this factor has led to increase in the premium per-se.

(vi) All these queries were addressed satisfactorily by the opponent Insurance Company vide mail dated 28-Dec-2020, 29- Dec-2020 and 30-Dec-2020. The copy of the same are attached with the SCN.

(vii) There is no misrepresentation or suppression of material facts by the opposite party. Therefore, the complaint is liable to be dismissed and is not entitled for any relief.

The Insurance Company has also given their consent to the Insurance Ombudsman to act as a mediator between the Complainant and themselves and to give his recommendation for the resolution of the complaint.

Observation and conclusions:

The Complainant was present and participated in the hearing. The Company tried to participate the hearing online, but disconnected immediately because of some technical glitch. However, vide their mail, they submitted to take a decision based on the Self Contained Note submitted by them. Following documents were placed for perusal:

(a) Complaint letter along with annexures, (b) Policy Copy, (c) Annexure–VI-A & (d) Self Contained Note from the insurer.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties & after going through the documents on record it is observed that the Insurer has every right to charge extra Premium based on their underwriting standards. However since complete disclosure is always expected from the proposer in any case of insurance,-which appears to have been done by the complainant truthfully in this case-same transparency and disclosure is expected from the insurer also. There might have been a technical problem at insurers end but they had a full one year before the renewal date to intimate the same to the insured. As per renewal quotation and the statement of insurer vide their SCN , the system glitch was rectified by then. We are inclined to note that the extra premium was charged in an opaque manner and without any explicit and specific (not implicit or blanket) consent.

But since the policy was in force for the entire period of insurance, the insurer is directed to refund only the extra premium charged along with applicable interest till the date of refund. Thus the complaint is disposed off.

Dated at Kolkata on the

Sd/-
SRI P. K. RATH
INSURANCE OMBUDSMAN
STATES OF WEST BENGAL, SIKIM, A & N ISLAND

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT– Sourav Saha

VS

RESPONDENT: Star Health & Allied Ins. Co. Ltd

COMPLAINT REF: NO: KOL-H-044-2021-0407

AWARD NO: IO/KOL/A/HI/0005/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td colspan="2">Sourav Saha
S/o- Late Nemai Chandra Saha
940, Purba Sinthee Road
Fakir Ghosh Para, Ghugudanga, South Dumdum,
Kolkata-- 700030</td></tr>
<tr><td>2.</td><td colspan="3">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>P/191111/01/2019/018067</td><td>100000</td><td>01.04.2019</td><td>31.03.2020</td><td>29.05.2020</td><td>5252</td><td>Mediclaim</td><td>Annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td colspan="2">Sri Sourav Saha</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td colspan="2">Star Health & Allied Ins. Co. Ltd</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td colspan="2">26.02.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td colspan="2">Non renewal of policy.</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td colspan="2">NA</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td colspan="2">NA</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td colspan="2">NA</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td colspan="2">Rule 13(1)(b) any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td colspan="2">12.04.2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td colspan="2"></td></tr>
<tr><td></td><td>a)For the Complainant</td><td colspan="2">Sri Sourav Saha</td></tr>
<tr><td></td><td>b)For the Insurer</td><td colspan="2">Ms Sudeshna Bhattacharjee</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td colspan="2">By conducting on line hearing.</td></tr>
<tr><td>14.</td><td>Date of Award</td><td colspan="2">19.04.2021</td></tr>
</table>

Brief Facts of the Case:

The complaint is basically for non renewal of Policy by Insurer because of late payment of premium after a gap of about two months. There existed a policy in the name of late Nemai Ch. Saha & his wife Sandhya Saha, both senior citizens, with Sum Insured one lakh. The policy year ended on 31.03.2020. Nimai Ch. Saha expired on 06.04.2019. Afterwards, the Complainant - son of the deceased Insured, deposited premium Rs 5252/- on 29.05.2020 for covering his mother. The complainant has stated that because of the prevailing COVID

pandemic situation, premium could not be deposited in time and there was a gap of more than two months in between. Besides, there was change in proposer also. But Policy was not renewed by Insurer on the ground that due date of deposit of Premium has exceeded. However, the deposited premium of Rs 5252/- is still lying with the Insurer. Complainant wants to continue the policy of his mother with all continuity benefits.

Contention of the complainant:

The complainant stated that since there was change of name in proposal because of death of his father, the earlier Proposer of the policy, he failed to deposit premium in time. Besides, as he was out of station for his service posting & conveyance facilities were disrupted due to the prevailing COVID-19 pandemic situation, he could not deposit premium by coming to Insurance Office. The complainant requested that considering such grave situation, continuation of the policy in the name of his mother, for which premium is still lying with the Insurer, should be allowed.

Contention of the Respondant:

The representative of the Insurance Company submitted that since the last allowable date as per date extension provided by the Government to Senior Citizens on account of COVID-19 pandemic, expired on 15-05-2020, policy was not permitted to continue by the Company.

Observation and conclusions:

As per Self Contained Note submitted by the Insurance Company, last date of deposit of premium, as per extension provided by Government was 15.05.2020. But because of unavoidable & precarious situation in the entire country due to COVID outbreak , delay in deposition of premium needs to be considered.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties in hearing and after going through the documents on record it is observed that Complainant was not responsible for delayed deposition of premium as circumstances were beyond the control of Insured due to the grave situation on account of COVID pandemic outbreak. Besides there is no moral hazard involved in continuation of Insurance cover on the life of the other Insured who was already enjoying the risk cover under the policy. The Insurer is therefore directed to renew the policy covering Mrs Sandhya Saha – the complainant's mother and provide continuity benefit from due date of policy as premium is already received by the Company. Thus the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands)

(UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES,2017)

Ombudsman Name:P.K.RATH

CASEOFCOMPLAINANT– AKASH SHIVANI

VS

RESPONDENT: NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO: KOL-H-048-2021-0521

AWARD NO: IO/KOL/A/HI/0036/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td colspan="7">AKASH SHIVANI
323 Jyotish Roy Road, New Alipore
Kolkata 700053</td></tr>
<tr><td>2.</td><td colspan="8">Type Of Policy: Life / Health / General
Policy Details: Individual Health Floater Policy
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>10160050191 0007505</td><td>300000</td><td>23.102019</td><td>22.102020</td><td></td><td>4994/-</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td colspan="3">Name of insured</td><td colspan="5">AKASH SHIVANI</td></tr>
<tr><td>4.</td><td colspan="3">Name of the insurer</td><td colspan="5">NATIONAL INSURANCE CO. LTD.</td></tr>
</table>

5.	**Date of receipt of the Complaint**	19-Feb-2021
6.	**Nature of Complaint**	Non settlement of accidental claim
7.	**Amount of Claim**	1794517/-
8.	**Date of Partial Settlement**	
9.	**Amount of relief sought**	150000
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	13(1)(b)
11.	**Date of hearing** **Place of hearing**	23-Apr-2021 Kolkata
12.	**Representation at the hearing**	
	a)For the Complainant	Akash Shivani - Complainant
	b)For the Insurer	Rudranil Pal – Representative of National Insurance Company Limited, DO-XVIII
13.	**Complaint how disposed**	By conducting online hearing
14.	**Date of Award**	29-Apr-2021

Brief Facts of the Case: The complainant Mr Akash Shibani met with an accident and was hospitalized at CMRI Kolkata for treatment from 22.1.2020 to 17.02.2020. The total hospital bill was for Rs. 17,94,517/-. The complainant has stated that he has lost all the documents pertaining to hospitalization bills & receipts. Subsequently only one Money Receipt (MR) of Rs. 2 lacs was traced and submitted. The Insurance Company has denied the claim as per policy condition No. 5.5.3 which states that submission of all the original documents is required for processing the claim.

Contention of the complainant:The complainant has stated that he has lost all the documents pertaining to his hospitalization bills, reports, Discharge summary etc. on 25th August and a General Diary (GD) was lodged with the Police Authorities on 14.9.2020 by Mr Nand Lal Shivani on behalf of Mr Akash Shivani.

Contention of the Respondent: As per Self Contained Note (SCN) of the Insurance Company the complainant did not avail cashless facility and lodged reimbursement claim for a sum of Rs.150000 (50% of SI as per policy condition). Instead of sending all bills the Complainant had submitted a MR for Rs. 2 lacs. As per Policy condition 5.5.4 the claim has to be supported by all original bills, cash memos, Dr. Prescription etc. but he failed to submit the same. In absence of original documents, no claim is payable and accordingly the claim has been denied.

Observation and conclusions: Both parties participated in the hearing. The complainant stated that he had lodged F.I.R. with Behala Police station and the original of the same has been

submitted to the Insurance Company for their perusal. He added that the Final Invoice of CMRI hospital amounting to Rs 18 lakh has also been submitted to the Insurer. The representative of the Insurer stated that the Insured has not submitted the original Hospital Discharge Summary and the original reports too have not been submitted. He added that as per policy conditions claim cannot be processed without these original documents. It is observed from the copies of relevant documents submitted to this office that the complainant has lodged a General Diary with the police declaring that he has lost all his original hospital documents and that the total hospital bill as per Final Invoice of Calcutta Medical Research Institute Hospital, Kolkata that the complainant cum Insured has incurred an expenditure of Rs 18 lakh for his treatment.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record it is revealed as per the recorded documents that the complainant has indeed undergone hospitalization for treatment pertaining to his accident and has paid the relevant hospital bills. It is also evident that as per Police GD done by his father, the Complainant has lost all the relevant hospital documents. Scrutiny of the policy schedule of policy number 101600501910007505 confirms the fact that the complainant is a bonafide policyholder of The National Insurance Company Ltd and was having an existing policy at the time of happening of the incident and during the period of his Hospitalization, with a coverage Sum Insured of Rs 1.50 lakh. In view of all the above the Insurer is directed to admit the claim on the basis of duplicate copies of all the documents and the Money Receipt and pay the complainant the admissible amount subject to submission of appropriate indemnity bond by him. The complainant is advised to submit relevant indemnity bond to the Insurance Company so that they can process the claim. With this the complaint is closed and the same is treated as disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Sd/-

Dated at Kolkata on 29th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(StatesofWestBengal,SikkimandUnionTerritoriesofAndaman&NicobarIslands)

(UNDER RULE NO. 16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name:P.K. RATH

CASEOFCOMPLAINANT–IRA BISWAS

VS

RESPONDENT: NATIONAL INSURANCE CO. LTD. DO-XIX

COMPLAINT REF: NO: KOL-H-048-2021-0524

AWARD NO: iO/KOL/A/HI/0034/2021-2022

1.	**Name &Address OfThe Complainant**	**IRA BISWAS** **New Garia** Housing Society, PO: Panchasayar Kolkata 700094
2.	**Type Of Policy:** Life / Health / General **Policy Details: Mediclaim**	
3.	**Name of insured**	**IRA BISWAS**
4.	**Name of the insurer**	**NATIONAL INSURANCE CO. LTD.**
5.	**Date of receipt of the Complaint**	17 Feb-2021
6.	**Nature of Complaint**	Repudiation of claim
7.	**Amount of Claim**	87644.00
8.	**Date of Partial Settlement**	
9.	**Amount of relief sought**	87644/-
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	13(1)(b)
11.	**Date of hearing Place of hearing**	23-Apr-2021 Kolkata
12.	**Representation at the hearing**	
	a) For the Complainant	Raghabendra Nath Biswas – Complainant's husband
	b) For the Insurer	K Gautham – Representative of National Insurance
13.	**Complaint how disposed**	By conducting online hearing
14.	**Date of Award**	29-Apr-2021

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
154300/50/19 / 10001625	250000	30.5.2019	29.5.2020		30369		

Brief Facts of the Case: The patient Shri Raghabendra Nath Biswas (80) was admitted in Ruby General Hospital Ltd. during 2.3.2020 to 3.3.2020 for Metastatic Carcinoma Prostate. Patient was clinically evaluated and relevant investigations were done and the patient was given injection DEGARELIX subcutaneously. The claim has been repudiated by the Insurance Company as per Policy Clause No. 4.22 which states that Stay in Hospital, which is not medically necessary for administering an injection, in not admissible.

Contention of the complainant: The complainant has stated in her complaint letter that her husband was diagnosed with Metastatic Carcinoma Prostate in February 2020 by Doctors at Tata Medical Centre who decided to administer the Hormone Injection instead of Radiation. She has also mentioned that considering her husband's physical condition, the treating Doctors had advised him to get admitted in the hospital for due observation before giving hormone injection

Contention of the Respondent: The Insurance Company has stated that they have scrutinized the claim documents and found that the insured patient was diagnosed with Metastatic Carcinoma Prostrate. The Company has submitted that they are not liable to make any payment under the policy in respect of expenses where "Stay in hospital which is not medically necessary" has been incurred and hence they have denied the claim.

Observation and conclusions: Both the parties participated in the hearing. During the hearing the complainant's husband cum patient stated that the policy is being continued since 1993 and that the policy is a non-exclusion policy. He further stated that he is undergoing treatment for cancer and the injection administered is a part of his Cancer treatment. The representative of the Insurance Company stated that the patient was admitted in hospital for only one day and only administering of injection for hormone therapy took place.

AWARD

Taking into account the fact & circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record it is revealed that the patient has been undergoing treatment for cancer for a long period. As per normal prudence it is for the treating doctor to decide what type of treatment to be undertaken and what should be the methodology adopted which will be most beneficial for the patient. Prima facie, it is obvious that considering the advanced age of the patient and treatment procedure adopted in this instant case, the doctors felt that it is necessary to observe the patient thoroughly as in-patient while administering such a procedure. In view of all the above the repudiation of claim made by the Insurance Company is not justified and therefore, the Insurer National Insurance Company Ltd is directed to admit the claim of

the complainant for Rs 87,644/- subject to deductions towards non-payables / ceilings / limitations / sub-limits / co-pay (if any) as per policy terms & conditions. The complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Sd/-

Dated at Kolkata on 29th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(StatesofWestBengal, Sikkim and Union Territories of Andaman & Nicobar Islands)

(UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name:P.K.RATH

CASEOFCOMPLAINANT– KISHAN KUMAR AGARWAL

VS

RESPONDENT: NATIONAL INSURANCE CO. LTD. DO-XVII

COMPLAINT REF: NO: KOL-H-048-2021-0529

AWARD NO:IO/KOL/A/HI/0037/2021-22

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td colspan="8">KISHAN KUMAR AGARWAL
24 Dwarik Jungle Lane, Uttarpara
Hooghly 712232</td></tr>
<tr><td>2.</td><td colspan="9">Type Of Policy: Health
Policy Details: Mediclaim
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>101500/50/10/1006608</td><td>250000</td><td>3-3-2019</td><td>2-3-2020</td><td>03/2016</td><td>13906</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td colspan="2">Name of insured</td><td colspan="7">KISHAN KUMAR AGARWAL</td></tr>
<tr><td>4.</td><td colspan="2">Name of the insurer</td><td colspan="7">NATIONAL INSURANCE CO. LTD.</td></tr>
<tr><td>5.</td><td colspan="2">Date of receipt of the Complaint</td><td colspan="7">22-Feb-2021</td></tr>
</table>

6.	**Nature of Complaint**	Repudiation of claim
7.	**Amount of Claim**	0.00
8.	**Date of Partial Settlement**	
9.	**Amount of relief sought**	32941/-
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	13(1)(b)
11.	**Date of hearing Place of hearing**	23-Apr-2021 Kolkata
12.	**Representation at the hearing**	
	a) For the Complainant	Mr Kisan Kr Agarwal - Complainant
	b) For the Insurer	Mr Subrata Biswas – Representative of National Insurance Company Ltd
13.	**Complaint how disposed**	By conducting online hearing
14.	**Date of Award**	29-Apr-2021

Brief Facts of the Case: The complainant cum Patient was admitted with complaints of sudden onset of right sided deviation of angle of mouth and slurring of speech. There was complaining of amnesia for few months. He is known case of Diabetes Mellitus (DM) Type 2. The patient was managed conservatively. The Insurance Company has repudiated the claim on the ground that pre-existing disease is not covered within the first 4 years and the claim has occurred in the 4th policy year.

Contention of the complainant: The complainant has stated in his complaint letter that he has not undergone any treatment in respect of DM prior to 22.4.2019. He has also stated that Dr Mohan's written report states that the treatment has started from 22-04-2019.

Contention of the Respondent: The Insurance Company has stated that the Claim has been repudiated as the Insured was suffering from DM prior to 22.4.2019 as per Mohan's Clinic report but he has not submitted the previous ailment sheet in spite of repeated queries. The Insurer states that without past treatment sheet it is difficult to ascertain the duration of DM. As such, the claim is repudiated as preexisting disease is not covered within first 4 years and the policy is running in its 4th year.

Observation and conclusions: Both parties participated in the hearing. The complainant repeated what h has already stated in his complaint letter submitted to this office. The representative of the Insurer stated that FBS and PP readings on 207 & 309 respectively cannot happen overnight and it is obvious that he has been suffering from Diabetes for several years. The date of commencement of the policy is 03-03-2016 and the patient was admitted to Hospital on 02-10-2019. As per standard Medical References Bell's ***palsy*** is a type of ***facial paralysis*** that results in a temporary inability to control the ***facial*** muscles on the affected side of the ***face***. Although it

can occur in anyone and the exact cause is unknown, it's more common in people with diabetes**.**

AWARD

Taking into account the fact & circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record it is observed that the Insurer has not been able to submit any documentary evidence prior to 03-03-2016 which can establish that the Insured was suffering from Diabetes Mellitus (DM) prior to policy inception. The high values of FBS and PP in the year 2019, though confirms existence of DM for a long period but the exact duration of existence of the disease cannot be ascertained. As such, rejection of the claim alleging four year waiting period on account of pre-existing Diabetes Mellitus was not justified. Therefore, the Insurance Company is directed to admit the claim of the complainant for Rs 32,941/- under the purview of the policy terms & conditions. The complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Sd/-

Dated at Kolkata on 29thDay of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(StatesofWestBengal,SikkimandUnionTerritoriesofAndaman&NicobarIslands)

(UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name:P.K.RATH

CASEOFCOMPLAINANT– RAMESH KUMAR KILLA

VS

RESPONDENT: NATIONAL INSURANCE CO. LTD. DO-XVII

COMPLAINT REF: NO: KOL-H-048-2021-0555

AWARD NO: IO/KOL/A/HI/0033/2021-22

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td colspan="8">RAMESH KUMAR KILLA
P-69 C I T Road - Scheme VI M
Kolkata 700054</td></tr>
<tr><td>2.</td><td colspan="9">Type Of Policy: Life / Health / General
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>1015005019/ 10003758</td><td>200000 + 25000 NCB</td><td>22.10.2019</td><td>21.10.2020</td><td></td><td>17340</td><td></td><td></td></tr>
<tr><td>101500/50/20/ 10003601</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td colspan="8">RAMESH KUMAR KILLA</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td colspan="8">NATIONAL INSURANCE CO. LTD. DO-XVII</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td colspan="8">15 Feb-2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td colspan="8">Settlement of lesser amount</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td colspan="8">273448.00 Settled Rs.118599</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td colspan="8"></td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td colspan="8">80856/-</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td colspan="8">13(1)(b)</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td colspan="8">23-Apr-2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td colspan="8"></td></tr>
<tr><td></td><td>a)For the Complainant</td><td colspan="8">Absent</td></tr>
<tr><td></td><td>b)For the Insurer</td><td colspan="8">Mr Subrata Biswas – Representative of National Insurance Company</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td colspan="8">By conducting online hearing</td></tr>
<tr><td>14.</td><td>Date of Award</td><td colspan="8">29-Apr-2021</td></tr>
</table>

Brief Facts of the Case: The complainant Shri RameshKumar Killa was hospitalized at AMRI Hospital from 12.12.2020 till 22.12.2020 with LVF, LRTI, HTN and Type II DM with sequel of post COVID Pneumonia on 20 August 2020. An amount of Rs.1,18,599/- was settled by the Insurance Company and the balance amount was not taken into account being reasonable and customer charges and non-payables as per policy clause 3.29.

Contention of the complainant: The complainant has stated in his complaint letter that he has incurred an expenditure of Rs 2,73,000/- but the Insurance Company has deducted large amounts from his claim. The complainant has requested for payment of the balance claim amount.

Contention of the Respondent: The Insurance Company has stated that out of the total Bill amount of Rs 2,73,448/- an amount of Rs.1,18,599/- was settled and the balance amount was not taken into account being reasonable and customer charges and non-payables as per policy clause 3.29. The Insurer has mentioned that the Insured hd opted for higher room rent and as his policy is for Sum insured of Rs.2 lakh proportionate deductions were made accordingly.

Observation and conclusions: The complainant was not present at the hearing. He has stated vide his letter dated 16th April 2021 that he was unable to attend the hearing because of his advanced age and due to the fact that as he stays alone with no one to support. The representative of the Insurance Company attended the hearing and stated that proportionate deductions have been made because the Insured was admitted in a hospital room at AMRI Hospital, Dhakuria, Kolkata whose rent was higher than that eligible under the instant policy with Sum Insured of Rs 2 lakh.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by the Insurer's representative during the hearing and after going through the documents on record, prima facie, it appears that the deductions effected by the Insurance Company from the billed amount is not inconsistent with the policy terms and conditions. As such, the decision of the Insurer towards settlement of claim seems to be justified. The instant complaint is therefore dismissed without any relief to the Complainant. Hence the complainant is treated as disposed of.

Sd/-

Dated at Kolkata on 29th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(StatesofWestBengal,SikkimandUnionTerritoriesofAndaman&NicobarIslands)

(UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name:P.K. RATH

CASEOFCOMPLAINANT–MANPREET SINGH SIDHU

VS

RESPONDENT: UNITED INDIA INSURANCE CO. LTD. DO-IIICOMPLAINT REF: NO: KOL-H-051-2021-0532

AWARD NO: IO/KOL/A/HI/0032/2021-2022

<table>
<tr><td>1.</td><td>Name &Address Of The Complainant</td><td>MANPREET SINGH SIDHU
46A Harish Chatterjee Street
Kolkata 700026</td></tr>
<tr><td>2.</td><td colspan="2">Type Of Policy:Health
Policy Details: Individual Health Insurance Policy
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>0303002819P 116340838</td><td>500000</td><td>24-3-2020-</td><td>23-03-2021</td><td></td><td>23043</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>MANPREET SINGH SIDHU</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>UNITED INDIA INSURANCE CO. LTD. DO-III</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>18-Feb-2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>158024</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>0.00</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>93300 - Cashless</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>64724/-</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td>13(1)(b)</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td>23-Apr-2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td></td></tr>
<tr><td></td><td>a)For the Complainant</td><td>Manpreet Singh Sidhu - Complainant</td></tr>
<tr><td></td><td>b)For the Insurer</td><td>Kalyan Majumder – Representative of United India</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td>By conducting online hearing</td></tr>
<tr><td>14.</td><td>Date of Award</td><td>29-Apr-2021</td></tr>
</table>

Brief Facts of the Case: The complainant was hospitalized at ILS Hospital Salt Lake during 28-9-2020 to 2.10.2020 on account of being COVID Positive. The total bill amount was Rs 1,58,024/- but the Insurance Company has settled lesser amount. The complainant wants relief for the

balance sum of Rs.64,724/- which has been deducted by the Insurer and hence this instant complaint has been submitted to this office.

Contention of the complainant: The complainant has also stated that he was admitted in ILS Hospital, Nagerbazar, Kolkata and had to face lot of difficulties in settlement of the Hospitalization bill. He has also stated that though the Bill amount was Rs1,58,000/- the Insurance Company has paid only Rs 93,000/- and proper explanation has not been provided even after taking up the matter with the Company several times.

Contention of the Respondent: The Insurance Company has stated that the Insured person took admission at ILS Hospital for Covid treatment and the Insurer had approved and settled the claim on the basis of GI Council guidelines.

Observation and conclusions: Both the parties participated in the hearing. The Complainant stated during the hearing that though he is having a policy with Sum insured of Rs 5 lakh, the Insurance Company has deducted huge sums from his Bill amount of Rs 1.58 lakh. He added that at that time he and his brother both had been admitted at the Hospital as both of them had been infected with COVID and as a result they had to face immense difficulties in arranging funds for making payments to the Hospital. The representative of Insurance Co. submitted that the claim was duly paid as per guidelines set by the appropriate authority.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties during the hearing and after going through the documents on record it is observed that the deductions made from the claimed amount do not conform to the policy terms and conditions and as such the deductions seem to be unjustified. Hence, the Insurer is directed to settle the claim as per policy terms and condition and without any reference to any guidelines or proposed directives as set by GI Council. Thus, the complaint disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Sd/-

Dated at Kolkata on 29th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT -- Sarad Kumar Saraff

VS

RESPONDENT: -- The National Insurance Company Ltd

COMPLAINT REF: NO: KOL-H-018-2021-0442

AWARD NO: IO/KOL/A/HI/0013/2021-2022

1.	**Name &Address OfThe Complainant**	Sri Sarad Kumar Saraff C/o Shri Navin Saraff. 38, Burtolla Srteet, Near Visudhanand Hospital , Kolkata- 700007
2.	**Type Of Policy:** Health **Policy Details:**	
3.	**Name of insured**	Sarad Kumar Saraff
4.	**Name of the insurer**	The National Insurance Company Ltd
5.	**Date of receipt of the Complaint**	09.02.2021
6.	**Nature of Complaint**	Repudiation of claim
7.	**Amount of Claim**	78502
8.	**Date of Partial Settlement**	NA
9.	**Amount of relief sought**	78502
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b), any partial or total repudiation of claim by an insurer
11.	**Date of hearing** **Place of hearing**	12-Apr-2021 Kolkata
12.	**Representation at the hearing**	
	a)For the Complainant	Sri Sarad kr. Saraff
	b)For the Insurer	Sri Pawan Kumar Roy
13.	**Complaint how disposed**	By conducting online hearing
14.	**Date of Award**	20.04.2021

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
100200/50/19/ 10001074	100000	01.09.2019	31.08.2020	08.06.2020	10434	Mediclaim	Annual

Brief Facts of the Case:

This is a claim for hospitalization expenses (including pre & post hospitalization) of Rs 78,502/-. The Insured Sri Nayan Saraff, then aged 14 yrs, was admitted in Isolation to Shree Jain Hospital & Research Centre on 08.06.2020 as per advice of attending Physician at the Emergency section of the said hospital on 07.06.2020, where he was first admitted. The patient was discharged on 15.06.2020. He was diagnosed with symptoms of respiratory distress, giddiness and headache and was made to undergo various tests including COVID, Typhoid, Dengue etc & treated conservatively. Finally he was released with COVID Negative. The Claim has been rejected by the Insurance Company as per policy condition 4.19 & 4.22 (diagnostic & evaluation purpose).

Contention of the complainant:

Complainant stated that the condition of his son, the Insured patient then aged 14 yrs, was very grave amidst the then prevailing Covid Pandemic Situation and external physician as well as the doctors at the emergency dept of Shree Jain Hospital & Research Centre had advised admission for proper management of the patient. As such as a father he had no other option but to admit his son in the Hospital and he was released only after seven days after undergoing proper treatment. The complainant stressed on the fact that the basic intention of admitting his son was to treat his son for the severe breathing problem and provide relief to him. He stated that the admission was made as per doctor's advice and the Insurer's contention of admission only for evaluation purpose is incorrect.

Contention of the Respondent:

The hospital Discharge Summary reveals that treatment was conservative. As such it can be inferred that it could have been taken outside. The Insurer's representative stressed on the fact that the Hospital admission was only for evaluation purpose.

Observation and conclusions:

1)Hospital documents reveal that basically the treatment was for management of fever with other symptoms.

2) The Hospital admission was as per advice of attending physician as also emergency dept of the said Hospital.

3) The suffering and duration of hospitalization has taken place during the COVID pandemic.

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the contention of the Insurer on rejection of claim is not just & proper keeping in view the actual condition of the patient as well as the then prevailing situation of COVID-19 outbreak. Hospital admission was based on advice of the attending Physician & the emergency dept of the Hospital. Therefore, the Insurance Company is directed to admit the claim & arrange payment of of Rs 78,502/-, as claimed by complainant, subject to terms, conditions & limitations of the Policy. The Complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman

Dated at Kolkata on 20th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT -- Anand Kulthia

VS

RESPONDENT:-- HDFC ERGO General Insurance Company Ltd.

COMPLAINT REF: NO: KOL-H-018-2021-0445

AWARD NO: IO/KOL/A/HI/0003/2021-2022

1.	**Name &Address OfThe Complainant**	Anand Kulthia 71/3, Canal Circular Road, Prasad Exotica, Block-5, Flat- 7D & 7E, Kolkata- 700054

<table>
<tr><td>2.</td><td colspan="2">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>151300/11121/ AA01372027</td><td>1000000</td><td>31.03.2020</td><td>30.03.2021</td><td>22.09.2020</td><td>23649</td><td>Floater mediclaim</td><td>Annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>Anand Kulthia</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>HDFC ERGO General Insurance Company Ltd</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>22.01.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>Repudiation of claim & cancellation of policy</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>63000</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>NA</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>63000</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td>Rule 13(1) (b) any partial or total repudiation of claims by an insurer.</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td>12-Apr-2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td></td></tr>
<tr><td></td><td>a)For the Complainant</td><td>Sri Anand Kulthia</td></tr>
<tr><td></td><td>b)For the Insurer</td><td>Ms Saswata Banerjee</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td>By conducting online hearing</td></tr>
<tr><td>14.</td><td>Date of Award</td><td>19.04.2021</td></tr>
</table>

Brief Facts of the Case:

The Complaint is against non-payment of claim & cancellation of policy. The subject Policy is a ported policy, initial Insurer was Oriental Insurance Company in the year 2015-16 with Sum insured (SI) Rs. 3.5 lakh. The Policy was then ported to Aditya Birla Health Insurance in 2019-20. The present claim has occurred in the policy year 31.03.2020 to 30.03.2021. Present Sum Insured is Rs. 10 lakh. The treatment is for Langerhans cell histocytosis & right iliac lesion of Miss Amaira Kulthia (7 years old) and the claim amount is Rs. 63,000/-. Hospital confirms that the suffering is from 2017. The Insurer Company has submitted that as the same was not disclosed while porting the policy, claim has been rejected & the policy cancelled. The Complainant's contention is that it is a ported policy, continuing since long. As such, there is no question of hiding anything.

Contention of the complainant:-

Complainant stated during the hearing that Insured had already availed claim for the same ailment in the year 2015-16 from Oriental Insurance Company, with whom the policy was at that time. The complainant added that as the claim is already recorded in system there is no question of any non-disclosure. He also stated that the present Insurer never asked any question after receiving the proposal. He added that the policy was shifted only for better service, as guided by the concerned agent. There was no claim prevailing earlier than that of first inception of the policy. Besides, the complainant stated that the present policy proposal was filled up by the concerned agent as he is not equipped with computer handling.

Contention of the Respondent:

The Insurer's representative submitted that the Policy was ported and purchased online. He added that previous ailments were not disclosed in the relevant proposal. As such, for non disclosure of material facts, claim has been rejected & the policy cancelled for all the members.

Observation and conclusions:

1) **Ported policy, renewal done on line.**
2) **Policy is being continued since long.**
3) **Earlier claim of the Insured with Oriental Insurance Company in the year 2015-16 for similar ailment has been admitted and paid.**

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the subject policy is a ported policy continuing since long without any break & there was a recorded claim earlier. Therefore, the contention of the Insurer seems to be not justified & proper in respect of non disclosure of facts. Insurance company is therefore directed to admit the claim of Rs 63,000/- subject to terms, conditions, limitations, sublimit & other provisions of the policy. The Insurer is further instructed to reinstate the policy with continuity benefit subject to receiving premium from Complainant's end. However, no risk is to be taken care of during the gap period. Thus the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASEOFCOMPLAINANT– Ishita Chatterjee

VS

RESPONDENT: Star Health & Allied Ins. Co. Ltd.

COMPLAINT REF: NO: KOL-H-044-2021-0415

AWARD NO: IO/KOL/A/HI/0006/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td>Ms Ishita Chatterjee
W/O- Shri Soumitra Chatterjee, 4, N.C. Chatterjee Street, P.O- Aridaha, P.S- Belghoria
Kolkata- 700057</td></tr>
<tr><td>2.</td><td colspan="2">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>P/191120/01/2021/002418</td><td>150000</td><td>31ST May 2021</td><td>30th May 2021</td><td>22.07.2020</td><td>10100</td><td>Mediclaim</td><td>Annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>Rita Banerjee</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>Star Health & Allied Ins. Co. Ltd</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>08.01.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>Claim not yet settled.</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>87224</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>NA</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>87224</td></tr>
</table>

10.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) any partial or total repudiation of claims by an insurer
11.	**Date of hearing** **Place of hearing**	12.04.2021 Kolkata
12.	**Representation at the hearing**	--
	a)For the Complainant	Ms Ishita Chatterjee
	b)For the Insurer	Ms Sudeshna Bhattacharjee
13.	**Complaint how disposed**	By conducting on line hearing.
14.	**Date of Award**	19.04.2021

Brief Facts of the Case:

The mother of the complainant and Insured Mrs Rita Banerjee was initially admitted to Sahid Khudiram Bose Hospital (SKBH) on 22-07-2020 where she was diagnosed as COVID-19 infected. She was discharged from the Hospital on 25.07.2020 and then transferred to Sagar Dutta Medical College & Hospital (SDMCH) for COVID treatment. After recovery she was discharged from the Hospital on 08.08.2020. Thereafter Claim was submitted for Rs 87,224/-. The Insurance Company denied the Claim on the ground that the original Discharge Certificate issued by SKBH has not been submitted. The complainant has stated that the original Discharge Certificate of the earlier Hospital was taken by the subsequent Hospital (SDMCH) for their record while admitting the patient. Complainant further submitted certified copy of Discharge Summary to the Insurer but The Insurance Company has still not allowed the claim in spite of submission of all other documents, including bills & cash memos in original, by the complainant.

Contention of the complainant:

During the hearing the complainant again repeated that Sagar Dutta Medical College & Hospital, the treating Hospital of COVID infection, took the original Discharge Certificate issued by the earlier Hospital (SKBH) for their records as proof of confirmation of COVID-19 infection. She further stated that on vigorous persuasion, the Hospital authority of SKBH provided her with a certified copy of the same which has already been submitted to Insurance Company along with all other documents in original including bills & cash memos.

Contention of the Respondant:-

The representative of the Insurer stated that in absence of Discharge Certificate in original, the Claim could not be approved.

Observation and conclusions:

1) It is the norms of allotted COVID treating Hospital to keep record of Covid Positive documents for their record. The complainant arranged to get a certified copy of Discharge Certificate confirming COVID infection and the same has been already submitted to the Insurer.

2) All other documents including bills & cash memos have been submitted by the complainant to the Insurer for her claim.

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties during the hearing and after going through the documents on record it is observed that due to the prevailing system in COVID treating Hospitals under such pandemic situation the complainant was compelled to submit the original Discharge Certificate issued by Sahid Khudiram Bose Hospital. As such, submission of certified copy of the same to the Insurer makes it imperative that the claim needs to be considered. In view of all the above the Insurer is Star Health and Allied Insurance Company is directed to settle the claim for Rs 87,224/-, based on submitted documents by the complainant & which are under the ambit of policy terms, conditions & coverage. Hence the Complaint disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021

SHRI P K RATH

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(StatesofWestBengal,SikkimandUnionTerritoriesofAndaman&NicobarIslands)
(UNDERRULENO.16/17OFTHEINSURANCEOMBUDSMANRULES,2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT– Kishan Lal Agarwal

VS

RESPONDENT: Star Health & Allied Ins. Co. ltd.

COMPLAINT REF: NO: KOL-H-044-2021-0419

AWARD NO: IO/KOL/A/HI/0014/2021-2022

1.	**Name &Address OfThe Complainant**	Kishan Lal Agarwal 36 E, Charu Avenue, Kolkata- 700033
2.	**Type Of Policy:** Health **Policy Details:**	

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
P/700004/01/ 2021/111551	1000000	21.05.2020 -	20.05.2021	13.09.2020	2750	Top up mediclaim	Annual

3.	**Name of insured**	Kishan Lal Agarwal
4.	**Name of the insurer**	Star Health & Allied Ins. Co. Ltd
5.	**Date of receipt of the Complaint**	13.01.2021
6.	**Nature of Complaint**	Repudiation of claim
7.	**Amount of Claim**	40049
8.	**Date of Partial Settlement**	NA
9.	**Amount of relief sought**	NA
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) any partial or total repudiation of claims by an insurer
11.	**Date of hearing** **Place of hearing**	12.04.2021 Kolkata
12.	**Representation at the hearing**	
	a)For the Complainant	Sri Kishan Lal Agarwal
	b)For the Insurer	Ms Sudeshna Bhattacharjee
13.	**Complaint how disposed**	By conducting on line hearing.

14.	**Date of Award**	20.04.2021

Brief Facts of the Case: --

This is a claim for dialysis against follow up treatment of CKD during the period from 02.08.2020 to 31.08.2020. The patient is Kishan Lal Agarwal. Related policy period is from 21.05.2020 to 20.05.2021. Sum Insured is Rs 10 lakh & defined limit is Rs 3 lakh. Since Hospitalization claim with HDFC was already exhausted by Rs 3 lakh, Insured claimed under Top Up policy with Star Health Insurance. The Insurer, having no record of earlier claim covering Rs 3 lakh with HDFC, rejected the claim assuming that claim not coming under the purview of present policy.

Contention of the complainant:-

During the hearing the complainant stated that his Basic policy with HDFC Insurance Co. is already exhausted by Rs 3 lakh and as such he claimed balance amount under Top Up policy with Star health, the present insurer.

Contention of the Respondent:

The representative of the Insurer stated that the claim is not coming under the cover of top up policy as they have no record of earlier claim which exceeded by Rs 3 lakh with any Insurance company.

.Observation and conclusions:

1) As per information provided by Insured during the hearing that he had already availed 3 lakh of claim under basic policy cover with HDFC Health Insurance Company. Record of the same has also been provided to this office.

2) The present claim of Rs 40,049 is coming under the Top Up policy cover with the present Insurer.

3) Contention of Insurer towards rejection of claim is not correct

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the contention of Insurer towards rejection of claim is not just & proper in view of the fact that the complainant's earlier claim exceeded & availed by Rs 3 lakh under basic policy with HDFC Health Insurance Company Ltd. As such, the Insurer Star Health & Allied Insurance Co, the respondent, is herewith directed to admit the present claim & arrange for payment of Rs 40,049/-, as raised by Complainant, subject to terms & conditions of the Top up Policy. With this, the Complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules, the Insurer shall comply with the Award within 30 days of the receipt of the acceptance letter of the Complainant and shall intimate the compliance to the same to the Ombudsman.

Dated at Kolkata on 20th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASEOFCOMPLAINANT– Sri Ajoy Kumar Modi

VS

RESPONDENT: The National Insurance Company Ltd.

COMPLAINT REF: NO: KOL-H-048-2021-0386

AWARD NO: IO/KOL/A/H/0007/2021-2022

1.	**Name &Address OfThe Complainant**	Sri Ajoy Kumar Modi 5, Rameshwar Malia Lane, 3rd floor, Howrah-711101
2.	**Type Of Policy:** Health **Policy Details:**	
3.	**Name of insured**	Sri Ajay Kumar Modi

Policy Number	Sum Assured	From Date	To Date	DOC	Premium	Policy Term	Paying Term
101600/50/17/10000760	500000	21.01.2018	20 01 2019	5.12.2018	8397	Paribar mediclaim	Annual

4.	**Name of the insurer**	National Insurance Company Ltd.
5.	**Date of receipt of the Complaint**	01.01.2021
6.	**Nature of Complaint**	Partial settlement
7.	**Amount of Claim**	22089
8.	**Date of Partial Settlement**	18.02.2019
9.	**Amount of relief sought**	17528
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	Rule 13(1)(b) any partial or total repudiation of claims by an insurer
11.	**Date of hearing** **Place of hearing**	12.04.2021 Kolkata
12.	**Representation at the hearing**	
	a)For the Complainant	Sri Ajay Kr. Modi
	b)For the Insurer	Sri Rudranil Pal
13.	**Complaint how disposed**	By conducting on line hearing.
14.	**Date of Award**	19.04.2021

Brief Facts of the Case:

The insured cum patient, Ms Shilpi Modi was admitted on 05.12.2018 to Shree Jain Hospital & Research Centre, Howrah where she underwent TAH + BSO for abdominal Uterine Bleeding / Leucomyoma for last 6 months. Cashless claim already availed. The present claim of Rs 22,089/-is for pre & post hospitalization. The complainant has submitted Bill for Rs. 20,289 and the Insurer has settled the claim for an amount of Rs 4561/-. Rs 17,528/- has been deducted against various heads like—1) 650/- (prior 15 days) 2) Doctor fees—11,100/- (extra paid than that of cashless doctor fees payment for Rs 40,000/-). 3) Investigation fees – 2800/- (prior 15 days) . 4) Misc Charges 878/-(inadmissible items) 5) Night stay- 300/-. Total 15728/-. Aggrieved with this deduction the complainant has approached this office. Policy is Paribar Mediclaim policy with 5 lakh Sum Insured for three members.

Contention of the complainant:

During the hearing the complainant stated that the Insurer has deducted huge amounts in an unjustified manner He added that the Hospital has charged Rs. 11,100/- from him as additional doctor fees and Money Receipt for the same has been already submitted to Insurer.

Contention of the Respondant:

The representative of the Insurer stated that they have already paid total hospital bill including Doctor Fees to Hospital Authority, after negotiation, while making cashless payment. He added that as amount paid to Hospital includes Doctor's Fees, no further doctor fees stands payable

under the claim. The representative also stated that an amount of Rs 2800/- was deducted as the same pertained to period prior to 15 days.

Observation and conclusions:

1) The concerned Hospital is not a PPN Hospital, as stated by Insurer during hearing.

2) Hospital Payment was done by the Insurer after negotiation with the Hospital Authority .

3) Hospital further obtained from the complainant Rs 11,100/- as additional Doctor Fees for which proper receipt was issued by them & the same receipt has been deposited to the Insurer by the complainant.

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the total deduction amount of Rs 17,528/- includes an amount of Rs 11,100/- which has been charged by the Hospital as additional doctor fees. As valid receipt for the same has been provided by the Hospital authority, the non-payment of the same is unjustified especially in view of the fact that the Hospital is a non PPN one. In view of all the above the Insurance Company is directed to make further payment of Rs 11,100/- to the complainant, as full and final settlement of the claim, under intimation to this office. The Complaint is thus disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASEOFCOMPLAINANT– Pratyush Bhagat

VS

RESPONDENT: The National Insurance Company Ltd.

COMPLAINT REF: NO: KOL-H-048-2021-0409

AWARD NO: IO/KOL/A/H/0008/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td>Sri Pratyush Bhagat
493/B. GT Road, Vikram Vihar Complex, Flat No-G-304, Howrah- 711101</td></tr>
<tr><td>2.</td><td colspan="2">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>101100/50/19/10005477</td><td>500000</td><td>16.09.2019</td><td>15.09.2020</td><td>23.07.2020</td><td>16644</td><td>Mediclaim</td><td>Annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>Sri Pratyush Bhagat</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>The National Insurance Company Ltd.</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>06.01.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>Partial repudiation</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>235746</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>01.08.2020</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>122792</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td>Rule 13(1)(b) any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td>12-Apr-2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td></td></tr>
<tr><td></td><td>a)For the Complainant</td><td>Sri Ayush Bhagat</td></tr>
<tr><td></td><td>b)For the Insurer</td><td>Sri Saurav Banerjee</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td>By conducting on line hearing.</td></tr>
<tr><td>14.</td><td>Date of Award</td><td>19.04.2021</td></tr>
</table>

Brief Facts of the Case:

The Insured cum complainant, Sri Pratyush Bhagat was admitted to AMRI Hospital on 23.07.2020 & discharged after treatment of COVID and Pneumonia. The total Hospital Claim was for Rs.2,10,924/- out of which Rs 1,00,000/- was allowed by the Insurer on 01.08.2020. Further, out of pre & post hospitalization claim of Rs. 24,822/-, Insurer allowed Rs. 12,954/-. The complainant is now claiming for his total balance claim amount of Rs 1,22,792/- (110923 + 11868). The complainant cum patient is covered under National Mediclaim Policy with Sum Insured of Rs 5 lakh.

Contention of the complainant:-

The complainant stated during the hearing that the Insurance Company has rejected Claim unjustifiably in spite of having sufficient Sum Insured & ignoring the policy terms & conditions.

Contention of the Respondant:-

The representative of the Insurer stated that the claim has been settled according to GI council rating guidance.

Observation and conclusions:

1) Insured is covered under mediclaim policy with Sum Insured of 5 lakh.

2) Insurer is required to settle the claim as per terms & conditions of the prevailing policy in force.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties in hearing and after going through the documents on record it is observed that the settlement of claim for the said suffering of the Insured has not being done by Insurer as per policy terms & conditions & it has not been based on the applicable Sum Insured under the policy. The Insurance Company is therefore directed to re-evaluate the claim & arrange for payment of balance amount to the complainant under intimation to this office. The Insurer is also directed to provide the complainant with a detailed copy of assessment / calculation sheet containing details of amounts deducted as per specified policy clauses & policy terms and conditions. With this, the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT– Kajal Kanti Samanta

VS

RESPONDENT: The National Insurance Company Ltd.

COMPLAINT REF: NO: KOL-H-048-2021-0452

AWARD NO: IO/KOL/A/HI/0009/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td colspan="8">Kajal Kumar Samanta
2Q, Bediadanga, 2nd lane , East End Park, Kolkata-700039</td></tr>
<tr><td>2.</td><td colspan="9">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>100700/50/19/10008725</td><td>250000</td><td>29.01.2020-</td><td>28.01.2021</td><td>26.07.2020</td><td>5411</td><td>mediclaim</td><td>annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured:-</td><td colspan="8">Kajal Kumar Samanta</td></tr>
<tr><td>4.</td><td>Name of the insurer:-</td><td colspan="8">The National Insurance Company Ltd.</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td colspan="8">20.01.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td colspan="8">Partial settlement of claim</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td colspan="8">269543</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td colspan="8">09.10.2020</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td colspan="8">35604</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td colspan="8">Rule 13(1)(b), any partial or total repudiation of claims.</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td colspan="8">12-Apr-2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td colspan="8"></td></tr>
<tr><td></td><td>a)For the Complainant</td><td colspan="8">Sri Kajal kr. Samanta</td></tr>
<tr><td></td><td>b)For the Insurer</td><td colspan="8">Sri Amit dutta</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td colspan="8">Through on line hearing</td></tr>
</table>

14.	**Date of Award**	19.04.2021

Brief Facts of the Case: -

The patient cum Insured Sri Kajal Kr. Samanta was admitted to Woodland Hospital on 26.07.2020 and released on 05.08.2020 after undergoing treatment for COVID-19. As per hospital documents the patient was co-morbid with HTN. Total claim submitted was for Rs 2,69,543/- and the amount settled is Rs 35,604/-. The Sum Insured (SI) under the policy was increased from Rs 50,000/- to Rs 2,50,000/- with effect from 29-01-2019. As there was co-morbidly of HTN, the increased SI of Rs 2,50,000/- was not considered by the Insurer and they calculated the claim on the basis of previous year's SI of Rs 50,000/-. Accordingly Rs 2,34,054/- was deducted from the claim by the Insurance Company. Aggrieved with this, the complainant has approached this office.

Contention of the complainant:

The complainant stated during the hearing that though he had submitted a total claim of Rs 2,69,543/- for treatment of COVID Pneumonia but the Insurer has paid only Rs 35,604/- which is not justified. He also stated that as his current Sum Insured is 250000/- the Claim should be reassessed accordingly.

Contention of the Respondant:

The representative of the Insurance Company stated during the hearing that as HTN is co-morbid in nature & the same is also pre-existing in this instant case, the earlier year Sum Insured of 50,000/- has been taken into consideration for settlement of the claim as per Policy Clause 4.1. He also stated that the Insured was having Pre-existing Disease (PED) – Hypertension (HTN) since 2018.

Observation and conclusions:

1) As per diagnosis, the patient was suffering from COVID Pneumonia & Glucose intolerance.

2) There is no reference in relevant medical documents to establish that HTN is related to COVID suffering.

3) No documents provided by Insurer, establishes the fact that HTN is a pre-disposing factor for COVID-19 infection. Outbreak of Covid-19 Pandemic is a worldwide phenomenon.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties in hearing and after going through the documents on record it is revealed that the decision of the Insurer towards assessment of claim in consideration of last year Sum Insured of Rs 50,000/- is not just & proper. Keeping in view the nature of suffering and cause of ailment of the Complainant, the Insurer is directed to reassess the claim based on the present year Sum Insured of Rs 2,50,000/- subject to deductions towards ceilings, limitations, non-payables, sub-limits and co-pay, if any, as per policy terms & conditions and arrange to pay the balance amount of claim to the complainant, under intimation to this office. Hence the complaint is disposed of in favour of the complainant.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the Insurance Ombudsman Rules 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance of the same to the Ombudsman.

Dated at Kolkata on 19th Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, Kolkata

(States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands) (UNDER RULE NO.16/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT: Sujit Kumar Sengupta

VS

RESPONDENT: The National Insurance company ltd.

COMPLAINT REF: NO: KOL-H-048-2021-0454

AWARD NO: IO/KOL/A/HI/0015/2021-2022

<table>
<tr><td>1.</td><td>Name &Address OfThe Complainant</td><td>Sri Sujit Kumar Sengupta
135/20,Srirampur (North) , Garia
Kolkata- 700084</td></tr>
<tr><td>2.</td><td colspan="2">Type Of Policy: Health
Policy Details:
<table>
<tr><th>Policy Number</th><th>Sum Assured</th><th>From Date</th><th>To Date</th><th>DOC</th><th>Premium</th><th>Policy Term</th><th>Paying Term</th></tr>
<tr><td>101100/50/19/10006356</td><td>250000</td><td>20.11.2019</td><td>19.11.2020</td><td>01.09.2020</td><td>25842</td><td>Mediclaim</td><td>Annual</td></tr>
</table></td></tr>
<tr><td>3.</td><td>Name of insured</td><td>Sri Sujit Kumar Sengupta</td></tr>
<tr><td>4.</td><td>Name of the insurer</td><td>The National Insurance company Ltd.</td></tr>
<tr><td>5.</td><td>Date of receipt of the Complaint</td><td>11.02.2021</td></tr>
<tr><td>6.</td><td>Nature of Complaint</td><td>Partial settlement</td></tr>
<tr><td>7.</td><td>Amount of Claim</td><td>175640</td></tr>
<tr><td>8.</td><td>Date of Partial Settlement</td><td>02.09.2020</td></tr>
<tr><td>9.</td><td>Amount of relief sought</td><td>49052</td></tr>
<tr><td>10.</td><td>Complaint registered under Insurance Ombudsman Rules 2017</td><td>Rule 13(1)(b) any partial or total repudiation of claims by an insurer</td></tr>
<tr><td>11.</td><td>Date of hearing
Place of hearing</td><td>12.04.2021
Kolkata</td></tr>
<tr><td>12.</td><td>Representation at the hearing</td><td></td></tr>
<tr><td></td><td>a)For the Complainant</td><td>Sri Sujit Kumar Sengupta</td></tr>
<tr><td></td><td>b)For the Insurer</td><td>Sri Sourav Banerjee</td></tr>
<tr><td>13.</td><td>Complaint how disposed</td><td>By conducting on line hearing.</td></tr>
<tr><td>14.</td><td>Date of Award</td><td>21.04.2021</td></tr>
</table>

Brief Facts of the Case: --

This is a claim of Angioplasty under National Mediclaim Policy having present Sum Insured Rs 2.5 lakh with CB Rs 87,000/-. The patient Sri Sujit Kr Sengupta underwent Angioplasty for the 2nd time with two implants of stent during the period from 01.09.2020 to 02.09.2020. The Hospital AMRI, Mukundapur, is a PPN Hospital. The Insurer has approved cashless amount of Rs 125588/- out of the total Hospital bill of Rs 1,66,858/-. For the remaining amount of Rs 41,270/- with Pre & post Hospitalization expenses of Rs 8,782/- (Total Rs 50052) was claimed

by the complainant under reimbursement but the Insurer has allowed only Rs 1000/- with the contention of exhaustion of Sum Insured under IC of the Subject policy. Insured is not agreed to this as it was a PPN Hospital. And is claiming that the balance amount of claim for Rs 49052/- if otherwise payable Under PPN procedure.

Contention of the complainant:-

The complainant stated during the hearing that the deduction details of Rs 49,052/- have not been clarified properly by Insurer in spite of requesting them several times. Moreover, the Insurer had initially settled the claim as PPN package charge for the same claim under same hospital for treatment of Angioplasty with Implant of one stent. But for 2nd claim after 45 days for Implant of double stent under Angioplasty, the Insurer has settled the claim as per open billing system (It seems so as by seeing the remark that eligible limit exhausted under I-C). He stated that total claim deducted for Rs 49,052/- (Hospital claim of Rs 41270/- + Pre& post claim of Rs 8782/-) though there was sufficient policy Sum Insured and only Rs 1000/- paid under pre & post hospitalization claim.

Contention of the Respondent:-

Insurer through TPA stated that the remaining balance under C head amount is Rs 19,363/-(details submitted) whereas initially settlement was done & confirmed through Self Contained Note that the balance amount under I-C as Rs1000/- & it was paid.

Observation and conclusions:-

1) Present claim is for angioplasty in PPN Hospital. 2) HTN being pre existing, Sum insured considered as 2 lakh (three years back) with CB 100000/- as stated by Insurer which is acceptable. 3) Deduction details not clear from Self Contained Note (SCN) submitted by the Insurer. 4) On quarries it reveals from calculation sheet of the Concern TPA that remaining balance under section I-C is Rs 19,363/- in place of earlier assessment as Rs 1000/-.

AWARD

Taking into account the facts & circumstances of the case, the submissions made by both the parties in hearing and after going through the documents on record it is observed that deduction details as stated by the Insurer in their SCN is not correct in respect of remaining balance actually under section I-C. It should be Rs 19,363/- as confirmed by the concern TPA through their calculation sheet. Therefore out of the total claim expenses of Rs 50052/-, as claimed by complainant, Rs 19363/- stands payable of which Rs 1000/- has already been paid by the Insurer. Hence the Insurance Company is directed to arrange for payment of balance claim amount of Rs 18,363/- towards full & final settlement of the claim, under stipulated policy terms & conditions. With this, the Complaint is disposed of.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rule 2017.

As per Rule 17(6) of the said rules the Insurer shall comply with the Award within 30 days of the receipt of the acceptance letter of the Complainant and shall intimate the compliance to the same to Ombudsman.

Dated at Kolkata on 21st Day of April, 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, KOLKATA

(States of West Bengal, Sikkim and Union Territory of Andaman & Nicobar Islands)

(UNDER RULE NO: 16(1)/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

Ombudsman Name: P.K.RATH

CASE OF COMPLAINANT– Souma Jyoti Ghosh

VS

RESPONDENT:. The United India Insurance Co. Ltd

COMPLAINT REF: NO: KOL-H-051-2021-0455

AWARD NO: IO/KOL/A/HI/0011/2021-2022

1.	**Name &Address OfThe Complainant**	**Souma Jyoti Ghosh** **76B, Rishi Arabinda Sarani, Nonamath** **Haridevpur, Kolkata- 700082**
2.	**Type Of Policy: Health** **Policy Details:**	
3.	**Name of insured**	**Sri Souma Jyoti Ghosh**
4.	**Name of the insurer**	**The United India Insurance Co. ltd**
5.	**Date of receipt of the Complaint**	**11.02.2021**

Policy Number	Sum Assured	From Date	To Date	DOC	Prem	Policy Tyope	Paying Term
030200/28/19/P1/15280816	500000	25.02.2020	24.02.2021	11.09.2020	9873	Mediclaim	Annual

6.	**Nature of Complaint**	**Partial settlement**
7.	**Amount of Claim**	**52055**
8.	**Date of Partial Settlement**	**Not mentioned**
9.	**Amount of relief sought**	**30000**
10.	**Complaint registered under Insurance Ombudsman Rules 2017**	**Rule 13(1)(b) any partial or total repudiation of claims by an insurer**
11.	**Date of hearing** **Place of hearing**	**12.04.2021** **Kolkata**
12.	**Representation at the hearing**	
	a)For the Complainant	**Sri Souma Jyoti Ghosh**
	b)For the Insurer	**Sri Arindam Naskar**
13.	**Complaint how disposed**	**By conducting on line hearing.**
14.	**Date of Award**	**19.04.2021**

Brief Facts of the Case:

The complainant cum patient Sri Souma Jyoti Ghosh underwent surgery of SOL LEFT THIGH EXCISED UNDER GA at Repose Nursing Home on 11.09.2020. He was discharged on 12.09.2020. Claimed amount is Rs 52,055/- out of which claim settled by the Insurer is Rs 20,145/-. Deduction has been made primarily for Doctor Fees of Rs 30,000/- as it was not part of the Hospital Bill & amount was paid by cash. The complainant is claiming for the amount of Rs 30,000/- as he has produced proper money receipt from the concerned Doctor.

Contention of the complainant:

During the hearing the complainant stated that the Insurance Company has not paid Doctor's fees of Rs 30000/- in spite of having sufficient Sum Insured. He also stated that as he has produced proper receipt from the concerned Doctor, the amount should be reimbursed to him. The complainant further stated that he is continuing the policy since 1988 and added that he was compelled to make the payment in cash as the demand was made by the treating surgeon.

Contention of the Respondant:

The representative of the Insurance Company stated that payment made by cash for the stated Doctor fees is not part of the Hospital bill. He also stated that as it has been paid by cash, the same is not payable as per policy clause 1.2 - Note 2. Payment of Doctor's fees made by card and cheque are allowed under the claim as per policy provision. The Insurer's representative further

added that the amount already paid under this instant claim also includes Doctor's Fees paid by the complainant through card.

Observation and conclusions:-

1) Policy exclusion clause 1.2 - note 2 says that no payment shall be made less than 1.2 c other than as part of hospitalization bill. But the bills raised by surgeon, anesthetists & paid directly, not forming part of hospital bill shall be paid only if receipt carrying pre receipted number & payment made by cheque /credit card/ debit card or digital/online transfer.

AWARD

Taking into account the facts & circumstances of the case, the submission made by both the parties in hearing and after going through the documents on record it is observed that the decision taken by Insurer towards deduction of additional Doctor's fees paid in cash, is as per policy terms & conditions. Therefore, the Complaint is dismissed without any relief to the Complainant and the Complaint is herewith treated as disposed of without any further reference.

Dated at Kolkata on 19th Day of April' 2021 **SHRI P K RATH**

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF KARNATAKA

(UNDER RULE NO: 16/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN- Smt.NEERJA SHAH

In the matter of: **Sri. RAJA REDDY** V/s **STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED**

Complaint No: BNG-H-044-2021-0803

Award No: IO/BNG/A/HI/0004/2021-22

- The Complaint emanated from rejection of Covid-19 claim under policy No.P/141128/01/2020/004321 and Claim No.CIR/2021/141128/0373295 on the ground of IP needs only self-isolation by home quarantine. Representation along with the RI could not be resolved. Hence the Complainant approached this Forum for relief. The complaint was registered on 18.03.2021.

- After scrutiny of the documents the Forum informed the R.I to relook the claim as per Government of Karnataka Notification dt.23.06.2020 for the settlement of Covid-19 claim. The R.I vide mail dt. 09.04.2021 informed the Forum that they reviewed the claim and agreed to settle Rs.78,962/- (Rs. 72,000/- Hospitalization as per prescribed Government package + Rs.3,800/- Pre-hospitalization +Rs.3,162/- Post hospitalization) against claimed amount of Rs.93,908. The Forum sent the mail to the complainant for his consent if agreeable. The complainant agreed for the settlement and gave his consent

- The complaint was resolved on compromise basis wherein both have agreed for the same and hence, the Complaint is treated as **Closed** and **Disposed off** accordingly.

Compliance of Award:

Attention of the Complainant and the Insurer is hereby invited to the following:

a. The Complainant shall submit all requirements/Documents required for settlement of award within 15 days of receipt of the award to the Respondent Insurer.

b. According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Dated at **Bangalore** on the **12th** day of **APRIL 2021**

(NEERJA SHAH)
INSURANCE OMBUDSMAN
FOR THE STATE OF KARNATAKA

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF KARNATAKA

(UNDER RULE NO: 17 OF THE INSURANCE OMBUDSMAN RULES,2017)

OMBUDSMAN - NEERJA SHAH

In the matter of: **MR. G K RANJITH** Vs **MAX BUPA HEALTH INSURANCE CO. LTD.**

Complaint No: BNG-H-031-2021-0662

Award No: IO/(BNG)/A/HI/0388/2020-21

1	Name & Address of the Complainant	**Mr. G K Ranjith** 63/2, S B Road, V. V. Puram, Bangalore Karnataka - 560004 Mobile: 9844366961 Email: ranjithgrandhi@ymail.com
2	Policy No. Type of Policy Duration of Policy/ Policy Period	30198958201906 Individual Mediclaim (Family First Silver Plan) 31.03.2019 to 30.03.2020
3	Name of the Insured/ Proposer Name of the policyholder	Mr. G K Ranjith Self
4	Name of the Respondent Insurer	Max Bupa Health Insurance Company Limited
5	Date of repudiation/rejection	03.01.2020
6	Reason for repudiation	Claim for unproven treatment
7	Date of receipt of the Ann VI A	22.01.2020
8	Nature of complaint	Rejection of claim
9	Amount of claim	Rs.1,01,500/-
10	Date of Partial Settlement	N.A.
11	Amount of relief sought	Rs.1,01,500/-
12	Complaint registered under Rule no:	13(1) (b) of Insurance Ombudsman Rules, 2017
13	Date of hearing/place	19.03.2021 / Online VC
14	Representation at the hearing	
	a) For the Complainant	Self
	b) For the Respondent Insurer	Ms. Shital Patwa
15	Complaint how disposed	**Disallowed**
16	Date of Award/Order	31.03.2021

17. Brief Facts of the Case:-

The complaint emanated from the repudiation of health claim on the ground that unproven treatment taken by the insured which is not covered under the policy. The Complainant approached the Grievance Redressal Officer (GRO) of the Respondent Insurer (RI), but the same was not resolved. Hence, the Complainant has approached this Forum for resolution of his grievance.

18. Cause of Complaint:-

a) Complainant's arguments: The Complainant (Insured Person – hereafter referred to as IP) was covered with RI under Family First Silver Plan vide policy number 30198958201906 from

31.03.2019 to 30.03.2020 with the base Sum Insured (SI) of Rs.1 lacs and floater SI of Rs.10 lacs. He was diagnosed with Osteoarthritis in both knees. He underwent Sequential Programmed Magnetic Field (SPMF) therapy for 21 days consecutively at SBF Healthcare Research Center Pvt. Ltd., Bangalore from 01.11.2019 to 21.11.2019. The reimbursement claim of Rs.1,01,500/- for the expense of treatment was repudiated by the RI vide their letter dated 03.01.2020 on the ground that SPMF is an unproven therapy and comes under permanent exclusion. The IP submitted that treating doctor Dr. V G Vasistha has patented the said procedure with Govt. of India. He approached to Grievance Redressal Officer of RI for reconsideration of claim, but his plea was not considered favourably. Hence he approached this Forum for help in getting his claim amount from the RI.

b) Respondent Insurer's Arguments: The Respondent Insurer in their Self Contained Note (SCN) dated 20.01.2021 whilst admitting insurance coverage and subsequent repudiation of claim submitted that IP was admitted on 01.11.2019 at SBF Healthcare, Bangalore with complaints of pain in both the knees and diagnosed with Gonarthrosis. As per treatment summary, IP was treated by SPMF therapy which is an unproven therapy and falls under permanent exclusion clause 8.14 of the policy terms and conditions.

19. Reason for Registration of complaint:-

The complaint falls within the scope of the Insurance Ombudsman Rules, 2017 and so it was registered.

20. The following documents were placed for perusal:-

a. Complaint along with enclosures,
b. Respondent Insurer's SCN along with enclosures and
c. Consent of the Complainant in Annexure VIA & and Respondent Insurer in VII A.

21. Result of personal hearing with both the parties (Observations & Conclusions):-

The dispute is whether repudiation of health claim under the policy is in order or not.

Personal hearing by the way of online Video-conferencing through GoTo Meet was conducted in the said case. Complainant and Representatives of RI joined using online VC and presented their case. Confirmation from all the participants about the clarity of audio and video was taken to which the participants responded positively.

During course of personal hearing the Complainant submitted that he was having pain in his knees post an accident. On consultation with doctors an MRI was done and he was advised and underwent treatment at SBF Healthcare. His problem was resolved upto of 95%. The treatment received by him has received a patent from government of India. He has learnt that SBI general and United India are considering the claims for the said treatment but the RI has denied his rightful claim.

The representative of the RI reiterated the submission already made.

This Forum has perused the documentary evidence available on record and the submissions made by both the parties during the personal hearing.

Forum finds that the Complainant underwent treatment for Osteoarthritis through a therapy known as Sequential Programmed Magnetic Field (SPMF) therapy at SBF Healthcare Pvt. Ltd on day care basis for 21 days from 01.11.2019 to 21.11.2019.

The Forum has also gone through the patent certificate dated 22.02.2009 in the name of Mr. Vishwanath Gopalakrishna Vasishta for an apparatus for inducing magnetic resonance in biological tissues. This certificate only certifies the apparatus and does not state anywhere that it can be used for therapeutic purposes.

Forum on perusal of standard treatment guidelines published by Ministry of Health & Family Welfare for management of osteoarthritis knee finds that currently SPMF procedure is not accredited by the Medical Council of India. In the absence of accreditation by the Medical Council of India, SPMF therapy has to be treated as experimental/unproven treatment which is excluded under Clause 8.14 which is reproduced as follows:

8. Permanent Exclusions

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Schedule of Insurance Certificate and has been accepted by You. This option will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

8.14 Experimental/Investigational or Unproven Treatment:

a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.

Under the circumstances, the Forum concurs with the decision of RI and the rejection of claim is found to be in order. The Complaint is disallowed.

A W A R D

Taking into account the facts & circumstances of the case and the personal submissions made by both the parties and the information/documents placed on record, the rejection of claim is found to be in order and in consonance with the terms and conditions of the policy and does not require any interference at the hands of Ombudsman.

The Complaint is **Disallowed.**

Dated at **Bangalore** on the **31st** day of **March, 2021**.

(NEERJA SHAH)
INSURANCE OMBUDSMAN
FOR THE STATE OF KARNATAKA

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF KARNATAKA

(UNDER RULE NO: 16/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN- Smt.NEERJA SHAH

In the matter of: **Sri. G.R.VISHNU** V/s **STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED**

Complaint No: BNG-H-044-2021-0819

Award No: IO/BNG/A/HI/0002/2021-22

- The Complaint emanated from rejection of Covid-19 claim under policy No.P/141111/01/2020/006857 and Claim No.CLI/2021/141111/2007836 on the ground of tampering the hospital case records. Representation along with clarification letter from the hospital with RI could not be resolved. Hence the Complainant approached this Forum for relief. The complaint was registered on 30.03.2021.

- After scrutiny of the documents the Forum informed the R.I to relook the claim as per Government of Karnataka Notification dt.23.06.2020. The R.I vide mail dt. 02.04.2021 informed the Forum and the complainant that they reviewed the claim and agreed to settle Rs.55,000/- as per prescribed Government package against claimed amount of Rs.1,07,400. The Forum also sent the mail to the complainant for his consent if agreeable. The complainant agreed for the settlement and gave his consent

- The complaint was resolved on compromise basis wherein both have agreed for the same and hence, the Complaint is treated as **Closed** and **Disposed off** accordingly.

Compliance of Award:

Attention of the Complainant and the Insurer is hereby invited to the following:

a. The Complainant shall submit all requirements/Documents required for settlement of award within 15 days of receipt of the award to the Respondent Insurer.

b. According to Rule 17(6) of the Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

Dated at **Bengaluru** on the **5th** day of **APRIL** 2021

(NEERJA SHAH)
INSURANCE OMBUDSMAN
FOR THE STATE OF KARNATAKA

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - MR. K.M. KURANI
VS
RESPONDENT : ROYAL SUNDARAM GENERAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-038-2021-1570
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. K.M. Kurani** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	MFG0020732000102 Family Health Floater Policy 04.09.2019 - 03.09.2020 Rs.3,00,000/-
3	Name of Insured Name of the policy holder	Mr.K.M. Kurani
4	Name of Insurer	**Royal Sundaram General Insurance Co. Ltd.**
5	Date of Repudiation	---
6	Reason for repudiation	---
7	Date of receipt of the complaint	
8	Nature of complaint	Non-renewal of policy
9	Amount of claim	----
10	Date of Partial Settlement	----
11	Amount of relief sought	Rs.15,75,000/-

12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(e)
13	Date of Hearing	20.04.2021 – 12.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. K.M. Kurani
	b) For the insurer	Ms. Hemakshi Joshi
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant Mr. K.M. Kurani was covered under Family Health floater Policy for the period 27.08.2019 to 26.08.2020. Complainant approached this Forum with a complaint against non-renewal by the Respondent Royal Sundaram General Insurance Co. Ltd. of the said policy without proper notice.

Contentions of the Complainant: Complainant contended that he along with his family members was insured with the Respondent since the year 2004 for S.I. of Rs.10,50,000/-. Company kept on changing the terms and conditions of the policy every year. In the year 2017, their Health Shield Policy was renamed as Family Health Floater Policy and the cover continued with S.I. of Rs.11,00,000/- and C.B. Rs.5,70,000/-. In 2018, all cumulative bonuses were withdrawn and four different invoices for premium were raised in the name of each individual member totaling to Rs.30,236/-. In 2019, both his children were dropped from the policy cover and he and his wife continued in the policy with a total premium of Rs.22,798/- for both with S.I. of Rs.3,00,000/- & C.B. Rs.3,15,000/-. In August 2020 he received an SMS to pay a premium of Rs.37,000/- which was remitted well within time thinking that the premium amount was for both himself and his wife and he was under the impression that the increase in premium could be to cover the additional risk of Covid-19. It was only in October 2020 when he received the policy, did he notice that the policy mentioned only his wife's name. When he enquired with the agent, he was told that it covered only his wife and that his own policy had lapsed as he had not paid the premium for renewal of his policy. Mr. Kurani stated that he did not receive any Renewal Notice for his policy nor any Notice of Product Withdrawal from the Respondent Company. The Company had suddenly discontinued his cover without any prior notice. He added that even in the previous year the Respondent had tried to drop him from the policy cover stating that his premium cheque was dishonoured without any supporting evidence and even without presenting the cheque to his bank as was evident from his Bank Statement. It was only after a protracted correspondence with the Company that the cover was restored. Now, after lodging a complaint with the Ombudsman, the Company offered to renew his policy with continuity benefits but quoted a very high premium of Rs.75,000/- which he was not in a position to bear. He eventually took another policy from Max Bupa Health Insurance Co.

However, this action of the Company to suddenly drop him from the policy at his advanced age of 83 years after being their loyal customer for 16-17 years with hardly any claims, without any prior notice and that too, during the times of Covid pandemic when it was very difficult for him to get a cover from any other Insurance Company, was with a malafide intention, totally beyond comprehension and unacceptable. He therefore requested the Forum to award him punitive damages and impose a penalty against the Company so that they do not repeat such unbusiness-like behaviour with any of their unsuspecting customers in future.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Complainant and his wife were individually covered under Family Floater policy with their Company since many years which was renewed till 04.09.2019-20. Mr. Kurani's policy was due for further renewal on 03.09.2020 and his wife's policy on 26.08.2020. They had sent him a Renewal Notice via email on 11.07.2020 (55 days in advance) on his registered mail id quoting renewal premium of Rs.50,031/-. The said product was however found unviable and was therefore withdrawn w.e.f 01.04.2020 with approval from IRDAI.Hence they sent him a Product Withdrawal notice on 08.07.2020 wherein two alternatives viz. Lifeline Policy & Arogya Sanjeevani Policy were offered to him. Complainant renewed his wife's policy by paying a premium of Rs.37.387/- on 27.08.2020 but did not renew his own policy as the premium quoted for alternative Lifeline policy (with superior features) was Rs.86,188/-. On receiving an enquiry from him on 18.11.2020, he was advised to opt for Arogya Sanjeevani Policy with a premium of Rs.32,544/- if the pricing of their Lifeline Policy was higher than his expectations. However he did not renew the policy. Company also contacted him recently before hearing and offered both the products for renewal with continuity benefits, but he refused to renew. They submitted that the Company had transparently informed the Complainant about the product withdrawal, reason for withdrawal and the options available for renewal so that he could make an informed choice. However, as the premium payment against the said policy was unpaid the Respondent company could not renew the policy and it lapsed. Thus he was given a fair chance by the Company to renew his policy and there was no deficiency in service on their part.

Forum's Observations/Conclusion: On hearing the depositions of both the parties, it was observed that the complainant is insured with the Respondent since the year 2004 and the policy underwent several changes over the years. His last policy renewal was due on 03.09.2020 for which the Respondent allegedly sent him a Renewal Notice in advance via email. But later on it was decided by them to discontinue the product and hence the Respondent claims to have sent him a Product Withdrawal Notice well in advance, mentioning the alternative products offered by them. However, the complainant stated that he did not receive any such email communication from the Company except for an SMS advising him to renew the policy by payment of Rs.37,387/- towards premium which he promptly paid only to later on learn that the said premium was for renewal of his wife's policy and his policy had lapsed due to non-payment of premium. Thereafter, on approaching the Respondent, he was again given the choice of opting for either of the two alternative products offered by the Company with continuity benefits. However, he chose not to renew the policy. The Forum notes that the complainant has already availed of a policy from another Insurer and does not wish to continue

his policy with the Respondent. He has however requested for awarding punitive damages and penalty to the Company for abruptly discontinuing his long-standing coverage without proper notice. In this connection, it may be noted that as per Ombudsman Rules, 2017 this Forum can award compensation only to the extent of the loss suffered by the complainant as a direct consequence of the cause of action and hence the complainant's request for punitive damages or for penalty, cannot be granted. The Forum however advises the Respondent to be more customer-centric in their approach, especially while serving policy-holders who are senior citizens to ensure that they are not faced with any kind of undue hardships in their dealings with the Company.

AWARD

Under the facts and circumstances of the case, no relief can be granted to the complainant Mr. K.M. Kurani under the complaint lodged by him against Royal Sundaram General Insurance Co. Ltd. The case is disposed of accordingly.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th day of April, 2021 at Mumbai.

MILIND KHARAT
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - MR. VIJAY NARKAR
VS
RESPONDENT : STAR HEALTH AND ALLIED INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-044-2021-1709
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Vijay Narkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171100/01/2020/019809 Senior Citizens Red Carpet Policy 28.02.2020 - 27.02.2021 Rs.3,00,000/-
3	Name of Insured Name of the policy holder	Mr. Shantaram Narkar
4	Name of Insurer	**Star Health and Allied Insurance Co. Ltd.**
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	02.042021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.1,54,375/-
10	Date of Partial Settlement	02.02.2021
11	Amount of relief sought	**Rs.1,05,592/-**
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	22.04.2021 - 1.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Vijay Narkar
	b) For the insurer	Dr. Arvind Thakkar, DGM
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainant's father Mr. Shantaram Narkar was admitted to Motiben Dalvi Hospital, Mumbai from 06.10.2020 to 17.10.2020 for the treatment of UTI, DM, HTN. Complainant approached this Forum with a complaint against short-settlement by the Respondent Star Health And Allied Insurance Co. Ltd. of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant : Complainant submitted that the claim lodged for a total amount of Rs.1,54,375/- for his fathers's hospitalization for the treatment of UTI was settled by the Respondent only for Rs.45,723/-, which was not even 50% of the claim amount. Respondent deducted Rs.5670/- from Investigation charges towards Covid test and partially for Dengue test (only Rs.600/- allowed). He argued that nowadays due to the pandemic situation, Covid test is compulsory for admission to any hospital and whatever investigations were done were as per doctor's advice. Besides, Rs.48,783/- were disallowed from the total Medicine bill of Rs.73,478/- citing the reasons as "Consumable items", "dates not clear" & "patient name is different". Also, Rs.14704/- were deducted from post hospitalization expenses stating "patient name is different". He stated that all the bills, reports and documents submitted by him were authenticated with proper sign & stamp. However, he would again submit these bills with proper details if required by the Respondent. While taking the policy, he had declared that his father is diabetic despite which insulin charges were disallowed. The deductions from the claim amount were not acceptable to him. He already had to bear 30% of the claim amount as Co-pay despite paying such a high premium. He therefore requested for settlement of the balance claim amount of Rs.1,05,592/-.

Contentions of the Respondent: Dr. Thakkar stated that the Insured submitted a claim for reimbursement of medical expenses of Rs.1,54,375/- for his hospitalization for 12 days in October 2020 plus post hospitalization expenses for the treatment of UTI with DM & HTN. The claim was settled for Rs. 45,723**/-** by allowing the entire Room charges and Professional fees with deduction of **Rs.89,864/-** as under:

Rs.32,000/- Consumables,
Rs.11,986/- Non-Medical expenses,
Rs. 4,256/- Dates on medicine bills not clear
Rs. 541/- Patient name on the bill was different.
Rs. 5,670/- Covid test not payable and excess Dengue test charges
Rs. 250/- Registration charges
Rs.35,161/- Post hospitalization payable only upto 7% of admissible claim excl. Room rent

A further amount of **Rs.18,788/-** was deducted towards 30% Co-pay on admissible amount.

Forum's Observations/Conclusion : On an analysis of the documents produced on record it is observed that the deductions from the claim amount on account of Consumables, Non-medical expenses and Registration charges being in accordance with policy terms and conditions, are found to be in order. However, the disallowance of Covid test charges and excess Dengue test charges is not justified as these tests were done as per the doctor's advice and paid for by the patient as billed by the hospital. As regards disallowance of bills for the reasons "Patient name different" and "Date not clear", since the complainant has agreed to re-submit proper supporting bills, these expenses may be considered for reimbursement under the main hospitalization claim. The settlement of post-hospitalization expenses restricted to 7% of admissible claim amount (excluding room charges) also being in keeping with the terms and conditions of the policy, cannot be faulted with. The decision of the Respondent is thus intervened by the following Order:

AWARD

Under the facts and circumstances of the case, Star Health And Allied Insurance Co. Ltd. is directed to pay a further amount of Rs.5,670/- towards Investigation charges + Rs.4,797/- towards Medicine charges subject to submission of proper supporting bills by the complainant less applicable Copay against the balance claim in respect of the hospitalization of Mr. Shantaram Narkar in October 2020, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. DHEER KAKU
VS
RESPONDENT : THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-050-2021-1676
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Dheer Kaku** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	124500/48/2020/5460 Happy Family Floater Policy 07.03.2020 - 06.03.2021 Rs.6,00,000/-
3	Name of Insured Name of the policy holder	Mr. Satish Kaku Mr. Dheer Kaku
4	Name of Insurer	**The Oriental Insurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	02.04.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.5,50,000/-
10	Date of Partial Settlement	17.12.2020
11	Amount of relief sought	**Rs.2,27,744/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 12.45 p.m.

14	Representation at the hearing	
	a) For the complainant	Mrs. Rupande Kaku - Wife
	b) For the insurer	Mrs. Shubhada Sawant
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant's father Mr. Satish Kaku was admitted to Criticare Hospital, Mumbai from 23.06.2020 to 25.06.2020 for the treatment of Acute Coronary Syndrome/ IWMI and underwent PTCA. Complainant approached this Forum with a complaint against short-settlement by the Respondent The Oriental Insurance Co. Ltd. of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: Mrs. Rupande Kaku stated that her husband Mr. Satish Kaku suffered a heart attack and was admitted to Criti Care Multispeciality Hospital since it was a non-Covid hospital where he underwent Angioplasty. They tried for cashless but were told by the TPA that due to the Corona-19 pandemic, cashless facility was not available. The total hospital bill amounted to Rs.5,08,212/- including Rs.2,00,000/- for Doctor fees against which they were given a discount of Rs.70,000/- by the doctor and they paid Rs.4,38,212/- to the hospital. After discharge, all necessary treatment related papers were submitted to TPA. However,after a long chase of almost 6 months the claim was settled with deduction of Rs.2,27,744/-. She stated that they have paid the full amount to the hospital and hence the deductions from the claim amount were not acceptable to them. She requested for settlement of the balance claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that Criticare Hospital being a network hospital, the claim was settled as per PPN Package Rate while the hospital had billed more than the Package Rate. Their TPA had taken up this case with the Hospital when it was given to understand verbally that Insured patient was treated by Dr. Ankeet Dedhia. Dr. Ankeet Dedhia is not a regular panel doctor of Criticare hospital, he was brought by the patient. However Dr. Dedhia was not ready to operate within package rates of GIPSA PPN and hence charges were over and above the PPN package. The hospital had also informed the patient that though his treating doctor was not agreeable for operating within GIPSA rates, the claim settlement will be done as per GIPSA rates only. The patient had signed the PPN declaration form which clearly stated that charges over and above the package charges shall be borne by himself.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, it is observed that the hospital has charged Package Rate of Rs.4,38,212/- for Angioplasty while the Respondent has settled the subject claim as per Agreed GIPSA Package Rate of Rs.2,82,702/-. As informed by their TPA, in this

regard the hospital has verbally clarified that since the patient had brought in his own doctor who was not agreeable to operate within the agreed rates, the charges were over and above the PPN Package. However, from the hospital bill it is evident that the doctor has given a discount of Rs.70,000/- against his fees of Rs.2,00,000/-. Therefore, the alleged verbal clarification given by the hospital does not appear to be convincing. The patient has taken treatment in the Company's network hospital and has paid the charges as billed by the hospital. If the hospital has not adhered to the agreed PPN rates and has overcharged the patient in violation of their Agreement with the TPA/Respondent, it would not be fair to penalise the insured for the same. The Forum is ,therefore,of the view that the insured is liable to be reimbursed the differential amount barring non-payable items and the Respondent may seek recovery of the same from the hospital, if deemed fit. Their decision is therefore intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co. Ltd. is directed to pay the balance admissible amount barring non-medical expenses against the claim lodged in respect of the hospitalization of Mr. Satish Kaku in June 2020, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. C.J. SANGHAVI

VS

RESPONDENT : NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-048-2021-1685
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. C.J. Sanghavi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	240600501910003118 National Mediclaim Policy 29.03.2020 - 28.03.2021 Rs.5,00,000/- + Rs.50,000/-
3	Name of Insured Name of the policy holder	Mrs. Nalini Sanghavi Mr. C.J. Sanghavi
4	Name of Insurer	**National Insurance Co. Ltd.**
5	Date of Repudiation	09.11.2020
6	Reason for repudiation	Hospitalization not justified
7	Date of receipt of the complaint	30.03.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.53,166/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.53,166/-
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 12.30 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. C.J. Sanghavi
	b) For the insurer	Mr. Vivek Sadavarte, Dy. Manager
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainant's wife, Mrs Nalini Sanghavi was admitted to Nanavati Hospital, Mumbai from 21.09.2020 to 22.09.2020 for the treatment of single Unproved Generalized Tonic Clonic Seizure with Hypoglycemia with DM/HTN. Complainant approached this Forum with a complaint against repudiation by the Respondent National Insurance Co. Ltd. of the claim lodged under the policy for reimbursement of hospitalization expenses on the ground that the hospitalization was not warranted.

Contentions of the Complainant : Complainant submitted that on 21.09.2020 early in the morning around 4.30 p.m. his wife suddenly had blood frothing from her mouth and fell unconscious. His son tried for an ambulance but it was not available. So they took her to Nanavati Hospital where she was evaluated and treated and was discharged on the next day. A claim lodged under the policy for reimbursement of hospitalization expenses was rejected by the Respondent stating that the admission was not necessary. He argued that a senior citizen lady aged 74 years with bleeding from the mouth will not go to a hospital at 5.00 a.m. just for diagnostic and evaluation purpose. The treating doctor at the hospital had issued a letter stating that it was not possible to treat her in OPD and she required hospitalization. Therefore, the reason cited by the Respondent for rejection of the claim was not acceptable to them. He requested for settlement of the claim.

Contentions of the Respondent: Mr. V. Sadavarte submitted that as per the document submitted by the insured, it was observed that the patient Mrs Nalini Sanghvi was admitted in Nanavati Hospital primarily for diagnostic/evaluation purpose and kept on oral medication for one day. Hence,the hospitalization is not justified. The claim stands non admissible as per clause no. 4.19 of the terms and condition of the policy which states that "The policy will not pay for expenses incurred on Diagnostic and Evaluation purpose where such diagnosis and evaluation can be carried out as outpatient procedure and the condition of the patient does not require hospitalization".

Forum's Observations/Conclusion: On scrutiny of the documents produced on record coupled with the depositions of both the parties, it is noted that Mrs. Nalini Sanghavi had an episode of frothing from the mouth and fell unconscious in the early hours of 21.09.2020 and was therefore,rushed to the hospital by her family members. During hospitalization, she was investigated and diagnosed with single Unproved Generalized Tonic Clonic Seizure with Hypoglycemia with DM/HTN. She was treated with oral medications and was discharged on the next day. Respondent repudiated the claim stating that the hospitalization was only for evaluation and since only oral medications were given, the treatment was possible on OPD basis and did not require hospitalization. However, the necessity of hospitalization cannot be straightaway questioned only on this basis when the patient had such kind of presenting symptoms. The treating doctor, Dr. Pradyumna Oak, Director & Head of Neurology Dept., Nanavati Hospital has certified that the patient needed hospitalization and it was not possible to treat her in OPD. Nobody would take a chance of keeping such a patient at home and go on treating him/her without proper evaluation of the health status. In hindsight many exigencies and emergencies appear to be normal much to the relief of the patient himself and to his family members. However, to arrive at this stage one has to go through a series of investigations and

proper evaluation. Health Insurance policy enjoins liability upon the Insurance Company to pay expenses for hospitalization done on the advice of a duly qualified medical practitioner. Therefore, the Respondent's argument that admission was primarily for evaluation not followed by active treatment does not sustain. The decision of the Respondent is therefore, set aside by the following order:

AWARD

Under the facts and circumstances of the case, National Insurance Co. Ltd. is directed to settle the claim in respect of the hospitalization of Mrs. Nalini Sanghavi on 21.09.2020 for the admissible amount of expenses barring non-medical items as per policy terms and conditions, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MRS. PADMAJA JADHAV
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1770
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mrs. Padmaja Jadhav** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14040034202800000662 New India Floater Mediclaim Policy 13.08.2019 - 12.08.2020 Rs.3,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Padmaja Jadhav 14040034202800000662
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	
8	Nature of complaint	Short-settlement of claim

9	Amount of claim	Rs.1,31,600/-
10	Date of Partial Settlement	24.09.2020 7 28.09.2020
11	Amount of relief sought	**Rs.74,265/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	20.04.2021 – 1.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Ms. Gauri Jadhav
	b) For the insurer	Ms. Bhavani Jeyaraman
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant Mrs. Padmaja Jadhav was admitted to K.J.Somaiya Hospital, Mumbai from 08.04.2020 to 15.04.2020 for the treatment of Acute Febrile Illness with CKD & HTN. Complainant approached this Forum with a complaint against short-settlement by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Ms. Gauri Jadhav stated that her mother was hospitalized in April 2020 for the treatment of Acute febrile illness. The hospital did not give them cashless facility. They then lodged a claim for reimbursement of hospitalization expenses of Rs.1,31,600/- which was settled for only Rs.57,335/- by the Respondent deducting Rs.74,265/- mainly disallowing PPE kit and Swab test expenses. She argued that the Government guidelines were issued in June 2020 while her mother was hospitalized in April 2020. They had now submitted additional documents including Swab test bills worth Rs.15,000/- and were told by the Respondent that they are going to reprocess the claim. She requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured lodged a claim for Rs.1,31,600/- which was settled for a total amount of Rs.57,335/-. The insured was eligible for room rent of Rs.3,000/- per day against which she had occupied a room with rent of Rs.4,500/- per day. Accordingly, they disallowed excess room charges and Doctor fees and Hospital service charges were allowed in proportion to the entitled room category. Ms. Bhavani gave the details of deductions from the claim amount as under:

1. Rs.10500/- Room & Nursing charges payable Rs. 3000/- per day for total 7 days
2. Rs.19814/- Proportionate deduction made as per policy condition 3.1

3. Rs. 7000/- Diet charges not payable.
4. Rs.19913/- PPE Kit charges payable Rs. 1088 for non-covid patient (Paid only for one day)

She added that the TPA has reassessed the claim for a total amount of Rs.1,19,000/- against which Rs.61,773/- becomes payable. Therefore a further amount of Rs.6538/- is payable to the insured. The balance amount disallowed was towards Investigation charges for which break-up was not available.

Forum's Observations/Conclusion: The Forum analyzed the case and observes that the deduction of Diet charges, excess Room charges and from other charges in proportion to the room rent in excess of the insured's eligibility being as per policy terms and conditions, is in order. However the disallowance of PPE Kit charges during Covid times even though the complainant was a non-covid patient, is not justified. During hearing, representative of the Complainant also stated that they have submitted additional bills for Swab test which also need to be considered for the admissible amount as per policy T & C. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay the amount deducted from PPE kit charges plus the admissible amount against the additional break-up of Investigation charges provided by the complainant Mrs. Padmaja Jadhav in addition to the payable amount of Rs.6538/- towards the balance claim in respect of her hospitalization in April 2020, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 30th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. PARAG SANGHAVI
VS
RESPONDENT : THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-050-2021-1651
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Parag Sanghavi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	131200/48/2021/4161 Corona Kavach Policy 04/08/2020 TO 15/05/2021 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Falguni P. Sanghavi Mr. Parag Sanghavi
4	Name of Insurer	**The Oriental Insurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.50,349/-

10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.24,400/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	20.04.2021 – 1.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mrs. Falguni Sanghavi
	b) For the insurer	Mr. Mahesh Kolin
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant's wife Mrs. Falguni Sanghavi was admitted to Apex Hospital from 26.09.2020 to 09.10.2020 for the treatment of Covid 19. Complainant approached this Forum with a complaint against short-settlement by the Respondent The Oriental Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Mrs. Falguni stated that she was admitted to Apex Hospital for the treatment of Corona positive. The total hospital bill was for Rs.1,26,952/-. But the hospital gave a discount and charged her only Rs.50,349/-. However, Respondent settled the claim only for Rs.26,000/- which was just about 50% of her claim. The settlement was not acceptable to her and she requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that Mrs. Falguni Sanghavi lodged a claim for Rs.50,349/- for her hospitalization from 26.09.2020 to 09.10.2020 for the treatment of Covid-19. The claim was settled for Rs.25,949/-, deducting Rs.24,400/-. He gave the details of deductions as under:

Room charges	2000	Paid for 13.5 days - deducted for 0.5 day
BMW	6200	
Care & Hygiene	7000	
Consumables	7000	
SPO2	2100	
Medical records	1000	
Dietician	600	
Registration charges	500	
Investigations	4520	X-ray films not provided

Forum's Observations/Conclusion: After hearing the depositions of both the parties, the Forum observes that the deduction of room charges for 0.5 days is not justified as no hospital charges for room rent on hourly basis and it is always charged on "per day" basis. Also, BMW and Care & Hygiene charges are integral part of Covid treatment; hence disallowance of the same is also not justified. The deductions under the remaining heads being as per policy conditions, are found to be in order. X-ray charges may be considered for payment subject to submission of X-ray films by the complainant. The Forum therefore passes the following Order:

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co. Ltd. is directed to pay further admissible amount of Rs.15,200/- plus admissible Investigation charges subject to submission of X-ray films against the balance claim lodged for of the hospitalization of Mrs. Falguni Sanghavi in September 2020, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 30th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. KETAN THAKKAR
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1635
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Ketan Thakkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11250034182800002009 New India Floater Mediclaim Policy 19.09.2018 - 18.09.2019 Rs./-
3	Name of Insured Name of the policy holder	Ms. Vyomi Thakkar
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	
6	Reason for repudiation	Treatment excluded under the policy
7	Date of receipt of the complaint	02.04.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.1,39,185/-
10	Date of Partial Settlement	--
11	Amount of relief sought	**Rs.1,39,185/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	20.04.2019 - 12.30 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Ketan Thakkar
	b) For the insurer	Ms. Nivedita Parulekar, A.O.
15	Complaint how disposed	Award

16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainant's daughter Ms. Vyomi Thakkar was admitted to Beramji's Hospital from 22.04.2019 to 03.05.2019 for the treatment of Lumbar Slip Disc with Sciatica. Respondent repudiated the claim for the said hospitalization stating that need for hospitalization was not established and the treatment could have been done on OPD basis.

Contentions of the Complainant : Complainant submitted that his daughter Ms. Vyomi Thakkar, aged 21 years had complaints of severe back pain for which she was admitted to Beramji's Hospital in April 2019 for 12 days. She was treated with Massage and Magnetic Acupuncture. A claim lodged under the policy for reimbursement of hospitalization expenses was repudiated by the Respondent stating that this kind of treatment is not payable under the policy. He stated that they were insured with the Respondent since the year 2002 and a claim for similar treatment undergone by his wife in the same hospital in March 2012 for Lumbar Disc Lesion was settled by the Company for Rs.65,000/-. Hence the reason cited now for repudiation of his daughter's claim was not acceptable to them. He requested for settlement of the claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that on scrutiny of the claim documents, it was observed that the patient Ms. Vyomi Thakkar had back pain since one month due to gymming. Discharge summary and the Indoor case papers mentioned "c/o pain in lower back radiating to the right leg. Better with treatment but started radiating to the left leg. At present pain is more on anterior aspect of lt thigh." She was treated with Acupuncture and Physiotherapy. However this treatment is not payable as per policy terms and conditions 4.4.18. Ms. Nivedita added that the claim lodged for the hospitalization of the complainant's wife in March 2012 was also repudiated by them and was paid by United India Insurance Co.

Observations/Conclusion: On examination of the documents it was observed that the complainant's daughter was admitted to the hospital for % Pain in lower back radiating to both legs which got aggravated after gym exercises. She underwent MRI and was diagnosed with Lumbar Slip Disc with Sciatica. During the course of hospitalization, she was treated with Acupuncture, Physiotherapy, Massage, TENS, Ultrasound on back and Posture Correction. Respondent repudiated the claim on the ground that the said treatment is not payable as per policy condition. The Forum notes that Exclusion Clause 4.4.18 specifically excludes Acupuncture & Physiotherapy treatment. There was virtually no other treatment involving medical management. Considering that the decision of the Respondent to repudiate the claim is in accordance with the terms and conditions of the policy, the Forum does not find any valid reason to intervene with the said decision and consequently no relief can be granted to the complainant in the matter.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Ketan Thakkar against repudiation by The New India Assurance Co. Ltd. of the claim lodged for the hospitalization of Ms. Vyomi Thakkar in April 2019, does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. SUSHIL KUMAR PUROHIT
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1750
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Sushil Kumar Purohit** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	12020034182800000177 New India Floater Mediclaim Policy 12.03.2019 - 11.03.2020 Rs.8,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Premlata Purohit Mr. Sushil Kumar Purohit
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	N.M.
6	Reason for repudiation	Clause 4.4.6.1 - Treatment related to obesity
7	Date of receipt of the complaint	03.03.2021
8	Nature of complaint	Total repudiation of claim
9	Amount of claim	Rs.3,97,165/-
10	Date of Partial Settlement	-
11	Amount of relief sought	**Rs.5,00,000/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	16.04.2021 – 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Sushil Kumar Purohit
	b) For the insurer	Mrs. Ankita Sanap
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant's wife Mrs. Premlata Purohit was admitted to LOC Healthcare LLP from 14.12.2019 to 18.12.2019 for the treatment of Obesity. A claim lodged under the policy for reimbursement of hospitalization expenses was repudiated by the Respondent The New India Assurance Co. Ltd. citing Clause 4.4.6.1 of the policy which excludes treatment of obesity and its complications.

Contentions of the Complainant: Complainant stated that the claim for Bariatric surgery undergone by his wife in December 2019 was rejected by the Respondent stating that treatment related to obesity is excluded under the policy. Mr. Purohit argued that his wife was suffering with Super Morbid Obesity with BMI – 61 + Severe obstructive Sleep Apnea and uncontrolled DM Type II + Grade IV NAFLD. In spite of taking so many dietary and other precautionary measures for weight reduction, all the comorbidities were in progressive nature and was an increasing threat to her life. Her treating doctor had also certified that the treatment was necessary to save her from a life threatening situation. He pleaded that his wife's case was very much exceptional and should not be treated as per normal grounds and policy terms and conditions for rejection of the claim as it was a life-saving surgery. Post-surgery, her weight came down to 102 kg and even her BP and sugar were within normal limits without having to take any medication now. He added that Hinduja Hospital and Lilavati Hospital had quoted more than Rs.8 lakhs for the surgery. Hence they got it done in Pune where the total expenses amounted to less than Rs.5 lakhs. He therefore requested for settlement of the claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that the patient was admitted for Super Morbid Obesity (Wt 139.350Kg, BMI 59) + Uncontrolled type II DM + HTN + OSA+ hypothyroid, Grade IV NAFLD, acanthosis & underwent laparoscopic partial gastrectomy for the same. The ailment is a complication of obesity. As per policy terms & conditions, treatment of obesity & its complications are not admissible. Hence this claim stood non-payable as per Policy Exclusion Clause 4.4.6.1.

Forum's Observations/Conclusion: On scrutiny of the documents produced on record, it is observed that the complainant's wife was hospitalized for the treatment of Super Morbid Obesity and its complications and underwent Laproscopic partial gastrectomy. The claim was repudiated by the Respondent on the ground that treatment of obesity and its complications is excluded under the policy. Complainant argued that in spite of optimal treatment, all the comorbidities were progressive and could be life threatening for her due to which they had no option but to go in for the surgery. Even accepting the complainant's contention that the treatment was done as a life-saving measure for the patient, the fact remains that it was primarily the condition of Obesity which resulted into the complications necessitating the hospitalization and treatment. The treatment of Obesity and its complications is expressly excluded from the scope of the Policy. Mediclaim policy is an annual contract and whenever any dispute arises it is settled based on the terms and conditions of the policy under which a claim has arisen. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and approved by the IRDAI. Under the circumstances, the decision of the Respondent to repudiate the claim being as per the terms and conditions of the policy, is found to be in order and does not call for any intervention by the Forum. Consequently, no relief can be granted to the complainant in the matter.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Sushil Kumar Purohit against repudiation by The New India Assurance Co. Ltd. of the claim lodged for the hospitalization of his wife Mrs. Premlata Purohit in December 2019, does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated at Mumbai this 30th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - MR. HARESH LALJI SANGOI
VS
RESPONDENT : STAR HEALTH AND ALLIED INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-044-2021-1637
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Haresh Sangoi** **Mumbai**

2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171123/01/2020/003631 Star Comprehensive Insurance Policy - 2015 13.08.2019 - 12.08.2020 Rs.5,00,000/- (floater)
3	Name of Insured Name of the policy holder	Mr. Haresh Lalji Sangoi
4	Name of Insurer	**Star Health and Allied Insurance Co. Ltd.**
5	Date of Repudiation	09.11.2019
6	Reason for repudiation	Non-disclosure of material facts
7	Date of receipt of the complaint	18.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.43,061/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.60,000/-
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	05.03.2021 - 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Haresh Sangoi
	b) For the insurer	Dr. Arvind Thakkar, DGM
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainant Mr. Haresh Sangoi was admitted to Smt. S.R. Mehta and Sir K.P Cardiac Institute, Mumbai from 06.09.2019 to 12.09.2019 for the treatment of Acute Internuclear Ophthalmoplegia. Respondent Star Health and Allied Insurance Co. Ltd. repudiated the claim for the said hospitalization on the ground of non-disclosure of insured's h/o IHD, DM, HTN and Right facio brachial paralysis prior to porting the policy to them.

Contentions of the Complainant : Complainant submitted that he was holding Mediclaim policy with National Insurance Co. since the year 2000. W.e.f. 13.08.2019, he ported the policy to the Respondent. He was hospitalized at S.R. Mehta Cardiac Institute on 06.09.2019 for Acute

Cerebrovascular Insufficiency. His cashless request was denied by the Respondent and he was advised to lodge a reimbursement claim. However, after lodging a claim for reimbursement, the Respondent raised several queries and asked him to submit past medical documents which were duly complied with. But thereafter there was no response from the Company. He mentioned that at the time of renewal of his policy in 2019, he was informed by NIC that they had discontinued bancassurance business and since the renewal was already due, he ported the policy to the Respondent. He had no intentions of misleading the Insurance Company regarding his past hospitalizations and while reporting the present claim, all the necessary papers including his past discharge summaries and old policy copies were submitted to them. He therefore requested for settlement of the claim and reinstatement of the policy.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured has earlier taken medical insurance policies from National Insurance Co. for the period from 13/08/2017 to 12/08/2019 and subsequently taken policy from their company from 13/08/2019 to 12/08/2020 under portability. The Insured made a claim for his admission to S.R. Mehta Hospital on 06.09.2019 for the treatment of Acute Internuclear Ophthalmoplegia, which was in the 3rd year of the Medical Insurance Policy and 1st month with Star Health. On scrutiny of the submitted documents, it was observed that the insured person was diagnosed to have Chronic Ischemic Heart Disease and undergone CABG on 11/07/2013. Also, the insured patient is diagnosed with acute right facio brachial paralysis, diabetes mellitus and hypertension in October 2014 which is prior to their policy. The proposer was well aware of the past medical history of the insured person and deliberately did not disclose the above mentioned health details of the insured in the proposal at the time of proposing (porting) the policy which would tantamount to Non-disclosure of Material Facts. Hence, the Company was constrained to repudiate the claim as per Condition No. 9 and to delete the policy cover of Mr. Haresh Sangoi with effect from 21.12.2019 as per Condition No. 14 of the policy.

Forum's Observations/Conclusion : On scrutiny of the documents produced on record, it is observed that the complainant lodged a claim under the policy with the Respondent for his hospitalization for the treatment of Acute Internuclear Ophthalmoplegia in the very first month since the commencement of the policy. Respondent contended that the insured had h/o IHD, DM, HTN and Right facio brachial paralysis which was not disclosed to them prior to porting the policy. Hence the claim was repudiated for non-disclosure of material fact and also his name stood deleted from the policy on the same ground. The Forum notes that the complainant was insured continuously under Individual Mediclaim policy since the year 2000 till 2017 after which he was covered under Baroda Health Policy from 2017 to 2019 with National Insurance Co. and since the said product was discontinued, had ported his policy to the Respondent in the year 2019. Although the complainant has failed in his duty to disclose the details of his health status while porting the policy, as per the rules of portability when the proposer had furnished his previous insurance details while obtaining the policy, it is equally the responsibility of the Insurer to verify the medical as well as claims history of the persons to be insured, from the previous insurer while accepting the proposal. Having failed to fulfil their part of the responsibility at the underwriting stage and having blindly accepted the proposal and premium, it is not fair on the part of the Respondent to later on try to absolve themselves from liability

when a claim arises, alleging non-disclosure on the part of the insured as the sole basis for rendering the contract void depriving him entirely of the benefit of his long-standing uninterrupted coverage. Besides, the Respondent has not contended and established that the ailment for which the insured was hospitalized is related to his past medical history. Therefore denial of the claim and cancellation of policy by the Respondent citing non-disclosure of PED, cannot be sustained and their decision is set aside by the following Order:

AWARD

Under the facts and circumstances of the case, Star Health And Allied Insurance Co. Ltd. is directed to reinstate the policy coverage of the complainant Mr. Haresh Sangoi and settle the claim lodged for his hospitalization in September 2019 for the admissible amount barring non-medical expenses as per policy terms and conditions, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MRS. POOJA SHUKLA
VS

RESPONDENT : STAR HEALTH AND ALLIED INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-044-2021-1827
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mrs. Pooja Shukla** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171147/01/2020/003664 Star Comprehensive Insurance Policy 30.03.2020 - 29.03.2021 Rs.
3	Name of Insured Name of the policy holder	Ms. Pooja Shukla
4	Name of Insurer	**Star Health And Allied Insurance Co. Ltd.**
5	Date of Repudiation	14.07.2020
6	Reason for repudiation	Hospitalization not justified
7	Date of receipt of the complaint	
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.2,18,750/-
10	Date of Partial Settlement	---
11	Amount of relief sought	**Rs.2,18,750/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	23.04.2021 – 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Ms. Pooja Shukla
	b) For the insurer	Dr. Arvind Thakkar - DGM
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case : Complainant Ms. Pooja Shukla was admitted to Sanjeevani Surgical And General Hospital, Mumbai from 27.05.2020 to 02.06.2020 for the treatment of COVID-19. Complainant approached this Forum with a complaint against repudiation by the Respondent Star Health And Allied Insurance Co. Ltd. of the claim lodged under the policy for reimbursement of hospitalization expenses on the ground that the hospitalization was not warranted.

Contentions of the Complainant : Complainant submitted that she had tested positive for COVID 19 and was admitted to Sanjeevan Hospital on 27.05.2020. After treatment, she was discharged from the hospital on 02.06.2020. On lodging a claim with the Respondent, it was repudiated stating that she needed only self isolation and hospitalization was not necessary. She stated that both her parents were hospitalized for Covid and her father was in the ICU for 17 days. Thereafter she started having complaints of breathlessness and as her condition started deteriorating with no family member at home to look after her, she was advised by their doctor to get hospitalized. Hence, the reason cited by the Respondent for rejection of the claim was not acceptable to her. She, therefore, requested for settlement of the claim.

Contentions of the Respondent: Dr. Thakkar submitted that they have settled the claims lodged for the hospitalization of both the complainant's parents. But on scrutiny of the subject claim documents, it was observed that the complainant Ms. Pooja Shukla had only mild symptoms and as per the guidelines from AIIMS, New Delhi and Ministry of Health and Family Welfare, GOI regarding the treatment of Covid 19 patients, this patient needed only self-isolation by home quarantine and admission to hospital was not required. Hence, the claim was initially repudiated. However, on receipt of Notice from the Ombudsman office, the claim was reviewed and considered for settlement for Rs.1,02,916/- against the total bill submitted for Rs.2,40,717/-. Although Sanjeevani Hospital is on their panel, the hospital did not extend cashless facility to the patient. They have approved the full amount of Room Rent, Doctor fees and Investigation charges. The deductions from the claim amount were Rs.2,451/- towards Non-medical expenses, Rs.350/- Registration Charges, Rs.3,000/- Food charges, Rs.6,000/- MRD charges, Rs.6,000/- BMW charges and Rs.1,20,000/- Covid Handling charges.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that although the claim was initially repudiated, the Respondent has now reconsidered their decision and have agreed to settle the claim for Rs.1,02,916/-, disallowing Non-payable items, BMW charges and Covid Handling charges. The settlement offered by them is not acceptable to the complainant who has requested for settlement of the entire hospitalization expenses. The Forum notes that although BMW and Covid Handling are an integral part of Covid treatment, the amount of Rs.1,20,000/- billed as Covid Handling charges is very much on the higher side. At the same time it is also noted that the complainant has taken treatment in the Company's network hospital. However, it appears that the hospital has not adhered to the Government guidelines and has overcharged the patient. Respondent has not sought any clarification from the hospital in this regard. In such a case, it would not be fair to penalise the insured who has no control on the same and has paid the charges as billed by the hospital. The Forum is ,therefore, of the view

that the complainant is entitled to be reimbursed the entire hospitalization expenses barring non-medical items specifically excluded under the policy and the Respondent may seek refund of the amount billed in excess of stipulated rates directly from the hospital. The decision of the Respondent is ,therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Star Health And Allied Insurance Co. Ltd. is directed to settle the claim lodged for the hospitalization of Ms. Pooja Shukla in May 2020, for the admissible amount of Rs.2,28,916/- barring excluded non-medical items as per policy terms and conditions, towards full and final settlement of the complaint within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 29th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. JAYESH DOSHI
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1725
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Jayesh Doshi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11060034189500005435 New India Mediclaim Policy 18.01.2019 - 17.01.2020 Rs.2,00,000/-
3	Name of Insured Name of the policy holder	Mr. Jayesh Doshi
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----

7	Date of receipt of the complaint	12.04.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.1,77,889/-
10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.1,21,390/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	27.04.2021 – 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Jayesh Doshi
	b) For the insurer	Ms. Pooja Devi, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief facts of the case: Complainant Mr. Jayesh Doshi was admitted to H.N. Reliance Hospital, Mumbai from 05.12.2019 to 09.12.2019 for the treatment of Right Inguinal Hernia. Complainant approached this Forum with a complaint against short-settlement by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant submitted that in December 2019, he was operated for hernia at H.N. Reliance Hospital. Against the total hospitalization expenses of Rs.1,75,783/- plus pre hospitalization expenses of Rs.19,838/- he was reimbursed only Rs.56,500/- plus Rs.18,536/- respectively by the Respondent disallowing Rs.1,21,389/- from the main hospitalization expenses stating that expenses for the treatment of Hemophilia B are not payable under the policy. He argued that hemophilia patients need factor nine medicine for precautions, which he had purchased from Hemophilia Society and has not claimed under the policy for the same. The hospital bill did not include hemophilia medicine (factor nine) charges of Rs.1,00,800/-. He even submitted the bill of Hemophilia Society and the Doctor's Certificate stating that the hospital has not charged for factor nine medicine which could also be confirmed from the hospital bill. He had given advance intimation of hospitalization to the TPA when it was also informed that the total hospitalization expenses would be around Rs.1,75,000/- as per the estimate given by the hospital. Hence, the deductions from the claim amount were not acceptable to him. He ,therefore, requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the patient was admitted in H.N. Reliance Hospital on 05.12.2019 and underwent surgery for hernia repair and was discharged on 09.12.2019. Reliance Hospital is on their GIPSA Panel. Hence the TPA paid Rs.56,500/- as GIPSA Package charges agreed for the said procedure against Rs.59,150/- billed by the hospital. It was also noted from the hospital papers that the patient was a known case of Hemophilia B and was treated for the same during hospitalization. Hemophilia B being a genetic disorder, expenses of Rs.1,18,739/- for the same were disallowed as expenses on treatment of genetic disorders are excluded as per Clause 4.4.18 of the policy.

On hearing the depositions of both the parties, since the complainant produced a bill for Rs.1,00,800/- towards medicines purchased for Hemophilia from outside, Respondent was directed to get a clarification from their TPA on the deductions of Rs..1,18,739/- made from the claim amount on account of treatment for Hemophilia. Accordingly, Respondent vide mail dt. 28.04.2021 forwarded to the Forum the following clarification furnished by their TPA:

"As per discussion with our cashless team and confirmation from hospital, during hospitalization patient was managed by Dr. Samir Shah (hematologist) Inj Factor 9 3500 unit IV push in normal saline given 1 hour before surgery ,Inj Pause 1 gm given 30 min before surgery Factor 9 to send from OT just before surgery report s/o PT 14.5, APTT 41.5, Factor 9-35% of normal pooled plasma. Factor 9 infusion given on 06/12/19,07/12/19,08/12/19. Hemophilia B being a genetic disorder not payable as per policy terms and conditions we have paid only Hernia PPN package charges. However,
1) As per final hospital bill provided, Rs 2650/- is further admissible as charges for hernia.
2) Also regarding investigation charges included in final hospital bill for Tests like Blood group, HIV, HbsAg, HCV are tests done before surgery as per protocol hence can be considered as for Hernia and other tests APTT Rs 500, TEG of Rs 3900/- are for Hemophilia treatment.
3) As per consultation charges Surgeon visit charges are for Hernia and other charges for Dr Samir Shah and Dr Aarti Kolte are for Hemophilia treatment.
4) Also Chemotherapy charges are for Hemophilia .
5) For other charges we can not differentiate whether for hernia or for hemophilia"

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the submissions of both the parties, the Forum observed that the complainant has taken treatment in the Company's network hospital and had given advance intimation of estimated hospitalization expenses to the TPA. Due to his history of hemophilia, he was also administered certain pre & post surgery treatment required for hemophilia during the course of hospitalization, At the same time, it also appears that the hospital has not adhered to PPN rates and has overcharged the patient even for the treatment of hernia, in violation of their Agreement with the Respondent. In such a case, the Respondent should have sought clarification from the hospital and it would not be fair to penalise the complainant for the same as he has genuinely incurred the expenses. While disallowance of the expenses (Investigations, Doctor fees and Chemotherapy charges) on the treatment of Hemophilia being as per policy conditions is found to be in order, the Forum is of the view that the amount charged for the

treatment of hernia has to be settled entirely barring non-medical items and the Respondent may seek refund of the amount billed in excess of the agreed rates directly from the hospital, if deemed fit. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay the balance amount of claim for the treatment of hernia excluding the expenses on treatment for Hemophilia and non-medical expenses incurred during the hospitalization of Mr. Jayesh Doshi in December 2019, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 29th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -Mr Ramesh M Chheda

VS

RESPONDENT : National Insurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-048-2021-1717

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Ramesh Chheda, 213 NarshiNatha Street, 1st floor, Bhat Bazar, Mumbai - 400009
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	240201501710008316 National Mediclaim Policy 29.07.2017 to 28.07.2018 Rs.500000/- plus CB
3	Name of Insured Name of the policy holder	Mr Ramesh M Chheda Mr Ramesh M Chheda
4	Name of Insurer	National Insurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	Original claim documents misplaced by TPA
7	Date of receipt of the complaint	18.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.552500/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.552500/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)

13	Date of Hearing	26.04.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Ramesh M Chheda
	b) For the insurer	MsLata Kumar Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case :

The complainant had preferred a claim of Rs.552500/- under the above policy for treatment of Coronary Artery Disease. The TPA had approved the claim for Rs.552500/-. However, the original claim papers were misplaced by DHS TPA (now merged with Mediassist TPA) and the Insurance Company's controlling Office decided that TPA should have maintained original documents, as a result of which, the claim couldn't be approved based on the copies and TPA should bear the responsibility of this claim. Aggrieved with the decision of the Company, the insured approached this Forum for justice.

Contentions of the Complainant :

The complainant submitted during the hearing that he underwent treatment for Coronary Artery Disease and had lodged the claim with the TPA . He received a message from the TPA

that the claim was approved for Rs.552500/- on 22.03.2018. Then he started following up with the TPA when the amount was not credited to his bank account, he came to know that DHS TPA had misplaced his original document during their shifting of Office.He made several requests to the Company/TPA and now it was more than two years, the claim was not yet paid to him. He,therefore,requested for settlement of his claim amount along with interest.

Contentions of the Respondent:

The Respondent submitted during the hearing that their DHS TPA (now merged with Mediassit TPA) had misplaced the complainant's original claim documents and they had referred this case to their Regional Office who stated that the claim couldn't be processed based on the xerox copies of documents and that the TPA should bear the liability under this claim.

Observations/Conclusion

The Forum observes in this case that the complainant has lodged the claim with original documents in 2018 and the insured has received the claim settlement message from TPA on 22.03.2018 that his claim was approved for Rs.552500/-. However, the amount was not credited to the insured's account as DHS TPA (now merged with Mediassist TPA) misplaced the original claim documents during their shifting of Office. The Company's contention that the responsibility of this claim to be borne by the TPA as they have misplaced the original documents and the claim cannot be processed based on xerox copies is not justifiable as claim is already processed for settlement of Rs.552500/- and the insured cannot be penalized for the mistake of the TPA. The Company may recover this amount post settlement of the above claim from TPA if they deem fit.

Based on the above facts, the Company is directed to settle the above claim for Rs.552500/- subject to availability of sum insured along with interest @ 2% above the prevailing bank rate from 22.03.2018 till the actual date of payment to the Complainant. It may be noted that the settlement and interest amount may go beyond the sum insured.

AWARD

M/s National Insurance Co.Ltd.is directed to settle the above claim for Rs.552500/- subject to the sum insured, additionally interest @ 2% above the prevailing bank rate from 22.03.2018 till the actual date of payment to be paid towards full and final settlement of above complaint and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 29th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. RAJIV KAMDAR

VS

RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1675
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Rajiv Kamdar** Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	140600/34/19/28/00001208 New India Floater Mediclaim Policy 22.06.2019 - 21.06.2020 Rs.8,00,000/-
3	Name of Insured Name of the policy holder	Mr. Rajiv Kamdar
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	22.02.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.2,78,218/-
10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.32,607/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	27.04.2021 – 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Rajiv Kamdar
	b) For the insurer	Mrs. Poonam Advani, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief facts of the case: Complainant Mr. Rajiv Kamdar was admitted to Sportsmed Mumbai Pvt. Ltd. – Mumbai from 11/06/2020 to 13/06/2020 for the treatment of Left Knee ACL insufficiency. Complainant approached this Forum with a complaint against short-settlement by the Respondent,The New India Assurance Co. Ltd. of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: Complainant stated that in June 2020,he underwent Left Knee ACL reconstruction at SportsMed Hospital. A claim lodged under the policy for reimbursement of hospitalization expenses of Rs.2,78,218/- was settled for Rs.2,19,461/- with a deduction of Rs.58,757/-. An amount of Rs.13,310/- towards Arthroscopic Cart Charges was paid subsequently. He was however, not agreeable for the deduction of Rs.11,979/- towards the use of anaesthesia equipment & gases as these were required for the surgery and these charges were not included in OT charges and also Rs.20,628/- deducted as non-medical expenses. Hospital informed him that all Disposable items used in his case were not more than Rs.2000/-. He therefore, requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that they received a claim for Rs.2,78,218/- for the hospitalization of Mr Rajiv Kamdar. The claim was settled for Rs.2,19,461/- consisting of Surgeon & Anesthetist fees, O.T. charges and Equipment charges like Flexible Drill system, Nerve Block Charges, Synthes Drill Charges. Out of the total difference of Rs.58,757/-, the TPA had further paid Rs.13,310/- towards Arthroscopy Cart Charges, post clarification received from the hospital. However, the insured represented against the below-mentioned deductions:

1. **Rs.11,979/**- Hospital charged towards anesthesia charges (machine & gases) - unable to consider as it is part of OT charges as per standard definition of OT. Hospital had already charged for OT & Anesthesia in the final bill which was considered for settlement. As per the opinion of TPA doctor, Machine & gases for anesthesia are Consumables & form part of O.T. charges only and it should not be charged separately by the hospital**.**
2. **Rs.20,628/-** deducted towards Camera Cover / Caps /Gauze/ Mask / gloves / sterillium/ mops/ cassette/ pouch / stockings/ knee brace. Food and other beverages charges are also not payable.
3. **Rs.1600/-** for food & Beverage & Rs 3000/- towards Registration charges.

Forum's Observations/Conclusion: The dispute in the present matter is about the disallowance of Anesthesia charges and Non-medical charges. It is the Respondent's argument that Anesthesia (machine & gases) charges form part of OT charges and are not payable separately. The Forum,however,notes that in the instant case these have been charged separately by the hospital. Had these charges been included in O.T. charges, the same would have been paid by the Respondent. The hospital has clarified in this regard that these charges are towards the use of anesthesia equipment & gases used for induction and maintenance of anaesthesia and hence are not included in O.T. charges. In view of the said clarification, since the hospital has not included these charges in the O.T. charges and has billed for it separately, disallowance of the same is not justified and cannot be sustained. The deduction towards Non-medical expenses, Food & Registration charges being as per policy terms and conditions and in accordance with

the guidelines issued by IRDAI, are found to be in order. The decision of the Respondent is therefore, intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay a further amount of Rs.11,979/- against the balance claim in respect of the hospitalization of Mr. Rajiv Kamdar in June 2020, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 29th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. RUSHABH SHAH
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1677
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the	**Mr. Rushabh Shah**

	Complainant	Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14060034189500008856 New Mediclaim 2012 Policy 06.01.2019 - 05.01.2020 Rs.10,00,000/-
3	Name of Insured Name of the policy holder	Mr. Rushabh Shah
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	03.04.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.2,85,691/-
10	Date of Partial Settlement	17.12.2019
11	Amount of relief sought	**Rs.10,890/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	15.04.2021 – 3.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Rushabh Shah
	b) For the insurer	Mrs. Poonam Advani, A.O. Dr. Ketaki - MDIndia Healthcare TPA
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief facts of the case: Complainant Mr. Rushabh Shah was admitted to Sportsmed Mumbai Pvt. Ltd. – Mumbai from 30.11.2019 To 02.12.2019 for the treatment of Left Knee Anterior Cruciate Ligament Insufficiency With Lateromedial Tear. Complainant approached this Forum with a complaint against short-settlement by the Respondent,The New India Assurance Co. Ltd. of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: Complainant stated that he underwent Left Knee Arthroscopic ACL reconstruction on 30.11.2019 at SportsMed Hospital. A claim lodged under the policy for reimbursement of hospitalization expenses of Rs.2,83,691/- was settled with a deduction of Rs.65,332/-. On furnishing the requisite clarification, the TPA paid further amounts of Rs.5,920.- & Rs.12,100/-. However, the balance of Rs.10,890/- towards Anaesthesia charges (machine & gases) still remained unpaid. He had even submitted to them a letter from the treating doctor stating that these charges are patient-specific and are not required for all patients; hence the same are not included in O.T. charges but charged separately as per individual patient's requirement. He therefore,requested for settlement of this balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that they received a claim for Rs.285691/- for the hospitalization of Mr Rushabh B Shah. The claim was settled for Rs.220359/-. Out of the total difference of Rs.65332/- the TPA had further paid Rs.12100 & Rs.5920 post clarification received from hospital. However, they were unable to consider below deductions:

1. **Rs.10890/**- Hospital charged towards anesthesia charges (machine & gases) - unable to consider this as it is part of OT charges as per standard definition of OT. Hospital already charged for OT & Anesthesia in the final bill which was considered for settlement.
2. **Rs.17947/-** deducted towards apron / Camera Cover / Caps / bandage / ecg lead / Gamjee Roll /Gauze/ Mask / plain sheet / sterillium / strips / gloves / plain sheet. / sterillium/ cassette/ pouch cover / usb pen. Food and other beverages charges are also not payable.

Dr. Ketaki added that they have reimbursed Rs.130,000/- towards Surgeon & Anaesthetist fees, Rs.31,910/- towards Equipment Charges like Arthroscopy Cart Charges, Flexible Drill System, Nerve Block Charges & Synthes Drill Charges plus O.T. charges of Rs.27,225/-, in all totaling to Rs.1,78,245/-. However, machine & gases for anesthesia are consumables forming part of O.T. charges and it should not have been charged separately by the hospital. Hence, the same were not considered for payment.

Forum's Observations/Conclusion: The dispute in the present matter is about the disallowance of Anesthesia charges. It is the Respondent's argument that Anesthesia (machine & gases) charges form part of OT charges and are not payable separately. The Forum, however,notes that in the instant case, these have been charged separately by the hospital. Had these charges been included in O.T. charges, the same would have been paid by the Respondent. The hospital has clarified in this regard that these charges are towards the use of anesthesia equipment & gases used for induction and maintenance of anaesthesia and hence are not included in O.T. charges. In view of the said clarification, since the hospital has not included these charges in the O.T. charges and has billed for it separately, disallowance of the same is not justified and cannot be sustained. The decision of the Respondent is therefore intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay a further amount of Rs.10,890/- against the balance claim in respect of the hospitalization of Mr. Rushabh Shah in December 2019, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 29th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. AMRITLAL L. MUTTA
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1773
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Amritlal L. Mutta** **Mumbai**
2	Policy No: Type of Policy	11080034199500002834 New India Mediclaim Policy

	Duration of Policy/Period Sum Insured	28.06.2019 - 27.06.2020 Rs.6,00,000/-
3	Name of Insured Name of the policy holder	Mr. Amritlal L. Mutta
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	11.01.2021
6	Reason for repudiation	OPD treatment
7	Date of receipt of the complaint	08.03.2021
8	Nature of complaint	Total repudiation of claim
9	Amount of claim	Rs. 36,788/-
10	Date of Partial Settlement	--
11	Amount of relief sought	**Rs.36,788/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	26.04.2021 – 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Amritlal Mutta
	b) For the insurer	Mrs. Vaishnavi Upadhyay, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief facts of the case: Complainant Mr. Amritlal Mutta was admitted to H.N. Reliance Hospital, Mumbai from 11.07.2019 to 13.07.2019 for the treatment of CLW face and head injury with h/o fall. A claim lodged under the policy in respect of the said hospitalization was repudiated by the Respondent The New India Assurance Co Ltd. on the ground that the treatment was possible on OPD basis and did not necessitate in-patient care and hospitalization.

Contentions of the Complainant: Complainant stated on 11.07.2019 that he had a fall on the road and sustained injuries on the forehead following which he was admitted to H.N. Reliance Hospital for treatment and underwent CLW suturing. TPA approved cashless authorization at midnight and he was discharged from the hospital on 13.07.2019 afternoon. However,later on,

Respondent rejected the claim stating that hospitalization was not necessary. He argued as to how the Respondent could reject the claim after it was approved by the TPA. He had even submitted a letter from the treating Neurosurgeon stating that "the patient Mr. Amritlal Mutta, aged 60 years was admitted to ER on 11.07.2019 with alleged history of fall on the road followed by 2 CLWs on the right side of frontal scalp region. The likely cause of fall is dizziness which is due to cardiac cause. Patient had sinus rhythm with left anterior fascicular block on ECG and 2D Echo showing mild LVH with normal cavity size with EF 60% and he required Holter Monitoring to exclude arrhythmia which might account for recurrence of event in future." Complainant therefore, stated that the reason given by the Respondent for rejection of the claim was not acceptable to him and requested for settlement of the claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that the patient was admitted with h/o fall on road, sustained cut injury on eyebrow & scalp, minor suturing was done. The treatment extended during hospitalization is usually given on outpatient basis and does not require in-patient treatment. Outpatient expenses are excluded from the scope of cover as per policy clause no. 6. Also, during the course of hospitalization, the patient was extensively investigated. The admission was primarily for investigation purpose which is excluded as per policy clause 4.12. Hence, the claim stood repudiated as per the terms and conditions of the policy.

Forum's Observations/Conclusion: On an analysis of facts of the case based on the documents produced on record coupled with the depositions of both the parties, it is observed that the complainant was admitted to the hospital with head injury and CLWs over the forehead- right eyebrow and right Temporal aspect following h/o fall on the road. On admission, CLW suturing was done in ER and he was shifted to the ward. Thereafter,he was investigated by MRI, ECG & 2D Echo and in view of his long standing systolic BP, the treating Neurosurgeon advised inpatient 24 hours Holter monitoring to rule out arrhythmia which could lead to recurrence of such an episode in future. Thus, the treatment in the hospital was for injuries sustained by the complainant due to an accidental fall and the following investigations were incidental to the diagnosis and done as per the treating doctor's advice. In view of the same, the contention of the Respondent that the treatment was possible on OPD basis and that the patient was admitted primarily for investigation purpose, does not sustain. Also, the TPA had approved cashless authorization based on Provisional diagnosis of "CLW face, head injury with h/o fall" which was also the final diagnosis. Therefore, subsequent repudiation of the claim on the ground mentioned by the Respondent does not hold good and their decision is set aside by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the claim for the hospitalization of Mr. Armritlal Mutta in July 2019 for Rs.36,788/- less non-medical expenses, if any, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 28th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. JITENDRA SHAH
VS
RESPONDENT : THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-050-2021-1665
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Jitendra Shah** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121700/48/2021/3802 Individual Mediclaim Policy 25.07.2020- 24.07.2021 Rs.400,000/-
3	Name of Insured Name of the policy holder	Mr. Jitendra Shah
4	Name of Insurer	**The Oriental Insurance Co. Ltd.**
5	Date of Repudiation	31.10.2020
6	Reason for repudiation	Hospitalization less than 24 hours
7	Date of receipt of the complaint	22.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.14,365/-
10	Date of Partial Settlement	---
11	Amount of relief sought	**Rs.20,000/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	26.04.2021 – 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Jitendra Shah
	b) For the insurer	Mr. Pravin Pashte, A.M.
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case : Complainant Mr. Jitendra Shah was admitted to Amey Eye Clinic & Microsurgery Centre, Mumbai on 07.09.2020 for the treatment of Left Eye Macro Aneurysm and was discharged on the same day. Complainant approached this Forum with a complaint against repudiation by the Respondent The Oriental Insurance Co. Ltd. of a claim lodged under the policy for the same on the ground that the admission to the hospital was for less than 24 hours.

Contentions of the Complainant : Complainant stated that he lodged a claim under the policy for reimbursement of Rs.14,365/- for the treatment of Left Eye Macro Aneurysm undergone by him on 07.09.2020 at Amey Eye Clinic. Respondent however rejected the claim stating that there was no hospitalization for 24 hours. He stated that his doctor has stated in the discharge summary that this was a minor surgery for 25 minutes done to recover his lost vision and does not require 24 hours hospitalization. He argued that any eye treatment including Cataract surgery does not require 24 hours hospitalization and yet it is paid under the policy. No eye clinics have overnight stay facility or nursing staff for night. If he had to stay in the hospital for 24 hours as per policy condition, then he would have to get hospitalized in a big hospital like Fortis etc. where the cost of treatment would have been in the range of Rs.40,000/- to Rs.45,000/-. Instead he had saved the cost by around Rs.30,000/-. He therefore requested for settlement of the claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Insured was suffering from Left Eye Macroaneurysm and was treated for the same in Amey Eye Clinic and Micro Surgery Centre. The treatment was done on OPD basis. Policy does not cover OPD basis treatments (minimum 24 hours of continuous hospitalisation is necessary for the claim to be admissible). Further if this is a Day care Procedure, their policy covers only those day care procedures which are listed in Appendix – I of the policy and this particular procedure is not included in the said list. Hence this claim was rejected as per Clause 2.17 which reads as: "HOSPITALISATION : means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours." and Clause 1.2 A : Note 2 which states: "Relaxation to 24 hours minimum duration for hospitalization as defined in 2.17, is allowed in (i) Day care procedures / surgeries (Appendix I) where such treatment is taken by an insured person in a hospital / day care centre (but not the outpatient department of a hospital); (ii) Or any other day care treatment as mentioned in clause 2.11 and for which prior approval from Company / TPA is obtained in writing."

Forum's Observations/Conclusion: The Forum analyzed the case and observed that the complainant was diagnosed with Left Eye Macroaneurysm and was treated with focal laser in Amey Eye Clinic and Micro Surgery Centre as an inpatient and was discharged on the same day. This procedure is not a surgical intervention but is to be carried out in a sterile environment under aseptic precaution. It is an advancement of medical technology where minimum of 24 hours of hospitalization is not required. In fact, nowadays almost all eye treatments are carried out on Day care basis and rarely require 24 hours' hospitalization. In this connection, attention is also invited to the Master Circular on Standardization of Health Insurance Products dt. 22.07.2020 issued by IRDAI which states that to ensure that the policyholders are not denied availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures shall not be excluded in the health insurance policy

contracts. These Procedures shall be covered (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital.

The Forum also notes that the treatment is a prolonged one wherein depending upon the prognosis the patient has to be administered the treatment in a number of sittings. Besides, the various opinions from the specialists in the field indicate divided opinion amongst the doctors regarding the procedure being an inpatient or outpatient one. Accordingly, taking a practical view of the facts of the case, which have been brought to the notice of this Forum, the Forum comes to the conclusion that the cost of the treatment is to be shared equally between the complainant and the Respondent. The decision of the Respondent is therefore intervened by the following order.

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co. Ltd. is directed to settle the claim for the treatment undergone by Mr. Jitendra Shah on 07.09.2020 for 50% of the admissible expenses, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer

Dated: This 28th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. AKSHAY SHAH
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1939
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Akshay Shah** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11140034209500003370 New India Mediclaim Policy 19.08.2020 - 18.08.2021

		Rs.1,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Vasumati Shah Mr. Akshay Shah
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	16.12.2020 & 05.02.2021
6	Reason for repudiation	Hospitalization less than 24 hours
7	Date of receipt of the complaint	30.03.2021
8	Nature of complaint	Repudiation of claims
9	Amount of claim	Rs.20,287/-, Rs.15,157/- & Rs.14,547/-
10	Date of Partial Settlement	---
11	Amount of relief sought	**Rs.49,991/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	27.04.2021 - 3.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Akshay Shah
	b) For the insurer	Mrs. Mansi Pawar
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case : Complainant's mother Mrs Vasumati R Shah was hospitalized in Kumta Eye and Retina Clinic and Laser Centre on 14/09/2020, 26/10/2020 and 07/12/2020 for the treatment of Left Eye Choroidal Neovascular Membrane. Complainant approached this Forum with a complaint against repudiation by the Respondent The New India Assurance Co. Ltd. of the claims lodged under the policy for the said treatment on the ground that there was no hospitalization for 24 hours.

Contentions of the Complainant : Complainant stated that his mother was suffering from CNVM due to which she was losing her vision. Hence as per the doctor's advice, she had to take three doses of Inj. Zaltrap with an interval of 6 weeks between each injection. Respondent rejected the claims for the same stating that there was no hospitalization for 24 hours. He

argued that in general, any eye treatment does not require hospitalization for 24 hours. Hence the reason cited by the Respondent for rejection of their claims was not acceptable to them. He added that his mother has been insured with the Company since more than 20 years and requested for settlement of the claims.

Contentions of the Respondent: It was contended on behalf of the Respondent that the patient Mrs Vasumati R Shah was admitted to Kumta Eye Centre with complaints of Left Eye CNVM and was treated with inj. Intravitreal Zaltrap.The total period of hospitalisation during these admissions was less than 24 hours and the said procedure does not fall under day care list. Since policy terms and conditions state that hospitalization benefits are admissible only if hospitalization is for a minimum period of 24 hours, the claims were repudiated under Clause nos. 2.16 & 2.10 of the policy..

Forum's Observations/Conclusion: This Forum has received a number of complaints against non-settlement of claims for such Anti VEGF injections and has made a detailed analysis of all the facts related to the treatment vis-a-vis the Insurance Company's stand in dealing with these claims which have been elaborated in the Awards issued by the Forum in similar cases heard earlier. During the hearing of these cases, the complainants have submitted to the Forum certificates from leading Ophthalmologists mentioning the fact that this procedure is not a surgical intervention but is to be carried out in Operation theatre to maintain a sterile environment. The Insurance Companies have also produced certificates from qualified Ophthalmologists stating that these Injections are given intravitreally in operation theatre under aseptic precaution and this can be done as an OPD procedure without indoor admission. The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology and does not require 24 hours' hospitalization. In this connection, attention is invited to the Master Circular on Standardization of Health Insurance Products dt. 22.07.2020 issued by IRDAI which states that to ensure that the policyholders are not denied availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures as mentioned therein which includes administration of Intravitreal injections shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital.

Based on the deposition of the complainant, the Forum notes that the treatment is a prolonged one wherein depending upon the prognosis the patient has to be administered more number of injections. Besides, the various certificates issued by the specialists indicate divided opinion amongst the doctors regarding the procedure being an inpatient or outpatient one. Accordingly, taking a practical view of the facts of the case, which have been brought to the notice of this Form, the Forum comes to the conclusion that the cost of the treatment is to be shared equally between the complainant and the Respondent. The decision of the Respondent is therefore intervened by the following order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the claims for the treatment undergone by Mrs. Vasumati Shah on 14/09/2020, 26/10/2020 and 07/12/2020 for 50% of the admissible expenses incurred, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer

Dated: This 28th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MRS. RATNA LAKHOTIA
VS
RESPONDENT : THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-050-2021-1663
AWARD NO: IO/MUM/A/HI/ /2021-2022

Complainant Mrs. Ratna Lakhotia was covered under Individual Mediclaim Policy No. 121700/48/2019/13184 for the period 11.03.2019 to 10.03.2020 for S.I. Rs.4,50,000/-, issued by the Respondent The Oriental Insurance Co. Ltd. Complainant underwent cataract

surgeries in both the eyes at Falor Eye Hospital and Nursing Home on & 29.08.2019 & 04.09.2019. Claims lodged under the policy for reimbursement of Rs.38,643/- and Rs.38,358/- were settled only for Rs.26,000/- per eye by the Respondent citing Customary & Reasonable Charges clause of the policy. Aggrieved by the short-settlement, Complainant approached this Forum seeking settlement of the balance claim amount.

A joint hearing of the parties to the dispute was scheduled to be held on 26.04.2021 at 3.15 p.m. Meanwhile, Respondent vide email of even date informed the Forum that the claims were reviewed at their end and settled for the balance admissible amount of Rs.12,058/- per claim excluding non-medical expenses. Complainant confirmed having received the said amounts in full and final settlement of both the claims. In view of the same, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated: This 27th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - MR. OMPRAKASH VISHWAKARMA
VS
RESPONDENT : FUTURE GENERALI INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-016-2021-1982
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Omprakash Vishwakarma** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	CRP-2J-20-7034171-00-000 Corona Rakshak Policy 24.07.2020 - 04.05.2021 Rs.2,50,000/-
3	Name of Insured Name of the policy holder	Mr. Rammurti Vishwakarma Mr. Omprakash Vishwakarma
4	Name of Insurer	**Future General India Insurance Co. Ltd.**
5	Date of Repudiation	04.12.2020
6	Reason for repudiation	Non-disclosure of material fact
7	Date of receipt of the complaint	22.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.2,50,000/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.2,50,000/-
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	23.04.2021 - 3.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Omprakash Vishwakarma
	b) For the insurer	Dr. Akanksha Saxena
15	Complaint how disposed	Award
16	Date of Award/Order	26.04.2021

Brief Facts of the Case : Complainant's father Mr. Rammurti Vishwakarma was admitted to Advanced Multispeciality Hospital from 17.10.2020 to 22.10.2020 for the treatment of Covid 19. Respondent Future General India Insurance Co. Ltd. repudiated the claim for the said hospitalization on the ground that the insured had history of Hyperuricemia prior to taking the policy which was not disclosed in the proposal form.

Contentions of the Complainant : Complainant submitted that on 10.10.2020 his father was diagnosed as Covid positive. As his symptoms were mild, he did not require hospitalization but was kept in isolation Centre at NESCO. However, as his fever persisted for 7 days and his condition deteriorated, he was shifted to hospital on 17.10.2020 and was discharged on 22.10.2020. While shifting him to the hospital, they had to fill in a form in which he mentioned that his father was having symptoms of gout which was told to them by the doctor at an Ayurvedic Kendra whom his father had consulted in June 2020 for his joint pains. Based on this information, it was noted in the hospital IPD papers that the patient had a history of hyperuricemia. On lodging a claim under the policy, it was repudiated by the Respondent stating that the history of hyperuricemia was not disclosed to the Company while obtaining the policy which amounts to non-disclosure/suppression of material information. Complainant stated that the reason cited by the Respondent for rejection of the claim was not acceptable to them as his father had only symptoms of gout which was told to them by the doctor of the Ayurveda Kendra in June 2020; however he was not on any treatment for the same. They had even submitted a letter from his Covid treating doctor certifying that he was currently not under medication for hyperuricemia. Hence, there was no question of disclosing the same in the proposal form. He added that as far as the declaration of PED was concerned, he had clearly mentioned his smoking habit and even his mother's diabetes and hypertension conditions in the proposal form and therefore,there was no reason for him to not disclose hyperuricemia ,if his father was suffering from the same while obtaining the policy. He, therefore, requested for settlement of the claim.

Contentions of the Respondent: Dr. Akanksha submitted that the insured had undergone hospitalization at Advanced Multi Specialty Hospitals for Covid-19. As per the noting in the hospital Discharge Card, he is a "Known case of Hyperuricemia" and was prescribed Tab. Urimax 0.4 mg per day during the entire course of hospitalization. His Uric Acid Report showed raised uric acid levels. It was observed that the insured had not disclosed material medical facts while buying the policy i.e. "Hyperuricemia". As per Exclusion Clause of the policy, non-disclosure of PED would lead to rejection of claim and also render the policy null and void. In view of non-disclosure of the insured's pre-existing ailment, the subject claim stood repudiated.

Forum's Observations/Conclusion : On hearing the depositions of both the parties, it is observed that the complainant's father Mr. Rammurti Vishwakarma was hospitalized for the treatment of Covid-19. Respondent rejected the claim lodged under the policy on the ground of non-disclosure of his pre-existing hyperuricemia while obtaining the policy. Complainant argued that although his father had symptoms of gout about which they learnt when he consulted an Ayurvedic doctor in June 2020 for joint pain, he was not on any medication for the same. Hence, he did not mention about the same in the proposal form while taking the policy in July 2020. Respondent has relied only on the Report showing elevated uric acid levels but has not produced any documentary evidence to establish that the insured was on any treatment for the same at the time of taking the policy. The treating doctor of the hospital where he was treated for Covid has also confirmed that he was not on any medication for the same. Besides, it is also observed that the ailment for which the insured was hospitalized is not

related to his history of hyperuricemia. Therefore, denial of the claim by the Respondent citing non-disclosure of PED, cannot be sustained. Their decision is therefore set aside by the following Order:

AWARD

Under the facts and circumstances of the case, Future Generali India Insurance Co. Ltd. is directed to settle the claim lodged for Rs. 2,50,000/- less non-medical expenses, and copay, if any, in respect of the hospitalization of Mr. Rammurti Vishwakarma in October 2020,within the availabile sum insured as per policy terms and conditions, in full and final settlement of the complaint within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 26th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. NITIN SHROFF
VS
RESPONDENT : NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-048-2021-1834
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr.Nitin Shroff** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	240300501910004368 National Mediclaim Policy 27.03.2020 - 26.03.2021 Rs.3,00,000/- + C.B. Rs.1,50,000/- each
3	Name of Insured Name of the policy holder	Mr. Nita Shroff Mr. Nitin Shroff
4	Name of Insurer	**National Insurance Co. Ltd.**
5	Date of Repudiation	---
6	Reason for repudiation	----
7	Date of receipt of the complaint	10.03.2021
8	Nature of complaint	Short-settlement of claims
9	Amount of claim	Rs.54,208/-, Rs.52,934/-, Rs.65,665/-, Rs.62000/-

10	Date of Partial Settlement	18.12.2019
11	Amount of relief sought	**Rs.75,000/-**
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Premal Nitin Shroff - Son
	b) For the insurer	Mrs. Shubhada Sawant
15	Complaint how disposed	Award
16	Date of Award/Order	26.04.2021

Brief Facts of the Case : Complainant Mr. Nitin Shroff along with his wife Mrs. Nita Shroff underwent Cataract surgeries in both eyes at Samyak Drishti Eye Centre, Mumbai on 24.09.202 & 02.10.2020. Complainant approached this Forum with a complaint against short-settlement by the Respondent National Insurance Co. Ltd. of claims lodged under the policy for reimbursement of these hospitalization expenses.

Contentions of the Complainant : Mr. Premal Shroff submitted that against the claims lodged for Rs.54,208/- & Rs.52,934/- for cataract surgeries in both eyes undergone by his father and Rs.65,665/- & Rs.62,000/- for his mother, they were reimbursed only Rs.40,000/- per claim by the Respondent stating that this was the maximum amount payable for cataract surgery. He argued that they had given advance intimation of claim to the Respondent asking as to how much amount would be paid for the surgery. However, there was no response from them. Also the policy did not mention any capping for cataract operation, the deductions from the claim amounts were not acceptable to them. Again, on representing to the Respondent against the short-settlement, they were told that this was the maximum they could pay for cataract and were asked to contact the TPA . He, therefore, requested for settlement of the balance claim amounts.

Contentions of the Respondent: It was contended on behalf of the Respondent that as per National Mediclaim Policy clause no 3.29 Reasonable and Customary charges were applied while processing the claim based on the rate prevailing in the area for the given procedure. In this case they have taken into consideration the Cataract Charges of leading Hospitals viz. H N Reliance Foundation Hospital, Girgaon - Rs.31200/-, Jaslok Hospital, Tardeo – Rs.24000/-, Kokilaben Hospital, Andheri - Rs.24000/-, S L Raheja Hospital, Mahim - Rs.24000. Insureds Mr.Nitin Shroff & Mrs. Nita Shroff underwent Right & Left Eye Cataract Surgeries in Samyak

Drishti Eye Centre in Girgaon area. Accordingly, they have paid the highest of the above charges of Rs 40,000/- per surgery.

Forum's Observations/Conclusion: On perusal of the documents produced on record,it is noted that the claims of the complainant have been settled by the Respondent based on comparison with the charges of PPN hospitals. In this regard, the Forum observes that the rates of PPN hospitals are agreed rates based on negotiations between the concerned hospital and the Respondent/TPA. However, these rates do not apply to non-PPN hospitals and therefore, it would not be proper to compare the rates charged by non-PPN hospitals with that of PPN hospitals. Also, there is no express condition in the policy requiring the insured to go in for a PPN hospital only neither was he guided properly by the Company/TPA despite giving advance intimation of claim. Further, there is no specific capping under the policy for Cataract surgery. The complainant is sufficiently covered under the policy and the expenses incurred for the surgeries undergone by the insured persons are not found to be unreasonable. The Forum is ,therefore, of the view that the deductions from the claim amounts on the grounds mentioned by the Respondent are not justified and the complainant is entitled to be reimbursed the balance admissible amounts under all the 4 claims barring non-medical items. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, National Insurance Co. Ltd. is directed to pay the balance admissible amount of Rs.75,000/-barring non-medical expenses against the claims lodged for cataract surgeries undergone by Mr. Nitin Shroff and Mrs. Nita Shroff on 24.09.2020 & 02.10.2020, in full and final settlement of the complaint within 30 days from issuance of this order so as to avoid penal interest applicable as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 26th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. SHYAM PAWAR
VS

RESPONDENT : BAJAJ ALLIANZ GENERAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-005-2021-1991
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Shyam Pawar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	Og-20-1904-8429-00001186 Health Guard Policy 27.07.2019 - 26.-7.2020 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Mr. Shyam Pawar
4	Name of Insurer	**Bajaj Allianz General Insurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	05.04.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.2,13,449/-
10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.42,320/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	23.04.2021 – 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Shyam Pawar
	b) For the insurer	Dr. Ravindra Shingate
15	Complaint how disposed	Award
16	Date of Award/Order	26.04.2021

Brief facts of the case: Complainant Mr. Shyam Pawar was admitted to United Multispeciality Hospital, Mumbai from 24.07.2020 to 01.08.2020 for the treatment of Atypical Viral Pneumonia secondary to Covid 19. Complainant approached this Forum with a complaint against short-settlement by the Respondent Bajaj Allianz General Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant stated that he was hospitalized in July 2020 for 8 days for the treatment of Covid-19 infection. He was denied cashless facility by the hospital. A claim lodged for reimbursement of hospitalization expenses was settled by the Respondent with a deduction of Rs.42,320/-. Major deductions from the claim amount were towards Mask, gloves, PPE kit, diet charges and charges for Ayurvedic treatment given to him. He argued that masks, gloves and PPE kits are absolutely necessary for treating a Covid patient. Also, since food was not allowed to be brought from outside for Covid patients, it was provided by the hospital only. As regards Ayurvedic treatment given along with allopathic treatment, he stated that the same was decided by the treating doctors and he did not have a choice on the line of treatment being administered to him. He ,therefore,repeatedly wrote to the Company requesting for reimbursement of the balance amount without any positive response. He requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured Mr. Shyam Pawar had lodged a claim for Rs.2,13,449/- against which Rs.1,71,129/- was paid to the insured disallowing Rs.42,320/- towards Non-medical expenses. The details of deductions were as follows:

1. Rs. 3970/- Gloves, mask, etc. not payable
2. Rs. 4500/- N95 mask
3. Rs. 800/- PPE kit
4. Rs. 600/- Excess Covid test charges
5. Rs. 2700/- BMW
6. Rs. 9000/- Covid care
7. Rs. 6750/- Diet supplement fee
8. Rs.13500/- Ayurvedic integrated treatment charges
9. Rs. 500/- Admission fee

Dr. Ravindra submitted that they had paid Rs.650/- per PPE kit and Covid test charges as per Government guidelines while the excess amount charged was disallowed. Also, the hospital had charged separately for Biomedical Waste Management and Covid care charges which were disallowed. Further, the policy covers only modern allopathic treatment and supplementary Ayurvedic treatment is not considered unless the patient is admitted in an Ayurvedic Hospital.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant has taken treatment in the Company's network hospital. However, it appears that the hospital has not adhered to Government guidelines and has overcharged the patient. Respondent has not sought any clarification from the hospital in this regard. As regards Ayurvedic treatment given

as a supplement to Allopathy,the Forum is in agreement with the complainant's argument that the line of treatment is decided by the doctors and the patient has no control on the same. Respondent has also not quoted any specific clause of the policy for disallowance of Ayurvedic treatment. In such a case, it would not be fair to penalise the insured who has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is ,therefore, of the view that the complainant is entitled to be reimbursed the entire hospitalization expenses barring non-medical items specifically excluded under the policy and the Respondent may seek refund of the amount billed in excess of stipulated rates directly from the hospital. The decision of the Respondent is ,therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Bajaj Allianz General Insurance Co. Ltd. is directed to pay the balance amount of admissible expenses of Ra. 42,320/-barring excluded items as per policy terms and conditions, incurred by Mr. Shyam Pawar for his hospitalization in July 2020, towards full and final settlement of the complaint within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 26th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. K. SHREEDHAR
VS
RESPONDENT : UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-051-2021-1957
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. K. Shreedhar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	01050020194841000007587 63 Arogya Raksha Policy 01.08.2019 - 31.07.2020 Rs.7,00,000/-
3	Name of Insured Name of the policy holder	Mr. K. Shreedhar
4	Name of Insurer	**United India Insurance Co. Ltd.**
5	Date of Repudiation	---
6	Reason for repudiation	----
7	Date of receipt of the complaint	05.04.2020
8	Nature of complaint	Nont-settlement of claim
9	Amount of claim	Rs.39,200/-
10	Date of Partial Settlement	-
11	Amount of relief sought	**Rs.37,800/-**
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 3.15 p.m.

14	Representation at the hearing	
	a) For the complainant	Mr. K. Shreedhar
	b) For the insurer	Mrs. Fanny Ronald, A.M.
15	Complaint how disposed	Award
16	Date of Award/Order	23.04.2021

Brief Facts of the Case : Complainant Mr. K. Shreedhar underwent left eye Cataract surgery on 25.02.2020 at Mahatme Hospital, Mumbai. Complainant approached this Forum with a complaint against non-settlement by the Respondent United India Insurance Co. Ltd. of a claim lodged under the policy for the same.

Contentions of the Complainant : Complainant stated that he underwent LE cataract surgery in February 2020. The claim lodged for Rs.37,800/- for the same on 22.02.2020 was not settled by the Respondent despite submitting all the claim related papers, even after passage of more than a year now. He had also complied with all the requirements called for by their TPA. He therefore requested for the Forum's intervention for settlement of his genuine claim along with interest for the delay in settlement.

Contentions of the Respondent: It was contended on behalf of the Respondent that the complainant had submitted all the documents related to the claim. The claim settlement was however pending only due to non-submission of Invoice of IOL for Rs.7,300/- for which query letters were sent to the insured by the TPA as well as the Company in response to his grievance letter addressed to them. Mrs. Fanny added that the policy stipulates a limit of Rs.25,000/- for cataract surgery.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and perusal of the documents produced on record, the Forum finds that the complainant has submitted the Final Bill issued by the Hospital for a total amount of Rs.37,800/- which mentions the charges of Rs.7,300/- towards IOL along with charges under other heads viz. Surgeon, O.T., Anesthesia, Nursing, Dressing etc. Therefore, again insisting for a separate invoice for IOL which the complainant stated was not given to him by the hospital, and withholding the claim for over a year for such a small and reasonable amount is not justified. The Forum is therefore of the view that the claim of the complainant be settled as per the capping for the said procedure stipulated under the policy and the Respondent is also liable to pay interest on the said amount for delayed payment. The decision of the Respondent is thus set aside by the following Order:

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to pay the admissible amount of Rs.25,000/- against the claim for cataract surgery undergone by Mr. K. Shreedhar on 25.02.2020 along with interest @ 2% above bank rate from one month after submission of the final claim documents till the date of actual payment, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 23rd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. ANIL R. SHAH
VS
RESPONDENT : UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-051-2021-1955
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Anil R. Shah** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0221002818P115456400 Super Top Up Policy 30.03.2019 - 29.03.2020 Rs.10,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Anila Shah Mr. Anil Shah
4	Name of Insurer	**United India Insurance Co. Ltd.**
5	Date of Repudiation	----

6	Reason for repudiation	----
7	Date of receipt of the complaint	05.04.2020
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.7,79,934/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.3,11,164/-
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 3.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Anil Shah
	b) For the insurer	Mrs. V.V. Parab
15	Complaint how disposed	Award
16	Date of Award/Order	23.04.2021

Brief facts of the case: Complainant's wife Mrs. Anila Shah was admitted to H.N. Reliance Hospital from 06.01.2020 to 16.01.2020 for the treatment of ACS-CAD with AKI, Liver Injury and HTN. Complainant approached this Forum with a complaint against short-settlement by the Respondent United India Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant stated that he along with his wife is insured with the Respondent under the Basic policy for S.I. of Rs.5 lakhs since 1996 and under Super Top Up policy with S.I. of Rs.10 lakhs. In January 2020, his wife was hospitalized for the first time in these 20 + years of coverage for cardiac related issues. A claim lodged for a total amount of Rs.7.79,937/- under both the policies was settled by the TPA for Rs.3,50,000/- plus Rs.24,000/- under the basic policy and the file was closed without referring to the claim under Top up policy. After protracted follow-up done by him and his agent in the midst of the ensuing Covid-19 pandemic, the TPA obliged by paying an additional amount of only Rs.94,770/- under the Super Top Up policy denying the balance claim citing some PPN Package rate. Mr. Shah argued that they were not aware of any such Package rates agreed by the Company/TPA with the hospital and have been religiously paying the premium as demanded by the Company from time to time including the frequent hikes in premium since the last 26 years. Therefore, such arbitrary deduction from the claim amount was not acceptable to them. He requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Complainant lodged a claim for a total amount of Rs.7,79,937/- against which they paid Rs.3,50,000/- (as per the limit of 70% for major ailments) under his basic policy with S.I. of Rs.5 lakhs plus Rs.24,627/- towards pre & post hospitalization expenses and Rs.94,770/- was paid under Super Top up policy. Thus a total amount of Rs.4,44,770/- was paid as per the GIPSA Package rate agreed with H.N. Reliance Hospital which is in their PPN, disallowing the balance amount of Rs.3,35,166/- charged in excess of the agreed Package rate.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant's wife has taken treatment in the Company's network hospital. However, the hospital has not adhered to PPN rates and has overcharged the patient in violation of their Agreement with the Respondent. In such a case, the Respondent should have sought clarification from the hospital and it would not be fair to penalise the complainant for the same as he has genuinely incurred the expenses and paid the amount as billed by the hospital. The Forum is therefore of the view that the complainant is entitled to be reimbursed the balance admissible amount of claim over and above the threshold limit as per the terms and conditions of Super Top Up policy and the Respondent may seek refund of the amount billed in excess of the agreed rates directly from the hospital, if deemed fit. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to settle the balance admissible amount of claim under the Super Top Policy in respect of the hospitalization of Mrs. Anila Shah in January 2020, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 23rd day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. SANJAY MANTRY
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1891
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Sanjay Mantry** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	13140034189500005721 New India Mediclaim Policy 30.03.2019 - 29.03.2020 Rs.4,00,000/-
3	Name of Insured Name of the policy holder	Mr. Yash Mantry Mr. Sanjay Mantry
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	26.03.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.1,74,667/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.42,000/-
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)

13	Date of Hearing	20.04.2021 – 3.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Sanjay Mantry
	b) For the insurer	Mrs. Sampada Tare
15	Complaint how disposed	Award
16	Date of Award/Order	20.04.2021

Brief facts of the case: Complainant's son Mr. Yash Mantry was admitted to Dr. Pareek's Deafness Clinic & ENT Hospital, Andheri, Mumbai from 22.05.2019 to 23.05.2019 for the treatment of Right Ear Cholesteatoma and underwent Tympanomastoidectomy. Complainant approached this Forum with a complaint against short-settlement by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant stated that the claim lodged for Rs.1,74,667/- for Right ear surgery undergone by his son in May 2019 was settled by the Respondent with a deduction of Rs.42,000/- under the heads of O.T. charges, Anesthetist Charges and Operation Charges citing "Reasonable & Customary charges" and also some additional amount as "non-medical items". He stated that the deductions on the ground of Reasonability were not acceptable to them as they cannot negotiate the rates with the hospital. He had already submitted a letter from the hospital stating that the charges were genuine and as per their standard tariff. The full amount of the hospital bill was paid by them in cheque. He had even taken quotations from other hospitals such as Nanavati Hospital and Lilavati Hospital but their charges were more than Dr. Pareek's Hospital. He added that they were insured with the Respondent since more than 20 years and this was the first claim lodged in all these years. He therefore sought the Forum's intervention for settlement of the above charges while the deductions under other non-medical heads were acceptable to them.

Contentions of the Respondent: It was contended on behalf of the Respondent that against the total claim for Rs.1,74,667/-, they settled an amount of Rs.1,23,159 plus Rs.8,033/-, deducting Rs.43,475/-. Out of this, O.T. charges of Rs.3,000/- Anesthetist charge of Rs.3,000/- & Surgery charges of Rs.36,000/- were disallowed as per Customary & Reasonable expenses Clause no.2.50 of the policy as the charges of Dr. Pareek's Hospital were on higher side as compared to other hospitals including tertiary care hospitals in metro cities i.e. Kokilaben Ambani Hospital & Apex Hospital which are in their PPN and where the charges for the same procedure were found to be lesser. The balance amount was deducted towards non-medical items.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum finds that the subject claim was settled by the Respondent based on comparison with the charges of PPN hospitals. However

Dr. Pareek's Hospital being a non-network hospital, it would not be proper to compare its rates with that of PPN hospitals. There is no restriction in the policy that the insured has to go in for a network hospital only. Also, the complainant has taken all the care by enquiring the rates in other hospitals which were in fact, found to be on higher side. Therefore penalising the insured having such long-standing association with the Company with nil claims experience in all these years, when he has genuinely incurred the expenses and paid the charges as billed by the hospital, would not be justified. The deductions from the claim amount on the ground of Reasonability therefore cannot be sustained and the decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay the balance amount of Rs.42,000/- deducted on the ground of Reasonability from the claim lodged in respect of the hospitalization of Mr. Yash Mantry in May 2019, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 20th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - DR. (MRS). USHA SHAH
VS

RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1855
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Dr. (Mrs.) Usha Shah** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14030034199500005720 New India Mediclaim Policy 18.08.2019 0 17.08.2020 Rs.8,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Usha Shah
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of Repudiation	
6	Reason for repudiation	Hospitalition less than 24 hours
7	Date of receipt of the complaint	10.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.49,225/-
10	Date of Partial Settlement	-----
11	Amount of relief sought	**Rs.49,225/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	20.04.2021 - 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Piyush Shah - Husband
	b) For the insurer	Mrs, Josephina Lemos
15	Complaint how disposed	Award
16	Date of Award/Order	20.04.2021

Brief facts of the case: Complainant Mrs. Usha Shah, diagnosed with Carcinoma of Breast, was admitted to Kokilaben Ambani Hospital on 17.12..2019 for administration of Inj. Zoldonat and again on 27.12.2019 for removal of port. A claim lodged for reimbursement of hospitalization expenses under the policy held with the Respondent The New India Assurance Co. Ltd,. was repudiated on the ground that the treatment taken did not require 24 hours' hospitalization and the procedure is not covered in the daycare list.

Contentions of the Complainant : Mr. Piyush Shah submitted that his wife Dr. Usha Shah is a k/c/o Ca Breast and as she had completed her treatment for the diagnosed ailment, she was admitted to Kokilaben Ambani Hospital on 27.12.2019 for removal of port. Prior to that she was admitted to the same hospital on 17.12.2019 for administration of Inj. Zoldonat. A claim lodged for reimbursement of hospitalization and pre-hospitalization expenses was rejected by the Respondent stating that it is an OPD procedure. She even submitted to them a letter from her treating oncosurgeon stating that she underwent the procedure of port removal under all aseptic precautions in O.T. under LA on day care basis and it is not an OPD procedure despite which they maintained their stand of rejection of the claim. He argued that the policy covers Day care procedures not requiring 24 hours hospitalization due to technological advancement and also the procedure of Incision of skin and other subcutaneous tissues is included in the Day Care list under the policy.Cancer patients having undergone radiation and chemotherapy. already have a compromised immunity and are required to be treated under strict aseptic conditions which is not possible on OPD basis. Hence the decision of the Respondent was not acceptable to them. He added that they have been insured with the Company since the last 23 years without a single claim till his wife was diagnosed with cancer. He therefore requested for settlement of the subject claim.

Contentions of the Respondent: It was contended on behalf of the Respondent that the patient Mrs Usha Shah was hospitalized in Kokilaben Ambani Hospital on 17.12.2019 for administration of Inj. Zoldonat Zolandronic acid intravenously and was discharged on the same day. She was readmitted to the same hospital on 27.12.2019 for chemo port removal on day care basis. There was no hospitalization for 24 hours and as per policy terms and conditions, both these are not listed as day care procedures. Hence the claims were denied under clause nos. 1 & 2.16 of the policy.

Forum's Observations/Conclusion: After hearing the depositions on behalf of both the parties, it is noted that the Respondent has denied the claims for administration of Inj. Zoldonat and for port removal undergone by the complainant on Day care basis. This Forum has received a number of complaints against non-settlement of claims for such injections. It is noted that some companies are paying claims for treatment by way of these injections even when given in isolation while some other Companies who were also paying such claims earlier have now taken a stand that it is admissible only when given as a part of chemotherapy/ radiotherapy or as pre & post hospitalization expenses for related hospitalization. Studies have shown that treatment of Cancer patients with antibodies when used alone or in combination with chemotherapy and radiotherapy, or conjugated to drugs or radioisotopes, prolongs overall survival in cancer patients. The antibodies used in cancer therapy are engineered to specifically target certain

types of cancer cells. When such antibodies are copied over and over in a lab, the result is a monoclonal antibody therapy, a treatment consisting of millions of identical antibodies aimed at the same molecules on tumor cells. As researchers have found more antigens linked to cancer, they have been able to make MABs against more and more cancers. Thus the treatment undergone by patients is one of the advancement of medical technology in as much as over the past couple of decades, more than a dozen monoclonal antibodies have been approved by the Food and Drug Administration to fight cancer, particularly breast, head and neck, lung, liver, bladder and melanoma skin cancers, as well as Hodgkin lymphoma.

In this connection attention is also invited to the recent Guidelines on Standardization of Exclusions in Health Insurance Contracts issued by IRDAI wherein it has been laid down that to ensure that the policyholders are not denied the availability of health insurance coverage to Modern Treatment Methods, insurers shall ensure that certain procedures as listed thereunder (which includes oral chemotherapy & Immunotherapy – Monoclonal Antibody to be given as an injection), shall not be excluded in the health insurance policy contracts. Although the Forum is aware that these guidelines would be applicable to policies issued from 01.10.2020, at the same time since the subject treatment is not specifically excluded under the present policy, the Forum is of the view that it would be in the interest of justice to allow the claim for administration of Inj. Zoldonat. As regards the claim for removal of port, since it is part of treatment for cancer and as certified by the treating oncologist, it has to be done in O.T. under strict aseptic conditions and is not an OPD procedure, the same should also be settled as a Day Care Procedure. The decision of the Respondent is therefore set aside by the following order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the claim for Rs.49,225/- less non-medical expenses, if any, for the treatment undergone by Mrs. Usha Shah at Kokilaben Ambani Hospital on 17.12.2019 & 27.12.2019, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 20th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. SANJAY DHIRAJLAL DOSHI
VS
RESPONDENT : NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-048-2021-1877
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Sanjay Dhirajlal Doshi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	240400501810001050 National Mediclaim Policy 18.01.2019 - 17.01.2020 Rs.3,00,000/- + Rs.1,40,000/-
3	Name of Insured Name of the policy holder	Mrs. Heena Doshi
4	Name of Insurer	**National Insurance Co. Ltd.**
5	Date of Repudiation	---
6	Reason for repudiation	----
7	Date of receipt of the complaint	24.03.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.52,935/-
10	Date of Partial Settlement	18.12.2019
11	Amount of relief sought	**Rs.18,935/-**
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	16.04.2021 – 3.15 p.m.

14	Representation at the hearing	
	a) For the complainant	Mr. Sanjay Doshi
	b) For the insurer	Mrs. Chabina Lokegaonkar
15	Complaint how disposed	Award
16	Date of Award/Order	16.04.2021

Brief Facts of the Case : Complainant's wife Mrs. Heena Doshi underwent Cataract surgery in the right eye on 15.11.2019 at Shah Eye Clinic and Microsurgery Centre, Malad, Mumbai. Complainant approached this Forum with a complaint against short-settlement by the Respondent National Insurance Co. Ltd. of a claim lodged under the policy for reimbursement of hospitalization expenses.

Contentions of the Complainant : Complainant submitted that against the claim lodged for Rs.52,935/- for right eye cataract surgery undergone by his wife, he was reimbursed only Rs.34,000/- by the Respondent mentioning the reason for deduction from the claim amount as "under customary and reasonable clause no. 3.29". He argued that the policy issued to him does not mention any capping for cataract operation and had they gone to any town side or bigger hospital, the expenses would have been much higher. Hence, the deduction from the claim amount was not acceptable to them. He requested for settlement of the balance claim amount of Rs.18,935/-.

Contentions of the Respondent: Mrs. Chabina submitted that they have settled the insured's claim after comparison with the rates charged by some of the hospitals. in Mumbai for Cataract treatment like MAA Hospital, Goregaon, Bombay Hospital, Bhatia hospital, Apex Hospital which were found to be in the range of Rs. 18,000/- to Rs. 30000/-. MAA Hospital is located in the same geographical area of the insured and hence they have paid Rs.34,000/-, in this case being Reasonable and Customary charges. She added that the Company/ TPA have a package rate agreement with hospitals in some cities for some specified procedures including cataract. These package rates have been negotiated by the Company/ TPA with different hospitals for their policyholders.Cataract surgery is a planned surgery and not an emergency treatment and policy-holders have the option to first hand contact the company in advance for availing the benefit of cashless treatment in the network hospitals. It is incumbent upon the Insured customer to act as if s/he is uninsured at all times; thereby meaning that while resorting to use of the coverage under the policy, the Insured is called upon to use due diligence, including while agreeing for rates of treatment ,as if, the same is supposed to be incurred by him/ her. Whereas the average cost of a successful cataract emulsification procedure in the area where the patient has been treated hovers around in the range of Rs. 25,000/- to Rs.35,000/-, it appears that the Insured agreed for the exorbitant cost of over Rs.52,935/- in the process unduly benefitting the eye clinic to take undue advantage of the Health Insurance Policy. Besides, the basic purpose of the cataract surgery is to restore the vision of the patient which

was lost due to the Cataract Disease. If the insured patient opts for an expensive procedure for correction of refractive error, which is well over the package rate, despite the availability of a standard and effective cataract surgery giving the same outcome for the treatment of the disease, then the additional expenses incurred for this expensive procedure is not Reasonable and Customary for payment from the insurance policy. For Non - PPN cases (reimbursement claims from non network hospitals), the claim is settled up to the extent of expenses of monofocal lenses only, used in conventional surgeries. Thus, the stand taken by the TPA for the settlement of the claim was in order and just.

Forum's Observations/Conclusion: On perusal of the documents produced on record it is noted that the claim of the complainant has been settled by the Respondent based on comparison with the charges of PPN hospitals. In this regard, the Forum observes that the rates of PPN hospitals are agreed rates based on negotiations between the concerned hospital and the Respondent/TPA. However, these rates do not apply to non-PPN hospitals and therefore, it would not be proper to compare the rates charged by non-PPN hospitals with that of PPN hospitals. Also, there is no express condition in the policy requiring the insured to go in for a PPN hospital only. Further, there is no specific capping under the policy for Cataract surgery nor any express condition that the policy will pay only for surgery done using monofocal lens. The complainant is sufficiently covered under the policy and the expenses incurred for the surgery undergone by the insured are not found to be unreasonable. The Forum is therefore, of the view that the deduction from the claim amount on the grounds mentioned by the Respondent is not justified and the complainant is entitled to be reimbursed the balance claim amount barring non-medical items. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, National Insurance Co. Ltd. is directed to pay an amount of Rs.18,935/- less non-medical expenses, if any, against the balance claim lodged for right eye cataract surgery undergone by Mrs. Heena Doshi on 15.11.2019, in full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 16th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MS. CHARMI DOSHI
VS
RESPONDENT : UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-051-2021-1781
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Ms. Charmi Doshi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0207002819P111069888 Individual Health Insurance Policy 26.11.2019 - 25.11.2020 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Daksha Doshi Ms. Charmi Doshi
4	Name of Insurer	**United India Insurance Co. Ltd.**
5	Date of Repudiation	
6	Reason for repudiation	Hospitalization less than 24 hours
7	Date of receipt of the complaint	08.04.2021
8	Nature of complaint	Repudiation of claims
9	Amount of claim	Rs.3,73,722/- (6 claims)
10	Date of Partial Settlement	-----
11	Amount of relief sought	**Rs.3,73,722/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	16.04.2021 - 2.45 p.m.

14	Representation at the hearing	
	a) For the complainant	Ms. Charmi Doshi
	b) For the insurer	Mr. Subodh Sawant
15	Complaint how disposed	Award
16	Date of Award/Order	16.04.2021

Brief facts of the case: Complainant's mother Mrs. Daksha Doshi, under treatment for Ca Breast Met (Bone), was administered Inj. Faslodex along with Inj. Zoledronic at BND Onco Centre, Dadar, Mumbai on 01.07.2020, 10.08.2020, 24.08.2020, 11.09.2020, 12.10.2020 & 12.11.2020. Complainant approached this Forum with a complaint against repudiation by the Respondent United India Insurance Co. Ltd. of claims lodged under the policy for reimbursement of expenses incurred for the said treatment on the ground that there was no hospitalization for 24 hours.

Contentions of the Complainant: Complainant stated that her parents are insured with the Respondent since the last 19 years. Her mother has been suffering from Metastatic Ca Breast (Relapse) for which she was started on Nano chemotherapy which involved administration of chemo injections once a month starting from July 2020. The claims for the said treatment being taken on various dates from 01.07.2020 to 12.11.2020 were, however,rejected by the Respondent stating that Hormonal Therapy is not payable under the policy. She stated that treatment for cancer is covered under the policy and this is the only treatment for her mother's recovery. She pointed out that it is not a preventive treatment as alleged by the Respondent but her mother was already a diagnosed case of cancer. Also, as per letter given by Dr. Boman Dhabhar, MD (Medicine) & Oncologist, this treatment is absolute and necessary for her survival. She added that the TPA had approved cashless authorization for the said treatment when it was planned to be taken at Fortis Hospital. However, since the cost involved was higher at the said hospital, they decided to take the treatment at Dr. Boman Dhabhar's private clinic where the actual expenses incurred were almost half as compared to that in Fortis Hospital. She, therefore, requested for settlement of all the claims.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Insured has mentioned incorrectly that she has undergone Nano Chemotherapy Treatment, However in the Discharge Card it is stated that she was treated with 2 Injections i.e. Faslodex & Zoledronic acid which does not fall under Chemotherapy. Discharge Card also does not mention this as Chemotherapy. Zoledronic acid (Reclast) is used to prevent or treat osteoporosis (condition in which the bones become thin and weak and break easily) in women who have undergone menopause ('change of life,' end of regular menstrual periods).Faslodex (fulvestrant) is not considered a form of chemotherapy, but is used as a hormonal therapy to block estrogen receptors in the body that may fuel breast cancer. Faslodex is used alone or in combination with other medications for the treatment of breast cancer in women. As per

terms and conditions 1.4 of Health Insurance policy- "Expenses on Hospitalisation for a minimum period of 24 hours are admissible." As the treatment was taken on OPD basis, all the claims stood rejected as per policy terms and conditions.

Forum's Observations/Conclusion: This Forum has received a number of complaints against non-settlement of claims for such injections. It is noted that Studies have shown that treatment of Cancer patients with antibodies when used alone or in combination with chemotherapy and radiotherapy, or conjugated to drugs or radioisotopes, prolongs overall survival in cancer patients. The antibodies used in cancer therapy are engineered to specifically target certain types of cancer cells. When such antibodies are copied over and over in a lab, the result is a monoclonal antibody therapy, a treatment consisting of millions of identical antibodies aimed at the same molecules on tumor cells. As researchers have found more antigens linked to cancer, they have been able to make MABs against more and more cancers.Thus the treatment undergone by patients is one of advancement of medical technology in as much as over the past couple of decades, more than a dozen monoclonal antibodies have been approved by the Food and Drug Administration to fight cancer, particularly breast, head and neck, lung, liver, bladder and melanoma skin cancers, as well as Hodgkin lymphoma.

These facts clearly indicate that this procedure is an advancement of medical technology and does not require 24 hours' hospitalization. In this connection, attention is invited to the Master Circular on Standardization of Health Insurance Products dt. 22.07.2020 issued by IRDAI which states that to ensure that the policyholders are not denied availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures as mentioned therein (which includes oral chemotherapy & Immunotherapy – Monoclonal Antibody to be given as injection) shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital. Although the Forum is aware that these guidelines would be applicable to existing policies from 01.10.2020, at the same time since the said treatment is not specifically excluded under the present policy, the Forum is of the view that the subject claims be paid barring non-medical expenses. The decision of the Respondent is ,therefore, set aside by the following order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to settle the claims for the treatment administered to Mrs. Daksha Doshi at BND Onco Centre, Mumbai on various dates from July 2020 to November 2020, for the admissible amount of Rs.3,73,722/- less non-medical expenses if any, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 16th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MRS. JASMINA R. MODI
VS
RESPONDENT : THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-050-2021-1682
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mrs. Jasmina R. Modi** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121800/48/2020/2404 Happy Family Floater Policy 19.06.2020 - 18.06.2021 Rs.15,00,000/-
3	Name of Insured Name of the policy holder	Mrs. Jasmina Modi Mr. Rajiv Modi

4	Name of Insurer	**The Oriental Insurance Co. Ltd.**
5	Date of Repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	24.02.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.2,41,000/-
10	Date of Partial Settlement	18.01.2021
11	Amount of relief sought	**Rs.1,28,509/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	12.04.2021 – 3.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Rajiv Modi - Husband
	b) For the insurer	Ms. Manisha Koli
15	Complaint how disposed	Award
16	Date of Award/Order	15.04.2021

Brief facts of the case: Complainant Mrs. Jasmina Modi was admitted to KLS Memorial Hospital, Vile Parle, Mumbai from 01.10.2020 to 13.10.2020 for the treatment of Covid 19. Complainant approached this Forum with a complaint against short-settlement by the Respondent The Oriental Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Mr. Rajiv Modi stated that his wife was hospitalized in October 2020 for the treatment of Covid-19 infection. The hospital did not give them cashless facility. Against the total claim lodged for reimbursement of hospitalization expenses of Rs.2,41,000/-, she was reimbursed only Rs.1,12,509/- by the Respondent deducting Rs.1,28,491/-. He argued that they were insured under the policy for Rs.15 lakhs and the huge deductions from the claim amount were not at all acceptable to them. He requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the claim was settled for a total amount of Rs.128,491/-. There were two bills for Rs.60,856/- & Rs.60,000/- for PPE kits against which their TPA allowed a total of Rs.15,000/- disallowing the

balance Rs.105,856/- and also Rs.18,250/- were deducted from Oxygen charges as per Customary and Reasonable charges Clause of the policy. The other deductions were against non medical items.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant has taken treatment in the Company's network hospital. However, it appears that the hospital has not extended cashless facility to the patient. A claim lodged for reimbursement was settled with major deductions under the heads of PPE kit and Oxygen charges on the ground of Reasonability. However these two items are essential for the treatment of any Covid patient. If the charges were found to be on the higher side, Respondent could have sought clarification from the hospital in this regard, which they have not done. In such a case, it would not be fair to penalise the insured who is sufficiently covered and has genuinely paid the charges as billed by the hospital. The Forum is therefore of the view that the complainant is entitled to be reimbursed the entire hospitalization expenses barring non-medical items specifically excluded under the policy and if the Respondent finds that the hospital has not adhered to Government guidelines and has overcharged the patient, they may seek refund of the amount billed in excess of agreed rates directly from the hospital. The disallowance of non-medical items being as per policy terms and conditions, is found to be in order. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co. Ltd. is directed to pay the amount deducted towards excess PPE kit & Oxygen charges totaling to Rs.1,24,106/- against the balance claim in respect of the hospitalization of Mrs. Jasmina Modi in October 2020, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated at Mumbai this 15th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

COMPLAINANT - MR. SAMEER K. MEHTA
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO:MUM-H-049-2021-1737
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr. Sameer K. Mehta** Mumbai
a	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11190034162500006498 New Mediclaim 2012 Policy 15.03.2017 - 14.03.2018 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Mr. Sameer K. Mehta
4	Name of Insurer	**The New India Assurance Co. Ltd.**
5	Date of repudiation	----
6	Reason for repudiation	----
7	Date of receipt of the complaint	26.02.2021
8	Nature of complaint	Short-settlement of claim
9	Amount of claim	Rs.3,69,606/-
10	Date of Partial Settlement	

11	Amount of relief sought	**Rs.40,158/-**
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	12.04.2021 – 2.45 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Sameer K. Mehta
	b) For the insurer	Mr. Sudam Koli, Dy. Manager
15	Complaint how disposed	Award
16	Date of Award/Order	15.04.2021

Brief facts of the case: Complainant Mr. Sameer K. Mehta was admitted to Dr. L.H. Hiranandani Hospital, Powai, Mumbai from 25.09.2017 to 26.09.2017 for Coronary Angioplasty. Complainant approached this Forum with a complaint against short-settlement by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: Complainant stated that he along with his family members is insured with the Respondent since the year 1996. In 2017, he had to undergo Angioplasty at L.H. Hiranandani Hospital for which he lodged a claim for a total amount of Rs.3,99,557/-. Against this, an amount of Rs.3,59,399/- was settled (including Rs.2,85,671/- approved on cashless basis) leaving an unpaid balance of Rs.40,158/- without any credible explanation. He stated that all documents in support of the claim were already submitted to the TPA. He added that post-surgery, he underwent 12 sessions of physiotherapy - thrice a week for one month as recommended by his treating cardiologist. He therefore requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the total claim including pre & post hospitalization expenses amounting to Rs.3,62,529/- (including cashless claim of Rs.285,671/-) was settled with final deduction of Rs.37,028/-. Mr. Koli gave the details of deductions from the claim amount as under:

1. Rs. 1800/- Doctor consultation charges as Doctors Note not available.
2. Rs. 2800/- Investigation reports not submitted i.e.2 D Echo, ECG, Stress tests.
3. Rs.11500/- CT Scan report not submitted
4. Rs. 700/- Investigation report not submitted.
5. Rs. 6900/- Physiotherapy treatment bills without dates and bifurcation submitted
6. Rs. 3568/- Medicine bill dated 1/11/2017 without prescription
7. Rs. 1000/- Room and Nursing Charges restricted
8. Rs. 718/- Dietician charges not payable

9. Rs. 733/- Non medical expenses
10. Rs. 1509/- Coronary stents pricing are capped as per Govt. Notification.
11. Rs. 5800/- Amount exceeds authorised limit sanctioned.

Forum's Observations/Conclusion: After hearing the depositions of both the parties, the Forum observed that the major deductions from the claim amount were made by the Respondent stating non-submission of supporting documents by the complainant for Consultation charges, Investigations and Medicines. Complainant however, pleaded that all these documents were already submitted to the TPA. In order to resolve the dispute, Complainant was advised to again submit copies of CT Scan and other required Investigation reports and Prescription for Medicines disallowed to enable the Respondent to settle these expenses. Also, since Physiotherapy was taken as per the recommendations of the treating cardiologist for which the complainant has furnished appropriate clarification, these expenses need to be reimbursed. As regards excess charges for stents, the patient has no control on the same and has genuinely paid the amount as billed by the hospital and hence these charges also have to be reimbursed. Respondent may seek necessary clarification/refund of the excess amount so charged directly from the hospital. The disallowance of excess Room & Nursing charges, non-medical expenses and dietician charges being as per policy terms and conditions, are found to be in order. The decision of the Respondent is thus intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay a further amount of Rs.34,577/- towards balance admissible claim in respect of the hospitalization of Mr. Sameer Mehta in September 2017, towards full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 15th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN :
CASE OF COMPLAINANT - Mr Phiroze M Engineer
VS
M/s The New India Assurance Co.Ltd.
COMPLAINT REF: NO:MUM-H-050-2021-1833
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Phiroze M Engineer, Amrut CHS, Flat 1, 511-C Adenwala Road, Matunga, Mumbai - 400019
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11250034209500000849 New India Mediclaim Policy 03.06.2020 to 02.06.2021 Rs.500000/-
3	Name of Insured Name of the policy holder	Mr Phiroze M Engineer Mr Phiroze M Engineer
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for Partial repudiation	Hospital Discount
7	Date of receipt of the complaint	09.03.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.5539/-
12	Complaint registered under Indian Ombudsman Rules 2017	13 (b)
13	Date of Hearing	16.04.2021 at 02.00 Pm
14	Representation at the hearing	

	a) For the complainant	Mr Phiroze M Engineer
	b) For the insurer	Ms Nivedita Parulekar Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case:

The complainant has preferred a hospitalization claim for himself at Masina Hospital from 14.10.2020 to 19.10.2020 and was diagnosed with Ncov Acute Respiratory Disease. The claim was lodged with the Company and the Company had deducted an amount of Rs.5539/- towards hospital discount, Rs.1000/- towards Registration and Administration Charges. The complainant has represented in his written statement that he is not agreeable with the above deductions.

Contentions of the complainant:

The complainant submitted during the hearing that he underwent treatment for Acute Respiratory disease at Masina Hospital and had lodged the claim. The Company has deducted an amount of Rs.5539/- towards Hospital discount and this discount should be passed to the policyholder as per IRDAI Circular and he requested for settlement of this discount amount.

Contentions of the Respondent:

The Forum asked the Respondent the reason for not passing the discount to the insured to which the Respondent replied that this discount is given to him by the hospital and this is not charged to the insured, so they have not paid to him. All other deductions are towards Non-payables.

Observations/Conclusion

The Forum notes in this case that the insured patient was admitted in Masina Hospital and the Company has deducted an amount of Rs.5539/- towards Hospital discount and the insured has claimed the same as per IRDAI Circular with regard to Hospital discount which says that **"During the settlements of claims under health insurance policies, the insurers or the third party administrators to ensure that the discounts that the hospital is providing will be passed on to the policyholder or to the claimant of the health insurance policy."** Thus Company's stand of

deduction of Hospital discount is not sustainable and the Company is directed to settle Rs.5539/- towards Hospital discount. All other deductions are in order.

AWARD

M/s The New India Assurance Co.Ltd is directed to settle Rs.5539/- towards Hospital discount towards full and final settlement of above claim. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 30th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017) OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Manish J Surelia

VS

RESPONDENT : The New India Assurance Co.Ltd.

COMPLAINT REF: NO:MUM-H- 051-2021-1729

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Manish J Surelia, 501 Shree Chamunda, 5th floor, Liberty Garden, Cross Road No 3, Malad West, Mumbai - 400064
2	Policy No: Type of Policy Duration of Policy/Period	**140300/34/19/28/0000/8971** New India Floater Mediclaim Policy 26.03.2020 to 25.03.2021

	Sum Insured	Rs.800000/-
3	Name of Insured Name of the policy holder	Ms Bindu M Surelia (Wife) Mr Manish J Surelia
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Hospitalization for less than 24 hours
7	Date of receipt of the complaint	
8	Nature of complaint	Repudiation of 7 claims
9	Amount of claim	Rs.177582/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.177582/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	30.04.2021 at 02.00 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Manish J Surelia
	b) For the insurer	Ms Josephina Lemos Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case :

Ms Bindu M Surelia 45 years old wife of the complainant insured under the above policy was admitted in Envision Super Speciality Retina and Laser Eye Hospital and was diagnosed with Left eye Central Retinal Vein Occlusion with Cystoid Macular Edema and she underwent medical management by Injection Razumab. Total seven claims were reported amounting to Rs.177582/-. The Company has repudiated all the claims on the ground of Policy Clause 2.10 and 2.15 which reads as under :

Policy Clause 2.10 reads as "Day Care treatment refers to medical treatment or surgery which are undertaken under General or Local Anesthesia in a Hospital/Day care Centre in less than 24 hours because of technological advancement, and which would have otherwise requred a hospitalization of more than 24 hours."

Policy Clause 2.15 reads as "Hospitalization means admission as an Inpatient in a hospital for a minimum period of 24 consecutive hours except for the following specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours." The complainant has expressed in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that his wife was diagnosed with Left Eye Central Retinal Vein Occlusion with Cystoid Macular Edema and was treated with Razumab Injection every month as advised by the treating Eye Surgeon. Total seven claims amounting to Rs.177582/- were lodged and the Company has repudiated all the seven claims on the ground that these intravitreal anti veg injections are not payable standalone as per policy terms and conditions and in this procedure there is neither 24 hours hospitalization nor listed in the Day care procedure as per Policy Clause 2.10 and 2.15 and the same is not acceptable to him as other Insurance Companies are paying such claims and he also quoted about the recent IRDAI Circular dated 22nd July,2020 which mentions that such treatment cannot be excluded under the Health Policy.

Contentions of the Respondent :

The Respondent submitted during the hearing that insured patient was diagnosed with Left eye Central Retinal Vein Occlusion with Cystoid Macular Edema and she underwent medical

management by Injection Razumab. Total seven claims were reported amounting to Rs.177582/-. The Respondent stated that these intravitreal anti veg injections are not payable standalone as per policy terms and conditions and in this procedure there is neither 24 hours hospitalization nor listed in the Day care procedure and therefore they have repudiated all the seven claims on the ground of Policy Clause 2.10 and 2.15. The Forum asked the Respondent whether they have a specific exclusion under the above policy for such type of treatment to which the Respondent replied that their policy excludes ARMD (Age related Macular Edema).

Observations/Conclusion

Analysis of the case reveals that insured patient was diagnosed with Left eye Central Retinal Vein Occlusion with Cystoid Macular and she was treated with Intravitreal Injection Razumab which is used to treat certain types of eye disorders. In this case the treatment took place under specialized Eye Surgeon and local anesthesia and this Forum has awarded couple of similar claims to this insured.

Therefore Company's stand of total denial of the above claim on the ground of Policy Clause 2.10 and 2.15 that this treatment is neither covered in their daycare list nor the hospitalization is for more than 24 hours s not justifiable as in case of all eye treatments/surgery, these are day care procedures and ARMD exclusion is also not sustainable as the insured patient's Macular Edema was not age related.

The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology where minimum of 24 hours of hospitalization is not required. Based on the deposition of the complainant, the forum notes that the treatment is a prolonged one wherein depending upon the prognosis the patient has to be administered more number of injections. Looking at the treatment undertaken by the complainant, the Forum finds that the doctors have been administering this injection.

Recently IRDAI has issued a Circular dated 22nd July,2020 which states that Modern Treatment methods and Advancement in Technologies shall not be excluded in the Health Insurance Policy Contracts and these Procedures shall be covered (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital. These are

subject to product design sub-limits which may be imposed for any of the above treatments by insurer.

Though the Forum is also able to appreciate the case of the complainant in expecting the Insurer to settle the claims in as much as the treatment being a prolonged one and repetitive in nature but for the reasons stated above, it would be reasonable that the complainant bears a part of the expenses.

Accordingly, taking a practical view of the facts of the case, which have been brought to the notice of this Forum, the Forum has come to the conclusion that the cost of the treatment is to be shared equally between the complainant and the Company. Accordingly the Company is directed to settle the above claim for 50% of the claimed amount of all the seven claims i.e. Rs.177582/- which works out to Rs.88791/- for the above seven claims (Injection Razumab)..

AWARD

M/s United India Insurance Co.Ltd. is directed to settle the above claim for 50% of the admissible claim amount (Injection Accentrix) which works out to Rs.88791/- towards full and final settlement of above seven claims and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed off accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

e) As per Rule 17 (6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
f) As per Rule 17 (8) the award of Insurance Ombudsman shall be binding on the insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated at Mumbai this 30th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Nandlal R Gaba
VS
RESPONDENT : Tata Aig General Insurance Co.Ltd.
COMPLAINT REF: NO:MUM-H-047-1920-1820
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Nandlal R Gaba, Sai Co-op Hsg.Soc., Bldg No 33, Room No 1157, Chembur, Mumbai - 400074
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	023860035900 Medicare Insurance Policy 28.08.2020 to 27.08.2021 Rs.300000/-
3	Name of Insured Name of the policy holder	Mr Nandlal R Gaba Mr Nandlal R Gaba
4	Name of Insurer	Tata Aig General Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Non disclosure and Policy reinstatement
7	Date of receipt of the complaint	05.03.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.97806/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.97806/-
12	Complaint registered under	13 (b)

	Insurance Ombudsman Rules 2017	
13	Date of Hearing	20.04.2021 at 2.15 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Nandlal R Gaba
	b) For the insurer	Mr Dhiraj Mhatre
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case :

Mr Nandlal R Gaba insured under the above policy was admitted at Shiv Polyclinic & Nursing Home from 22.08.2020 to 26.08.2020 and he was diagnosed with Covid 19 positive with Bilateral lower lobe pneumonitis. Total claim of Rs.97806/-was lodged. On scrutiny of claim documents, it was revealed that insured patient had history of heart attack inferior wall myocardial infarction in 2013 and he underwent Angioplasty apart from being a chronic smoker and the same was not disclosed at the time of inception of insurance in 2015. Therefore, the Company has denied the claim on the ground of Non-disclosure. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that this policy was purchased online through telephonic call in the year 2015 and he had declared his previous history of Angioplasty during the phone call. He stated that he was now admitted for treatment of Covid 19 and has incurred total expense of Rs.97806/- which the Company has disclaimed on the ground of Non-disclosure which is unfair in the current pandemic situation , and the same is not acceptable to him as he is insured under the above policy since 2015 paying regular premiums and moreover, the current Covid claim is not at all related to heart.

Contentions of the Respondent :

The Respondent submitted during the hearing that the complainant was admitted in the hospital for treatment of Covid 19 and on scrutiny of claim documents, it was revealed that insured patient had history of Inferior Wall Myocardial Infarction in 2013 and he underwent

Angioplasty and was a chronic smoker. The Respondent stated that this was not declared at the time of inception of insurance and if it would have been declared, they would not have issued the policy at all. Therefore, they have denied the claim under Non-disclosure. The Forum asked the Respondent whether medical test was done to which the Respondent replied No. The Forum asked the Company whether they have cancelled the policy to which the Respondent replied that they would examine. The Forum asked the Company to submit the call recordings at the time of policy issuance in 2015 to which the Company agreed.

Observation/Conclusion :

The Forum observes in this case that the insured patient is covered under the above policy since 2015 and now in August,2020 he was admitted for treatment of Covid 19. On scrutiny of claim documents, it was revealed that insured patient had history of Angioplasty in 2013 and he was a chronic smoker which was not revealed at the time of inception of insurance as per contention of the Respondent. The Respondent has not submitted the call recordings and also not confirmed whether the policy is cancelled or not till date.

Based on the above facts, the Forum has come to the conclusion that the insured patient underwent treatment for Covid 19 which has got no relevance with the patient's history of heart ailment and chronic smoking and the insured is covered under the above policy since 2015. Thus Company's stand of denial of above claim on the ground of non-disclosure is not justifiable and the Company is directed to settle the above claim from the claimed amount of Rs.97806/- except non-medicals and also reinstate the policy with continuity benefits if the policy is cancelled subject to collection of appropriate premium, if any.

AWARD

M/s Tata AIG General Insurance Co.Ltd. is directed to settle the above claim from the claimed amount of Rs.97806/- except non-medicals and also reinstate the policy with continuity benefits, if the policy is cancelled subject to collection of appropriate premium ,if any. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai, this 30th April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -Mr Hitesh G Hakani

VS

RESPONDENT : Star Health and Allied Insurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-044-2021-1726

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Hitesh Hakani, B/103 Om Ashish Bldg, Liberty Garden, Link Road, Malad West, Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171131/01/2021/005342 Corona Rakshak Policy 20/07/2020 to 01/05/2021. Rs.250000/-
3	Name of Insured Name of the policy holder	Mr Hitesh G Hakani Mr Hitesh G Hakani
4	Name of Insurer	Star Health and Allied InsuranceCo.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	No active line of treatment
7	Date of receipt of the complaint	22.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.250000/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.250000/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	12.04.2021 AT 02.00 PM

14	Representation at the hearing	
	a) For the complainant	Mr Hitesh G Hakani
	b) For the insurer	Dr A Thakker Manager Claims
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case :

The Insured, Mr. Hitesh G Hakani, 46 years old was admitted to Dr D Y Patil Medical College Pune from 10.10.2020 to 21.10.2020 . As per Discharge Summary , the insured was diagnosed with Covid 19 infection with Hypothyroidism with Diabetic Mellitus with Hypertension. On scrutiny of the indoor case papers,the patient was comfortable, vitals were stable, asymptomatic and had beenmaintaining optimum oxygen saturation throughout the admission. There was no active medical line of treatment, was treated with oral medications. The insured had claimed an amount of Rs.250000/- towards lumpsum benefits of Covid 19 positive. The Company has repudiated the claim on the ground of Policy Clause 4.1. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant

The complainant submitted during the hearing that he is insured under the above CoronaRakshak Policy. He was admitted at Dr D Y Patil Medical College Pune for eleven days for treatment of Covid 19. He had fever and his sugar level had gone up during admission and as

per HRCT report and Government guidelines, he was admitted in the hospital and was treated with Injections and oral medicines. He stated that he lost his mother also who was also affected with Corona two months back. He submitted that the Company had repudiated the claim on the ground of guidelines from All India Institute of Medical Sciences that the Covid 19 patient can be cured at home and there was no need of hospitalization. He stated that he had submitted all the reports and the Doctor's letter which states that patient should be admitted. He submitted that the same Company has settled his claim under Mediclaim Policy but denied under the above policy. Therefore, he requested for settlement of his claim under the above policy.

Contentionsof the Respondent :

The Respondent submitted during the hearing that on scrutiny of claim documents on the same day of admission, the patient was comfortable-- vitals were stable, asymptomatic and had been maintaining oxygen saturation throughout the admission. There was no active line of treatment and was managed with oral medicines only. As per 4.1 "**COVID Cover Lump sum benefit equal to 100% of the sum insured shall be payable on positive diagnosis of COVID, requiring hospitalization for minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized Diagnostic Centre. Please note that as per the guidelines from All India Institute of Medical Sciences, New Delhi and Ministry of Health and Family Welfare, Government of India regarding the treatment of COVID 19 patients, this patients need only Self- Isolation by Home quarantine" based on the submitted claim documents.**

Observations/Conclusion

The Forum observes in this case that the insured patient was admitted in the hospital for 11 days with presenting symptoms of fever and his sugar level also had gone up . He was diagnosed with Covid 19 positive and was treated with Injections and oral medicines during hospitalization. Thus this fulfils the conditions of Policy Clause 4.1. As the complainant has satisfied the the policy stipulations, he is entitled to the benefit under the policy.The Forum notes that the Company has settled the claim under the Mediclaim Policy. However, the Company has repudiated the claim on the ground that all the vitals were normal with no active

line of treatment, is not sustainable and the Company is directed to settle the above claim for Rs.250000/-.

AWARD

M/s Star Health and Allied Insurance Co.Ltd.is directed to settle the above claim for lumpsum benefit of Rs.250000/- under the above policy

towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 30th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Vinodkumar Singh

VS

RESPONDENT : National Insurance Co.Ltd

COMPLAINT REF: NO:MUM-H-048-2021-1842

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Vinodkumar Singh, B/46, 4th floor, Bilwa Kinj CHS, LBS Marg, Mulund West, Mumbai 400082
2	Policy No: Type of Policy Sum Insured Duration of Policy/Period	240800501910001790 and 240800502010001536 National Mediclaim Policy Rs.350000/- plus CB 30.06.2019 to 29.06.2020 30.06.2020 to 29.06.2021
3	Name of Insured Name of the policy holder	Ms Saroj V Singh Mr Vinodkumar Singh
4	Name of Insurer	National Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Sum Insured exhausted claim falling under two policy periods
7	Date of receipt of the complaint	10.02.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.770000/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.324720/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	15.04.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Vinodkumar Singh
	b) For the insurer	Ms Suchita More Deputy Manager
15	Complaint how disposed	AWARD
16	Date of Award/Order	30.04.2021

Brief facts of the Case :

Mrs. Saroj V Singh, wife of the complainant, insured under the above policy was admitted at Aashirwad Critical Care Unit and Multispeciality Hospital on 24.06.2020 for treatment of Covid 19,expired on 10th July,2020. Total claim of Rs.770000/- was lodged . The Company,however, settled an amount of Rs.57930/- under Policy No: 240800501910001790 and deducted the balance amount on the ground that sum insured got exhausted under the above Policy. The insured claimed the balance claim amount under the renewed Policy No: 240800502010001536. The Company didn't consider the renewed policy for above claim settlement. Aggrieved with the decision of the Company, the insured approached this Forum for justice and submitted in his written statement that decision of the Company was not acceptable to him as According to Policy Clause 5.8 **"Medical expenses incurred during two policy periods, the claims will be settled taking into consideration the available sum insured in both the Policy."**

Records were perused and a joint hearing of the parties to the dispute was scheduled on 15th April,2021 at 02.30 Pm. Meanwhile,the Company informed the Forum before the hearing that they were now considering this claim for settlement for the balance amount of Rs.259045/- under Policy No: 240800502010001536 subject to submission of certified copy of Death Certificate and original receipts of Rs.550000/-deposited on various dates with Hospital. The complainant has also agreed for the same. All other deductions are found to be in order. In view of settlement of the claim by the Insurance Company and pursuant withdrawal of the complaint by the complainant, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this 30th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Jayant Pawar
VS
RESPONDENT : Oriental Insurance Co.Ltd.
COMPLAINT REF: NO: MUM-H-050-2021-1767
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Jayant Pawar, 611 Taal Veena Saaz, Videocon Layout, Thakur Complex, Kandivali East. Mumbai - 400101
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	124700/48/2020/7151 Happy Family Floater Policy 10.02.2020 to 09.02.2021 Rs.500000/-
3	Name of Insured	Mr Jayant Pawar
	Name of Insured	Mr Jayant Pawar
4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Covid 19 Quantum dispute
7	Date of receipt of the complaint	
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.160952/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.89309/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	23.04.2021 at 02.00 Pm
14	Representation at the hearing	

	a) For the complainant	Mr Jayant Pawar
	b) For the insurer	Ms Bhavika Parekh, Deputy Manager
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case

Mr Jayant Pawar insured under the above policy was admitted at Saifee Hospital from 19.08.2020 to 24.08.2020 for treatment of Covid 19. Total claim of Rs.160952/- was lodged and the Company has settled the claim for Rs.71643/- and deducted an amount of Rs.89309/- on the ground of Government notification for Covid claims, proportionate deduction, co-pay and non-payables. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant:

The complainant submitted during the hearing that he was admitted at Saifee Hospital for treatment of Covid 19 and he is insured under the above policy for more than 20 years. He stated that he had lodged total claim of Rs.160952/- and the Company has deducted major amount of Rs.89309/-. However,the details of deductions were not shared with him either till date. He stated that these deductions were not acceptable to him and he requested for settlement of his balance amount.

Contentions of the Respondent:

The Forum asked the Respondent to give the bifurcation of the above deductions and the reason for the same to which the Respondent agreed and stated that they will relook into the claim and inform the Forum within two days.

Observation/Conclusion :

As directed, the Respondent submitted the bifurcation of deductions detailed as under :

DESCRIPTION	AMOUNT DEDUCTED RS.
EXCESS ROOM RENT	8750
DOCTOR FEES (PROPORTIONATE)	1167
INVESTIGATIONS	9330
MEDICINES AND CONSUMABLES (PPE KIT)	14787
MISCELLANEOUS CHARGES	6835
PRE HOSPITALIZATION	760
POST HOSPITALIZATION	1233
CO PAY	11809

The Company has calculated the additional amount payable to the insured detailed as under :

Total claimed amount -	160952
Less: Amount not payable – as per policy T & C in claim calculation	42862
Claim payable before co-pay deduction	**118090**
Less : 10% co-pay.	11809
Amount payable.	**106281**
Less :Claim already paid.	71643
Balance payable	**34638**

On detailed analysis of the above, the Forum is of the view to allow PPE Kit Charges of Rs.13565/- deducted over and above Rs.34638/-. All other deductions are in order.

AWARD

M/s Oriental Insurance Co.Ltd. is directed to settle the above claim for the balance amount of Rs.48203/- towards full and final settlement of above claim subject to availability of sum insured and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 30th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017) OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Kartik Jayaraman
VS
RESPONDENT : HDFC ERGO Health Insurance Co.Ltd.
COMPLAINT REF: NO:MUM-H-003-2021-1693
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Kartik Jayaraman, A-1302 Safal Twins Co-op Hsg Society Ltd., Sion Trombay Road, Deonar, Mumbai - 400088
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	160900/11120/AA01115516 Optima Restore Floater Insurance Policy 08/07/2019 to 07/07/2021
3	Name of the Insured Name of the Policy holder	Mr Kartik Jayaraman Mr Kartik Jayaraman
4	Name of Insurer	HDFC ERGO Health Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Fraudulent
7	Date of receipt of the complaint	
8	Nature of complaint	Repudiation of claim and cancellation of Policy
9	Amount of claim	Rs.303786/-

10	Date of Partial Settlement	
11	Amount of relief sought	Rs.303786/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	16.03.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Kartik Jayaraman
	b) For the insurer	Mr Neeraj Shivangikar Assistant Vice President
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case :

The complainant insured under the above policy was admitted at Dr Reena Mokal Hospital, Kandivali from 20.06.2020 to 29.06.2020 for treatment of Covid 19. Total claim of Rs.303768/- was lodged. On scrutiny of claim documents and based on the investigation report, the Insurance Company found certain discrepancies and denied the claim on the ground of misrepresentation of material facts and also cancelled the policy. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant

The complainant submitted during the hearing that he and his family are insured under the above policy and he has paid premium for two years. He and his father both were diagnosed with Covid 19 positive and were admitted on the same day i.e. on 20.06.2020 at Dr Reena Mokal Hospital, Kandivali. He stated that he got discharged on 29.06.2020 and his father was discharged on 04.07.2020. In case of his father Mr Jayaraman Srinivasan's claim, HDFC ERGO appointed a third party Investigator J D Insurance who approached him and got the consent for mode of claim form duly signed by him along with Aadhar Card, Pan Card, Photo,etc. Later they approached the hospital for verification and the claim was settled after some deduction. He further submitted that his claim was denied by the Company on the ground of misrepresentation of material facts without verifying the facts either from him/hospital and have also cancelled the policy which was not acceptable to him. He stated that he approached the hospital post rejection of his claim and they have given a Certificate which reads as **"Patient**

Mr Kartik Jayaraman aged 36 years was admitted in our hospital on 20th June,2020 along with his father Mr Jayaraman Srinivasan for treatment of Covid 19. Mr Kartik Jayaraman got discharged on 29th June,2020. Till date no representative from any Insurance Company approached our hospital for verification pertaining to Mr Kartik Jayaraman. Till date there is no physical or telephonic verification done regarding this patient."

Contentions of the Respondent:

The Respondent submitted during the hearing that the complainant is insured under the above policy since 08.07.2019 and the policy is for two years till 07.07.2021. They received the claim intimation from the complainant that he was admitted at Dr Reena Mokal Hospital from 20.06.2020 to 29.06.2020 for treatment of Covid 19. On scrutiny of claim documents such as Discharge Summary and ICP the following discrepancies were found :

1) As per the vitals TPR chart, all vitals were stable throughout the hospitalization period whereas ICP mentioned that fever was there every day and he was managed with oral medications.

2) Further SPO2 / Oxygen level were within the normal limit throughout the hospitalization but Oxygen charges of Rs.8,000/- we're billed.

3) In ICP daily fever & breathlessness is shown but captured vitals do not support the same. Tab. Dolo was given without fever as Evident from TPR chart.

4) On 29.06.2020 when temp was slightly up i.e. 99 deg as compared to other hospitalization period, patient was discharged.

5) The Complainant was charged Rs.56,000/- for medicines in the hospital bill, but no In-house pharmacy record was shown for the verification.

6) No payment receipts were shown by the hospital and all entries appear to be made at stretch. No lab register was presented for verification No OPD pt. found during visit.

7) It is further noted that as per the Discharge Card, Dr. Arpan Dokha was the in-charge. However, the said doctor issued a Certificate stating that during the Karthik's hospitalization, he was not examined by him and / or treated by him.

Based on the above verification, it is noted that the complainant has lodged a fraudulent claim and therefore, they have repudiated the claim and have also cancelled the Policy under Section VI of the policy terms and conditions.

Observations/Conclusion

The Forum observes in this case that both the complainant and his father were admitted in the same hospital on the same day for treatment of Covid 19. The Insurance Company has settled the claim of complainant's father but have denied the complainant's claim based on the

Investigation Report which shows certain discrepancies between the Discharge Summary and Indoor case papers of the hospital. As per contention of the complainant during the hearing, his father's case was investigated by an outside Agency with him and hospital also. However,in his case, no Investigator approached him or the hospital authorities .

The Forum notes that the Respondent has denied the claim on the ground of the Investigation report which showed discrepancies with regard to diagnosis, treatment given, all vitals were normal during hospitalization. However, the Insurance Company has not obtained any clarification from the hospital authorities nor could they produce any documentary evidence to prove their stand. It has to be noted that the insured patient was admitted in the hospital during the pandemic situation of Covid 19 when the beds were not available. Therefore, Company's stand of denial of above claim on the ground of fraudulent and subsequent cancellation of policy on the ground of misrepresentation of material facts is not justifiable and the Company is directed to settle the above claim for the admissible claim amount out of the claimed amount of Rs.303786/- except Non Payables subject to availability of sum insured and also reinstate the policy with continuity benefits subject to collection of appropriate premium if any.

AWARD

M/s HDFC ERGO Health Insurance Co.Ltd is directed to settle the above claim for the admissible claim amount from the claimed amount of Rs.303786/- except Non Payables subject to availability of sum insured and also reinstate the policy with continuity benefits subject to collection of appropriate premium ,if any, towards full and final settlement of above complaint. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 29th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -Mr Prakash Khilnani

VS

RESPONDENT :United India Insurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-051-2021-1853

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Prakash H Khilnani, Flat No 302, SeetaGeeta, 15th Road, Near Agarwal Nursing Home, Bandra West, Mumbai – 400050
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0205002819P114740110 Individual Health Insurance Policy 16.02.2020 to 15.02.2021 Rs.400000/- plus CB
3	Name of Insured	Mr Prakash Khilnani
	Name of Insured	Mr Prakash Khilnani
4	Name of Insurer	United India Insurance Co.Ltd.
5	Date of Repudiation	

6	Reason for repudiation	4.11 (Diagnostic purpose)
7	Date of receipt of the complaint	
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.87513/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.87513/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	16.04.2021 at 02.15 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Prakash H Khilnani
	b) For the insurer	MsJagruti V Shah Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case :

Mr Prakash Khilnani, 63 years old, had preferred a claim under the above policy for treatment taken at Lilavati Hospital from 10.12.2020 to 11.12.2020 for Nephrotic Syndrome. Total claim

of Rs.87513/- was lodged which the Company denied on the ground that Kidney Biopsy is a diagnostic procedure as per Policy Clause 4.11 which reads as under :

Policy Clause 4.11 **"Charges incurred at hospital or Nursing home primarily for diagnosis, X-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a hospital/nursing home is excluded under the policy."**

The complainant has represented in his statement that he is not agreeable with the decision of the Company.

Contentions of the complainant:

The complainant submitted during the hearing that he had swelling all over his body and abdominal distension since 15 days before admission. As per advice of the doctor, he was admitted in Lilavati Hospital and was diagnosed with Nephrotic Syndrome and he underwent Kidney Biopsy under Local Anesthesia. He stated that his Histopath report was normal and he lodged the claim for reimbursement.However, the Company repudiated the claim on the ground of Policy Clause Diagnostic purpose which is not acceptable to him, as his admission was mandatory and he pleaded for settlement of his claim.

Contentions of the Respondent:

The Respondent submitted during the hearing that the insured patient underwent Kidney Biopsy during hospitalization and the Biopsy report was normal and therefore, the claim was repudiated as per Policy Clause 4.11 Diagnostic purpose.

Observations/Conclusion:

The Forum observes in this case that the insured patient was admitted in Lilavati Hospital with presenting complaints of swelling all over his body and abdominal distension since 15 days before admission. As per advice of the doctor,he was admitted in the Hospital and was

diagnosed with Nephrotic Syndrome and he underwent Kidney Biopsy under Local Anesthesia. Although, the Biopsy report was normal, he was treated in the hospital for the diagnosed ailment and thus admission to the hospital was essential for treatment of the patient. Therefore, Company's stand of denial of above claim on the ground of Policy Clause 4.11 is not justifiable and the Company is directed to settle the above claim except Non-Payables from the claimed amount of Rs.87513/-.

AWARD

M/s United India Insurance Company Limited is directed to settle the above claim except non-payables from the claimed amount of Rs.87513/- subject to availability of sum insured towards full and final settlement of above claim. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 29th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Ms Rashmi S Adani
VS
RESPONDENT : HDFC ERGO General Insurance Co.Ltd
COMPLAINT REF: NO:MUM-H-018-2021-1990
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Ms Rashmi Suresh Adani, 1 Wing, 936 Govardhan Nagar Complex, Opp Poisar Gymkhana, Kandivali West, Mumbai - 400067
2	Policy No: Type of Policy Sum Insured Duration of Policy/Period	2828100833374000004 Health Insurance Suraksha Policy Rs.500000/- plus CB 09.08.2020 to 08.08.2021
3	Name of Insured Name of the policy holder	Ms Rashmi Suresh Adani Ms Rashmi Suresh Adani
4	Name of Insurer	HDFC ERGO General Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial Repudiation	Quantum Dispute Reasonability(Cataract)
7	Date of receipt of the complaint	16.02.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.147505/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.55932/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	28.04.2021 at 02.15 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Ankeet Adani (Son) SETTLED BEFORE HEARING
	b) For the insurer	Mr Neeraj Shivangikar Assistant Vice President SETTLED BEFORE HEARING
15	Complaint how disposed	AWARD

16	Date of Award/Order	29.04.2021

Ms Rashmi Suresh Adani, the complainant insured under the above policy, was admitted at Lilavati Hospital and Research Centre on 2nd January,2021 for Right Eye Cataract surgery and lodged total claim of Rs.147505/-.However,the Company settled the claim for Rs.91573/- and deducted the balance amount of Rs.55932/- on the ground that multifocal lens was used ;whereas the type of lens allowed for settlement of claim was unifocal lens. The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

Aggrieved, she approached this Forum requesting relief in the matter for settlement of the balance claim amount. Records were perused and a joint hearing of the parties to the dispute was scheduled on 28th April,2021 at 02.15 Pm. Meanwhile, the Company during the hearing has informed the Forum that they have reviewed the case and are ready to settle additional amount of Rs.53500/- as full and final settlement and the complainant has also agreed for the same. In view of settlement of the claim by the Insurance Company and pursuant withdrawal of the complaint by the complainant, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this 29th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Umang Maniar

VS

RESPONDENT : Oriental Insurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-050-2021-1940

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Umang Maniar, 101-Embassy Chamers, 3rd Road, Khar West, Mumbai - 4000052
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121700/48/2020/4629 HAPPY FAMILY FLOATER POLICY 16.08.2019 to 15.08.2020 Rs.8,00,000/-
3	Name of Insured Name of the policy holder	Mr Naresh Maniar (Father) Mr Umang Maniar
4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	COVID 19 Positive
7	Date of receipt of the complaint	26.02.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.344629/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.119853/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	28.04.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Umang Maniar
	b) For the insurer	Mr Pravin Pasthe, Assistant Manager
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case :

The complainant, Mr Umang Maniar insured under the above policy along with his family members, had preferred two claims under the above policy for his mother and father who were admitted at Sanjeevani Hospital on the same day 09.08.2020. Father expired on 13.08.2020 and mother got discharged on 21.08.2020. The Company had settled mother's claim by cashless with some deductions. In respect of father's claim,total claim of Rs.344629/- was lodged and the Company settled the claim for Rs.224776/- while deducting the balance amount on the ground of Government notification dated 21.05.2020 in respect of Covid 19 claims. The complainant has expressed in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that both his parents were diagnosed with Covid 19 and were admitted in the same hospital in the same room on 09.08.2020. He lost his father on 13.08.2020 and his mother was discharged on 21.08.2020. He stated that Sanjeevani Hospital was a network hospital and initially the hospital told him to pay a deposit of Rs.200000/- which he paid. The TPA had sanctioned cashless for both his father and mother. However, they withdrew the cashless of his father and mother's claim was paid with certain deductions by cashless. Then he lodged father's claim for reimbursement which the Company settled the claim for Rs.224776/- out of the claimed amount of Rs.344629/- with huge deduction of Rs.119853/- on the ground of Government notification and the same was not acceptable to him as he had genuinely incurred those expenses. Therefore, he pleaded for settlement of his balance amount.

Contentions of the Respondent :

The Respondent submitted during the hearing that the insured patient underwent treatment for Covid 19 in Sanjevani Hospital and lodged total amount of Rs.344629/- which they settled for Rs.224776/- as per Government notification dated 20.05.2020 with regard to Covid 19 claims. The Forum asked to submit the bifurcation of the deductions to which the Respondent agreed.

Observations/Conclusion :

The Forum has received a mail from the Respondent with regard to bifurcation of the deductions made. The Forum is of the view that the insured patient has no choice but to pay those expenses and even the hospital authorities were incurring additional expenses due to the current pandemic situation. On scrutiny of the same, the Forum is of the view to allow additional amount of Rs.8500/- towards Room charges, Doctor Charges of Rs.18500/-, Investigation Charges of Rs.26570/-, Laboratory Charges of Rs.600/-,PPE Kit Charges and Food charges of Rs.6750/- thus totaling to Rs.60920/-. All other deductions are towards Non-Payables and are in order.

AWARD

M/s Oriental Insurance Co.Ltd. is directed to settle the above claim for the balance amount of Rs.60920/- from the claimed amount of Rs.119853/- subject to availability of sum insured towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 29th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -MrDaulatram Gupta

VS

RESPONDENT : The New India Assurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-049-2021-1811

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	MrDaulatram Gupta, Omkar Auto 2475, Sai SevaSangh, 92/93 Juna Ration Gali, Gazdar Bandh, Santacruz West, Mumbai - 400054
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14200034192800000457 New India Floater Mediclaim 22.06.2019 to 21.06.2020 Rs.300000/-
3	Name of Insured Name of the policy holder	MrOmkar Gupta (Son) MrDaulatram Gupta
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	Diagnostic purpose

7	Date of receipt of the complaint	04.03.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.26341/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.26341/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	27.04.2021 at 02.30 PM
14	Representation at the hearing	
	a) For the complainant	MrDaulatram Gupta
	b) For the insurer	Mr Ashok Nikam, Assistant Manager(D)
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case :

MrOmkar Gupta, son of the complainant insured under the above policy, was admitted at Nanavati Hospital from 23.09.2019 to 25.09.2019 with complaints of fever for five days where he was diagnosed with Viral fever. Total claim of Rs.26341/- was lodged. On scrutiny of claim documents, it was revealed that patient was treated with oral medicines and IV fluids. All vitals were normal and there was no active line of treatment. Therefore, the Company has repudiated the claim on the ground of Policy Clause 1, 2.15 and 4.4.11 which reads as :Please find the policy clause:

Policy Clause 1 : **"WHAT WE COVER If during the Period of Insurance, You or any Insured Person incurs Hospitalization Expenses which are Reasonable and Customary and Medically Necessary for treatment of any Illness or Injury sustained in Accident, We will reimburse such expense incurred by You, in the manner stated herein. Please note that**

the above coverage is subject to Limits, Terms and Conditions contained in this Policy and no Exclusion being found applicable. In this policy all the members as stated in the schedule will be covered under Single Sum Insured. This Sum Insured will be available for all claims by one or more persons covered in this policy."

Policy Clause 2.15: "HOSPITALIZATION. means Note: Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours".

Policy Clause 4.4.11: "Charges incurred at Hospital primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any Illness or Injury for which confinement is required at a Hospital."

ich confinement is required at a Hospital/Nursing Home."

The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that his 18 years old Son was admitted at Nanavati Hospital with complaints of high fever for four to five days. He first approached his family doctor and when the fever didn't come down,and his platelets level was also reduced, the doctor suspected itto be Dengue and as per advice of the doctor, he was admitted in the hospital. During hospitalization all investigations were done and all the reports were normal and he was diagnosed with Viral fever which was managed with IV fluids, oral medicines, injections. He **submitted that the hospital had given a Certificate which states "the patient**

was admitted for three days for viral fever and the reason for admission was that he had very high grade fever since five days theombocytopenia. In view of high grade fever and theombocytopenia patient needed admission for further evaluation and treatment." He stated that the Company has denied the claim stating that it was for diagnostic purpose and the same could have been done on OPD basis. Such plea was not acceptable to him. He, therefore,requested for settlement of his genuine claim.

Contentions of the Respondent :

The Respondent submitted during the hearing that the insured patient had fever for three to four days and was admitted at Nanavati Hospital. All investigations were done and Dengue, Widal test were negative . Platelets count were 157000. During hospitalization insured patient was managed with oral tablets, IV fluids and all vitals were normal. As such, there was no active line of treatment and therefore, hospitalization was not justified. The treatment could have been taken on OPD basis. Therefore, they have repudiated the claim on the ground of Policy Clause 1, 2.15 and 4.4.11.

Observations/Conclusion :

The Forum observes in this case that the insured patient 18 years old boy was admitted at Nanavati Hospital as per advice of his family Physician with complaints of fever for five days and in the Discharge Card of the Hospital,it is mentioned that last temperature recorded was 106 F (as per patient).The temperature recorded in the hospital was reduced to 101 F. It is noted that all Investigations reports were normal including Dengue test, Widal test and he was diagnosed with Viral fever which was managed with oral medicines and Iv fluids during hospitalization period. Further the hospital has given a clarification that the reason for admission in the hospital was thathe had very high grade fever for five days "theombocytopenia" which means a condition in which the patient has a low blood platelet count.Thus the hospitalization was on the medical advice and was necessary,and therefore,Company's stand of denial of claim on the ground of Policy Clause 1, 2.15(OPD) and 4.4.11 (Diagnostic purpose) is not sustainable and the Company is directed to settle the above claim except Non-Payables subject to availability of sum insured.

AWARD

M/s The New India Assurance Co.Ltd. is directed to settle the above claim from the claimed amount of Rs.26341/- except Non-Payables subject to availability of sum insured towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 28th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Kiran J Mehta

VS

RESPONDENT : Oriental Insurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-050-2021-1668

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Kiran J Mehta, 302 E Square Sky Tower, ACC Cement Road, Near Mulund Checknaka Mulund West, Mumbai - 400080
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121700/48/2020/4264 Individual Mediclaim Policy 22.07.2019 to 21.07.2020 Rs.200000/-
3	Name of Insured Name of the policy holder	Mr Kiran J Mehta Mr Kiran J Mehta
4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	Quantum Dispute Cataract
7	Date of receipt of the complaint	
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.42295/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.10295/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	20.04.2021 at 02.30 PM
14	Representation at the hearing	
	a) For the complainant	Mr Kiran J Mehta
	b) For the insurer	Ms Pravin Paste, Assistant Manager
	omplaint how disposed	Award
16	Date of Award/Order	27.02.2021

Brief Facts of the Case :

The complainant insured under the above policy underwent Right Eye Cataract surgery on 18.03.2020 at Swaraashi Netralaya and lodged total claim of Rs.42295/-.The Company settled the claim for Rs.32000/- and deducted the balance amount of Rs.9900/- on the ground of Policy Clause Reasonable and Customary Charges which reads as **"services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services taking into account the nature of the illness/injury involved".** The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant

The complainant submitted during the hearing that he underwent Cataract surgery for his Right Eye at Swaraashi Netralaya in Thane and incurred total expense of Rs.42295/- which the Company could pay Rs.32000/- only while deducting the balance amount on the ground of Policy Clause Reasonability and the same was not acceptable to him. The complainant further submitted that there was no capping for the procedure under the policy and the hospital where he underwent treatment was an economical hospital as compared to other hospitals. He, therefore, requested for settlement of his balance amount.

Contentions of the Respondent:

The Forum asked the Respondent the basis for above deductions to which the Company submitted during the hearing that the insured patient underwent cataract surgery for his Right Eye at Swaraashi Netralaya and lodged total claim of Rs.42295/-.However, they settled the claim for Rs.32000/- in comparison with the charges of other hospitals located in the same area for the same surgery and deducted the balance amount on the ground of Reasonability. The Forum asked the Respondent whether the hospital where the insured underwent Cataract surgery was a network hospital to which the Company replied No.

Observations/Conclusion

The Forum observes in this case that the insured patient underwent Right Eye Cataract surgery in a non-network hospital and have lodged total amount of Rs.42295/- which the Company has settled for Rs.32000/- and deducted the balance amount on the ground of Reasonability

Policy Clause in comparison with the rates of other network hospitals located in the same geographical area for the same type of ailment, is not justifiable as the rates of network hospitals are bound to be cheaper in comparison with the rates of other non-network hospitals. It is noted that there is no capping under the above policy for cataract surgery.

Based on the above facts the Company is directed to settle the above claim for balance amount of Rs.9900/- except Non-Payables, if any. All other deductions are in order.

AWARD

M/s Oriental Insurance Co.Ltd. is directed to settle the above claim for balance amount of Rs.9900/- except Non-payables, if any, towards full and final settlement of the above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 27th April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI-MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Kamlesh C Tolia

V/S

RESPONDENT : The New India Assurance Co. Ltd.

COMPLAINT REF: No: MUM-H-049-2021-1690

AWARD No: IO/MUM /A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Kamlesh C Tolia, 1B-36 Ganjawala Apartments, Mandpeshwar Road, Borivali West, Mumbai - 400092
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	140300/34/19/95/00003595 New India Floater Mediclaim 28.06.2019 to 27.06,2020 Rs.500000/-
3	Name of Insured Name of the policy holder	Mr Kamlesh C Tolia Mr Kamlesh C Tolia
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	PPN Package rate
7	Date of receipt of the complaint	25.01.2021
8	Nature of complaint	Quantum dispute
9	Amount of claim	Rs.441380/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.158385/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	17.03.2021 at 02.00 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Kamlesh C Tolia
	b) For the insurer	Ms Josephine Lemos Administrative Officer and Dr Komal Shinde Mediassist TPA
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case :

The complainant insured under the above policy was admitted at S R Mehta Hospital from 10.12.2019 to 18.12.2019 for complaints of Dyspnoea on exertion, was diagnosed with severe Aortic Stenosis. Therefore, he underwent AVR (Aortic Valve Replacement). Total claim of Rs.467098/- was lodged which the Company settled for Rs.282995/- and deducted the balance amount as the GIPSA Package for Valve replacement was Rs.170000/- plus cost of Valve. The complainant has expressed in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that he was admitted in a network hospital where he underwent AVR. He stated that he had opted for cashless and the hospital filled in the PPN declaration form and he opted for first class. Total claim of Rs.467098/- was lodged which the Company settled for Rs.282995/- and deducted the balance amount on the ground of PPN Package rate. It was not acceptable to him and he requested for settlement of his balance amount.

Contentions of the Respondent :

The Respondent submitted during the hearing that they had raised a query with the hospital the reason for overcharging the patient to which the hospital has replied that GIPSA Package for AVR is Rs.170000/- plus cost of valve upto twin sharing in their hospital and for first class it was open billing, so the insured had requested for additional sanction. The package applied for first class by the hospital is Rs.351000/- .Therefore, the TPA deducted Rs.181000/- and paid Rs.171000/- as per GIPSA Package. The Forum asked the Respondent whether insured was eligible for first class to which the Respondent replied Yes.

Observations/Conclusion :

The Forum observes in this case that the insured patient underwent AVR in a network hospital and he had opted for PPN Package for first class for which he was eligible. However, the TPA had settled the claim for Rs.282995/- out of the claimed amount of Rs.467098/- as per twin sharing PPN Package. Thus there was a mis communication between the hospital and the patient and therefore, deduction of Rs.158385/- on the ground of PPN Package is not sustainable and the Company is directed to settle the balance amount except Non-Payables, if any, subject to availability of sum insured.

AWARD

M/s The New India Assurance Co. Ltd. is directed to settle the above claim for the balance amount except Non-Payables, if any, from the claimed amount of Rs.158385/- subject to availability of sum insured towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 25th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Dilip T Devani
VS
RESPONDENT : National Insurance Co.Ltd.
COMPLAINT REF: NO: MUM-H-048-2021-1689
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Dilip T Devani, 13-B Dahisar Apartment,

		Shivaji Road Corner, S V Road, Dahisar East, Mumbai - 400068
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	246006501810000572 National Mediclaim Policy 01.12.2018 to 30.11.2019 Rs.100000/-
3	Name of Insured Name of the policy holder	Mr Dilip T Devani Mr Dilip T Devani
4	Name of Insurer	National Insurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	Domiciliary treatment
7	Date of receipt of the complaint	06.01.2021
8	Nature of complaint	Claim not registered
9	Amount of claim	Rs.3200/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.3200/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	19.03.2021 at 02.15 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Dilip Devani
	b) For the insurer	Mr Vijay P Dighe Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case

The complainant has preferred a claim of Rs.3200/- (ECG, tests done) along with the reports were submitted to the TPA on 6th January,2020. There is no response from the TPA/Company for more than one year. Aggrieved, he approached this Forum for justice.

Contentions of the Complainant:

The complainant submitted during the hearing that he had taken ECG and other tests done along with Bill of Rs. 3200/-which were submitted to the TPA on 6th January,2020. However, till

date he has not received any response from the Company/TPA . Therefore, he requested the Forum for settlement of his bills.

Contentions of the Respondent:

The Forum asked the Respondent the reason for not giving any response to the insured when he had submitted the bills for his check up in January,2020 to which the Respondent replied that he had submitted the bills to the TPA and domiciliary claim is not payable under this policy .Therefore, the TPA has not registered this claim.

Observations/Conclusion

The Forum observes in this case that insured patient has submitted claim of Rs.3200/- towards ECG, other tests along with Reports and bills to the TPA. However, TPA has not registered the same as domiciliary claim is not payable under the above policy. However, the Company could have registered this claim under Medical check up when there are no claims for two years for the above insured, he is eligible for 1% of the sum insured plus Cumulative Bonus. Therefore, the Company is directed to settle the above claim under medical check up as per policy norms.

AWARD

M/s National Insurance Co.Ltd. is directed to settle the above claim under medical check up as per policy norms towards full and final settlement of above claim. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 25th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI-MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Ms Sarika R Shetty

V/S

RESPONDENT : Oriental Insurance Co. Ltd.

COMPLAINT REF: No: MUM-H-050-2021-1716

AWARD No: IO/MUM /A/GI/ /2021-22

1	Name & Address of the Complainant	Ms Sarika R Shetty, A2/41 Mahindra Gardens Tulip CHS, S V Road, Goregaon West, umbai - 400104
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121800/48/2019/13540 Happy Family Floater2015 11.03.2019 to 10.03.2020 Rs.500000/-
3	Name of Insured Name of the policy holder	Ms Sarika R Shetty Ms Sarika R Shetty

4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Reasonability
7	Date of receipt of the complaint	18.02.2021
8	Nature of complaint	Quantum dispute
9	Amount of claim	Rs.177920/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.81765/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	18.03.2021 at 02.00 Pm
14	Representation at the hearing	
	a) For the complainant	Ms Sarika R Shetty
	b) For the insurer	Ms Manisha R Koli Assistant Manager
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case :

The complainant, Ms Sarika R Shetty, 42 years old, insured under the above policy was admitted at Nanda Nursing Home from 03.11.2019 to 09.11.2019 where she underwent Hystrectomy. Total claim of Rs.179520/- was lodged and the Company settled the claim for Rs.96159/-while deducting the balance amount of Rs.81765/- on the ground of Policy Clause 3.41 Reasonable and Customary Charges which reads as **"means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved."** The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that she was admitted at Nanda Nursing Home with complaints of Abnormal Uterine and vaginal bleeding unspecified and she underwent Hystrectomy and lodged total claim of Rs.179520/-.The Company, however, deducted Rs.81765/- towards Surgeon's fee, Anesthesia, OT Charges on the ground of Reasonability Clause and 10% co-payment and the same was not acceptable to her. Therefore, she requested for settlement of her balance amount.

Contentions of the Company :

The Respondent submitted during the hearing that the insured patient was admitted in Nanda Nursing Home for Hystrectomy and lodged total claim amount of Rs.179520/-which they ha

settled for Rs.96159/- in comparison with the Package rates of hospitals like Criticare Hospital and deducted total amount of Rs.81765/- towards Reasonability Clause and 10% co-pay as per policy norms. The Forum asked the Respondent whether this hospital was a network hospital to which the Company replied in the negative.

Observations/Conclusion :

The Forum observes in this case that insured patient underwent Hystrectomy in Nanda Nursing Home which is a non network hospital and lodged total claim of Rs.179520/-. The Company, however, settled the claim for Rs.96159/- and deducted an amount of Rs.81765/- on the ground of Policy Clause Reasonable and Customary Charges.

The Forum notes that the above hospital is a non network hospital and the Respondent has compared the charges of this hospital with other network hospitals for the same type of procedure and accordingly have settled the claim which is not justifiable and the Company is

directed to settle the above claim for the balance amount except 10% co pay from the deducted amount of Rs.81765/-. All other deductions are in order.

AWARD

M/s Oriental Insurance Co. Ltd. is directed to settle the above claim for the balance amount except 10% co pay from the deducted amount of Rs.81765/- towards full and final settlement of above claim and inform the payment particulars to this Forum within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 25th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI-MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -MrAbhay M Shah

V/S

RESPONDENT : The New India Assurance Co. Ltd.

COMPLAINT REF: No: MUM-H-049-2021-1615

AWARD No: IO/MUM /A/GI/ /2021-22

1	Name & Address of the Complainant	MrAbhay M Shah, E/511 Kamla Nagar, 5th floor, M G Road, Kandivali West, Mumbai – 400 067
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	140600/34/18/27/00000769 New India Asha Kiran Policy 14.01.2019 to 13.01.2020 Rs.800000/-
3	Name of Insured Name of the policy holder	MrAbhay M Shah MrAbhay M Shah
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Reasonability

7	Date of receipt of the complaint	14.01.2021
8	Nature of complaint	Quantum dispute
9	Amount of claim	Rs.180000/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.100000/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	17.03.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	MrAbhay M Shah
	b) For the insurer	Ms Poonam Advani Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case :

MrAbhay M Shah, the insured under the above policy, was admitted to MIB Super Speciality Hospital(Mumbai) from 29/12/2019 to 31/12/2019 for surgery of 3 RD Ureteric Calculus. Claim was preferred for Rs.180000/-. On scrutiny of claim documents,it was observed that the charges of this hospital were on the higher side as compared to other hospitals located in the same jurisdiction like Nupur Nursing Home, Shree Krishna Hospital and Bhagat Nursing Home. The Company, therefore, reduced the admissible amount and settled the claim for Rs.72000/- and deducted the balance amount on the ground of Policy Clause 2.41 which reads as **"REASONABLE AND CUSTOMARY CHARGES means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved."** The complainant has expressed in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that he was admitted in a network hospital for surgery of kidney stone where cashless was rejected and ,therefore,he lodged the claim for reimbursement of Rs.180000/- . However,the Company could settle the claim for Rs.72000/- only while deducting an amount of Rs.83000/- towards Reasonability. It was not acceptable to the complainant as he had genuinely incurred those expenses.

Contentions of the Respondent :

The Respondent submitted during the hearing that the insured patient underwent surgery for kidney stone and lodged total claim of Rs.180000/-,out of which, they settled the claim for Rs.72000/- and deducted an amount of Rs.83000/- on the ground of Reasonability Policy Clause 2.41 whilecomparing the charges of other hospitals like Nupur Nursing Home, Shree Krishna Hospital and Bhagat Nursing Home.

The Forum asked the Respondent whether those hospitals were PPN Hospitals to which the Respondent replied in the affirmative. However, they had compared it with Open Tariff rates for the same type of surgery.

Observations/Conclusion :

The Forum observes in this case that the insured patient underwent kidney stone surgery in a network hospital and the cashless request was rejected and reimbursement claim of Rs.180000/- was lodged. The Company has settled the claim for Rs.72000/- and have deducted an amount of Rs.83000/- on the ground of Reasonability Policy Clause 2.41 in comparison with the three hospitals located in the same jurisdiction for the same type of surgery. However, the Respondent has not obtained any clarification from the hospital authorities the reason for rejecting cashless when it was a network hospital and overcharging the patient. Therefore,Company's stand of deduction of Rs.83000/- is not sustainable and the Company is directed to settle the above claim for the balance amount of Rs.83000/- except Non-Payables, if any. All other deductions are in order.

AWARD

M/s The New India Assurance Co. Ltd. is directed to settle the above claim for the balance amount of Rs.83000/- towards the unsettled amount of above claim and inform the payment particulars to this Forum within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI. They may recover the excess amount from the hospital if they deem fit.There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 24th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -Mr Vinod D Soni

VS

RESPONDENT : Star Health and Allied Insurance Co.Ltd

COMPLAINT REF: NO:MUM-H-044-2021-1747

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Vinod D Soni, C-404 Panchavati Apartments, S V Road, New Police Station, Dahisar East, Mumbai - 400068
2	Policy No: Type of Policy Sum Insured Duration of Policy/Period	P/171119/01/2021/002137/P/171127/01/2020/008388 Family Health Optima Insurance Policy Rs.500000/- 28.08.2019 to 27.08.2020
3	Name of Insured Name of the policy holder	Mr Vinod D Soni Mr Vinod D Soni
4	Name of Insurer	Star Health and Allied Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Covid quantum dispute
7	Date of receipt of the complaint	
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.318255/-

10	Date of Partial Settlement	
11	Amount of relief sought	Rs.127285/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	12.04.2021 at 2.15Pm
14	Representation at the hearing	
	a) For the complainant	Mr Vinod Soni
	b) For the insurer	Dr Arvind Thakker Manager claims
15	Complaint how disposed	AWARD
16	Date of Award/Order	24.04.2021

Brief facts of the Case :

Mr Vinod Soni insured under the above policy was admitted at Life Care Hospital from 07.07.2020 to 14.07.2020 for treatment of Covid 19. He lodged total claim of Rs.318255/- and the Company settled the claim for Rs.190970/- while deducting an amount of Rs.127285/- as per Maharashtra Government guidelines. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that he was admitted at Life Care Hospital for treatment of Covid 19 in July,2020 and had lodged claim of Rs.318255/- . The Company, however, deducted an amount of Rs.127285/- as per Maharashtra Government guidelines for Covid claims. He stated that the Hospital where he underwent treatment was a Private Hospital and the Private hospitals hardly followed guidelines of notification issued by the Government of Maharashtra and ultimately he had to incur the expenses genuinely. He pleaded to the Forum for settlement of his balance amount.

Contentions of the Respondent :

The Respondent submitted during the hearing that the insured patient was admitted in the hospital for treatment of Covid 19 and lodged total claim of Rs.318255/- ,out of which, they deducted an amount of Rs.127285/- detailed as under as per Government notification :

DESCRIPTION	**DEDUCTED AMOUNT RS.**
COVID TEST	9600
PPE KIT	41399
COVID CONSUMABLES	10000
INFUSION GLOVES MASKS	3000
REGISTRATION	500
RMO	3000
COVID MANAGEMENT	15000
BIOMEDICAL WASTAGE	16000
MEALS	2800
HOSPITAL DISCOUNT	**10255**
NON PAYABLES	29758

Observations :

The Forum observes in this case that the insured patient underwent treatment in a Private Hospital for Covid-19 and the total claim lodged was for Rs.318255/.The Company, none the less, made a deduction of Rs.127285/- as per Notification of the Government of Maharashtra with regard to Covid 19 claims and also deducted expenses incurred towards Non Payables. The complainant has submitted during the hearing that hospitals have not beencharging as per the Government's notification,being private entities.

The Forum is of the view that the insured patient has no choice but to pay these expenses and even the hospital authorities have been incurring additional expenses due to the current pandemic situation. Therefore the Company is directed to settle the above claim for the balance amount except Non medicals out of the balance claimed amount of Rs.127285/-.

AWARD

M/s Star Health and Allied Insurance Co.Ltd.is directed to settle the above claim for the balance amount except Non medicals out of the additional claimed amount of Rs.127285/- towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 24th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Vinod D Soni

VS

RESPONDENT : United India Insurance Co.Ltd

COMPLAINT REF: NO:MUM-H-051-2021-1746

AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Vinod D Soni, C-404 Panchavati Apartments, S V Road, New Police Station, Dahisar East, Mumbai - 400068
2	Policy No: Type of Policy Sum Insured Duration of Policy/Period	0203002819P111902752 Individual Health Insurance Rs.300000/- (Gold) 22.12.2019 to 21.12.2020
3	Name of Insured Name of the policy holder	Ms Meena Soni Ms Meena Soni
4	Name of Insurer	United India Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Covid quantum dispute
7	Date of receipt of the complaint	24.02.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.169381/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.69525/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	12.04.2021 at 2.15Pm
14	Representation at the hearing	
	a) For the complainant	SETTLED BEFORE HEARING
	b) For the insurer	SETTLED BEFORE HEARING
15	Complaint how disposed	AWARD
16	Date of Award/Order	24.04.2021

Ms Meena Soni, wife of the complainant insured under the above policy, was admitted at Karuna Hospital for treatment of Covid 19 from 01.07.2020 to 14.07.2020 and lodged total claim of Rs.169381/-.The Company, out of the lodged amount, settled the claim for Rs.99856/- and deducted major amount of Rs.69525/- as per Maharashtra Government guidelines.

Aggrieved, he approached this Forum requesting relief in the matter of settlement of the balance claim amount. Records were perused and a joint hearing of the parties to the dispute was scheduled on 12th April,2021 at 02.15 Pm. Meanwhile, the Company has informed the Forum before the hearing that they have now considered this claim for settlement for the balance amount except Non-Payables of Rs.4874/- from the claimed amount of Rs.69525/- and the complainant has also agreed for the same. In view of settlement of the claim by the Insurance Company and pursuant withdrawal of the complaint by the complainant, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this 24th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Ms Tarlika Sanghavi
VS
RESPONDENT : Star Health and Allied Insurance Co.Ltd.
COMPLAINT REF: NO:MUM-H- 044-2021-1917
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Ms Tarlika B Sanghavi, 102 Sanskruti Bhavan,

		K M Munishimarg, Near Bhavans College, Grant Road, Mumbai - 400007
2	Policy No: Type of Policy Sum Insured Duration of Policy/Period	P/171149/01/2020/001204 Star Comprehensive Insurance Policy 19.01.2019 to 18.01.2020
3	Name of Insured Name of the policy holder	Ms Tarlika B Sanghavi Ms Tarlika B Sanghavi
4	Name of Insurer	Star Health and Allied Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Non disclosure
7	Date of receipt of the complaint	19.03.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.607830/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.607830/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	22.04.2021 at 02.30 PM
14	Representation at the hearing	
	a) For the complainant	SETTLED BEFORE HEARING
	b) For the insurer	SETTLED BEFORE HEARING
15	Complaint how disposed	AWARD
16	Date of Award/Order	23.04.2021

The complainant aged 65 years old, insured under the above policy was admitted at HN Reliance Foundation Hospital on 24/10/2020 for the treatment of CA Breast and lodged three claims. On scrutiny of claim documents, it was observed that the bilateral mammography report showed an oval mass with minimal lobulation seen in the left breast as described possibly a fibroadenoma. Then the insured patient was on regular followup and consultation towards the left breast lump which was diagnosed as carcinoma breast. The present admission

and treatment of the insured patient is for non disclosed disease. Hence, the claims were repudiated on the ground of Non disclosure of material facts under Condition 6 of the Policy.

Aggrieved, he approached this Forum requesting relief in the matter of settlement of the claim. Records were perused and a joint hearing of the parties to the dispute was scheduled on 22.04.2021 at 02.30 Pm. Meanwhile, the Company has informed us before the hearing that their Review Committee has considered the three claims for settlement. In view of settlement of the claims by the Insurance Company and pursuant withdrawal of the complaint by the complainant, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this 23rd day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017) OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr Vishwanath T Kesharwani

VS

RESPONDENT : HDFC ERGO Health Insurance Co.Ltd.

COMPLAINT REF: NO:MUM-H-003-2021-1627

AWARD NO: IO/MUM/A/GI/ /2020-21

1	Name & Address of the Complainant	Mr Vishwanath T Kesharwani, Room No 103, 1st floor, D Wing, Sai Akruti CHS, Khumbdev Nagar, Sant Rohidas Marg, Dharavi, Mumbai - 400017
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	160900/11121/AA00729138 Optima Restore Insurance Policy 20.02.2020 to 21.02.2021
3	Name of the Insured Name of the Policy holder	Mr Vishwanath Tarachand Kesharwani Mr Vishwanath Tarachand Kesharwani
4	Name of Insurer	HDFC ERGO General Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Fraudulent
7	Date of receipt of the complaint	
8	Nature of complaint	Repudiation of claim and cancellation of Policy
9	Amount of claim	Rs.43000/-

10	Date of Partial Settlement	
11	Amount of relief sought	Rs.43000/-
12	Complaint registered under Insurance Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	09.03.2021 at 02.15 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Vishwanath T Kesharwani
	b) For the insurer	Mr Neeraj Shivangikar Assistant Vice President and Dr Danish
15	Complaint how disposed	Award
16	Date of Award/Order	22.04.2021

Brief Facts of the Case :

The complainant insured under the above policy was admitted at Aayush Hospital from 23.05.2020 to 27.05.2020 with presenting complaints of fever and was diagnosed with Acute Febrile Illness with Pneumonitis. On scrutiny of claim documents it was revealed that the said hospital is blacklisted by many of the insurers due to manipulation in records and the Company has investigated this case and various discrepancies were observed. Therefore the Company has repudiated the claim on the ground of misrepresentation of material facts and have also cancelled the policy as per Section VI (General conditions). The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant

The complainant submitted during the hearing that he and his wife both were taking treatment under Dr Manoj Jain before admission and they were advised to do tests and both were diagnosed with Typhoid and both of them were hospitalized at Aayush Hospital on 23.05.2020 and were discharged on 27.05.2020. The claim was lodged with M/s HDFC Ergo General Insurance Co.Ltd. and they have repudiated his claim on the ground of fraud and also cancelled

his policy. He submitted that the hospital authorities have accepted their mistake and have given a Certificate which reads as **"Mr Vishwanath Tarachand Kesharwani 54 years old had been hospitalized during period of 23.05.2020 to 27.05.2020. In the Discharge Card Acute Febrile Illness is written instead of Entric Fever the etiology of fever was multifactorial (Pneumonitis also been the cause of fever). Diagnosis written on IPD paper was mistakenly mentioned its being of his wife (Mrs Renu Kesharwani) who was hospitalized during same time. The correction on IPD paper has been done and forwarded to you."** The complainant stated that he has genuinely incurred the expense and he requested for settlement of his claim.

Contentions of the Respondent:

The Forum asked the Respondent the reason for repudiation of above claim to which the Respondent replied that insured patient was admitted in the hospital with complaints of fever and was detected with Typhoid one day prior to admission and in the Discharge Card the diagnosis was Acute Febrile Illness with Pneumonitis and all the vitals were normal. The Respondent stated that the said hospital is a blacklisted hospital and they appointed an Investigator to investigate and it was observed that TLC Report (Total Leucocyte Count) which is indicative test of any infection but such test came within normal limits and thus there was no infection in the body. The diagnosis was Acute Febrile Illness with LZ Pneumonitis whereas report of Typoid was positive but no treatment was given for Typhoid. Further No X ray chest report was submitted by the complainant in support of diagnosis LZ Pneumonitis. Throughout the hospitalization temperature of complainant was normal. If the temperature is within the normal limits, then diagnosis of AFI as mentioned in the Discharge Card is suspected. No significant findings in the blood reports and Covid 19 test is negative. In all the papers of ICP, handwriting of advising Doctor were changed. Based on the above investigation report, the claim was found to be misrepresented and hence repudiated and they have also cancelled the policy.

Observations/Conclusion

The Forum observes in this case that both the complainant and his wife were admitted in the same hospital during the same period with the same diagnosis Typhoid as per the contention of the complainant during hearing and his written submission. However for his admission, in the Discharge Card of the hospital the diagnosis mentioned was Acute Febrile Illness with Pneumonitis. Then the hospital has corrected the same vide their Certificate which states that

"**Diagnosis written on IPD paper was mistakenly mentioned its being of his wife (Mrs Renu Kesharwani) who was hospitalized during same time. In the Discharge Card Acute Febrile Illness is written instead of Entric Fever the etiology of fever was multifactorial (Pneumonitis also been the cause of fever).**"

The Forum notes that the Respondent has denied the claim on the ground of the Investigation report which showed discrepancies with regard to diagnosis, treatment given, all vitals were normal during hospitalization and the said hospital is a black listed hospital. However the Insurance Company has not obtained any clarification from the hospital authorities nor produced any documentary evidence to prove their stand point. It has to be noted that the insured patient was admitted in the hospital during the pandemic situation of Covid 19 when the beds were not available and the hospital authorities have also made necessary correction in their diagnosis as well as IPD papers.In the repudiation letter the Respondent has not specified as to what exact fraud has been done by the complainant. Therefore Company's stand of denial of above claim on the ground of fraud and subsequent cancellation of policy on the ground of misrepresentation of material facts is not justifiable and the Company is directed to settle the above claim for the admissible claim amount from the claimed amount of Rs.43000/- except Non Payables and also reinstate the policy with continuity benefits subject to collection of appropriate premium if any.

AWARD

M/s HDFC ERGO General Insurance Co.Ltd is directed to settle the above claim for the admissible claim amount from the claimed amount of Rs.43000/- except Non Payables and also reinstate the policy with continuity benefits subject to collection of appropriate premium if any towards full and final settlement of above claim. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :
a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 22nd day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Laxmichand Gianani
VS
RESPONDENT : United India Insurance Co.Ltd.
COMPLAINT REF: NO: MUM-H-051-2021-1616
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Laxmichand Gianani, 12 A Emera Da, 14th Road, Khar West, Mumbai - 400052
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0221002819P115967855 Individual Health Insurance Policy 14.03.2020 to 13.03.2021 Rs.725000/-
3	Name of Insured	Mr Laxmichand Gianani
	Name of Insured	Mr Laxmichand Gianani
4	Name of Insurer	United India Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Covid 19 Government notification
7	Date of receipt of the complaint	
8	Nature of complaint	Partial Repudiation of two claims
9	Amount of claim	Rs.
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.57413/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	10.03.2021 at 02.00 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Kumar Gianani
	b) For the insurer	Ms Vidisha Parab Administrative Officer
15	Complaint how disposed	Award

16	Date of Award/Order	21.04.2021

Brief Facts of the Case

Mr Laxmichand Gianani, insured under the above policy was admitted at S L Raheja Hospital from 23.09.2020 to 05.10.2020 for treatment of Covid 19. The claim lodged with the Company was settled while deducting an amount of Rs.57413/- on the ground of Public Health Department Circular for Covid 19 issued by the Government of Maharashtra. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant:

Mr Kumar Gianani, Son of the complainant, duly authorized appeared and deposed before the Honourable Ombudsman in the joint hearing held with the Company. He submitted that his father had been insured under the above policy ever since the year 1982 and now he is 79 years old and this was the first claim preferred under the above policy for treatment of Covid 19. He submitted that the Company had made major deduction of Rs.57413/- on the ground of Government notification and the same is not acceptable to him .Therefore,he requested for settlement of balance amount of claim.

Contentions of the Respondent:

The Forum asked the Respondent to submit bifurcation of the above deductions and the reason for the same to which the Respondent submitted that according to Public Health Department Circular No: CORONA2020/C.R.97/Arogya-5, the excess bills charged by the hospital were disallowed from the claim detailed as under :

DESCRIPTION	**AMOUNT DEDUCTED RS.**
TWIN SHARING	400
CONSULTATION CHARGES	16302
WARD CONSUMABLES	5914
PHARMACY CHARGES	10977
HAEMATOLOGY CHARGES	3801

PATHOLOGY CHARGES	5917
ECG	292
MISCELLANEOUS CHARGES	800
BIO MEDICAL WASTE	3900
FOOD CHARGES	9110
TOTAL DEDUCTED AMOUNT	**57413**

Observations/Conclusion:

The Forum notes in this case that the Company has settled the claim as per Government notification for Covid claims and have deducted an amount of Rs.57413/- detailed as above. However, the insured patient has no choice but to pay these expenses and even the hospital authorities are incurring additional expenses due to the current pandemic situation. Therefore, the Company is directed to settle the above claim for the balance amount of Rs.57413/- except Non-Payables under Consumables head and Miscellaneous charges, if any.

AWARD

M/s United India Insurance Co.Ltd. is directed to settle the above claim for the balance amount of Rs.57413/- except Non-Payables under Consumables head and Miscellaneous charges ,if any, towards full and final settlement of above claim subject to availability of sum insured and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 21st day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT
CASE OF COMPLAINANT - Mr Girish Mav
VS
RESPONDENT : Oriental Insurance Co.Ltd.
COMPLAINT REF: NO: MUM-H-050-2021-1839
AWARD NO: IO/MUM/A/GI/ /2021-22

1	Name & Address of the Complainant	Mr Girish Mav, D-204 Shiv Parvati Complex, Near Shiv Sena Office, NSS Road, Asalpha Village, Ghatkopar West, Mumbai - 400084
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	124200/48/2020/13034 Happy Family Floater 2015 25.02.2020 to 24.02.2021 Rs.600000/-
3	Name of Insured Name of the policy holder	Ms Priti Mav (Wife) Mr Girish Mav
4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Partial Repudiation	
6	Reason for repudiation	GIPSA PACKAGE
7	Date of receipt of the complaint	10.02.2021
8	Nature of complaint	Partial Repudiation of claim
9	Amount of claim	Rs.135000/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.43750/-
12	Complaint registered under Indian	13(b)

	Ombudsman Rules 2017	
13	Date of Hearing	15.04.2021 at 02.00 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Girish Mav
	b) For the insurer	Ms Geetha Vijayan Sr.Divisional Manager
15	Complaint how disposed	Award
16	Date of Award/Order	17.04.2021

Brief Facts of the Case :

Ms Priti Mav,wife of the complainant insured under the above policy, was admitted at Shree IVF Clinic from 13.10.2020 to 14.10.20 where she was diagnosed with Multiple Fibroid Uterus and underwent surgery for the same. Total claim of Rs.134740/- including pre-post hospitalization expenses was lodged. However, the Company deducted an amount of Rs.81250/- in comparison with other hospitals on the ground of GIPSA Package under Policy Clause 3.14 **"REASONABLE AND CUSTOMARY CHARGES means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved."** The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant

The complainant submitted during the hearing that his wife underwent surgery for multiple Fibroids at Shree IVF Clinic and had lodged total claim of Rs.134740/-.The Company, however, deducted a major amount of Rs.81250/- on the ground of GIPSA Package and the same is not acceptable to him as he has actually incurred these expenses. The Forum asked the complainant whether this hospital was a network hospital to which the complainant replied No.

Contentions of the Respondent:

The Respondent submitted during the hearing that the insured patient underwent surgery for multiple Fibroids and lodged a reimbursement claim of Rs.134740/- including pre-post hospitalization expenses. Out of the claimed amount, they have deducted an amount of

Rs.81250/- as per GIPSA Package of other hospitals like Hindu Sabha Hospital of Ghatkopar under Reasonable and Customary Policy Clause.

Observations/Conclusion

The Forum observes in this case that insured patient underwent treatment (surgery) for multiple fibroids in a non network hospital and has lodged total claim of Rs.134740/- out of which, the Company has deducted major amount of Rs.81250/- on the ground of Reasonability Policy Clause 3.14 in comparison with the GIPSA Package rates of other network hospitals for the same ailment.

The Forum notes that the rates of network hospitals are bound to be cheaper in comparison with the rates of non network hospitals. Therefore, the Forum is of the view that Company's stand of limiting the claim settlement to GIPSA Package rates is not justifiable and the Company is directed to settle the balance amount of Rs.81250/- except Non-payables, if any, subject to availability of sum insured.

AWARD

M/s Oriental Insurance.Ltd. is directed to settle the balance amount of Rs.81250/- except Non-payables, if any, subject to availability of sum insured towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 17th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI-MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)
OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Ms Shonali Datta
V/S
RESPONDENT : Oriental Insurance Co. Ltd.
COMPLAINT REF: No: MUM-H-050-2021-1613
AWARD No: IO/MUM /A/GI/ /2021-22

1	Name & Address of the Complainant	Ms Shonali Datta, 501 Sagar Sangeet, A B Nair Road, Juhu Vileparle West, Mumbai - 400049
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	131100/48/2020/6965 Individual Mediclaim Policy 18.10.2019 to 17.10.2020 Rs.200000/-
3	Name of Insured Name of the policy holder	Ms Shonali Datta Ms Shonali Datta
4	Name of Insurer	Oriental Insurance Co.Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Not a Government Hospital (Ayurvedic treatment)
7	Date of receipt of the complaint	14.01.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.198608/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.198608/-
12	Complaint registered under Indian Ombudsman Rules 2017	Yes 13(b)
13	Date of Hearing	23.02.2021 at 02.15 Pm

14	Representation at the hearing	
	a) For the complainant	Ms Shonali Datta
	b) For the insurer	Ms Neeta Dixit Assistant Manager
15	Complaint how disposed	Award
16	Date of Award/Order	17.04.2021

Brief Facts of the Case :

Mrs. Sonali Datta, insured under the above policy for almost 25 years, was treated at The Arya Vaidya Chikisalayam & Research Institute, Coimbatore from 01/08/2020 to 23/08/2020 for pain in nape of neck. Total claim of Rs.190608/- was lodged which the Company repudiated on the ground that the above hospital is a Private Hospital not a Government Hospital as per Policy Clause 1.2 note 1 which reads as **"The policy covers reasonable and customary charges in respect of Hospitalization and or Domiciliary Hospitalization for medically necessary treatment only for illness/diseases contracted or injury sustained by the Insured Person(s) during the policy period, upto the limit of Sum Insured (SI), as detailed below: Note: 1. In case of Ayurvedic 1 Homeopathic 1 Unani treatment, Hospitalization expenses are admissible only when the treatment is taken as an in-patient, in a Government Hospital or a hospital associated with a Medical College. 2. 2. Relaxation to 24 hours minimum duration for hospitalization as defined in 2.17, is allowed in i. Day care procedures 1 surgeries (Appendix I) where such treatment is taken by an insured person in a hospital 1 day care centre (but not the outpatient department of a hospital) ii. Or any other day care treatment as mentioned in clause 2.11 and for which prior approval from Company 1 TPA is obtained in writing."** The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

Contentions of the Complainant :

The complainant submitted during the hearing that she underwent treatment for Pain in Nape of Neck at The Arya Vaidya Chikitsalayam & Research Institute from 01.08.2020 to 23.08.2020 and had lodged total claim of Rs.190608/-.The Company, however, denied the claim on the ground that this hospital is not a Government Hospital which is not acceptable to her. Previously, claim for treatment of Cyst in the same hospital in the year 2018 was settled by the Company and even her mother's claim for similar treatment in the same hospital was settled by this Company. She submitted that the hospital has issued a Certificate which states that this is Government recognized hospital . Therefore, she pleaded for settlement of her claim.

Contentions of the Respondent :

The Respondent submitted during the hearing that during hospitalization, the insured patient underwent ayurvedic treatment for Pain in Nape of Neck at THE ARYA VAIDYA CHIKITSALAYAM & RESEARCH INSTITUTE which is a private hospital, not a government hospital nor is it a hospital associated with a Medical College. Hence, this claim is denied on the ground of Policy Clause 1.2 note 1. The Forum asked the Respondent as to how the earlier claims were paid to which the Respondent replied that they have confirmed with their earlier and present TPA also that they have not settled any claim of this type of the above insured.

Observations/Conclusion :

The Forum observes in this case that insured patient underwent Ayurvedic treatment for Pain in Nape of Neck at THE ARYA VAIDYA CHIKITSALAYAM & RESEARCH INSTITUTE, Coimbatore and lodged total claim of Rs.190608/-. It is noted that the insured patient had also underwent treatment for cyst in the year 2018 in the same hospital and as per the contention of the complainant during the hearing, the Company had paid that claim and also the claim of insured patient's mother for similar treatment in the same hospital. Contrary to this, the Respondent has stated during the hearing that their earlier as well as the present TPA have not settled any such type of claim of the above insured of this hospital.

The Forum notes that that the insured has submitted a clarification from the above hospital that this is a Government recognized hospital and therefore, Company's stand of denial of above claim on the ground that this is not a Government Hospital as per Policy Clause 1.2 note 1 is not sustainable and the Company is directed to settle the above claim for the admissible claim amount except Non Payables as per policy norms subject to availability of sum insured.

AWARD

M/s Oriental Insurance Co. Ltd. is directed to settle the above claim for the admissible claim amount except Non Payables as per policy norms subject to availability of sum insured from the claimed amount of Rs.190608/- towards full and final settlement of above claim and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 17th day of April,2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -Mr Pritesh K Mehtalia and MsArunaMehtalia

VS

RESPONDENT :The New India Assurance Co.Ltd.

COMPLAINT REF: NO: MUM-H-049-2021-1573 And 1589

AWARD NO: IO/MUM/A/GI/ /2020-21

1	Name & Address of the Complainant	Mr Pritesh K Mehtalia, 1604 Prerna Apartments, L T Road, OppManubhaiJewellers, Borivali West, Mumbai - 400091

2	Policy No: Type of Policy Duration of Policy/Period Sum Insured Policy No: Type of Policy Policy Period Sum Insured	131500/34/19/95/00009225 New India Mediclaim Policy 20.12.2019 to 19.12.2020 Rs.500000/- 13150034199500006718 New India Mediclaim Policy 17.08.2020 to 24.08.2020 Rs.500000/-
3	Name of Insured	Ms Pritesh K Mehtalia
	Name of Insured	MsArunaMehtalia (Mother)
4	Name of Insurer	The New India Assurance Co.Ltd.
5	Date of Repudiation	
6	Reason for Partial repudiation	Covid 19 Government notification
7	Date of receipt of the complaint	
8	Nature of complaint	Partial Repudiation of two claims
9	Amount of claim	Rs.343391/- and Rs.200000/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.174972/- and Rs.103912/-
12	Complaint registered under Indian Ombudsman Rules 2017	13(b)
13	Date of Hearing	09.03.2021 at 02.30 Pm
14	Representation at the hearing	
	a) For the complainant	Mr Pritesh Mehtalia
	b) For the insurer	Mr Raj Kumar Singh

15	Complaint how disposed	Award
16	Date of Award/Order	16.04.2021

Brief Facts of the Case :

The complainant and his mother insured under the above two policies both were diagnosed with Covid 19 positive. Mr Pritesh underwent treatment for the same at Gem Super Speciality Hospital from 09.08.2020 to 23.08.2020 andMsAruna, mother of the complainant, underwent treatment from 17.08.2020 to 24.08.2020 in the same hospital and lodged total claim of Rs.343391/- and Rs.214062/- respectively. The Company settled the claim for Rs.168419/- and Rs.110150/- while deducting the balance amount of Rs.174972/- and Rs.103912/- on the ground of Government notification. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Contentions of the complainant:

The complainant submitted during the hearing that he and his mother were insured under the above two policies and both were diagnosed with Covid 19 positive in August,2020. They were admitted in the same hospital .He had lodged total claim of Rs.343391/- and Rs.214062/- for treatment of both of them. However,the Company deducted major amount of almost 50% in both the claims on the ground of Government notification. The deduction was not acceptable to him as he had genuinely incurred those expenses. He pleaded for settlement of balance amount under both of the above claims.

Contentions of the Respondent:

The Forum asked the Respondent the reason for the above deductions to which the Respondent replied that they had processed the above claims as per Notification issued by the Government of Maharashtra to redress the grievances regarding the exorbitant amount of money charged by the Healthcare providers. The Respondent stated that the said notification

was applicable for all to avoid the exorbitant amount of money charged by the hospitals and the intention behind the said notification is clear that the Hospitals should not charge arbitrarily to any person whether he is insured under the policy or not. Accordingly,they have settled this claim.

Observations/Conclusion

The Forum notes in this case that both the complainant and his mother were admitted in a Private Hospital for treatment of Covid 19 positive.They were treated for the same in an isolated room.The complainant has lodged total claim of Rs. 343391/- and Rs.214062/- respectively.

The Forum notes that the Insurance Company has processed this claim as per Notification issued by the Government of Maharashtra for Covid-19 claims. The Forum observes that this notification has been passed by the Government with the good intention that Hospitals should not charge exorbitantly for treatment of Covid-19. However, this is not followed by the Hospitals (Private) and Nursing Home and in bargain,the customer is penalized for no reason.

Under the facts and circumstances of the above case, the Forum is of the view that Company's stand of deduction of amount of Rs.12782/- and Rs.120960/- in respect of Mr Pritesh Mehtalia's claim and deduction of Rs.600/- and Rs.77600/- towards Government notification, PPE Kit not payable in respect of MsArunaMehtalia's claim are not justifiable. Therefore, the Company is directed to settle the same subject to availability of sum insured. All other deductions are in order.

AWARD

M/s The New India Assurance Co.Ltd is directed to settle the above claim for the balance amount of Rs.133742/- in respect of Mr Pritesh and Rs.78200/- in respect of MsArunaMehtalia's claim towards full and final settlement of above two claims subject to

availability of sum insured under the above two respective policies. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award

within thirty days of the receipt of the award and intimate compliance of

the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on

the insurers.

Dated at Mumbai this 16th day of April,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

The Forum asked the Respondent the reason for repudiation of both the claims to which the Respondent replied that both the insured patients were treated with Oral medications and all the vitals being within normal limits and as per the Guideline issued by Ministry of Health and Family Welfare the need for hospitalization was not established nor it was justified and therefore the claim was repudiated by them.

Observations/Conclusion:

The Forum observes in this case that both the complainant and his wife were admitted in the hospital for 9 days for treatment of Covid 19 as advised by their Family doctor and BMC Officials. Thus the Company's stand of denial of both the claims on the ground that all the vitals were normal and there was no need for admission in the hospital is not justifiable and the Company is directed to settle both the claims for the admissible claim amount except non-medicals.

AWARD

M/s HDFC Ergo General Insurance Company Limited is directed to settle both the claims for the admissible claim amount except non-medicals towards full and final settlement of above claim. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

a) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 29th day of March,2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MRS SANGEETA B GHARGE
VS
RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1699
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mrs. Sangeeta B Gharge** **Mumbai**
2	Policy No:	P/171134/01/2020/012965

	Type of Policy Duration of Policy/Period Sum Insured	Star Comprehensive Insurance Policy 09.02.2020 to 08.02.2021 Rs.7,50,000/-
3	Name of Insured Name of the policyholder	Mrs Sangeeta B Gharge Mr Bhagyawan K Gharge
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	17.10.2020
6	Reason for repudiation	Bariatric Surgery payable only on a cashless basis subject to special conditions
7	Date of receipt of the complaint	16.02.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.3,84,774/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.3,84,774/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	28.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mrs. Sangeeta B Gharge
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case: Complainant was admitted to LOC Healthcare, Pune on 23.09.2020 for the diagnosis of Central Obesity with BMI 43 + Sleep Apnoea + Osteoarthritis + history of Covid 19 with increased breathlessness and underwent Diagnostic Laparoscopy, Grade II Nash + Lap Sleeve Gastroscopy with 4 ports and discharged on 27.09.2020. The complainant approached this Forum with a complaint against total repudiation by the Respondent, Star Health & Allied Insurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization on the ground that Bariatric surgery is payable only on a cashless basis subject to special conditions as per Section 6 of the policy terms and conditions.

Contentions of the Complainant: The Complainant submitted that she had preferred a reimbursement claim with the Respondent which was rejected by the insurer stating that as per policy terms, Bariatric Surgery is payable only on a cashless basis. However, Complainant

argued that she was in touch with her agent and informed about her surgery to the agent. The agent prior to eight days of her admission had called customer care and upon enquiring about the admissibility of Bariatric Surgery with the officials of the Company, informed the insured that she can claim for the same up to Rs.2,50,000/- under the subject policy. The Complainant further stated that within 24 hours of admission to the hospital as per criteria of the Company, had intimated the claim with the details of the hospital on which she also received verification call and confirmation message of intimation of claim on her mobile from the Company, the image of the same she produced as evidence. She contended that during these communications with the Company, the respondent never even once asked her to go to a network hospital for this surgery. Also produced her Agent, Ms. Vidya Shinde's email dated 27.09.20 to the Company stating that the condition of admission to the Network hospital for Bariatric Surgery has not been informed to her earlier and since the patient had now been already operated upon, she requested the Company to pay the claim on a reimbursement basis. Nonetheless, Complainant provided an email dated 01.10.2020 received from the customer care department of the Company to submit all the reimbursement claim documents through a Company's email ID, the arrangement made by them in view of Covid lockdown and the claim would be processed and payment would be released on receipt of originals by them. The Complainant added that she has been continuously covered with the Company since 2015 and she is claiming for the first time. The Complainant also stated that she tried for Hinduja Hospital but the cost of surgery was too expensive. In consultation with the agent, not aware of the policy condition to get operated in only Network hospital of the Company, she chose Non-Covid hospital with reasonable surgery cost. Based on the aforesaid facts, the Complainant not agreeing with the reason cited for repudiation of the claim requested the Forum for settlement of the subject claim.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured preferred a reimbursement claim for Bariatric Surgery underwent by the insured patient at LOC Healthcare LLP, Pune. The Respondent submitted that the claim has been lodged under Section 1 Hospitalisation of the Star Comprehensive Policy wherein obesity is not covered. However, under additional benefits Section 6- Bariatric surgery expenses incurred on hospitalization for bariatric surgery is payable subject to a maximum of Rs.2,50,000/-on cashless basis (inclusive of pre and post hospitalization expenses) subject to the following special conditions:

1. This benefit is subject to a waiting period of 36 months from the date of first commencement of this policy and continuous renewal thereof with the Company
2. The minimum age of the Insured at the time of surgery should be above 18 years
3. This benefit shall not apply where the surgery is performed for

a) Reversible endocrine or other disorders that can cause obesity

b) Current drug or alcohol abuse

c) Uncontrolled, severe psychiatric illness

d) Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery.

e) Bariatric surgery performed for Cosmetic reasons

4. The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval for cashless treatment from the Company.

5. To make a claim, the insured person should satisfy the following criteria as devised by NIH (National Institute of Health)

a) The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure, etc.)

b) Is unable to lose weight through traditional methods like diet and exercise.

The Respondent submitted that as per policy conditions the claim is not made on a cashless basis and also as per policy condition, Bariatric Surgery is payable subject to aforesaid special conditions, hence the subject claim has been rightly repudiated as per terms and conditions of the policy.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent has denied the claim on the ground that Bariatric Surgery is payable only on a cashless basis subject to special conditions as mentioned above on Section 6 the policy. Though the Forum is able to appreciate the concern of the complainant in this regard, it has also to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelled out in the policy and also approved by the Regulator. The Forum do not find any valid reason to intervene with the same and pass the following Order. At the same time it is observed that the complainant was not provided timely guidance in respect of the policy conditions by the Agent

and the Company officials as well. Respondent is directed to be vigilant and ensure that such kind of incidences are not repeated in future so as to avoid causing uncalled for hardships to their customers.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mrs. Sangeeta B Gharge against Star Health and Allied Insurance Company Limited does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN
OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT -MS MOKSHA VIPULSHAH

V/S

RESPONDENT:MANIPAL CIGNA HEALTH INSURANCE COMPANY LIMITED

COMPLAINT REF: NO:MUM-H-053-2021-1840

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Ms. Moksha Vipul Shah
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	PROHLN000357156 Pro-Health-Protect (Individual) 12.11.2019 to 11.11.2020 Rs.20,00,000/-
3	Name of Insured Name of the policyholder	Mrs.Rupal Shah Ms. Moksha Vipul Shah
4	Name of Insurer	Manipal Cigna Health Insurance Company Limited
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	10.02.2021
8	Nature of complaint	Short settlement of Covid claim
9	Amount of claim	Rs.1,82,276/-
10	Date of Partial Settlement	28.10.2020
11	Amount of relief sought	Rs.75,252/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	28.04.2020- 12.00
14	Representation at the hearing	
	a) For the complainant	Ms.Moksha Shah
	b) For the insurer	Jaswinder Singh Shekhawat ; Manager- Legal
15	Complaint how disposed	Award

16	Date of Award/Order	30.04.2021

Brief Facts of the Case: Complainant's mother, Mrs. Rupal Shah was admitted to Holy Family Hospital, Mumbai from 21.09.2020 to 27.09.2020 for the treatment of Covid-19. The complainant approached this Forum with a complaint against a short-settlement by the Respondent, Manipal Cigna Health Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: The Complainant submitted thatagainst the total hospitalization claim reported forRs.1,82,276/- including pre and post hospitalization expenses for treatment of COVID, she was reimbursed only Rs.1,07,025/- by theRespondent disallowing the balance amount of Rs.75,252/- citing the reason that the settlement was as per GR passed by Government of Maharashtra guidelines. The Complainant argued that they had intimated to the Company about her mother's admission to the hospital for the treatment of COVID vide email dated 21.09.2020, but the Company did not inform anything about these guidelines. However on receipt of claim payment, she approached the hospital raising query about rates higher rates charged, hospital confirmed that the charges are as per the government guidelines and the excess amount has not been charged by them. The Complainant added that she is covered with her mother since 11.11.2014 with Max Bupa and ported her policy with the Respondent on 09.11.2019. Further, she contended that though the insured patient is covered under the policy adequately for Sum Insured of Rs.20,00,000/-, the Respondent had allowed only 1,07,025/- cutting away 40% of the claim amount which is not acceptable. Hence requested the Forum for settlementof the genuine expenses incurred by her for the balance claim amount of Rs.75,252/-.

Contentions of the Respondent: The Respondent contended that the claim preferred by the Complainant for the treatment of COVID has been settled in accordance with the guidelines provided by GIC. The insured patient was admitted to Holy Family Hospital which has a capacity of 268 beds, falls under the category of Tertiary Hospital, and also NABH Accredited Hospital situated in Metropolitan city. Hence as per the guidelines, the assessment of hospitalization expenses amount has been calculated as per rates mentioned against NABH Accredited Hospitals in Metropolitan Cities under Category A which is Rs.10,000/- per day which includes supportive care and oxygen charges as part of the per diem cost. Accordingly, Respondent has allowed Rs.80,000/- (Rs.10,000 x 8 days), Rs.8,000/- for Di Dimer test, X-Ray, CBC, Blood Sugar Level, CT Scan, ECG, and further Rs.19,025/- allowed for higher antibiotics. Thus totaling to Rs.1,07,025/- has been allowed and deducted Rs.75,752/- as per the guidelines issued by the Government and submitted a copy of GIC guidelines (NitiAyog) dated 10.06.2020 to the Forum.

Forum's Observations/Conclusion: After hearing the depositions of both the parties, the Forumobserved that while settlement of the subject claim, the expenses of the Isolation ward was restricted to Rs.10,000/- per day including medication and investigation charges and the excess amount has been disallowed by the Respondent as per the Package approvedby the Government for treatment of Covid-19 patients. The Respondent in the subject claim, if the hospital has overcharged the patient, they should havesoughtclarificationforviolationofGovernmentguidelinesfromthehospitalinsteadof penalizing the patient by deducting the amount from the expenses incurred by them. Meanwhile, it is observed that Complainant had approached the hospital for clarification and it was confirmed by the hospital that the rates charged by the hospital are in line with the guidelines of the Government.

It is to be noted that since Covid-19 is a pandemic disease with no established protocols, various guidelines have been issued by the authorities to standardize the treatment costs to avoid any hardship to customers. However, in the instant case, it is observed that the Complainant is sufficiently covered under the subject policy for Sum Insured of Rs.20,00,000/. Therefore it is not justified to reduce the claim amount based on government guidelines that were genuinely incurred and have been paid by the Complainant as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed a further amount of Rs.72,767/-(Rs.75,252/- less Rs.2,485 /-) excluding non-medicals of Rs.1,225/- towards syringe, mask, betadine, etc., Rs.30/- file charges, Rs.230/- medical record charges, Rs.1,000/- excess Ambulance charges which are non-payables as per policy terms and conditions. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case,Manipal Cigna Health Insurance Company Limited is directed to pay a further amount of Rs.72,767/- for the hospitalization of Ms.Rupal Shah from 21.09.2020 to 27.09.2020 towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT – MR VIPUL B SHAH

V/S

RESPONDENT: HDFC ERGO GENERAL INSURANCE COMPANY LIMITED

COMPLAINT REF: NO:MUM-H-018-2021-1795

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Vipul B Shah**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	160900/11121/AA01206352-01 Optima Restore Floater Policy 30.09.2020 to 29.09.2021 Rs.10,00,000/- (Base Sum Insured)

3	Name of Insured Name of the policy holder	Mrs. Preeti Shah Mr. Vipul Shah
4	Name of Insurer	HDFC ERGO General Insurance Co.Ltd.
5	Date of Repudiation	07.01.2021
6	Reason for repudiation	Non Disclosure of facts
7	Date of receipt of the complaint	08.02.2021
8	Nature of complaint	Repudiation
9	Amount of claim	Rs.2,10,970/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.2,10,970/- + Interest
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	23.04.2021 - 12.00
14	Representation at the hearing	
	a) For the complainant	Mr. Vipul Shah
	b) For the insurer	Mr. NeerajShivangikar, Asst Vice President, Legal Claims
15	Complaint how disposed	Award
16	Date of Award/Order	30/4/2021

Brief Facts of the Case: Complainant's spouse, Mrs. Preeti Shah was admitted to four different hospitals from 09.10.2020 to 14.10.2020 and underwent Coronary Angiography. The complainant approached this Forum with a complaint against denial and cancellation of the policy by the Respondent, HDFC Ergo General Insurance Company Limited of a claim lodged under the policy in respect of the said hospitalisation on the ground of Non-disclosure of

history of DM, HTN, Rheumatoid Arthritis, and Hypothyroidism before the inception of the policy.

Contentions of the Complainant: Complainant submitted that his wife was suffering from a cold and cough for 8 to 9 days. Initially, she was treated under their family doctor, however, she did recover and had breathlessness too, hence treated in P D Hinduja Hospital, K J Somaiya and subsequently admitted to Bombay Hospital for the severe shortage of breath and was given oxygen support and upon investigation, treating doctor advised her to undergo CAG. The Complainant admitted her to Smt Sushilaben R Mehta & Sir KikabhaiPremchand Cardiac Institute from 12.10.2020 to 14.10.2020 where she underwent Coronary Angiography. The claim for these hospitalizations reported with the Respondent was denied by them on the ground of Non-disclosure of a medical history of insured as k/c/o Diabetes, Hypertension for 5 years, Rheumatoid Arthritis 3 to 4 years and Thyroid disorder for 15 years at the time of inception of the policy that is 30.09.2019 and also canceled the subject policy. The Complainant pointed out that in the discharge summary dated 09.10.2020 of K J Somaiya wherein it mentions patient k/c/o DM on medication since 6 to 7 months and Hypothyroidism since 6 months. Also referred to the S R Mehta Cardiac Institute Discharge Summary showing Hypertension and Hypothyroidism as a newly diagnosed ailment. The Complainant also produced a doctor certificate dated 10.11.2020 certifying that the insured patient was under medication for Rheumatoid Arthritis since 15.06.2020. Thus the complainant contended that all the aforesaid ailments of the patient were diagnosed in 2020 which was after the inception of the policy with the Respondent and stated that he has not hidden any facts from the insurer and had disclosed about his eye treatment in the proposal form but his wife was completely healthy and this claim is the first claim lodged for her. He added that his policy was in force since 1999 with other insurers and ported to HDFC Ergo General Insurance Co Ltd in October 2019 expecting better service from them. Based on the facts, not agreeing with the reason cited by the Company for repudiation of the claim, the complainant requested the Forum reimbursement of his claim and to reinstate his policy with all the continuity benefits and also to impose interest on the delayed claim settlement.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured patient took treatment from P D Hinduja Hospital, K J Somaiya Hospital, Bombay Hospital, and Sushilaben R Mehta Cardiac Institute for Pneumonia and Bilateral Pleural Effusion, and also mentioned that k/c/o DM, Hypertension and Thalassemia minor and she also took treatment for Dilated Cardiomyopathy. On scrutiny of the claim documents, it was observed from the history sheet of Bombay Hospital that patient is a k/c/o DM for 15 to 20 years,

Hypertension, Hypothyroidism, Thyroid, and Thalassemia diagnosed two years back and Rheumatoid Arthritis since 3 to 4 years. The Respondent stated that the history of the ailments of the insured patient was not disclosed in the proposal form by the Complainant and hence the claim lodged for the said hospitalizations was denied on the ground of Non-disclosure of material facts as per condition no.6 of policy terms and conditions. Also, the disclosure of ailments before the inception of the policy that is 30.09.2019 is important in terms of underwriting perspective, hence the Respondent canceled the policy from inception as per policy terms and conditions.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent repudiated the claim based on Non-disclosure of material facts and produced two pieces of evidence from history sheets of Bombay Hospital for the same. However it is observed from the Evidence sheet 1 of the Bombay hospital which mentions insured patient having **DM for 15 – 20 yrs,** Hypothyroidism since 20 years, and Evidence sheet 2 of Bombay Hospital mentions patient having a history of **DM, HTN since 5 years**, and Thyroid 15 to 20 yrs and RA 3 to 4 yrs. However, it is observed that both the pieces of evidence produced are from the same hospital but the duration of ailments mentioned are not matching. Hence such evidence cannot be accepted. At the same time, Complainant has produced the evidence for DM detected 6 to 7 months back, Rheumatic Arthritis since 15.06.2020, and the recent diagnosis of Hypothyroidism and HTN in discharge summary of the hospitals were found. Further, it was observed that the policy is ported from another insurer after continuous coverage of twenty years.The complainant has ported the policy with the Respondent with effect from 30.09.2019. Since the Respondent was not aware of the policy being ported, Forum asked to confirm the same which Respondent agreed later through email. Meanwhile, the Complainant to prove the portability submitted the insured's earlier policy copies with United India along with a copy of the portability form. The Complainant also produced a Diabetes Report dated 11.11.2019 of the insured patient to prove the insured patient was not suffering from DM in 2019. Since the present policy claim has been lodged on the ported policy with continuous coverage of more than twenty years and as per the medical documents all the ailment quoted for Non-disclosure found tohave been detected after 30.09.2019 that is after the inception of the policy, denial of the subject claim and cancellation of the policy on the ground of Non-disclosure of history of ailments DM, HTN, Hypothyroidism, etc cannot be sustained. The decision of the Respondent is therefore intervened by the following Order:

AWARD

Under the facts and circumstances of the case, the Respondent is directed to settle the claim for admissible amount less non-medicals if any together with interest as per IRDAI Regulations from the date of repudiation of claim till actual payment and also to reinstate the policy with continuity benefit in favour of the Complainant, Mr. Vipul B Shah within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

Dated: This 2nd day of May 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR BISWAJIT GUPTA

VS

RESPONDENT: THE NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-048-2021-1791

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Mr. Biswajit Gupta
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	260502501910003454 National Mediclaim Policy 11.01.2020 to 10.01.2021 Rs.2,00,000/-+C.B. Rs.1,00,000/-
3	Name of Insured Name of the policyholder	Mr. Biswajit Gupta
4	Name of Insurer	National Insurance Co. Ltd.
5	Date of Repudiation	--
6	Reason for repudiation	--

7	Date of receipt of the complaint	08.02.2021
8	Nature of complaint	Reduction of Cumulative Bonus and increase in premium on Renewal
9	Amount of claim	--
10	Date of Partial Settlement	--
11	Amount of relief sought	Restoring of Rs.2 lakhs C.B.
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (f)
13	Date of Hearing	23.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Biswajit Gupta
	b) For the insurer	Mrs Rohini Agavane, Sr Branch Manager
15	Complaint how disposed	Award
16	Date of Award/Order	02.05.2021

Brief Facts of the Case: The Complainant, Mr. Biswajit Gupta was covered under Policy no.2605025018100004882 for period 11.01.2019 to 10.01.2020 for a sum insured of Rs.4,00,000/- + C.B. Rs.2,00,000/-. At the time of renewal of the subject policy, on his request, the renewed policy was issued with a reduction of Sum Insured to Rs.2,00,000/-. However,the Complainant approached the forum against the Insurer, National Insurance Company Limited for reducing his Cumulative Bonus to Rs.1,00,000/- under renewed policy instead of Rs.2,00,000/- earned by him on his previous policy sum insured due to nil claim reported till the time of renewal of the policy.

Contentions of the Complainant: The complainant appeared and deposed before the Forum. He submitted that he is covered under National Mediclaim Policy since 2002 continuously for a Sum Insured of Rs.4 lakhs. Due to claim-free years, he had earned 50% of C.B. under the policy

issued for the period from 11.01.2019 to 10.01.2020 and there was also no claim in the policy period 2019-20. At the time of renewal of policy on 10.01.2020, he opted to reduce his sum insured from 4 lakhs to 2 lakhs, and to his surprise, he received the renewed policy no.2605025019100003454 issued for the period 11.01.2020 to 10.01.2021 with a reduced Sum Insured of Rs.2 lakhs as required but Company also reduced the Cumulative Bonus from Rs.2,00,000/- to Rs.1,00,000/- on the ground that maximum accumulation of CB is 50% of the Basic Sum Insured of the renewed policy. The Complainant argued that if he would have increased the sum insured to 6 lakhs, Company would not have granted 3 lakhs CB. He added that as per policy condition 2.4.1, the maximum CB will be 50% of the sum insured and CB will be reduced by 5% of the Sum Insured in case of a claim. He contended that CB is a benefit given to the insured and this amount acts as a supplement to the Policy Sum Insured hence this benefit cannot be taken away from the insured. Further, CB is related to claim free year hence is earned from the previous policy period and sum insured. The Complainant also stated that CB can be reduced only if the policy is renewed with a break or there is a claim. Given the same, Complainant was not ready to accept the reduction of CB under the renewed policy. He also raised a complaint against an unjustified 48% increase in renewal premium for policy period 2021-22 that is the premium amount was Rs.5,738/- in 1920-21 increased to Rs.8,490/- for 2021-22. Aggrieved, he approached this Forum requesting to direct the company to pass endorsement restoring the CB of Rs.2 lakhs for the entire policy period 11.01.2020 to 10.01.2021.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Insured had Sum Insured of Rs.4,00,000/- in his earlier policy and Rs.2,00,000/- as CB i.e. maximum permissible limit of 50% of Sum Insured as per policy terms and conditions. However, the insured choose to opt for a reduction in sum insured from Rs.4,00,000/- to Rs.2,00,000/- and hence the renewed policy no.260502501910003454 was issued to him with a Cumulative Bonus of Rs.1,00,000/-(50% of Sum Insured Rs.2,00,000/-) which is the maximum permissible limit as per the policy terms and conditions.

Forum's Observations/Conclusion: On perusal of the documents produced on record and submissions made by both the parties, the forum verified the terms of policy 2.4.1 which states that *"Sum Insured (excluding CB) will be increased by 5% in respect of each claim-free policy period (no claims are reported), provided the policy is continuously renewed with the Company without a break subject to a maximum of 50% of the sum insured (excluding CB) under* ***the current policy****."* As the policy wording specifically restricts CB amount to 50% of current policy, in the instant case, the revision made by the Respondent was found to be in order. Forum also verified with the Insurer as to whether CB is mentioned as a percentage or in terms of amount on the policy copy. The Respondent replied that Cumulative Bonus is shown on the policy in amount based on eligible percentage. As regards the contention of the insured for the increase in sum insured, it is to be noted that in case of increase in SI also, the policy would show the CB in amount as per the insured's entitlement and the CB amount shown on the policy would increase by 5% with each claim-free year without a break until it reaches 50% of sum insured of the current policy. Further Complainant's subsequent complaint raised for the hike in premium, Respondent was asked to provide the reason for the increase in renewal premium of 2021-22. Accordingly Respondent through email submitted that the National Mediclaim Policy revised rate chart was applicable from 01.10.2020 which was revised after 6 years and 3 months and the revised policy is listed under the heading **"Health Products approved during the financial year 2020-21"** by IRDA at **serial no. 251** and also provided the link on IRDA's website*https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo4220&mid=27.3.8*. Also provided the premium charged to the insured both old and revised premium:-

Particular	**For year 2020-21** (Fig in INR)	**For year 2021-22** (Fig in INR)
Basic Premium before TPA charges	5,413	10,011
Add ::6% TPA fees	325	601
Premium with 6% TPA fees	5,738	10,612
Minus Discount :: 10% for Direct Business	0	2,122

and 10% on account of pandemic		
Premium after discount	5,738	8,490
GST @ 18%	1,032	1,528
Gross Premium	**6,770**	**10,018**

Considering all the facts the decision of the respondent is in order and the Forum does not find any valid reason to intervene with the decision of the Company.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Biswajit Gupta against National Insurance Company Limited does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 2nd May 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR PANKIT M SHAH

VS

RESPONDENT: THE ORIENTAL INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-050-2021-1778

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Pankit M Shah** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121700/48/2020/12248 Happy Family Floater 2015 (Gold Plan) 01.03.2020 to 28.02.2021 Rs.10,00,000/-
3	Name of Insured Name of the policyholder	Mr. Mahesh T Shah Mr. Pankit M Shah
4	Name of Insurer	Oriental Insurance Co. Ltd.
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	02.03.2021
8	Nature of complaint	Short settlement
9	Amount of claim	Rs.2,19,975/-
10	Date of Partial Settlement	11.11.2020
11	Amount of relief sought	Rs.81,203/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	26.04.2021 - 11.45 am
14	Representation at the hearing	

	a) For the complainant	Mr.Pankit Shah
	b) For the insurer	Mr.PravinPasthe, Asst Manager
15	Complaint how disposed	Award
16	Date of Award/Order	02.05.2021

Brief Facts of the Case: Complainant's father, Mr. Mahesh T Shah was admitted to Ashirwad Critical Care Unit and Multispeciality Hospital from 02.10.2020 to 10.10.2020 for the treatment of Covid 19. The complainant approached this Forum with a complaint against a short-settlement by the Respondent The Oriental Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: The Complainant submitted thatagainst the total claim reported for Rs.2,19,975/- (Hospitalisation – Rs.2,02,447/- + Pre-Hospitalisation – Rs.14,148/- and Post Hospitalisation Expenses – Rs.3,380/-) for the treatment of COVID, he was reimbursed only Rs.1,38,772/- by the Respondent disallowing the balance amount of Rs.81,203/- citing the reason that the settlement was as per GR passed by Government of Maharashtra wherein hospital cannot charge Bed charges more than Rs.4,000/- per day for COVID 19 patients. The Complainant argued that the Company never gave any information about the same. If known to them they would have availed the bed as per the restricted limit. The Complainant added that his father is covered under the policy adequately for Sum Insured of Rs.10,00,000/- and the Respondent had disallowed all the charges which were necessary for the treatment and hence is not at all acceptable to him. Hence requested the Forum for settlement of the balance claim amount of Rs.81,203/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the reimbursement claim preferred by the insured for the treatment of COVID was settled for Rs.1,45,772/- (Rs.1,38,772/- + Rs.7,000/- Hospital Cash Benefit) based on the Notification dated 21.05.2020 of the Public Health Department of Maharashtra State. The deductions from the claim amount were towards Room Rent of Rs.7,000/- (Rs.4,000/- x 8 days – Rs.32,000/- allowed), disallowed Rs.27,000/- Doctor's fees as the same is included in the Room Rent, Rs.7,000/- deducted was towards investigation charges of Rs.6,850/- included in Room charges and Rs.150/- non-payables, Deducted Rs.6,000 for Oxygen charges included in Room Rent, Rs.6,700/- disallowed for PPE kits (allowed Rs.600/- per day as per guidelines) and out of balance deduction of Rs.27,503/- deducted Rs.20,800/- towards Kits, non-medicals of Rs.3,303/-, MRD charges of Rs.1,000/- and Rs.2,400/- for BioMedical Waste charges as per clause 4.17 of policy terms and conditions.

Forum's Observations/Conclusion: After hearing the depositions of both the parties, the Forum observed that Room Rent has been allowed only Rs.4,000/- per day, and the deductions from the claim amount were towards Medication charges and Investigation charges stating that these were part of Room charges as per the Package approved by the Government for treatment of Covid-19 patients. However, in the instant case, it is noted that the hospital has charged for these separately. In such an event, the Respondent should have sought clarification for violation of Government guidelines from the hospital instead of penalizing the patient for the same. It is to be noted that since Covid-19 is a pandemic disease with no established protocols, various guidelines have been issued by the authorities to standardize the treatment costs to avoid any hardship to customers. However, in the instant case, it is observed that the Complainant is sufficiently covered under the subject policy for Sum Insured of Rs.10,00,000/-. Hence it is not justified to reduce the claim amount based on government guidelines that were genuinely incurred and have been paid by the Complainant as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed a further amount of Rs.76,750/- (Rs.7,000/- Room Rent+ Rs.27,000/- Doctor fees + Rs.12,700 Oxygen charges and PPE Kit + Rs.6,850 Investigation charges+ Rs.20,800 kit + Rs.2400/- BMW charges not excluded in the expenses list of policy) The other excluded expenses made towards Nonmedicals-Rs.3,303/-, Rs.1,000/- MRD charges and Visit charges-Rs.150/- are found in order. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co. Ltd. is directed to pay a further amount of Rs.76,750/- under claim no.55622021335379 in favour of the Complainant, Mr. Pankit M Shah towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 02nd day of May 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT – MS MARILYN SALDHANA
V/S
RESPONDENT: HDFC ERGO GENERAL INSURANCE COMPANY LIMITED

COMPLAINT REF: NO:MUM-H-018-2021-1723

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Ms. Marilyn Saldhana**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	2828 1008 0813 5200 000 My: Health Suraksha Policy 20.07.2020 to 19.07.2021 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Ms. Marilyn Saldhana
4	Name of Insurer	HDFC ERGO General Insurance Co.Ltd.
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	29.01.2021
8	Nature of complaint	Short Settlement of claim
9	Amount of claim	Rs.1,28,927/-
10	Date of Partial Settlement	Rs.45,987/- on 07.12.2020 Rs.27,675/- on 19.01.2020
11	Amount of relief sought	Rs.55,265/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	22.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Ms. Marilyn Saldhana
	b) For the insurer	Dr. Ravi Upadhayay, Manager-Health Claims
15	Complaint how disposed	Award
16	Date of Award/Order	01.05.2021

Brief Facts of the Case: Complainant, Ms. Marilyn Saldhana underwent Cataract surgery in the Left Eye on 09.11.2020 at The Vission Eye Center, Mumbai. The complainant approached this Forum with a complaint against a short-settlement by the Respondent HDFC Ergo General Insurance Company Limited of a claim lodged under the policy.

Contentions of the Complainant: Complainant submitted that the claim preferred for her left eye cataract surgery was partially settled by the Insurer for Rs.45,987/- as against the total claim of Rs.1,28,927/-. The Complainant argued that her insurance agent informed her before

the surgery that mono lens surgery would cover the entire amount of the surgery. However, at the time of settlement, the Company denied the full amount and settled the claim after deduction of a substantial amount. She added that she is continuously covered with the Insurer since 2009 and the present claim is the first claim reported by her. In view of the same, not accepting the settlement made by the Respondent, requested the Forum for settlement of balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the claim lodged by the Complainant for Rs.1,28,662/- was paid in two installments for the total amount of Rs.73,662/-. The balance deduction of Rs.55,000/- was made as the expenses are consumable as mentioned in the treating doctor's certificate wherein the doctor had certified that the patient interface is a consumable use for a Laser procedure and has fixed charges, hence breakup is not available for Rs.55,000/-. Given the same, Respondent, based on the doctor's letter considering the charges as consumables denied the payment of Rs.55,000/- as per policy terms and conditions.

Forum's Observations/Conclusion: On the analysis of the documents produced on record, it is observed that the claim lodged by the Complainant was settled barring Rs.55,000/- which was not paid by the Respondent treating the same as consumables as per doctor's certificate. However, it is to be noted that Rs.55,000/- is charged for Laser machine charges along with disposable patient interface. As the charges are fixed for both, consumable charges were separately not available, as certified by the treating doctor. The Forum asked the Complainant to provide the break up from her doctor to enable Insurer to make the payment excluding consumable charges which is not payable as per policy terms and conditions. The Complainant in reply provided a letter dated 28.04.2021 from the doctor certifying that the insured patient was diagnosed with dense posterior polar cataract in both eyes. Hence, she was strongly recommended Femtosecond Laser for safety and to reduce the chances and risk and complications. From the foregoing, it is observed that a laser machine was medically required for the surgery as certified by the doctor but due to the breakup of unpayable consumable charges not available, deduction of Rs.55,000/- out of total claim amount of Rs.1,28,927/- is not justified. Hence the Forum is of the view that it would be in the interest of justice to allow a further amount of Rs.38,500/- with a view to strike a reasonable balance and resolve the dispute in the matter. The decision of the Respondent is intervened by the following order:

AWARD

Under the facts and circumstances of the case, HDFC ERGO General Insurance Company Limited is directed to pay a further amount of Rs.38,500/- (CCN RR-HS20-12160707) in favour of the complainant, Ms. Marilyn Saldhana, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 1st day of May, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN
OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR PREMCHAND R YADAV

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1787

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Premchand R Yadav** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11190034199500003906 New India Mediclaim Policy 14.12.2019 to 13.12.2020 Rs.3,00,000/-
3	Name of Insured Name of the policyholder	Mr. Jayesh P Yadav Mr. Jayesh P Yadav
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	02.02.2021
8	Nature of complaint	Short Settlement of claim
9	Amount of claim	Rs.3,09,351/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.1,41,972/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)

13	Date of Hearing	20.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Premchand Yadav
	b) For the insurer	Ms Sayali Bahadkar, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case: Complainant's son, Mr. Jayesh P Yadav was admitted to Amardeep Nursing Home on 27.08.2020 for displaced comminuted 3 part fracture of upper end of right humerus surgery and discharged on 03.09.2020. The complainant approached this Forum with a complaint against short-settlement by the Respondent, The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant submitted that his son, Dr. Jayesh Yadav, M.D. third year resident of Santosh Medical Hospital, Ghaziabad met with an accident in Ghaziabad on 13.08.2020. He was admitted to Yashoda Hospital in Ghaziabad and subsequently brought to Mumbai for surgery as advised by the doctor due to serious injuries on the hand, stomach, knee, face, and a huge fracture on the right shoulder. After the surgery, they lodged the claim with the Insurer for Rs.3,09,351/- against which TPA allowed only Rs.1,67,379/- thereby deducting a huge amount of Rs.1,41,972/-. He submitted that Insurer had deducted Room Rent, medicines supplied by the hospital, OT charges, and also Rs.31,685/- towards necessary expenses incurred for C arm, dressing charges, etc and Rs.81,500/- of Surgeon charges. The Complainant stated that out of the Surgeon charges of Rs.1,25,000/-, Company has deducted Rs.81,500/- on the ground of reasonable charges. He argued that charges of surgeons are based on their skill, expertise, and complication in the surgery hence, this deduction was not acceptable to him. As regards C arm deduction of Rs.16,000/-, he contended that no surgeon would be able to conduct any operation without C arm for Orthopaedic Operation. Further after the operation, at least three dressing is required for inspecting the healing process which had also been disallowed by the Company. The medicine replacement of Rs.10,900/- was disallowed for which he submitted that either the medicines brought before or replaced it subsequently it didn't matter, the hospital had charged the actual expenses and he had paid for it. The Complainant also added that his son is continuously covered under the policy since 14.12.2001 and due to a major accident, this is the first time he has lodged the claim with the Insurer. In view of the facts, not agreeing with the deductions made by the Company for the

genuine expenses incurred by him, the Complainant requested the Forum for settlement of balance claim amount of Rs.1,41,972/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that Insured had reported a claim for Rs.3,09,351/- for his son's hospitalization. The claim was settled for Rs.1,67,379/- with a deduction of Rs.1,41,972/-. Deduction Details were as under:-

1. Excess Room rent Charges (Nursing Charges are inclusive of room rent charges) – Rs.28,000/- charged for 8 days (Rs.3,500/- per day). Insured is eligible for Rs.3,000/- per day hence deducted Rs.4,000/- (excess rate of Rs.500 x 8) and Incremental proportionate deduction of Rs.8,916/-, Rs.32/-, Rs.1,285/- and Rs.7,140/- towards Surgeon charges, investigations, OT, etc as per policy terms and conditions.
2. Deduction of Rs.81,500/- towards Surgeon Charges as per Reasonability and Customary Clause2.37 of the policy.
3. Rs.16,000/- disallowed for C-arm charges as included in OT
4. Dressing charges of Rs.3,500/- disallowed as the same is included in Nursing charges
5. Rs.10,900/- charges deducted towards OT replacement charges which Company agrees to pay if the breakup is provided to them.
6. Non-medicals of Rs.8,699/- deducted as per policy terms from non-pharmacy utilities.

Forum's Observations/Conclusion: After scrutiny of the deductions made by the Respondent under the subject claim, as regards to the justification given by the Respondent for the deducted amount under the head of Room Rent, the Forum observed that as per 3.2 of the policy clause which provides that Reimbursement/payment of Room rent, boarding and nursing expenses incurred at the hospital shall not exceed 1% of the Sum Insured per day. In case of admission to a room at rates exceeding the aforesaid limit, the payment of all other expenses incurred at the hospital, with the exception of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent. Hence deduction of excess Room Rent and proportionate deduction are found in order as per policy terms and conditions. As regards the amount disallowed for Rs.16,000/-, Rs.3,500/-, Rs.10,900/- towards C arm charges, dressing charges, and OT Replacement respectively need to be allowed as the insured has paid the same as billed by the hospital. Further Surgeon Charges have been deducted based on the Reasonability Clause of the policy. Generally, the doctor's fees will depend on his individual skill, time, and complications involved in the surgery and the patient has no control over it. There is no doubt that the individual has every right to

go in for the best treatment available but the policy would pay only the charges which are necessarily and reasonably incurred. As such, whenever it is observed that the charges are unreasonably high, the "Reasonable & Customary charges" Clause of the policy would come into operation, and even in the absence of a specific capping in the policy, the Company is within its right to limit the expenses payable for a particular procedure by comparing the charges prevalent in the same geographical area. Considering all the above facts, the Forum is of the view that it would be in the interest of justice to allow a further amount of Rs.40,750/- against Rs.81,500/- deducted by the Respondent with a view to strike a reasonable balance and resolve the dispute in the matter. The balance deduction of Rs.8,699/- deducted towards non-medicals are as per policy condition hence in order. The decision of the Respondent is intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay Rs. 71,150/- (Rs.40,750/- + Rs.16,000/- + Rs.3,500/- + Rs.10,900/-)towards the hospitalization of Dr. Jayesh Yadav from 27.08.2020 to 03.09.2020, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR SANDEEP V PENDHARKAR

VS

RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1586

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Sandeep V Pendharkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171112/01/2021/006904 Star Comprehensive Insurance Policy 30.09.2020 to 29.09.2021 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mr. Sandeep V Pendharkar
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	10.02.2021
6	Reason for repudiation	Non Disclosure

7	Date of receipt of the complaint	08.01.2021
8	Nature of complaint	Reimbursement and Reinstatment
9	Amount of claim	Rs.1,15,284/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.1,15,284/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	16.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Sandeep V Pendharkar
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award
16	Date of Award/Order	29.04.2021

Brief Facts of the Case: Complainant was admitted to Global Hospital on 14.12.2020 for diagnosis of Cortical Venous Thrombosis and discharged on 18.12.2020. The complainant approached this Forum with a complaint against total repudiation and deletion of his coverage by the Respondent, Star Health & Allied Insurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization on the ground that the insured had DVT since two years and the same was not disclosed in the Proposal form at the inception of the policy i.e.30.09.2019.

Contentions of the Complainant: The Complainant vide email dated 11.04.2021 requested the Forum to proceed with the hearing based on the written submissions provided by him. The insured had purchased the Star Comprehensive Policy with effect from 30.09.2019 and also renewed the policy from 30.09.2020 to 29.09.2021. On 14.12.2020 he got headache and uneasiness and, as advised by the doctor, CT Scan was done and was immediately admitted to

ICU in Global Hospital from 14.12.2020 and 18.12.2020 for the treatment of Cortical Venous Thrombosis. It was very shocking for him to know that the cashless approval for his admission was rejected by Insurer and Company also rejected the post reimbursement claim and also deleted his coverage under the policy on the ground of Non-disclosure of DVT suffered by him in 2018 which was before the inception of the policy. The Complainant in his submission stated that in August 2018, he had swelling in the Right Lower Limb/leg and recovered from the illness completely and resumed his duties on 17.10.2018 till his retirement 31.08.2020 in Central Government after submission of fitness certificate issued by CGHS medical officer. Also submitted a copy of the CGHS Fitness certificates dated 01.09.2018, 19.09.2018, 04.10.2018, and 17.10.2018 in support of the same. He further stated that his present admission for headache was different from the swelling of the Right Lower Limb/DVT problem which took place in August 2018. He reaffirmed that he had not withheld any details with the Insurer or made any false claim and he had disclosed all the facts to the Agent. Hence,not agreeing with the reason cited by the Insurer for repudiation of the claim, requested the Forum for settlement of claim amount of Rs.1,15,284/- and also to reinstate his coverage under the subject policy.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured patient aged 60 yrs was admitted to Global Hospital, Mumbai on 14.12.2020 and discharged on 18.12.2020 for the treatment of Cortical Venous Thrombosis. The Pre Authorization Request for cashless treatment and subsequent reimbursement claim was denied on the ground that the insured had DVT for two years and the same was not disclosed in the Proposal which amounts to non-disclosure of material facts. The Respondent submitted that on scrutiny of Discharge Summary and Indoor Case papers, it was observed that insured was a known case of Deep Vein Thrombosis (DVT) for the past two years which was before the inception of the subject policy that is 30.09.2019. However, the insured had replied in negative for the question of the History asked in the proposal form of any other disease apart from the specified diseases. The Insured answering in negative for the specific question relating to medical history in the proposal amounts to Non-Disclosure of material fact making the Contract of Insurance voidable. Based on the above-mentioned facts, as per policy condition no.6, if there is any non-disclosure of material facts whether, by the Insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claim. Further as per Condition No.12 of the policy, “the Company may cancel this policy on grounds of misrepresentation/non-disclosure of material fact as declared in proposal form/at the time of claim.” Hence, the cover in respect of Mr. Sandeep V Pendharkar was canceled from the

coverage with effect from 26.01.2021 due to non-disclosure of Pre Existing Disease. The Respondent further submitted the Discharge Summary of the insured's admission from 27.08.2018 to 31.08.2018 wherein he was treated for Right Lower Limb DVT- Chronic Thrombosis of distal CFV, SFV, and PV in support of their contention of insured suffering from the Thrombosis since August 2018. Given the facts, Respondent stood by their decision being made as per terms and conditions of the policy.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent had denied the claim reported for the treatment of Cortical Venous Thrombosis on the ground of Non-disclosure and also discontinued the coverage of the Complainant from the policy. In this regard, Respondent produced the evidence of present discharge summary and ICP mentioning insured's history of DVT (Deep Vein Thrombosis) two years back along with the discharge summary of August 2018 hospitalisation, wherein insured was treated for DVT in support of their contention for repudiation and discontinuation of insured's coverage on the ground of Non-disclosure of PED at the time of inception of the policy i.e.30.09.2019 as per Condition 9 and 12 of policy terms and conditions. As per IRDAI guidelines, Pre-Existing Disease means **any condition, ailment, injury or disease : (a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer (b) For which medical advice or treatment was recommended by, or received from, a physician 48 months prior to the effective date of the policy**. In the instant case, it is observed that the ailment suffered by the insured falls within 48 months prior to the effective date of the policy and hence as per policy terms, the claim had been rejected based on the ground of Non-disclosure of Pre Existing Disease. At the same time Complainant in his submission has mentioned about all disclosures were made to his Agent. But any evidence of such disclosure prior to the inception of the policy to the Agent not been produced in reply to the mail dated 16.04.2021. Though the Forum is able to appreciate the concern of the complainant in this regard, it is to be noted that Mediclaim policy is an annual contract and whenever any dispute arises it is settled based on the terms & conditions of the policy under which a claim has arisen. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions spelled out in the policy and also approved by the Regulator. In view of the decision of the Respondent to repudiate the subject claim found to be in accordance with the terms and conditions of the policy, the decision of the Respondent, therefore, does not call for any intervention and consequently, no relief can be granted to the complainant.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Sandeep V Pendharkar against Star Health Insurance & Allied Insurance Co. Ltd. does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 29th April 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR KIRITKUMAR K PRAJAPATI
VS
RESPONDENT: UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-051-2021-1789

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Kiritkumar K Prajapati** **Mumbai**
2	Policy No Type of Policy Duration of Policy/Period Sum Insured	0204002819P100856094 Individual Health Insurance Policy - Gold 18.04.2019 to 17.04.2020 Rs.5,50,000/-
3	Name of Insured Name of the policyholder	Mr. Kiritkumar K Prajapati
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	08.02.2021
8	Nature of complaint	Short Settlement
9	Amount of claim	Rs.1,44,338/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.1,04,338/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	26.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Mehul Prajapati
	b) For the insurer	Ms Aarti S Pandhare, Assistant Manager
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case: Complainant, Mr. Kiritkumar Keshavlal Prajapati underwent Cataract surgery in the Right Eye on 06.01.2020 at Mehta International Eye Institute, Mumbai. The complainant approached this Forum with a complaint against a short-settlement by the Respondent United India Insurance Co. Ltd. of a claim lodged under the policy on the ground of Reasonable and Customary clause of policy terms and conditions.

Contentions of the Complainant: Complainant's son, Mr. Mehul Prajapati appeared and deposed before the Forum. He submitted that the claim lodged for Rs.1,44,338/- for Right eye

cataract surgery underwent by his father, was settled for Rs.40,000/- with a substantial deduction of Rs.1,04,338/- towards Surgeon Charges, IOL Charges, and Procedure charges on the ground of Reasonable and Customary charges. The Complainant pointed out the policy condition which mentions the limit of Cataract operation as 25% of Sum Insured or actual expense incurred whichever is less. He argued that his father was covered under the policy for Sum Insured of Rs.5,50,000/- and the Company violating the terms of policy has short settled the claim based on irrelevant grounds of comparing the rates of other hospitals. In view of the same, not agreeing with the reason cited by the Insurer, requested the Forum for settlement of balance claim amount of Rs.1,04,338/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the claim preferred by the insured for the Right Eye cataract was settled for Rs.40,000/- as against a total claim amount of Rs.1,44,338/-. The Respondent stated that the deductions of Rs.6,000/- made towards Surgeon Charges, Rs.18,000/- for Procedure charges, and Rs.80,338/- for Implant charges was due to higher rates charged by the hospital and hence disallowed as per Reasonable and Customary Clause no.3.33 of policy terms and conditions which states that **the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.**

The Forum asked the Respondent about any capping for Cataract Surgery that had been imposed under the subject policy, the Respondent replied that as per the data furnished by TPA, the Insured policy is a Gold Policy which has the capping of Rs.40,000/- per cataract surgery. However,since Complainant had contended of not having any such capping in the policy terms and condition, Forum asked the Respondent to confirm on the same and accordingly Respondent vide email reverted that the new policy with the capping of Rs.40,000/- was introduced with effect from 25.03.2019 but till 25.06.2019 during renewals, insured was given the option to choose between old terms and conditions and new policy terms and condition. But all the policies renewed after 25.06.2019 were issued with new terms and conditions.

Forum's Observations/Conclusion: On perusal of the documents produced on record, it is observed that Complainant contended the case for short settlement of claim by the Respondent overruling the policy condition of actual expenses or 25% of sum insured whichever is less is to be paid for per cataract surgery. Whereas Respondent submitted that the settlement has been made on the Reasonable and Customary Clause of the policy. In the instant case, it is observed that the subject Gold Policy availed by the Insured was revised with new policy terms and conditions with the capping of Rs.40,000/- for each eye Cataract surgery was imposed with effect from 25.06.2019. At the same time, it is noted that the present policy of the insured had been issued from 18.04.2019 which is prior to the issuance of policy with new terms and conditions and it also appears that the insured had not opted for new terms and

conditions at the time of renewal if the option for the same was given to him by the Respondent. Since the policy issued to the Complainant has specific condition 1.2.1 restricting Limit per surgery for the Cataract expenses as "Actual Expenses incurred or 25% of Sum Insured whichever is less", the deduction of claim amount on the ground of Reasonable and Customary Clause of the policy is not justified, the claim has to be paid as per policy terms and conditions. In the present claim, the insured had claimed for Rs.1,44,338/- but his entitlement is for the maximum amount of Rs.1,37,500/- (25% of Rs.5,50,000/-). Hence, Respondent is directed to pay a further amount of Rs.97,500/- (Rs.1,37,500 less Rs.40,000/- already paid) as per the policy terms and conditions. The decision of the Respondent is intervened by the following order:

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to pay a further amount of Rs.97,500/- (claim no. 20RB03UIC1859) in favour of the complainant, Mr. Kiritkumar K Prajapati, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 29th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR KIRITKUMAR K PRAJAPATI
VS
RESPONDENT: UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-051-2021-1813
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Kiritkumar K Prajapati** **Mumbai**
2	Policy No Type of Policy Duration of Policy/Period Sum Insured	0204002819P100856094 Individual Health Insurance Policy - Gold 18.04.2019 to 17.04.2020 Rs.5,50,000/-
3	Name of Insured Name of the policyholder	Mr. Kiritkumar K Prajapati
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	08.02.2021
8	Nature of complaint	Short Settlement (Left Eye Cataract surgery)
9	Amount of claim	Rs.1,41,910/-
10	Date of Partial Settlement	
11	Amount of relief sought	Rs.1,01,910/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	26.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Mehul Prajapati
	b) For the insurer	Ms Aarti S Pandhare, Assistant Manager
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case: Complainant, Mr. Kiritkumar Keshavlal Prajapati underwent Cataract surgery in the Left Eye on 15.01.2020 at Mehta International Eye Institute, Mumbai. The complainant approached this Forum with a complaint against a short-settlement by the Respondent United India Insurance Co. Ltd. of a claim lodged under the policy on the ground of Reasonable and Customary clause of policy terms and conditions.

Contentions of the Complainant: Complainant's son, Mr. Mehul Prajapati appeared and deposed before the Forum. He submitted that the claim lodged for Rs.1,41,910/- for Left eye cataract surgery underwent by his father, was settled Rs.40,000/- with a substantial deduction of Rs.1,01,910/- on the ground of Reasonable and Customary charges. The Complainant pointed out the policy condition, which mentions the limit of Cataract operation as 25% of Sum Insured or actual expense incurred whichever is less. He argued that his father was covered under the policy for Sum Insured of Rs.5,50,000/- and the Company by violating the terms of policy has short settled the claim based on irrelevant grounds of comparing the rates of other hospitals. In view of the same, not agreeing with the reason cited by the Insurer, requested the Forum for settlement of balance claim amount of Rs.1,01,910/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the claim preferred by the insured for the Left Eye cataract was settled for Rs.40,000/- as against a total claim amount of Rs.1,01,910/-. The Respondent stated that the doctor charges, Implant charges, etc were very high as compared to other hospitals and hence disallowed as per Reasonable and Customary Clause no.3.33 of policy terms and conditions which states that **the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.**

The Forum asked the Respondent about any capping for Cataract Surgery was imposed under the subject policy, the Respondent replied that as per the data furnished by TPA, the Insured policy is a Gold Policy which has the capping of Rs.40,000/- per cataract surgery. However, since Complainant had contended of not having any such capping in the policy terms and condition, Forum asked the Respondent to confirm on the same and accordingly Respondent vide email reverted that the new policy with the capping of Rs.40,000/- was introduced with effect from 25.03.2019 but till 25.06.2019 during renewals insured was given the option to choose between old terms and conditions and new policy terms and condition. But all the policies renewed after 25.06.2019 were issued with new terms and conditions.

Forum's Observations/Conclusion: On perusal of the documents produced on record, it is observed that Complainant contended the case for short settlement of claim by the Respondent overruling the policy condition of actual expenses or 25% of sum insured whichever is less is to be paid for per cataract surgery. Whereas Respondent submitted that the settlement has been made on the Reasonable and Customary Clause of the policy. In the instant case, it is observed that the subject Gold Policy availed by the Insured was revised with new policy terms and conditions with the capping of Rs.40,000/- for each eye Cataract surgery with effect from 25.06.2019. At the same time, it is noted that the present policy of the insured had been issued from 18.04.2019 which is prior to the issuance of policy with new terms and conditions and it appears that the insured had not opted for new terms and conditions at the time of renewal if the option for the same was given to him by the Respondent. Since the policy issued to the Complainant has specific condition 1.2.1 restricting Limit per surgery for the Cataract expenses as "Actual Expenses incurred or 25% of Sum Insured whichever is less", the deduction of claim amount on the ground of Reasonable and Customary Clause of the policy is not justified, the claim has to be paid as per policy terms and conditions. In the present claim, the insured had claimed for Rs.1,41,910/- but his entitlement is for the maximum amount of Rs.1,37,500/- (25% of Rs.5,50,000/-). Hence, Respondent is directed to pay a further amount of Rs.97,500/- (Rs.1,37,500 less Rs.40,000/- already paid) as per the policy terms and conditions. The decision of the Respondent is intervened by the following order:

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to pay a further amount of Rs.97,500/- (claim no. 20RB03UIC1938) in favour of the complainant, Mr. Kiritkumar K Prajapati, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as

he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 29th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR SANDEEP V PENDHARKAR

VS

RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1586

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Sandeep V Pendharkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171112/01/2021/006904 Star Comprehensive Insurance Policy 30.09.2020 to 29.09.2021 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mr. Sandeep V Pendharkar
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	10.02.2021
6	Reason for repudiation	Non Disclosure
7	Date of receipt of the complaint	08.01.2021
8	Nature of complaint	Reimbursement and Reinstatment
9	Amount of claim	Rs.1,15,284/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.1,15,284/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	16.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Sandeep V Pendharkar
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award

16	Date of Award/Order	29.04.2021

Brief Facts of the Case: Complainant was admitted to Global Hospital on 14.12.2020 for diagnosis of Cortical Venous Thrombosis and discharged on 18.12.2020. The complainant approached this Forum with a complaint against total repudiation and deletion of his coverage by the Respondent, Star Health & Allied Insurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization on the ground that the insured had DVT since two years and the same was not disclosed in the Proposal form at the inception of the policy i.e.30.09.2019.

Contentions of the Complainant: The Complainant vide email dated 11.04.2021 requested the Forum to proceed with the hearing based on the written submissions provided by him. The insured had purchased the Star Comprehensive Policy with effect from 30.09.2019 and also renewed the policy from 30.09.2020 to 29.09.2021. On 14.12.2020 he got headache and uneasiness and,as advised by the doctor,CT Scan was done and was immediately admitted to ICU in Global Hospital from 14.12.2020 and 18.12.2020 for the treatment of Cortical Venous Thrombosis. It was very shocking for him to know that the cashless approval for his admission was rejected by Insurer and Company also rejected the post reimbursement claim and also deleted his coverage under the policy on the ground of Non-disclosure of DVT suffered by him in 2018 which was before the inception of the policy. The Complainant in his submission stated that in August 2018, he had swelling in the Right Lower Limb/leg and recovered from the illness completely and resumed his duties on 17.10.2018 till his retirement 31.08.2020 in Central Government after submission of fitness certificate issued by CGHS medical officer. Also submitted a copy of the CGHS Fitness certificates dated 01.09.2018, 19.09.2018, 04.10.2018, and 17.10.2018 in support of the same. He further stated that his present admission for headache was different from the swelling of the Right Lower Limb/DVT problem which took place in August 2018. He reaffirmed that he had not withheld any details with the Insurer or made any false claim and he had disclosed all the facts to the Agent. Hence,not agreeing with the reason cited by the Insurer for repudiation of the claim, requested the Forum for settlement of claim amount of Rs.1,15,284/- and also to reinstate his coverage under the subject policy.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured patient aged 60 yrs was admitted to Global Hospital, Mumbai on 14.12.2020 and discharged on 18.12.2020 for the treatment of Cortical Venous Thrombosis. The Pre Authorization Request for cashless treatment and subsequent reimbursement claim was denied on the ground that the insured had DVT for two years and the same was not disclosed in the Proposal which amounts to non-disclosure of material facts. The Respondent submitted that on scrutiny of Discharge Summary and Indoor Case papers, it was observed that insured was a known case of Deep Vein Thrombosis (DVT) for the past two years which was before the inception of the subject policy that is 30.09.2019. However, the insured had replied in negative for the question of the History asked in the proposal form of any other disease apart from the specified diseases. The Insured answering in negative for the specific question relating to medical history in the proposal amounts to Non-Disclosure of material fact making the Contract of Insurance voidable. Based on the above-mentioned facts, as per policy condition no.6, if there is any non-disclosure of material facts whether, by the Insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claim. Further as per Condition No.12 of the policy, "the Company may cancel this policy on grounds of misrepresentation/non-disclosure of material fact as declared in proposal form/at the time of claim." Hence, the cover in respect of Mr. Sandeep V Pendharkar was canceled from the coverage with effect from 26.01.2021 due to non-disclosure of Pre Existing Disease. The Respondent further submitted the Discharge Summary of the insured's admission from 27.08.2018 to 31.08.2018 wherein he was treated for Right Lower Limb DVT- Chronic Thrombosis of distal CFV, SFV, and PV in support of their contention of insured suffering from the Thrombosis since August 2018. Given the facts, Respondent stood by their decision being made as per terms and conditions of the policy.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent had denied the claim reported for the treatment of Cortical Venous Thrombosis on the ground of Non-disclosure and also discontinued the coverage of the Complainant from the policy. In this regard, Respondent produced the evidence of present discharge summary and ICP mentioning insured's history of DVT (Deep Vein Thrombosis) two years back along with the discharge summary of August 2018 hospitalisation, wherein insured was treated for DVT in support of their contention for repudiation and discontinuation of insured's coverage on the ground of Non-disclosure of PED at the time of inception of the policy i.e.30.09.2019 as per Condition 9 and 12 of policy terms and conditions. As per IRDAI guidelines, Pre-Existing Disease means **any**

condition, ailment, injury or disease : (a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer (b) For which medical advice or treatment was recommended by, or received from, a physician 48 months prior to the effective date of the policy. In the instant case, it is observed that the ailment suffered by the insured falls within 48 months prior to the effective date of the policy and hence as per policy terms, the claim had been rejected based on the ground of Non-disclosure of Pre Existing Disease. At the same time Complainant in his submission has mentioned about all disclosures were made to his Agent. But any evidence for the same has not been produced in reply to the mail dated 16.04.2021. Though the Forum is able to appreciate the concern of the complainant in this regard, it is to be noted that Mediclaim policy is an annual contract and whenever any dispute arises it is settled based on the terms & conditions of the policy under which a claim has arisen. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions spelled out in the policy and also approved by the Regulator. In view of the decision of the Respondent to repudiate the subject claim found to be in accordance with the terms and conditions of the policy, the decision of the Respondent, therefore, does not call for any intervention and consequently, no relief can be granted to the complainant.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Sandeep V Pendharkar against Star Health Insurance & Allied Insurance Co. Ltd. does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 29th April 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR P ANANTHA KUDVA
VS
RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1805
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. P Anantha Kudva** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14030034199500015831 New India Mediclaim Policy 26.03.2020 to 25.03.2021 Rs.3,00,000/- + Rs.75,000/- C.B.
3	Name of Insured Name of the policyholder	Mr. P Anantha Kudva
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Hospitalization less than 24 hrs. and not listed in Day Care
7	Date of receipt of the complaint	08.02.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.42,500/-
10	Date of Partial Settlement	--
11	Amount of relief sought	Rs.42,500/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	26.04.2021 - 12.00

14	Representation at the hearing	
	a) For the complainant	Mr. P Anantha Kudva
	b) For the insurer	Ms. Josephina Lemos, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	28.04.2021

Brief Facts of the Case: Complainant, Mr. P Anantha Kudva aged 74 years, k/c/o Carcinoma Prostate was under treatment of administration of Inj. Zoledronate and Oral Chemotherapy as advised by his Oncologist. The complainant approached this Forum with a complaint against repudiation by the Respondent, The New India Assurance Co. Ltd. of claim reported under the policy in respect of the reimbursement of expenses incurred for Tab. Abiraterone an Oral Chemotherapy drug for Rs.42,500/- on the ground of 2.16 of the policy clause stating that there was no hospitalization and oral chemotherapy is not payable.

Contentions of the Complainant: Complainant submitted that he had been suffering from BP, DM, and Prostrate Cancer IV stage diagnosed in 2017. Since then, as advised by the treating doctor, he was under treatment of Injection Zoldonate and Oral Chemotherapy. His earlier three claims lodged with the Insurer for similar treatment were rejected by the Company and he had to approach the Forum for the relief and in all the three cases received the awards favourably. The present claim reported by him was the fourth time Company had denied again for the similar treatment based on 2.16 clause of policy terms and conditions. The Complainant contended that his treating Oncologist advised him to take Zoledronic acid injection IV once in three months along with Abiraterone acetate tablet 1000 mg daily (Oral Chemotherapy). The Complainant added that due to the covid pandemic and considering his age and its related ailments, he had been confined to his home taking Oral Chemotherapy and also pointed out that the present claim reported by him was for the expenses incurred for Oral Chemotherapy. In view of Forum having honored his earlier complaints for the treatment of Injection and Oral Chemo as well, the Complainant requested the Forum for settlement of the subject claim for the amount of Rs.42,500/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured, a k/c/o Ca Prostate, was administered Inj. Zoledronate intravenously on 22.06.2020 at P.D. Hinduja Hospital on a stand-alone basis as an immune booster which is an OPD treatment not payable under the policy unless accompanied by any active chemotherapy agent. There was no hospitalization for 24 hours and the procedure is not listed under Day Care treatment. As per NIA Health Manual guidelines, it is payable for multiple myeloma even as a daycare procedure, as an exception but not for any other ailment. The claim for oral chemotherapy also was not payable as per policy T & C unless forming part of pre/post-hospitalization expenses of

the main admissible claim. Hence, the claim reported for the same was repudiated as per policy clause 2.16 which reads as **" Hospitalisation means admission in a hospital for a minimum period of twenty-four consecutive hours of inpatient care except for specified procedure/treatments listed in Annexure 1, where such admission could be for a period of less than twenty-four consecutive hours.**

Forum's Observations/Conclusion: In the instant case, on scrutiny of the documents it is observed that the Complainant reported the claim for the Oral Therapy Tab. Abiraterone acetate was taken by him during the month from May 2020 to September 2020 as advised by his treating doctor. The instant claim is only for Oral Chemotherapy treatment and not for Inj Zoledronate as contended by the Respondent. In this connection, Forum has received several complaints against non-settlement of claims for Chemo injections as well as Oral Chemo treatments. Cancer is a multifactorial disease and is one of the leading causes of death worldwide. Chemotherapy is an effective treatment against cancer but undesirable chemotherapy reactions and the development of resistance to drugs which results in multi-drug resistance are the major obstacles in cancer chemotherapy. So alternative formulations are in practice these days which are liposomes, resistance modulation, hormonal therapy, cytotoxic chemotherapy, and gene therapy. Many doctors have found Oral Chemo also as one of the effective methods for the treatment of cancer. Although the policy mentions coverage of parental Chemo, modern cancer treatment methods like oral chemo cannot be denied. The facts that have been brought to the notice of the Forum indicate that this procedure is an advancement of medical technology where hospitalization is not required. In this connection, attention is invited to the Master Circular on Standardization of Health Insurance Products issued by IRDAI which states that to ensure that the policyholders are not denied the availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures as mentioned therein (which includes oral chemotherapy & Immunotherapy – Monoclonal Antibody to be given as an injection) shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as an in-patient or as part of domiciliary hospitalization or as daycare treatment in a hospital. In view of the repeated course of treatment, having already decided vide earlier Awards passed for similar treatment undergone by the complainant, the Respondent is directed to settle the admissible claim excluding non-medicals, if any. The decision of the Respondent is therefore intervened by the following order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the claim for oral chemotherapy taken by the Complainant, Mr P Anantha Kudva during May 2020 to September 2020, for the admissible amount excluding non-medicals, if any, subject to availability of Sum Insured towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 28th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MS NIMISHA K SHAH
VS
RESPONDENT: THE NATIONAL INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-048-2021-1752

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Ms. Nimisha K Shah
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	260500502010001090 National Mediclaim Policy 19.05.2020 to 18.05.2021 Rs.3,00,000/-+C.B. Rs.1,50,000/-
3	Name of Insured Name of the policyholder	Ms. Nimisha K Shah
4	Name of Insurer	National Insurance Co. Ltd.
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	03.02.2021
8	Nature of complaint	Short settlement of the claim
9	Amount of claim	Rs.40,783/-
10	Date of Partial Settlement	30.07.2020
11	Amount of relief sought	Rs.3,900/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	22.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Manoj Shah
	b) For the insurer	Mrs Madhuri G Naik, AO
15	Complaint how disposed	Award
16	Date of Award/Order	27.04.2021

Brief Facts of the Case: Complainant was admitted to Pawandham Covid Care Centre from 24.06.2020 to 30.06.2020 for treatment of Covid19. He approached this Forum with a complaint against short settlement by the Respondent, National Insurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: The Complainant's brother, Mr. Manoj Shah appeared and deposed before the Forum. He submitted that his sister was hospitalized at Pawandham Covid Care Centre from 24.06.2020 to 30.06.2020 and reported a claim for the same which was

settled for Rs.36,883/- as against total expenses incurred for Rs.40,783/-. The Respondent stated that Company had deducted Rs.600/- of Dietician charges/- and Rs.500/- Registration charges from the hospital bill, Rs.300/- Covid Test charges, and Rs.2,500/- towards CT Scan charges. However, Complainant argued that Pawandham Covid Care Centre is a Temporary Hospital administered by Apex Hospital made for the treatment of COVID 19 patients with reasonable rates. The billing was done according to Apex Hospital's software under various heads and then deducted the amount as a discount to arrive at the reasonable rates fixed by them. He clarified that the total bill was raised for Rs.1,07,148/- out of which deducted a discount of Rs.80,450/- and a net amount of Rs.26,698/- was only charged to them. Mr. Manoj Shah also submitted bifurcation of Rs.26,698/- showing Bed charges Rs.1000/- per day x 7 days = Rs.7,000/-, ECG charges of Rs.630/-, Medicine Rs.12,278/-, Pathology Routine of Rs.3,660/-, Pathology special of Rs.2,000/-, X-ray charges of Rs.1,130/-. He contended that neither Registration charges nor Dietician charges were included in the amount incurred by them, hence the Insurer has incorrectly disallowed the same. Regarding deduction of COVID test charges, the sample was collected from Residence, the reason being all the members were home quarantined and Rs.2,800/- was as fixed by the State Government for the covid test at home, yet Company has deducted Rs.300/- which is not acceptable to him. In support of the same, he also produced the charges quoted in the press release literature. As regards the deduction of Rs.2,500/- on CT Scan which he explained that the same was pre-hospitalization expenses and explained that he had inquired at other diagnostic centers and opted for the cheapest one for Rs.3,500/-. Because of the aforesaid facts, not agreeing with the deductions made by the Insurer, requested the Forum for settlement of balance claim amount of Rs.3,900/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the claim lodged for insured's treatment for Covid was settled for Rs.36,883/- as against Rs.40,783/-. The deductions made are as per Apex Hospital Bill, Rs.500/- Registration Charges and Rs.600/- Dietician charges which are non-medical expenses and not payable as per Annexure-II of the policy terms and conditions. The CT Scan charges of Rs.2,500/- deducted against total bill amount of Rs.3,500/- and disallowed Covid Test Charges of Rs.300/- and paid Rs.2,500/- on the ground of Reasonable and Customary charges clause of policy terms.

Forum's Observations/Conclusion: On perusal of the documents produced on record and submissions made by both the parties, it is observed that since the bifurcation of the discount amount was not provided by the hospital, the Respondent settled the claim based on Apex Hospital Bill deducting only Registration and Dietitian charges as per policy terms and

conditions. The Complainant after the hearing vide email also produced a press release stating that the treatment center was opened for treatment of needy masses at the time of global pandemic with only Rs.1,000/- per day bed charges and nominal amount are charged for medicine and investigations. Based on the clarifications given by the Complainant in detail, it is observed that a substantial amount discount had been granted of Rs.80,450/- against a total bill amount of Rs.1,07,148/- and the insured patient was treated for eight days at a very reasonable rate of Rs.26,698/-. Also, CT Scan and Covid Test charges are found very reasonable and hence not justified to deduct the same on Reasonability and Customary ground. To resolve the matter, Respondent is directed to pay Rs.3,400/- disallowing Registration charges of Rs.500/- towards a full and final settlement of the claim. The decision of the Respondent is, therefore,intervened by the following Order.

AWARD

Under the facts and circumstances of the case, National Insurance Insurance Co. Ltd. is directed to pay a further amount of Rs.3,400/- to the Complainant, Ms. Nimisha K Shah towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 27th April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR VINAYAK L CHOUBEY
VS
RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1753
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Vinayak L Choubey** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171123/01/2020/011370 Mediclassic Insurance Policy (Individual) 26.03.2020 to 25.03.2021 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mr. Vinayak L Choubey
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	--
6	Reason for repudiation	--
7	Date of receipt of the complaint	03.02.2021
8	Nature of complaint	Short settlement – COVID Claim
9	Amount of claim	Rs.2,24,818/-
10	Date of Partial Settlement	23.07.2020 - Rs.98,803/- 08.09.2020 - Rs.7,200/-
11	Amount of relief sought	Rs.1,18,815/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	20.04.2021 - 12.30 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Sanjay Upadhyay
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award

16	Date of Award/Order	26.04.2021

Brief Facts of the Case: Complainant, Mr. Vinayak L Choubey ,aged 42 yrs, was admitted to Sanjeevani Surgical and General Hospital, Mumbai from 20.05.2020 to 27.05.2020 for the treatment of Covid-19. The complainant approached this Forum with a complaint against a short-settlement by the Respondent, Star Health, and Allied Insurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: The Complainant's sister, Mrs. Neelam Upadhayay was not available, hence complainant authorized his brother-in-law, Mr. Sanjay Upadhaya to appear and depose before the Forum. He submitted that the claim preferred by them for the hospitalization of his brother in law for the treatment of covid was settled by the Insurer for Rs.1,06,003 in two installments as against a total bill amount of Rs.2,24,818/- with a huge deduction of Rs.1,18,815/-. He argued that the patient was admitted to a very reasonable hospital and they tried for cashless but the hospital refused the same due to lack of staff in the hospital and Company for processing of cashless claims. He pointed out that the admission to the hospital was intimated to the Company immediately,but nobody guided them about cashless and also deducted a major portion of the expenses incurred on the reimbursement claim reported with them. He added that the insured patient was in the sixth year of policy and this was the first claim. Also stated that the insured was sufficiently covered for Sum Insured of Rs.5,00,000/- hence, not agreeing with deductions made under the subject claim, requested the Forum for reimbursement of balance claim amount of Rs.1,18,815/-.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured preferred a reimbursement claim for his admission to Sanjeevani Surgical and General Hospital from 20.05.2020 to 27.05.2020 for the treatment of COVID-19. The claim reported was initially settled for Rs.98,803/- and the claim was subsequently reviewed and paid for a further amount of Rs.7,200/-. As regards bifurcations of total deduction of Rs.1,18,815/-, disallowed components were: food charges of Rs.4,000/-, BMW charges of Rs.4,000/- not payable. As regards Covid patient handling charges,Rs.84,600/- was deducted as against Rs.1,00,000/- charged based on GIC Niti Ayog guidelines. Other excluded charges were Non-payables of Rs.4,581/-, Doctor charges of Rs.12,000/-, MRD charges of Rs.2,400/-, Rs.230/- Steam Machine charges, Registration Charges of Rs.350/-, HGT charges of Rs.200/-, Oximeter charges of Rs.4,800/- . Further, an amount of Rs.1,654/- was deducted as the bill date was not clear. Hence, the respondent concluded that the claim had been processed within the scope of the policy terms and conditions, as explained.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the complainant has taken treatment in the Company's network hospital. Since the hospital refused settlement on a Cashless basis, the Complainant had to opt for a claim on a reimbursement basis. The hospital is in PPN Network hospitals of Star Insurance Company and therefore,they are duty-bound to attend to the insured on a cashless basis. Contrary to that, it appears that they have overcharged the patient without adhering to the PPN rates in violation of their agreement with the Respondent. Further, it is also noted that Respondent has settled the claim based on Niti Ayog Guidelines, which are effective from 20.06.2020, however, the insured's admission to the hospital was in May 2020. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and paid the charges as billed by the hospital. Given the facts, the complainant is entitled to be reimbursed for the entire hospitalization expenses barring non-medical items and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The Forum is, therefore, of the view that the Complainant is entitled for further amount of Rs.1,02,946/- excluding non-medical/non-payables of Rs.14,215/- (Rs.4,581/- non-medicals, Rs.2,400/- MRD Charges, Rs.230/- Steam Machine, Rs.350/- Registration charges, Rs.200/- HGT charges, Rs.4,800/- Pulse Oximeter charges). The balance amount of Rs.1,654/- can be paid subject to submission of a proper bill with the date by the Complainant. The decision of the Respondent is, therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Star Health & Allied Insurance Co. Ltd. is directed to pay further amount of Rs.1,02,946/- for the hospitalization of Mr. Vinayak Lallan Choubey from 20.05.2020 to 27.05.2020 as per policy terms and conditions towards full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 26th April 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR RITESH GOSALIA

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1608

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. RiteshGosalia** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11170034162500008574 11170034199500006473 New India Mediclaim Policy 18.01.2017 to 17.01.2018 18.01.2020 to 17.01.2021 Rs.2,00,000/-
3	Name of Insured Name of the policyholder	Mr. DhimantGosalia
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Hospitalization less than 24 hrs.
7	Date of receipt of the complaint	28.01.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.1,50,830/- (3 claims)
10	Date of Partial Settlement	--
11	Amount of relief sought	Rs.1,50,830/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	15.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr. RiteshGosalia

	b) For the insurer	Mrs. HarinakshiKarkera, Admn officer
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case: Complainant's father, Mr. DhimantGosalia was diagnosed with Carcinoma Prostrate and had been administered with Inj. Eligardas advised by his treating doctor at Aditi Super Speciality Hospital. The complainant had lodged three claims for the total amount of Rs.1,50,830/- which were repudiated by the Company as per policy clause 2.16 on the ground that the policy covered only for parental administration of only chemotherapeutic agents and the procedure is neither listed in Daycare nor does it justify hospitalization. The complainant is not agreeable with the said decision, approached the Forum for settlement of the claims.

Contentions of the Complainant: Complainant submitted that his father, Mr. DhimantGosalia had been suffering from Prostate Cancer and unfortunately passed away on 22.02.2021. The three claims reported for the treatment of Prostate Cancer for administering Injection Eligard were repudiated by the Insurer on the ground that hospitalization was less than 24 hrs and not listed in Daycare. He added that earlier his claims were settled by the Insurer but the rejection of the subsequent claims was not convincing to him. He raised his query several times with TPA/Insurer but did not get any response. In view of the same, not agreeing with the reason cited by the Insurer for denial of the claims, requested the Forum for settlement of all the three claims and provided the details of claims which are as follows:-

Sr.no.	**Policy No.**	**Claim No.**	**Amount**
1	11170034162500008574	MDI3573191	Rs.50,000/-
2	11170034199500006473	20RB03NIP0453	Rs.43,000/-

3	11170034199500006473	21RB03NIP1318	Rs.57,830/-
	TOTAL		Rs.1,50,830 /-

Contentions of the Respondent: It was contended on behalf of the Respondent that Mr. DhimantGosalia was a patient of Prostate Carcinoma and had reported three claims for administering Injection Eligard. The Respondent stated that Injection Eligard is a Hormonal Drug that is used to treat Prostate Cancer but the policy covers only parental administration of chemotherapeutic agents. Also for administering of Immunotherapy drug, Injection Eligard, the admission was less than 24 hours and the procedure is also not listed in Daycare, hence the claims reported for the same were repudiated as per policy clause 2.16 which reads as **" Hospitalisation means admission in a hospital for a minimum period of twenty-four consecutive hours of inpatient care except for specified procedure/treatments listed in Annexure 1, where such admission could be for a period of less than twenty-four consecutive hours.** Respondent concluded that the claim has been processed within the scope of the policy terms and conditions as explained.

Forum's Observations/Conclusion: This Forum has received several complaints against non-settlement of claims for Injection Eligard used for the treatment of cancer. It is noted that some companies are paying claims for treatment by way of these injections even when given in isolation while some other Companies who were also paying such claims earlier have now taken a stand that it is admissible only when given as a part of chemotherapy/ radiotherapy or as pre & post hospitalization expenses for related hospitalization. Studies have shown that treatment of Cancer patients with antibodies when used alone or in combination with chemotherapy and radiotherapy, or conjugated to drugs or radioisotopes, prolongs overall survival in cancer patients. The antibodies used in cancer therapy are engineered to specifically target certain types of cancer cells. When such antibodies are copied over and over in a lab, the result is a monoclonal antibody therapy, a treatment consisting of millions of identical antibodies aimed at the same molecules on tumor cells. As researchers have found more antigens linked to cancer, they have been able to make MABs against more and more cancers. Thus the treatment undergone by patients is one of the advancements of medical technology in as much as over the past couple of decades, more than a dozen monoclonal antibodies have been approved by the Food and Drug Administration to fight cancer.

Although the policy mentions coverage of parental Chemo, modern cancer treatment methods like Immunotherapy cannot be denied. The facts that have been brought to the notice of the Forum indicate that this procedure is an advancement of medical technology where a minimum of 24 hours of hospitalization is not required. The various certificates issued by the specialists indicate divided opinions amongst the doctors regarding the procedure being an inpatient or outpatient one. In this connection, attention is invited to the Master Circular on Standardization of Health Insurance Products issued by IRDAI which states that to ensure that the policyholders are not denied the availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures as mentioned therein (which includes oral chemotherapy & Immunotherapy – Monoclonal Antibody to be given as an injection) shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as an in-patient or as part of domiciliary hospitalization or as daycare treatment in a hospital. In the light of the same, the Forum is of the view that the subject claims be paid barring non-medical expenses. The decision of the Respondent is therefore set aside by the following order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the three claims nos.MDI3573191, 20RB03NIP0453, and 21RB03NIP1318 for an admissible amount less non-medicals,if any,subject to availability of Sum Insured towards full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 25th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR GHEESULAL A KOTHARI

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1711

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Gheesulal A Kothari** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	13100034192800000515 New India Floater Mediclaim Policy 30.06.2019 to 29.06.2020 Rs.3,00,000/-
3	Name of Insured Name of the policyholder	Mr. Gheesulal A Kothari
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	25.01.2021
8	Nature of complaint	Short Settlement of claim
9	Amount of claim	Rs.95,445/-
10	Date of Partial Settlement	14.03.2020
11	Amount of relief sought	Rs.58,015/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	15.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Jitendra Kothari
	b) For the insurer	Mr. Amit Kumar Karn, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	25.04.2021

Brief Facts of the Case: Complainant, Mr. Gheesulal A Kothari was admitted to KokilabenDhirubhaiAmbani Hospital on 10.03.2020 for the diagnosis of Abdominal Wall Cellulitis, Myositis, and Right basal pneumonia and discharged on 14.03.2020. The complainant approached this Forum with a complaint against short-settlement by the Respondent, The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant's son, Mr. Jitendra Kothari appeared and deposed before the Forum. He submitted that his father was admitted for the complaints of cough with expectoration and redness over the lower abdomen. The cashless claim for the said hospitalization was approved for Rs.30,289/- as against a total hospital bill of Rs.95,445/-. The reimbursement claim lodged for the balance disallowed amount was denied by the Company stating that there was recently diagnosed DM which was after enhancement of Sum Insured from one lakh to three lakhs in 2018-19. Hence, as per condition of waiting period, Sum Insured for settlement of the claim was capped to One lakh Sum Insured along with proportionate deduction and thus, he was not eligible for any further amount under the subject claim. However, Mr. Jitendra Kothari argued that his father was treated for pneumonia and not for diabetes. He further added that his father was covered with the insurer since 30.06.2003 and till now claimed only once for Hernia surgery. Given the fact, not agreeing with the reason cited by the Insurer for the short settlement of the claim, requested the Forum for payment of Rs.58,015/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Complainant aged 64 years was admitted to the hospital from 10.03.2020 to 14.03.2020 for diagnosis of Abdominal Wall Cellulitis, Myositis, Right Basal Pneumonia with Diabetes Mellitus (Recently diagnosed). The Respondent pointed out that Insured had enhanced the Sum Insured under the policy from One Lakh to Three Lakhs in 2018-2019 and the policy was in the second year of enhanced Sum Insured. At the time of pre-authorization cashless approval, the Sum Insured was restricted to insured's two years previous sum insured of Rs.1 lakh as uncontrolled diabetes mellitus was one of the co-morbid condition and diabetes was one of the risk factors for cellulitis and the subject policy had two years waiting period for HT and Diabetes. In support of the same, the Respondent also quoted the insured patient's findings of Blood Glucose level as 356 mg/dl and Urine Glucose 4+. Accordingly Rs.30,289/- cashless amount was approved as against a total amount of Rs.95,445/- thereby deducting Rs.65,156/- wherein Rs.4,779/-was deducted as non-payables, Rs.13,400/- as excess room rent allowing Rs.4,000/- for 4 days (Rs.1,000/- per day i.e.1% of Rs. One Lakh) and Rs.46,977/- towards proportionate deduction as per terms and conditions of the policy. Since the cashless amount approved was as per policy

terms, the subsequent reimbursement claim reported by the Complainant for the balance disallowed amount for the same was denied by the Respondent.

Forum's Observations/Conclusion: After scrutiny of the documents produced together with the depositions of both the parties, the Forum observed that settlement of the claim had been done based on the applicability of two years waiting period on the enhanced sum insured for insured patient's recently diagnosed diabetes as per policy terms and conditions and Diabetes was one of the risk factors of Cellulitis for which the insured was treated in the present admission. However, Forum is of the view that Cellulitis refers to inflammation of the skin which can start with any break in the skin, including a minor scratch or insect bite that allows bacteria to penetrate to the deeper layers of the skin and Diabetes is not the only risk factor for Cellulitis. It is also noted from the discharge summary that the insured patient had been treated for Myositis and Right basal pneumonia apart from Abdominal Wall Cellulitis and also treatment was given during the stay observed to be not related to Diabetes. Therefore, the deductions on account of the applicability of the waiting period for Diabetes on the enhanced sum insured in the aforesaid claim are not justified. In view of the same, Respondent is directed to rework the admissible amount considering policy sum insured of Rs.3,00,000/- and settle the claim accordingly. The decision of the Respondent is ,therefore,intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to recalculate admissible amount less non-medicals, if any,based on Policy Sum Insured of Rs.3,00,000/- subject to policy terms and conditions and pay balance admissible amount towards the hospitalization of Mr. Gheesulal A Kothari from 10.03.20 to 14.03.2020, towards full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI and inform the payment particulars with settlement details to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 25th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR SHANKAR A KERKAR
VS
RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1701
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Shankar A Kerkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11250034209500002462 New India Mediclaim Policy 24.07.2020 to 23.07.2021 Rs.3,00,000/-
3	Name of Insured Name of the policyholder	Mr. Shankar A Kerkar
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	25.01.2021
8	Nature of complaint	Short Settlement of Covid claim
9	Amount of claim	Rs.1,16,375/-
10	Date of Partial Settlement	18.12.2020
11	Amount of relief sought	Rs.10,978/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	12.04.2021 - 12.00
14	Representation at the hearing	
	a) For the complainant	Mr. Shankar A Kerkar
	b) For the insurer	Ms Nivedita Parulekar, Admn officer
15	Complaint how disposed	Award

16	Date of Award/Order	24.04.2021

Brief Facts of the Case: Complainant, Mr. Shankar A Kerkar aged 63 yrs was admitted to Oscar Hospital & Research Centre, Mumbai from 28.09.2020 to 08.10.2020 for the treatment of Covid-19. The complainant approached this Forum with a complaint against a short-settlement by the Respondent, The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant submitted that he had preferred a claim with the Respondent for the hospitalization expenses incurred by him for the treatment of Covid. The claim was settled for Rs.87,407/- as against the total claimed amount of Rs.1,16,375/-. He stated that he has been an agent for the company for the last twenty years and argued that disallowance of RMO charges of Rs.3,600/- and BMW charges of Rs.4,500/-, had been wrongly deducted as the same is not mentioned in the policy conditions. As regards the deduction of Infusion Pump of Rs.1,000/-, Pulse Oximeter Rs.1,000/-, and Accu check of Rs.878/-, these were the genuine expenses paid by him which were advised and prescribed by his treating doctor as a precautionary measure hence has to be paid. In view of the same, not agreeing with the deductions, requested the Forum for payment of Rs.10,978/- deducted towards the aforesaid expenses incurred by the Complainant.

Contentions of the Respondent:: It was contended on behalf of the Respondent that the insured patient was admitted for 2019-NCOV Acute Respiratory Disease. The claim lodged by the Complainant for the total amount of Rs.1,16,375/- was settled for Rs.87,407/- deducting Rs.28,968/-. The Respondent explained that out of total deduction of Rs.28,968/-, insured has not submitted prescriptions for the investigations done for total amount of Rs.16,275/- (Rs.4,300 + Rs.7,960/- + Rs.825/- + Rs.570/- + Rs.1,420/- + Rs.1,200/-), Infusion Pump-Rs.1,000/-, Accucheck-Rs.878/-, Pulse Oximeter- Rs.1,000/- and BMW charges of Rs.4,500/- are not payable as per policy terms and conditions. Regarding disallowance of RMO Charges, Respondent clarified that as per policy conditions these charges are included in the Room Rent and the maximum Room Rent amount of Rs.3,000/- per day has been allowed to him as per his entitlement under the subject policy. Thus Respondent stated that the claim has been processed within the scope of the policy terms and conditions as explained.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record and the depositions of both the parties, it is observed that the Complainant has contended against the deductions made under the heads of RMO charges, BMW charges, Infusion Pump, Pulse Oximeter, and Accucheck. As regards the disallowed charges of Infusion pump, Pulse Oximeter, and Accucheck which fall under IRDAI approved non-medical list of policy terms, are in order. Regarding RMO Charges, as per policy definition, Room Rent means the amount

charged by the hospital towards Room and Boarding expenses and shall include associated medical expenses such as Nursing charges, RMO charges, etc. In the present case, the insured is covered for a sum insured of Rs.3,00,000/- and he is entitled to Room Rent (Room + Nursing + RMO) of 1% of Sum Insured (excluding Cumulative Bonus) per day. On scrutiny of the bills, it is noted that the Complainant has been allowed Room Rent of Rs.3,000/- per day (Bed Charges – Rs.2,000/- + Nursing Charges – Rs.1,000/-) which is the maximum payable amount under the head of Room Rent in the policy. At the same time, it is observed that disallowed BMW charges are not mentioned in the excluded list (Non-Medicals) of the policy terms and conditions. Hence, the Respondent is directed to pay Rs.4,500/- towards the expense incurred for BMW charges in the subject claim. The decision of the Respondent is therefore, partly intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay a further amount of Rs.4,500/- deducted for BMW charges for the COVID treatment in favour of the Complainant, Mr. Shankar A Kerkar in respect of his hospitalization from 28.09.2020 to 08.10.2020 subject to availability of Sum Insured under the policy, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 24th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR HEMANT G GANDHI
VS
RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1680
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Hemant G Gandhi** **Mumbai**
2	Policy No Type of Policy Duration of Policy/Period Sum Insured	14060034199500009016 New India Mediclaim Policy 21.01.2020 to 20.01.2021 Rs.3,00,000/-
3	Name of Insured Name of the policyholder	Mrs. Jayshree G Anam
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	04.03.2020
6	Reason for repudiation	Clause 2.16 – Not listed in Day Care
7	Date of receipt of the complaint	06.02.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.23,032/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.23,032/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	12.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Hemant Gandhi
	b) For the insurer	Ms. Poonam Advani, A. O.

		Dr Ketaki Tand – MD India TPA
15	Complaint how disposed	Award
16	Date of Award/Order	23.04.2021

Brief Facts of the Case: Complainant, Mr. Hemant Gandhi was treated for Left Eye Retina Silicone Oil Insitu at Kumta Eye & Retina Clinic & Laser Centre on 17.02.2020. The Complainant approached this Forum with a complaint against repudiation of the claim reported for the said treatment by the Respondent, The New India Assurance Company Limited on the ground that the said treatment was not listed in Day Care and that it was an OPD procedure, hence denied as per clause 2.16 of policy terms and conditions.

Contentions of the Complainant: Complainant submitted that the claim was preferred with the Insurer for Rs.23,032/- for the treatment of Left Eye Retina Silicone Oil Insitu, was denied by the Respondent stating the procedure was not listed in the daycare list of the policy. However, Complainant argued that his earlier three claims for the same procedure had been paid by the Insurer vide Claim No.MDI4458626 dated 13.10.2018 for Rs.83,162/-, Claim No.MDI4742816 dated 23.02.2019 for Rs.52,110/- and Claim No.MDI4791552 dated 11.03.2019 settled for Rs.57,660/-. He added that the initial two treatments were unsuccessful and hence he shifted to Kumta Eye & Retina Clinic. The insured patient underwent the said procedure a third time on 11.03.2019 which was also settled by the Insurer. Hence, not agreeing with the reason cited by the Respondent for the denial of the fourth claim reported by him for the same treatment, requested the Forum for the settlement of the claim amount of Rs.23,032/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the insured patient was diagnosed with Retina Silicone Oil Insitu and treated with Silicon Oil Removal, Air, C3F8, and Fax application under LA on 17.02.2020. The claim lodged by the insured was repudiated on the ground that the procedures were not listed in the admissible daycare treatment, and was an OPD procedure and not Eye Surgery as per clause 2.16 which states that **Hospitalisation means admission in a hospital for a minimum period of twenty-four consecutive hours of in-patient care except for specified procedures/treatment as mentioned in Annexure I, where such admission could be for a period of less than twenty-four consecutive hours. Note: Procedures/treatments usually done in the outpatient department are not payable under the Policy even if converted as an in-patient in the hospital for more than twenty-four consecutive hours.**

The Respondent further clarified in detail about the procedures underwent by the patient in earlier three settled claims wherein under each hospitalization, Vitrectomy surgery was done along with various other procedures such as Vitreous base dissection, Silicon oil injection, Cryo & SF6 gas, etc. . Since Vitrectomy is payable as a daycare procedure as per policy terms and conditions, the claims were made payable. However, in the instant claim, the patient had undergone other procedures except for Vitrectomy on a stand-alone basis which are not payable. The Respondent also produced all three previous discharge summaries in support of the same. Given the facts, Respondent stood by their decision of the denial of the aforesaid claim being made as per terms and conditions of the policy.

Forum's Observations/Conclusion: On scrutiny of the documents produced on record and deposition made by both the parties, it is observed that the instant claim was not paid by the Respondent as the discharge card did not mention about Vitrectomy procedure done as was mentioned in the previously settled claims. In this connection, it is noted that in the subject claim, the insured patient underwent treatment for Silicon oil removal, Air, C3F8, and Fax application which was also a surgical procedure. The C3F8 is the treatment of retinal detachment associated with vitreoretinal proliferation. At the same time, it should be noted that Vitrectomy surgery is done for the treatment of Retinal Detachment and which is also mentioned in the diagnosis of all the discharge cards. Since the present treatment appears to be a follow-up procedure and is related to Vitrectomy, it is not justified to reject the claim citing the reason that the procedure was not Vitrectomy. In view of the settlement of earlier claims and policy terms do not specifically exclude the aforesaid treatment on a stand-alone basis, Respondent is directed to settle the subject claim for the claimed amount less non-medicals, if any. The decision of the Respondent is therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay Rs.23,032/- less non-medicals ,if any, (claim no.MDI5509400) in favour of the Complainant, Mr. Hemant G Gandhi towards full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 23rd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MRS MANDAKINI B JAGTAP

VS

RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1649

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mrs. Mandakini B Jagtap** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171149/01/2021/002160 Family Health Optima Insurance Policy 17.06.2020 to 16.06.2021 Rs.3,00,000/-
3	Name of Insured Name of the policyholder	Mr. Mandakini B Jagtap
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Claim lodged in break period of policy
7	Date of receipt of the complaint	19.01.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.34,434/- and Rs.3,38,585/- (two hospitalizations)
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.3,73,019/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)

13	Date of Hearing	09.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Pankaj Jagtap
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award
16	Date of Award/Order	22.04.2021

Brief Facts of the Case: Complainant was admitted to P D Hinduja Hospital on 10.12.2019 for treatment of CKD/HTN, on maintenance dialysis and IC Bleed then shifted to S L Raheja Hospital from 10.12.2019 to 20.12.2019 due to non-availability of ICU bed. The claim reported by the Complainant for the said hospitalizations was denied by the Respondent, Star Health, and Allied Insurance Co. Ltd on the ground that the claim was not admissible as the same fell during the break period of the policy. The Complainant's submission is that it was not his fault as Insurer did not reinstate his previous policy as ordered by the Ombudsman Award no.IO/MUM/A/HI/0457/2019-2020 from the date of cancellation of the policy. Instead,Respondent issued a fresh policy with effect from 17.06.2020. Aggrieved, he approached this Forum requesting relief in the matter of settlement of both hospitalization claims.

Contentions of the Complainant: The Complainant's son, Mr. Pankaj Jagtap appeared and deposed before the Forum. He submitted that his mother was hospitalized in 2018 and had reported a claim under Policy no.P/171127/01/2019/005534 which was issued for the period from **31.07.2018 to 30.06.2019**. The Respondent had rejected the said claim on the ground of Non-disclosure and had canceled the policy. The Complainant not accepting the reason for repudiation,had registered a complaint in the Ombudsman Office and the Forum through award dated 21.01.2020 had directed the Respondent to settle the claim and also reinstate the policy. Meanwhile, his mother was again hospitalized on 10.12.2019 to P D Hinduja and S L Raheja Hospital with the complaints of drowsiness, headache, and vomiting four to five hours post-dialysis (on maintenance dialysis), the claim for the same he could not report as her earlier

claim was under dispute in the Forum. The Respondent settled the insured's earlier claim as per the award passed in February 2020,but did not reinstate the policy. Mr. Pankaj Jagtap submitted his mother's claim documents of December 2019 hospitalization and also tried to renew the policy but as the policy was not reinstated, he could not renew the policy. Subsequently,Respondent issued fresh policy no. P/171149/01/2021/002160 for the period from **17.06.2020 to 16.06.2020** to the insured and the claim reported for his mother's hospitalizations in December 2020 was denied by the Respondent on the ground that the claim lodged was during the break period of the policy and hence, claim was not admissible. The Complainant argued that theinsurer,though the award was passed to reinstate the policy, issued fresh policy with effect from 17.06.2020 with a gap of one year and rejected their genuine claim lodged during December 2019 on the ground of claim falling in the break period which is not acceptable to him. Hence, requested the Forum for settlement of the total claim for Rs.3,73,019/- towards the two hospitalization expenses incurred by him.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured preferred a reimbursement claim for her admission to P D Hinduja Hospital on 10.12.2019 and shifted to S L Raheja Hospital from 10.12.2019 to 20.12.2019. Since the insured's earlier policy had expired on 30.06.2019 and the next policy was issued with effect from 17.06.2020 and since the admission fell during the break-in period of the policy, the claim was repudiated and was conveyed to the Insured. However, on review of the claim, it was noticed by the Respondent that due to covid issues in the year 2020, the policy was erroneously issued from 17.06.2020 without reinstating it from the date of cancellation of the policy as per Ombudsman's Award released on 21.01.2020. Hence, accepting the mistake on Respondent's part, they agreed for settlement of both of the hospitalization claims lodged by the Complainant. The Respondent agreed to settle the first hospitalization claim lodged for treatment in P D Hinduja Hospital for an admissible amount of Rs.23,607/- as against a total bill amount of Rs.34,434/- with a deduction of Rs.10,827/-. The deductions made were towards the non-availability of CT scan reports and non-medicals. Since the Bill Summary for S L Raheja Hospital was under process, Respondent promised to submit it shortly. Accordingly, vide email dated 16.04.2021,submitted the Bill Summary for the second hospitalization with the admissible amount of Rs.2,90,482/- as against total bill amount of Rs.3,38,585/-.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent did not

comply the order of Ombudsman dated 21.01.2020 to reinstate the policy no.P/171127/01/2019/005534 with the expiry date of 30.06.2019 and issued a fresh policy with effect from 17.06.2020 after a gap of one year to the insured.The Forum has taken very serious view of this lapse on the part of the Respondent.Had the Respondent complied with the said order the present complaint would not have arisen. However, now the Respondent has accepted the error on their part and consented to rectify the same, also agreed to pay the admissible amount for the two hospitalization claims reported by the Complainant for Rs.23,607/- and Rs.2,90,482/- towards expenses incurred at P D Hinduja Hospital and S L Raheja respectively. After scrutiny of the bill summary in the first hospitalization in P D Hinduja Hospital, Complainant has forwarded the CT Scan Report, hence Rs.5,000/- can be paid to the insured. As regards the second hospitalization to S L Raheja Hospital, Room Rent of Rs.70,200/- (Rs.7500 room rent + Rs.300 nursing charges x 9 days) has been allowed deducting Rs.7,500/- room rent charged for the 10th day. Since the insured has incurred the expenses as billed by the hospital, it is not justified to deduct the same. Also Ambu bag charges of Rs.3,100/- should have been paid as the same didn't appear in the list of excluded non-medicals.

Hence, Respondent is directed to pay Rs.3,29,689/- (Rs.3,01,082/- + Rs.28,607/-) towards two hospitalization expenses incurred by the Complainant from 10.12.2019 to 20.12.2019 along with interest@ 2% above the prevailing bank rate from 30 days after the date of complete submission of claim documents till the date of actual payment towards full and final settlement of the complaint and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly. The decision of the Respondent is intervened by the following order:

AWARD

Under the facts and circumstances of the case, Star Health & Allied Insurance Co. Ltd. is directed to pay an admissible amount of Rs.3,29,689/- of the two hospitalizations from 10.12.2019 to 20.12.2019 as per policy terms and conditions along with interest @2% above the prevailing bank rate from 30 days after the date of complete submission of claim documents till the date of actual payment towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid further penal interest as per guidelines of the IRDAI and inform the payment particulars to this Forum. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 22nd April 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN: SHRI MILIND KHARAT

COMPLAINANT - MRS. ASHITA P SHAH
VS

RESPONDENT: MAX BUPA HEALTH INSURANCE CO.LTD.

COMPLAINT REF. NO: MUM-H-031-2021-1765
AWARD NO: IO/MUM/A/GI/ /2020-2021

Complainant, Mrs. Ashita P Shah was covered under Max Bupa Insurance Co. Ltd under Policy No. 30104292202008 for Sum Insured of Rs.10,00,000/- for the period from 29.05.2020 to 28.05.2021. She lodged a claim for an amount of Rs.2,65,794/- under the policy for her admission to Agarwal Hospital, Mumbai for the treatment of Acute Calculus Cholecystitis and was admitted from 12.08.2020 to 14.08.2020. The claim no.561581 for Rs.2,65,794/- was settled for Rs.2,04,194/- by deducting Rs.61,600/-. The Complainant's spouse, Mr. Purav Shah argued for the deduction of Rs.50,000/- made under the Reasonability and Customary clause which is not justified as the payment is made as charged by the treating doctor and it varies based on the doctor's skill and expertise.

A joint hearing of the parties to the dispute was scheduled on 20.04.2021 at 11.45 a.m. During the hearing, Respondent informed the Forum that they have reviewed the matter and are ready to make a further payment of Rs.50,000/- which had been deducted under the head of Reasonable and Customary Clause of the policy. The complainant agreed to accept the settlement offered by the Respondent as full and final. In view of the same, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated: This 20th day of April 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR DEVANG THAKKAR
VS
RESPONDENT: UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-051-2021-1697
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Devang Thakkar** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0204002819P115453771 Family Medicare Policy 2014 26.03.2020 to 25.03.2021 Rs.10,00,000/-
3	Name of Insured Name of the policyholder	Mr. Devang Thakkar
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	
6	Reason for repudiation	Oral Chemotherapy – OPD treatment
7	Date of receipt of the complaint	16.02.2021
8	Nature of complaint	Repudiation
9	Amount of claim	Rs.1,19,079/-(5 nos. claims)
10	Date of Partial Settlement	--
11	Amount of relief sought	Rs.1,19,079/-

12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	09.04.2021 - 12.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Devang Thakkar
	b) For the insurer	Ms. Aarti S Pandhare, Asst Manager
15	Complaint how disposed	Award
16	Date of Award/Order	19.04.2021

Brief Facts of the Case: Complainant, Mr. Devang Thakkar, diagnosed with Hodgkin Lymphoma was treated with Oral Chemotherapy in Empire Centre. The five claims for reimbursement of expenses incurred by him during the period from October 2020 to March 2021 for the total amount of Rs.1,19,079/- was repudiated by the Respondent, United India Insurance Company Limited as per policy clause 1.1 on the ground that the treatment was done on OPD basis, hence not payable.

Contentions of the Complainant: Complainant submitted that he was diagnosed with Hodgkin Lymphoma and his treating doctor advised him Tab.Ibrumat (Oral Chemo) as a part of the treatment. He submitted that his earlier three claims for the same procedure had been rejected and after approaching the Forum was awarded favorably. However, Insurer once again has denied his subsequent five claims on the same ground that the treatment is an OPD treatment. He further stated that the Insurer did not respond despite repeated follow-ups by him to know the status of these claims. The Complainant submitted that the treatment is an ongoing treatment and the claim will arise every month. He added that going through the same procedure again and again for getting these claims paid is waste of time and harassment for a patient like him undergoing the treatment. He also pointed out not to apply co-payment in settlement of the claims as done earlier by the Insurer as he is been covered for the Sum Insured of Rs.10,00,000/- since 25.03.1997. Based on the facts, the Complainant not agreeing with the repudiation of the claims requested the Forum for settlement of the following claims lodged for the total amount of Rs.1,19,079/-.

Sr.no.	Claim No.	Date of Submission	Amount
1	21RB03UIC1003	10.10.2020	Rs.23,220/-

2	21RB03UIC1522	19.11.2020	Rs.22,800/-
3	Not Received	28.12.2020	Rs.25,309/-
4	21RB03UIC2080	12.02.2021	Rs.22,800/-
5	21RB03UIC2371	16.03.2021	Rs.24,950/-
	TOTAL		**Rs.1,19,079/-**

Contentions of the Respondent: It was contended on behalf of the Respondent that the Insured patient has been treated with Oral Chemotherapy medicine on an OPD basis for the diagnosis of Hodgkin Lymphoma. As per clause no.1.1 of the policy terms and conditions, the claims lodged for the same have been repudiated as the procedure on OPD is not payable and hence is beyond scope of the policy.

Forum's Observations/Conclusion: This Forum has received several complaints against non-settlement of claims for Chemo injections and Oral Chemo treatments. Cancer is a multifactorial disease and is one of the leading causes of death worldwide. Chemotherapy is an effective treatment against cancer but undesirable chemotherapy reactions and the development of resistance to drugs which results in multi-drug resistance are the major obstacles in cancer chemotherapy. So alternative formulations are in practice these days which are liposomes, resistance modulation, hormonal therapy, cytotoxic chemotherapy, and gene therapy. Many doctors have found Oral Chemo also as one of the effective methods. Although the policy mentions coverage of parental Chemo, modern cancer treatment methods like oral chemo cannot be denied. Further Oral Chemo is not specifically excluded in the exclusion list of the policy.

In this connection, attention is invited to the Master Circular on Standardization of Health Insurance Products dated 22.07.2020 issued by IRDAI which states that to ensure that the policyholders are not denied the availability of health insurance coverage to Modern Treatment Methods, Insurers shall ensure that certain treatment procedures as mentioned therein (which includes oral chemotherapy & Immunotherapy – Monoclonal Antibody to be given as an injection) shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as an in-patient or as part of domiciliary hospitalization or as daycare treatment in a hospital. Further during the hearing, the

Complainant verbally requested not to apply co-payment deduction while settlement of the claims as he is continuously covered under the policy since 1997. In this regard, the Respondent is directed to settle the claim as per policy terms and conditions as approved by IRDAI. As regards the hardship faced by the Complainant to follow repeated procedures, Forum can only attend to the disputes given to them. Besides, it should be noted that as per terms and conditions of the Policy and as per Ombudsman Rules, 2017 claim/compensation can be awarded only for the loss suffered by the insured as a direct consequence of the insured peril; hence compensation on the ground of harassment and mental agony is out of the purview of this Forum and therefore, cannot be awarded. At the same time, Respondent is directed to be vigilant and should respond immediately to avoid causing hardships to their customers.

Given the facts, based on the repeated course of the treatment and having already decided vide earlier Award passed for similar treatment undergone by the complainant, the Respondent is directed to settle the claim for the admissible expenses incurred less non-medicals if any as per terms and conditions of the policy. The decision of the Respondent is therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to settle the oral chemotherapy claims (Five claims for the total amount of Rs.1,19,079/-) for the admissible amount less non-medicals, if any,as per terms and conditions of the policy in favour of the complainant, Mr. Devang Thakkar, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 19th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MRS KRISHNA NANGALIA

VS

RESPONDENT: UNITED INDIA INSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-051-2021-1612

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mrs. Krishna Nangalia** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0221002819P114227845 Individual Health Insurance Policy 17.03.2020 to 16.03.2021 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mrs. Krishna Nangalia
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-

7	Date of receipt of the complaint	14.01.2021
8	Nature of complaint	Short Settlement of claim
9	Amount of claim	Rs.2,23,461/-
10	Date of Partial Settlement	26.11.2020
11	Amount of relief sought	Rs.1,43,953/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	08.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	MrRonakNangalia
	b) For the insurer	Mrs.VidhishaParab, A.O.
15	Complaint how disposed	Award
16	Date of Award/Order	16.04.2021

Brief Facts of the Case: The Complainant, Mrs. Krishna Nangalia was admitted to Aastha Hospital, Mumbai from 18.08.2020 to 21.08.2020 for the treatment of a Left-Hand open fracture of the Ulna and Radius. The Complainant approached this Forum with a complaint against short-settlement by the Respondent, The United India Insurance Company Limited of a reimbursement claim lodged under the policy in respect of the said hospitalization on the ground of Reasonable and Customary Clause no.3.33 of the policy.

Contentions of the Complainant: Complainant's son, Mr. RonakNangalia appeared and deposed before the Forum. He submitted that his mother had a fall in their building premises

and suffered a fracture of Ulna and radius for which she was treated in Aastha Hospital. The reimbursement claim preferred with the Insurer for Rs.2,23,461/- was settled for Rs.79,508/- with a substantial deduction of Rs.1,43,953/-. The deductions were made by the Respondent on the ground that the hospital is a PPN network hospital hence, the claim was settled as per GIPSA package and disallowed the excess expenses on the basis of Reasonable and Customary Clause of the policy terms and conditions. However, Mr. RonakNangalia argued that as the admission of the patient was in emergency and due to covid situation, the doctor advised him to go for reimbursement claim. He also submitted a letter dated 28.08.2020 and 30.11.2020 from the treating doctor certifying that the cashless facility was not utilized by the patient as the admission was on emergency and lack of enough backup staff due to covid pandemic in the hospital and also certified that all the patients were given separate rooms at the time of Covid 19 and due to non-availability of rooms, the insured patient was allotted super deluxe room. Based on the facts, the complainant did not agree with the reason cited by the Insurer for deductions made under the subject claim, the Complainant requested the Forum for settlement of the genuine expenses incurred by him for the balance amount of Rs.1,43,953/-.

Contentions of the Respondent: It was contended on behalf of the Respondent that the reimbursement claim preferred by the insured for Rs.2,23,461/- had been settled for Rs.79,508/- with a deduction of Rs.1,43,953/-. Respondent submitted that while processing of the claim, it was observed that the admission of the insured patient was to the GIPSA PPN network hospital and since separate hospital package is followed for Network Hospitals as agreed between the Company and the Hospital, according to the package rate Rs.79,508/- was approved and the excess charges were not admissible as per policy clause no.3.33 which states that **Reasonable and customary charges are the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.** Given the facts, Respondent stood by their decision of the aforesaid claim settlement being made as per terms and conditions of the policy.

Forum's Observations/Conclusion: On an analysis of the case, the Forum finds that the complainant has taken treatment in the Company's network hospital. However, as the admission of the patient was on an emergency basis and since the hospital refused cashless facility, the Complainant could not avail the cashless facility. In support of the same, the Complainant had also provided letters from the Hospital. In the instant case, it also appears

that the hospital has charged open rates and not adhered to their PPN rates. Since Complainant opted for reimbursement claim as asked to him by the hospital, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the entire hospitalization expenses barring non-medical items and the Respondent may seek a refund of the amount billed over agreed rates directly from the hospital. The decision of the Respondent is therefore,intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co. Ltd. is directed to pay a further amount of Rs.1,43,953/- less non-medicals, if any, as per terms and conditions of the policy in favour of the complainant, Mrs. Krishna Nangalia, towards full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 16th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN: SHRI MILIND KHARAT

COMPLAINANT - MRS. NEELAM CHATURVEDI

VS

RESPONDENT: STAR HEALTH AND ALLIED INSURANCE CO LIMITED

COMPLAINT REF. NO: MUM-H-044-2021-1707

AWARD NO: IO/MUM/A/HI/ /2020-2021

Complainant's husband, Mr. DevendraChaturvedi was covered under Star Group Health Insurance Policy (Gold) no.P/171113/01/2020/001186 for the period 16.05.2019 to 15.05.2020 for floater Sum Insured of Rs.4,00,000/- issued to the customers of Bank of Baroda . Mr. DevendraChaturvedi was admitted to Asian Heart Institute, Mumbai on 09.01.2020 and underwent Mitral Valve Repair. The claim lodged under the policy for reimbursement of hospitalisation expenses was repudiated by the Respondent as per Exclusion No.3 of the policy on the ground of admission and treatment was for the ailment which was Pre Existing based on ECHO report showing long-standing ailment before the inception of the subject policy. The Complainant argued that the said ailment was not pre-existing but was diagnosed after taking the policy. Hence not agreeing with the decision of the Respondent, approached this Forum seeking relief up to policy sum insured of Rs.4,00,000/- as against the expenses incurred by her amounting to more than Rupees seven lakhs.

A joint hearing of the parties to the dispute was scheduled on 12.04.2021 at 12.15 pm and during the hearing, Respondent stated that they had reviewed the claim and were willing to settle the claim. Since the bill summary was under process, Respondent confirmed the submission of the same soon. Accordingly, the respondent, vide email dated 16.04.2021,informed the admissible amount of

Rs.4,00,000/-(under claim no.CLI/2020/171113/0777009), the maximum amount payable under the policy as against the total claimed amount of Rs.7,10,545/- towards a full and final settlement of the claim. In view of the complaint had been resolved, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated: This 16th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MR MOHAMED FAIZAN KHAN

VS

RESPONDENT: STAR HEALTH & ALLIED INS.CO.LTD.

COMPLAINT REF: NO: MUM-H-044-2021-1628

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr. Mohamed Faizan Khan** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171132/01/2020/008464 Star Comprehensive Insurance Policy 26.10.2019 to 25.10.2020 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mr. Mohamed Faizan Khan
4	Name of Insurer	Star Health & Allied Ins. Co. Ltd.
5	Date of Repudiation	05.10.2020
6	Reason for repudiation	Misrepresentation of facts
7	Date of receipt of the complaint	14.01.2021
8	Nature of complaint	Reimbursement
9	Amount of claim	Rs.58,000/-
10	Date of Partial Settlement	---
11	Amount of relief sought	Rs.58,000/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	07.04.2021 - 11.45 am
14	Representation at the hearing	
	a) For the complainant	Mr. Mohamed Faizan Khan
	b) For the insurer	Mr Arvind B Thakkar, AGM
15	Complaint how disposed	Award

16	Date of Award/Order	15.04.2021

Brief Facts of the Case: Complainant was admitted to Kolekar Hospital &ICCU on 20.02.2020 for treatment of Abscess over distal Phalanx of the second toe of Right foot with Cellulitis and discharged on 23.02.2020. The complainant approached this Forum with a complaint against total repudiation by the Respondent, Star Health & Allied Insurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the Complainant: The Complainant submitted that he had preferred a reimbursement claim with the Respondent which was rejected based on discrepancy found in the statement of the insured that he was not suffering from Pulmonary embolism as against the consultation letter dated 30.01.2020 wherein the Cardiologist, Dr. Brian Pinto mentioned that the insured patient had been suffering from Pulmonary Embolism five years back. The Complainant stated that as regards the query raised by the Insurer for submission of medical documents relating to the treatment of Pulmonary Embolism based on the remarks on the discharge summary, he submitted a letter dated 26.02.2020 from the hospital confirming history as provided by Insured and relatives that patient was k/c/o DVT/Pulmonary Embolism for 2 to 3 months attaching the consultation paper of Dr. Brain Pinto prescribing Tab. Warf, other reports, and CT Scan and MRI not done. The Complainant further clarified that though the medicines were prescribed to him by Dr. Brain Pinto on 30.01.2020 based on the investigations, he did not take medicines. The Complainant also added that he was covered with Oriental Insurance Company Limited since 26.10.2015 and subsequently from 26.10.2019 ported that policy with Star Health and Allied Insurance Company Limited. At the time of porting the policy i.e. on 26.10.2019, he was under medication for DM and HTN which he had genuinely disclosed in the proposal form submitted to the Company. The Complainant stated that he was not under any medication except HTN and DM at the time of inception of the policy with the Insurer. Aggrieved, he approached this Forum requesting relief in the matter of settlement of the claim.

Contentions of the Respondent: Dr. Arvind Thakkar, AGM contended that the insured was admitted to Kolekar Hospital & ICCU for the treatment of Cellulitis. On submission of

reimbursement of medical expenses, it was observed from the Discharge Summary that the insured had a history of DVT?Pulmonary Embolism. Hence, query was raised for submission of the first consultation paper, treatment records, etc. However, the insured denied of history of pulmonary embolism 5 years back and submitted a letter from the hospital for the same with the consultation papers along with other investigation reports. It was observed from the consultation report dated 30.01.2020 provided by the insured of Cardiologist, Dr. Brain Pinto which mentioned that the insured patient had a history of pulmonary embolism 5 years back. Given the discrepancy in facts produced which amounted to misrepresentation of facts. The Respondent added that the Insured earlier had a policy with The Oriental Insurance Company from 26.10.2015 to 25.10.2019 and ported to Star Health and Allied Insurance Co. Ltd. Moreover, while porting of the policy,the proposal form was obtained wherein the insured had not disclosed about his suffering from Pulmonary embolism. Based on the facts as per policy condition no.9(misrepresentation of facts) and Condition no.4 (non-submission of required documents), Respondent has denied the claim.

Forum's Observations/Conclusion: On hearing the depositions of both the parties and on analysis of the documents produced on record, it is observed that the Respondent has denied the claim on the ground of misrepresentation of facts and also not producing the required documents for processing of the claim. In this regard, it is observed that the insured patient had visited Cardiologist Dr. Brain Pinto and based on investigation reports, the doctor had prescribed him in his consultation letter dated 30.01.2020, blood thinner Tablet Warf for DVT and had mentioned about patient’s history of Lower Respiratory Disease on an antibiotic five years back. In this regard, the Complainant submitted hospital's letter dated 26.02.2020 which certified that Pulmonary Embolism was diagnosed two to three months before the present hospitalization but no details of treatment underwent by the patient were available which was also confirmed by the insured that he did not take the medicine prescribed and also did not go for CT Scan and MRI. As regards proposal form dated 14.10.2019 duly filled by the Complainant, it was noted that he had disclosed the details of DM and HTN and had also provided the details of medications he was taking for these ailments for the past two years. Since he was not under any medication for the ailment Pulmonary Embolism at that particular time, he had not mentioned the same in the proposal form. The Complainant also clarified the submission of all the reports and consultation letter dated 30.01.2020 but could not produce any medical reports/documents pertaining to the treatment of Pulmonary Embolism as he did not take any treatment for Pulmonary Embolism. Considering the above-mentioned facts, the denial of the claim on the ground of alleged misrepresentation of fact and non-submission of

documents is not justified. The Forum directs the Respondent to settle the admissible claim barring non-medicals towards full and final settlement of the claim. The decision of the Respondent is intervened by the following order:

AWARD

Under the facts and circumstances of the case, Star Health & Allied Insurance Co. Ltd. is directed to pay an admissible amount out of the claimed amount of Rs. 58,000/-excluding non-medicals for hospitalization of the insured during the period from 20.02.2020 to 23.02.2020 to the Complainant, Mr. Mohamed Faizan Khan towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 15th April 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN: SHRI. MILIND KHARAT

CASE OF COMPLAINANT - MRS LATA K GUPTA

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1654

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mrs. Lata K Gupta** **Mumbai**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11170034199500008112 New India Mediclaim Policy 15.03.2020 to 14.03.2021 Rs.5,00,000/-
3	Name of Insured Name of the policyholder	Mrs. Lata K Gupta
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	-
6	Reason for repudiation	-

7	Date of receipt of the complaint	19.01.2021
8	Nature of complaint	Short Settlement of Covid claim
9	Amount of claim	Rs.1,49,562/-
10	Date of Partial Settlement	29.10.2020
11	Amount of relief sought	Rs.88,400/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	08.04.2021 - 12.00
14	Representation at the hearing	
	a) For the complainant	Mr. Kamal Gupta
	b) For the insurer	Mrs. HarinakshiKarkera, Admn officer
15	Complaint how disposed	Award
16	Date of Award/Order	12.04.2021

Brief Facts of the Case: Complainant, Mrs. Lata K Gupta aged 72 yrs was admitted to Saifee Hospital, Mumbai from 01.09.2020 to 07.09.2020 for the treatment of Covid-19. The complainant approached this Forum with a complaint against short-settlement by the Respondent, The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: Complainant's spouse, Mr. Kamal Gupta appeared and deposed before the Forum. He submitted that they had preferred a claim with the Respondent for the hospitalization of his wife, Mrs. Lata K Gupta for the treatment of Covid. The claim reported for Rs.1,49,562/- was settled with a deduction of Rs.88,400/- which he stated to have been deducted for Rs.34,800/- towards Personal Protection Equipment (PPE), Rs.20,600/- for Profession charges, and Rs.33,000/- for Room Rent. However, Mr. Kamal Gupta submitted that on review of subsequent payments received from the Respondent under the subject claim, he requested the forum for settlement of the disallowed amount of Rs.16,800/-

towards PPE kit charges which is the basic mandatory requirement for the treatment ofCovid. Hence,requested the forum to consider the genuine expenses incurred by him towards PPE Kit charges for Rs.16,800/-.

Contentions of the Respondent:: It was contended on behalf of the Respondent that the insured patient was admitted for 2019-NCOV Acute Respiratory Disease. The claim lodged by the Complainant for the total amount of Rs.1,53,312/- was settled for Rs.1,05,578/- in three installments that were Rs.48,728/- on 29.10.2020, Rs.12,250/- on 14/12/2020, and Rs.44,600/- on 01.02.2020. Respondent further stated that the insured was covered under the policy for Sum Insured of Rs.5,00,000/- and so was eligible for room rent of Rs.5,000/- per day while she had opted for room rent of Rs.9,500/- per day. However, she had also opted for Optional Cover 1 and therefore, no proportionate deduction was made from other expenses except for Rs.27,000/- deducted from the total room rent of Rs.57,000/-. The hospital charged Rs.6,300 x 6 days and Rs. 600/- (for CT Scan) i.e. total charged amount was Rs.38,400/- for the PPE kit which was found to be on the higher side. Therefore, as per the Reasonable and Customary clause, they paid for 3 PPE kits per day @ Rs.1200/- per kit i.e.Rs.3,600 x 6 days= Rs.21,600/- and hence disallowed Rs.16,800/- for PPE kits as per the Internal Guidelines issued by the Company. Further Rs.524/- were disallowed towards Non-medical expenses and Rs.3,410/- towards Miscellaneous Charges for Bio-medical Waste disposal and meals. Thus Respondent stated that the claim had been processed within the scope of the policy terms and conditions as explained.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record and the depositions of both the parties, it is observed that the major deductions from the claim amount were under the heads of Room rent and PPE kit charges. The Complainant during the hearing agreeing with other deductions requested for the disallowed amount of Rs.16,800/- under the head of PPE kits. In this regard, the Forum notes that the charges for PPE kits depend on the number of doctors, nurses, and other hospital staff attending to the patient. These charges are included in the hospital bill and are genuinely paid by the patient who has no control over it. Therefore,deduction under this head on the pretext of Reasonability is not justified and cannot be sustained. The decision of the Respondent is therefore,partly intervened by the following Order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to pay a further amount of Rs.16,800/- deducted from the PPE Kit charges in favour of the Complainant, Mrs. Lata K Gupta in respect of her hospitalization from 01.09.2020 to 07.09.2020, towards a full and final settlement of the complaint within 30 days from the issuance of the award so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8), the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated: This 12th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI. MILIND KHARAT

CASE OF COMPLAINANT - Mr. Samratharam Mali

VS

RESPONDENT : United India Insurance Co. Ltd.

COMPLAINT REF: NO:MUM-H-051-2021-1748

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Mr. Samratharam Mali Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0201002819P116768513 Family Medicare Policy 2014 22.03.2020 to 21.03.2021 Rs.2,00,000/-
3	Name of Insured Name of the policy holder	Mr. Samratharam Mali …….-…….
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	-

6	Reason for repudiation	Exclusion Clause 1.2.1 - OPD
7	Date of receipt of the complaint	03.02.2021
8	Nature of complaint	Repudiation of claim
9	Amount of claim	Rs.93,490/-
10	Date of Partial Settlement	--
11	Amount of relief sought	Rs.93,490/-
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	08.04.2021 @ 12.45 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Samratharam Mali
	b) For the insurer	Mrs. SayaliTawde
15	Complaint how disposed	Award
16	Date of Award/Order	12.04.2021

Brief Facts of the Case :The Complainant was diagnosed to have been suffering from tuberculosis in lungs and treated at home under advise of his treating Dr. Yogesh Jain. He lodged the claim amounting to Rs.93,490/- with the Respondent. The Respondent repudiated the claim under Policy Exclusion Clause 1.2.1 stating that the treatment could have been done on OPD basis.

Contentions of the Complainant : Complainant submitted that he was diagnosed Tuberculosis and due to COVID pandemic, he was treated at home under advise of Dr. Yogesh Jain. He stated that he was covered under the above policy ever since 2009,and this was his first claim since inception of the policy. He added that a claim lodged thereafter for medical expenses was rejected by the Respondent stating that the treatment was done on OPD basis. The reason cited by the Respondent for rejection of the claim was not acceptable to him and he requested for settlement of the claim.

Contentions of the Respondent: The Respondent submitted that the claimant was treated on OPD basis for MDR Tuberculosis. The policy covers hospitalization treatment more than 24 hours or specified daycare procedures. Hence the claim was rejected based on Policy Clause 1.2.1 which states ***"Expenses on Hospitalization for minimum period of 24 hours are admissible. This condition will also not apply in case of stay in hospital of less than 24 hours provided a) The treatment is undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement and b) Which would have otherwise required a hospitalization of more than 24 hours. Procedures/treatments usually done on outpatient basis are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centers."***

Forum's Observations/Conclusion : The Forum observed that the Complainant was suffering from Tuberculosis and has undergone home treatment as per the advice of treating doctor. There was no hospitalisation and it was observed that medical expenses incurred in the procedure were related to the treatment taken on Outdoor Patient Department (OPD) basis. It is also noted that the said treatment does not fall under list of Day care procedure. Since OPD treatment is not covered under the Policy, the Company's decision of repudiation of the claim is as per the terms and conditions of the policy.

Though the Forum is able to appreciate the concern of the complainant in this regard. It has also to be borne in mind that whenever any dispute arises, it is settled based on the terms & conditions of the policy under which a claim has arisen since these form the very basis of the contract between the parties. The Forum therefore, does not find any valid ground to intervene with the same and hence the following Order.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Samratharam Mali against United India Insurance Co. Ltd., does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 12th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT - MR BHARAT H DEDHIA
VS
RESPONDENT :THE ORIENTAL INSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-050-2021-1730
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**MrBhara H Dedhia** **Mumbai 400 031**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	121700/48/2019/7438, 121700/48/2019/7441,121700/48/2019/8680,121700/48/2020/4756,121700/48/2020/4759,121700/48/2019/13124 **Happy Fly Floater-2015, Individual Mediclaim,Oriental Super Health Top** **30.06.2019-29.06.2020** **Rs.5,00,000/- Rs.4,00,000/- and Rs.30,00,000/-** **(w.e.f.28.2019)**
3	Name of Insured Name of the policy holder	**MrBharat H Dedhia** - **do** -
4	Name of Insurer	**The Oriental Insurance Co Ltd**
5	Date of Repudiation	**……..-……..**
6	Reason for repudiation	**…….-……..**
7	Date of receipt of the complaint	**26.02.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.37,02,293/-**
10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.29,24,374/-**
12	Complaint registered under The Insurance Ombudsman Rules 2017	**13(b)**
13	Date of Hearing	**29.04.2021,03.45 pm**
14	Representation at the hearing	
	a) For the complainant	**MrRahul B Dedhia, complainant's son**

	b) For the insurer	**Mr Pravin Pashte, AM**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**03.05.2021**

Brief Facts of the Case : Complainant was admitted to Breach Candy Hospital Trust from 12.10.2019 till 29.10.2019 and underwent CABG on 15.10.2019.Complainant approached this Forum with a complaint against short-settlement by the Respondent, The Oriental Insurance Co Ltd of a claim lodged under the policies for the said hospitalization.

Contentions of the complainant : Complainant's son, Mr Rahul B Dedhia, duly authorized by him, appeared and deposed before the Forum. He submitted that his father iseligible for a total claim amount of Rs. 28,00,000/- across all the Individual Mediclaim and Floater Mediclaim Policies and additional Rs.30,00,000/- in Super Health Top-up Policy. He has never claimed for the maximum 1% Sum Insured for Health Check Up available for every block of 3/4 claim free policy years in any of the policies. He was hospitalized from 12.10.2019 till 29.10.2019 and underwent CABG on 15.10.2019 and the total hospitalization cost incurred was Rs. 37,02,293/-. Inspite of having informed the TPA well in advance regarding the planned surgery, neither the TPA nor the Insurance Company has provided any information regarding the Breach Candy Hospital not being a PPN hospital. Also they haven't provided the package rates of PPN Hospitals at the time of intimation. After discharge from hospital, the claim documents were submitted to the TPA. All the above referred 6 Policies were clearly superscribed on the 1st page of Part A of the claim form. However, while processing the claim amount, the same had been overlooked by the TPA and the Insurance Co.Thereafter, a single query has been repeatedly raised 4 times by the TPA despite a reply being given immediately when the query had been raised first. A similar reply along with supporting document from the treating surgeon has also been submitted on 13.12.2019.However, although whimsically, inspite of all of the above, on 01.02.2020 when he checked the status of his claim online, he was shocked to see that the TPA decided to classify the claim as not payable with a remark as **"Claim Recommended for Non-pay"** underclause 5.5 which states, **"CLAIM DOCUMENTS : Final claim along with original bills/cash memos/reports, claim form and documents as listed below should be submitted to the Company/TPA within 15 days of discharge from the Hospital/Nursing Home. i. Original bills, all receipts and discharge certificate/card from hospital."**After rigorous follow ups, the TPA then proceeded to settle the claim at Rs. 5,81,466/- only as full and final settlement against the total claim amount of Rs. 37,02,293/-, againwhimsically considering only one Policy No. 121700/48/2019/8680 and overlooking all other policies. They considered only SI of Rs.10 lacs and not considered 4 other Mediclaim Policies of collective Sum Assured Rs. 18,00,000/- and additional Rs. 30,00,000/- in Super Health Top-up. The TPA clarified regarding the deductions citing the Reasonable and Customary Clause and rates of other hospitals which are a part of their PPN network.

The Insured explained that he suffered a stroke in 2016 and this time,had suffered a heart attack wherein the Angiography showed 7 blockages ranging from 80% to 100% depicting

Severe Multi Vessel Damage thereby prompting the treating Cardiologist to suggest CABG. Hence, he immediately engaged one of the world's best Cardiac Surgeon DrSudhanshu Bhattacharyya who, on going through the case history and apprehending some uncertain events that could possibly occur and which could be much better managed and handled in Breach Candy Hospital, suggested him to get admitted in Breach Candy Hospital. On taking a second opinion from Dr A B Mehta, he also opined that not only Bypass Surgery is difficult but also Angioplasty. Hence, it was not out of choice but due to the complexity of his case that theInsured preferred to get admitted in Breach Candy Hospital. During the earlier hospitalization, he had preferred to get admitted in Global Hospital.

Contentions of the Respondent : It was contended on behalf of the Respondent that the Insured claimed for Rs.37,02,293/-. He is covered under policies as under :

Policy no.	Policy	Policy period	Sum Insured
121700/48/2019/7438	Happy Family Floater Policy	01.11.2018 to 31.10.2019	Rs.5,00,000/-
121700/48/2019/7441	Happy Family Floater Policy	01.11.2018 to 31.10.2019	Rs.5,00,000/-
121700/48/2019/8680	Happy Family Floater Policy	24.12.2018 to 23.12.2019	Rs.10,00,000/-
121700/48/2020/4756	Individual Mediclaim Policy	20.08.2019 to 19.08.2020	Rs.4,00,000/-
121700/48/2020/4759	Individual Mediclaim Policy	29.08.2019 to 28.08.2020	Rs.4,00,000/-
121700/48/2019/13124	Oriental Super Health top up Policy	28.02.2019 to 27.02.2020	Rs.30,00,000/- (DOI 28.02.2019)

Reason for Rejection/short payment :

Insured lodged above mentioned claims for the reimbursement of expenses incurred for the treatment of CABG done in Breach Candy Hospital. The Respondent settled the claim at Rs.5,81,466/- (Rs.5,71,466/- + Rs.10,000/- hospital cash) against total claim amount of Rs.37,02,293/-. Detail computation of the claim is given below :

Sr.No.	Procedure / Services	Claimed Amount	Deduction	Paid amount	Reason for deduction
1	Room Rent	25500	0	25500	
2	ICU Charges	156500	0	156500	
2	Anaesthesia	212500	162500	50000	
3	Surgeon Fees	2254695	2054695	200000	As per Cutomary and Reasonable Expenses Clause
4	Consultation Charges	9000	0	9000	
5	Investigation expenses	254239	178839	75400	As per Cutomary and Reasonable Expenses Clause
6	Registration fees	350	350	0	Registration fees not payable
7	Ambulance charges	3800	1800	2000	As per capping under the policy
8	Operation Theatre Charges	109670	59670	50000	As per Cutomary and Reasonable Expenses Clause
9	Hospital Services	92909	92909	0	Hospital Services charges not payable
10	Medical expenses	3066		3066	
11	Non-Medical expenses	76025	76025	0	Non- Medical and Consumables are not payable
12	Medication expenses	330733	330733		As per Cutomary and Reasonable Expenses Clause
12	Doctor's Visit Charges	185806	185806	0	As per Cutomary and Reasonable Expenses Clause
13	Non-Medical expenses	13231	13231	0	Error in calculation (No details available)
14	Hospital Cash	10000		10000	
	Total	**3738024**	**3156558**	**581466**	

The settlement was made under Clause 3.41 which states,**"REASONABLE AND CUSTOMARY CHARGES : means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved."** The Respondent pointed out that the charges involved in this case were very high, especially Surgeon Fees which are unreasonably higher than the prevailing Surgeon Fees for this surgery in Mumbai in same category of hospitals. As Insurance companies are the custodians of the public money, we are supposed to use this money judicially for the well being of all the Insured persons over which therisk is spread. They added that if they pay any such amount which is unreasonably high, hospital may tend to increase their fees further and it will result in inflation in overall medical expenses. The same would ultimately affect health insurance cost and poor population who cannot afford health insurance. They compared these charges with other such hospitals and allowed the expenses as mentioned above.

Claimed Rs.37,02,293/-		Breach Candy	KokilabenDhirubhaiAmbani	Jaslok Hospital	Sir H N Reliance Hospital
	Surgeon	21,87,500	5,40,000	5,25,000	5,57,400

	Fees				
	Anesthesist Fees	2,50,000			
	OT	88,000 for 8 hours			

The Respondent pointed out during the hearing, that Insured has suffered a stroke in 2016 which is a pre-existing disease as far as the Super Health Top-up Policy is concerned which has incepted w.e.f.19.02.2019 and has a waiting period of 48 months, hence the aforesaid policy's SI cannot be available for payment of the instant claim.

Forum's Observations/Conclusion: The Forum perused the documents filed by both the parties and the depositions made by them.It is observed that the complainant had seven blockages and had undergone very complex heart surgery with six grafts by the internationally acclaimed heart surgeon, Dr SudhanshuBhattacharya and incurred expenses of Rs.37,38,024/ against which the Co. paid only Rs.5,81,466/- despite the fact that the complainant was having total insurance coverage of Rs.58,00,000/-. This Forum is of the view that while disallowance of non-medical expenses being as per policy terms and conditions was in order,the huge deductions made on grounds of the Reasonability and Customary Clause is not justifiable. It was also noted that a surgeon of Breach Candy Hospital and Jaslok Hospital will not charge the same fees as the feesdepend on the surgeon's skills,experience,time taken and the complexities of the surgery. The captioned surgery was a highly complicated one. Therefore the comparison of fees of PPN listed hospital, i.e. Jaslok Hospital, Sir H N Reliance Hospital and KokilabenDhirubhaiAmbani Hospital, where the rates are negotiated with between TPA and Hospital, with a non PPN listed hospital, like Breach Candy would not be proper. Moreover there is no restriction in the policy on where he/she can be admitted. It is noted that the hospital has billed Rs.3,51,570/- for Hospital share on Doctor's Fees. The Forum is informed that 'Hospital Share' is a revenue sharing arrangement between the doctor and the hospital at their will, choice and convenience. The Doctor's Fees are already billed in the hospital bill. The said revenue sharingarrangement is between the hospital and doctor and the insurance policy

is not contemplated to cover the same. The Respondent's contention that current hospitalization is a fall out of the pre-existing condition suffered in 2016 was not found in order since the same defence was not taken in their Written Statement and hence is an after-thought. It was also noted by the Forum, from the discharge summary of Global Hospital's hospitalization on 14.5.2016, that the diagnosis was Transient Ischaemic Attack (TIA) which is not related to the current hospitalization for Heart Attack. Hence the whole sum insured of Rs 58 Lacs is available for the instant claim.Under the circumstances, the Respondent is directed to pay the balance Anaesthesia charges Rs.1,62,500/-, Surgeon Fees Rs.20,54,695/- **Less: Hospital share Rs.3,51,570/-,** Investigation charges Rs.1,78,839/-, OT charges Rs.59,670/-, Hospital Services Rs.92,909/-, Medical Expenses Rs.3,30,733/- and Doctor's visit charges Rs.1,85,806/- = Total Rs.27,13,582/- less:**Non-medical expenses Rs.13,231/- (to be paid subject to submission of details)**, in favour of the complainant. The decision of the Company is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co Ltd is directed to settle the balance as stated above, totaling to Rs.27,13,582/-less: Non-medical expenses Rs.13,231/- (to be paid subject to submission of details),in favour of the complainant, MrBharat H Dedhia for his hospitalization in October 2019, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 3rd day of May, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance OmbudsmanRules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT –MR RAMNIKLAL D GOSRANI
VS
RESPONDENT : UNITED INDIA INSURANCE CO LTD

COMPLAINT REF: NO : MUM-H-051-2021-1650
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr Ramniklal D Gosrani** **Mumbai 400 068**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**0207002819P100605796,** **207002820P100207286** **Individual Health Insurance Policy** **28.04.2019 to 27.04.2020, 28.04.2020 to 27.04.2021** **Rs.2,50,000/-**
3	Name of Insured Name of he policy holder	**Mrs Manjula R Gosrani** **Mr Ramniklal D Gosrani**
4	Name of Insurer	**United India Insurance Co Ltd**
5	Date of Repudiation	**Various**
6	Reason for repudiation	**No active line of treatment (Cancer)**
7	Date of receipt of the complaint	**19.01.2021**
8	Nature of complaint	**Total repudiation of 7 claims, Short settlement of 2 claims**
9	Amount of claim	**Rs.2,97,727/-**
10	Date of Partial Settlement	

11	Amount of relief sought	**Rs.1,83,647/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**27.04.2021, 03.45 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Nikhil R Gosrani, complainant's son**
	b) For the insurer	**Mr Subodh Sawant, AO**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant's wife, Mrs Manjula R Gosrani was admitted to Goel's Krishna Nursing Home, Dahisar East, Mumbai on 23.12.2019 for treatment of Ca Right Breast wherein she underwent Rt.Modified Radical Mastectomy and thereafter underwent chemotherapy treatments on 22.01.2020, 12.02.2020, 05.03.2020, 31.03.2020, 21.04.2020, 12.05.2020, 03.06.2020 and Chemotherapy reaction treatment on 11.03.2020. Complainant approached this Forum with a complaint against total repudiation by the Respondent, United India Insurance Co Ltd of 7 claims and short settlement of 2 claims lodged under the policy in respect of the said hospitalizations.

Contention of the complainant : The complainant's son, duly authorized by him, appeared and deposed before the Forum. He submitted that a claim was preferred for Rt Breast Mastectomy which his mother underwent on 23.12.2019, for Rs.1,26,012/- and the same was settled for Rs.87,673/- only, deducting Surgeon Charges Rs.32,500/- in full and Anesthetist Charges Rs.4,290/- out of Rs.10,000/- under the Reasonbility and Customary Clause. Subsequently, she underwent 7 sittings of chemotherapy and preferred claims as under:

1st Chemotherapy	22.01.2020	Rs.20,500/- Repudiated
2nd Chemotherapy	12.02.2020	Rs.20,040/- Repudiated
3rd Chemotherapy	05.03.2020	Rs.19,930/- Repudiated
4th Chemotherapy	31.03.2020	Rs.20,870/- Repudiated
5th Chemotherapy	21.04.2020	Rs.29,860/- Paid Rs.26,407/-
6th Chemotherapy	12.05.2020	Rs.31,630/- Repudiated
7th Chemotherapy	03.06.2020	Rs.29,300/- Repudiated
8th Chemotherapy Reaction treatment	11.06.2020	Rs.61,810/- Repudiated

The complainant's son was unable to understand why the 5th chemotherapy claim has been partly settled whereas the same treatment for the first 4 chemotherapy treatments has been totally rejected. He pointed out their claim denial was that it is an adjuvant treatment whereas the same is a parenteral chemotherapy which is covered under the policy. The last 8th treatment was for chemotherapy reaction treatment which also is totally repudiated by the

Insurance Co. The complainant's son was not agreeable to the repudiation of his mother's claims and requested for the settlement of the same.

Contention of the Respondent : It was submitted on behalf of the Respondent that the Insured lodged a claim of Rs.1,26,012/- and Rs.8,7673/- was settled and Rs.32,500/- deducted from Surgeon Fees and Rs.4,290/- from Anesthetist Fees out of Rs.10,000/- under the Reasonable and Customary Clause which states, **"Reasonable and customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking in to account the nature of illness/injury; involved"** The Surgeon Charges and Anesthetist Charges were on the higher side, hence the same was compared with the package rates of Thunga Hospital hence the same was deducted. Thereafter, 7 OPD claims were submitted for hospitalization expenses of Adjuvant Therapy. The Respondent pointed out that as per policy terms and conditions, they are not liable to pay claims for Adjuvant Therapy since the same is not an active therapeutic treatment. It is just a supportive therapy to prevent further increase of the disease. They added that the day care treatment list clearly mentions only Cancer Chemotherapy and not Adjuvant Therapy. The claims were repudiated under Clause 1.4 which states, **"Expenses on hospitalization for minimum period of 24 hours are admissible."**

Forum's Observations/conclusions : It is noted that cancer is a multifactorial disease and is one of the leading causes of death worldwide. The contributing factors include specific genetic background, chronic exposure to various environmental stresses, and improper diet. All these risk factors lead to the accumulation of molecular changes or mutations in some important proteins in cells that contribute to the initiation of carcinogenesis. Chemotherapy is an effective treatment against cancer but undesirable chemotherapy reactions and the development of resistance to drugs which results in multi-drug resistance are the major obstacles in cancer chemotherapy. So, alternative formulations are in practice these days which are liposomes, resistance modulation, hormonal therapy, cytotoxic chemotherapy and gene therapy. Although there was allegedly no active line of treatment but the fact remains that there was medically necessary treatment given for the advanced malignancy related complications.

This Forum has received a number of complaints against non-settlement of claims for such injections. It is noted that some companies are paying claims for treatment by way of these injections even when given in isolation while some other Companies who were also paying such claims earlier have now taken a stand that it is admissible only when given as a part of chemotherapy/radiotherapy or as pre and post hospitalization expenses for related hospitalization. The basic ground for denial of these claims is that it is an OPD procedure and hence beyond the scope of the policy. On an examination of all the facts/documents produced before the Forum by the Complainant and the Company, the Forum is of the view that:

As per information collected from various websites, both chemotherapy and targeted therapy are two effective methods for cancer therapy. Chemotherapy is a type of cancer treatment that uses one or more anti-cancer drugs (chemotherapeutic agents) as part of a standardized chemo-therapy regimen. It may be given with curative intent. However, while chemotherapy can also kill the normal cells when eliminating the cancer cells, the normal cells can survive the targeted therapy, when the growth of cancer cells is limited.

The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology where a minimum of 24 hours of hospitalization is not required. Even IRDAI has come out with a recent circular stating that Insurance Companies cannot deny claims for modern treatments. As far as the high Surgeon Charges and Anesthetist Charges is concerned, their comparison with the charges of a network hospital, namely, Thunga Hospital is not in order since they are negotiated rates between the TPA and hospital. In view of the above, Respondent is ordered to pay the admissible hospitalization expenses after deductions of non-medicals as per policy terms and conditions. The Respondents decision is, therefore, set aside by the following order of the Forum:

AWARD

Under the facts and circumstances of the case, United India Insurance Co Ltd is directed to settle the admissible claim, barring non-medicals, if any, in favour of the complainant's wife, Mrs Manjula R Gosrani, as full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 3rd day of May, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR PRAKASH PAMECHA
VS
RESPONDENT : UNITED INDIA INSURANCE CO LTD

COMPLAINT NO : MUM-H-051-2021-1769
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the complainant	**Mr Prakash Pamecha** **Mumbai 400 017**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**0221002820P103191845** **Individual Health Insurance Policy** **30.06.2020 – 29.06.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**Mr Prakash Pamecha** - **do** -
4	Name of Insurer	**United India Insurance Co Ltd**
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	**03.02.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.50,133/-**
10	Date of Partial Settlement	**09.11.2020**
11	Amount of relief sought	**Rs.6,011/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**28.04.2021, 04.15 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Prakash Pamecha**
	b) For the insurer	**Mrs Vidisha Parab, AO, assisted by Dr Vaishali Ashetkar, M/s Health Ins TPA of India Ltd**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant was admitted to P D Hinduja National Hospital & Medical Research Centre on 08.10.2020 to 11.10.2020 for treatment of Covid-19. Complainant approached this Forum with a complaint against short-settlement by the Respondent, United India Insurance Co Ltd of a claim lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant appeared and deposed before the Forum. He submitted that the hospitalization expense of Rs.50,133- was settled for Rs.43,122/- by the Respondent, with a deduction of Rs.6,011/-. He stated that he was covered under the policy since 28 years. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that they had initially settled the claim for Rs.31,760/ out of the claimed amount of Rs.50,133/- after which they reviewed the claim after the Insured approached their Grievance Cell. The claim was processed as per Maharashtra Govt circular No.CORONA 2020/C.R.97/Arogya-5, settling an additional amount of Rs.11,362/- and deducted total Rs.6,011/- towards Folder Charges

Rs.200/-, Certificate Charges Rs.320/-, Hospital Service charge Rs.2,250/-, Variables Rs.1,518/- and Non-medical expenses (Gloves, Mask) Rs.1,723/-.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant has taken treatment in the Co.'s PPN hospital. The Maharashtra Regulations were issued in June 2020 and the instant hospital should have adhered to it. However, it appears that the hospital has not adhered to the same and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the deducted amount, i.e. Hospital Services Rs.2,250/- and Variables Rs.1,518/-, barring the non-payables, if any, and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co Ltd is directed to settle the deducted amount, i.e. Hospital Services Rs.2,250/- and Variables Rs.1,518/-, barring the non-payables, if any, in favour of the complainant, Mr Prakash Pamecha for his hospitalization in October 2020, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 3rd day of May, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MRS SUKHI P PAMECHA
VS
RESPONDENT : UNITED INDIA INSURANCE CO LTD

COMPLAINT NO : MUM-H-051-2021-1768
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the complainant	**Mrs Sukhi Pamecha** **Mumbai 400 017**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**0221002820P103192531** **Individual Health Insurance Policy** **30.06.2020 – 29.06.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**Mrs Sukhi Pamecha** - **do** -
4	Name of Insurer	**United India Insurance Co Ltd**
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	**03.02.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.1,51,619/-**
10	Date of Partial Settlement	**13.11.2020**
11	Amount of relief sought	**Rs.40,622/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**28.04.2021, 04.00 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Prakash Pamecha, complainant's husband**
	b) For the insurer	**Mrs Vidisha Parab, AO, assisted by Dr Vaishali Ashetkar, M/s Health Ins TPA of India Ltd**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant was admitted to P D Hinduja National Hospital & Medical Research Centre on 01.10.2020 to 08.10.2020 for treatment of Covid-19. Complainant

approached this Forum with a complaint against short-settlement by the Respondent, United India Insurance Co Ltd of a claim lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant's husband, Mr Prakash Pamecha, duly authorized by her, appeared and deposed before the Forum. He submitted that his wife's hospitalization expense of Rs.1,51,619/- was settled for Rs.43,651/- by the Respondent, with a deduction of Rs.1,07,968/-. He stated that she was covered under the policy since 28 years. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his wife's balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that they had initially settled the claim for Rs.43,651/ out of the claimed amount of Rs.1,51,619/- post which, they reviewed the claim after the Insured approached their Grievance Cell. The claim was processed as per Maharashtra Govt circular No.CORONA 2020/C.R.97/Arogya-5, settling an additional amount of Rs.67,306/- and deducted total Rs.40,662/- towards Admn Charges Rs.500/-, Urine Bag Rs.250/-, Thermometer Rs.395/-, Mask Rs.726/-, Safety Charges Rs.300/-, Excess Ambulance Charges (charged Rs.4,800/- while paying Rs.2,500/-, CT Scan duplicate bill Rs.13,500/-, Bio-medical Waste Charges Rs.2,800/- and PPE Kit Charges Rs.19,891/-. They clarified that Ambulance Charges of Rs.2,500/- was erroneously paid since the Insured has not opted for benefit of Ambulance Charges in his policy.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant has taken treatment in the Co.'s PPN hospital. The Maharashtra Regulations were issued in June 2020 and the instant hospital should have adhered to it. However, it appears that the hospital has not adhered to the same and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the deducted amount, i.e. BMW Charges Rs.2,800/-, PPE Kit charges Rs.19,891/-, CT Scan (subject to receipt of original bill) Rs.13,500/-, barring the non-payables, if any, and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The Ambulance charges are not payable since the complainant has not opted for that cover in his policy. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co Ltd is directed to settle additional amount as stated above, in favour of the complainant, Mrs Sukhi P Pamecha for her hospitalization in October 2020, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.
c) It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 3rd day of May, 2021 at Mumbai.

MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of the Insurance Ombudsman Rules, 2017)
OMBUDSMAN : MR MILIND KHARAT
CASE OF COMPLAINANT - MR RITESH RUPANI
VS
RESPONDENT : THE ORIENTAL INSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-050-2021-1638
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	**Mr Ritesh Rupani** **Mumbai 400 092**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**121700/48/2021/244** **Happy Family Floater-2015 Policy** **17.04.2020 to 16.04.2021** **Rs.10,00,000/-**
3	Name of Insured Name of the policy holder	**Mr Ritesh Rupani** **- do -**
4	Name of Insurer	**The Oriental Insurance Co Ltd**
5	Date of Repudiation	**-**
6	Reason for repudiation	**-**
7	Date of receipt of the complaint	**19.01.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.3,83,786/-**
10	Date of Partial Settlement	**14.10.2020**

11	Amount of relief sought	**Rs1,62,788/-**
12	Insurance Ombudsman Rules, 2017	**13(b)**
13	Date of Hearing	**28.04.2021 at 03.30 p.m.**
14	Representation at the hearing	
	a) For the complainant	**Settled before the hearing**
	b) For the insurer	**Settled before the hearing**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the case : Complainant was admitted to Thunga Healthcare LLP in Covid-19 suspected ward on 28.07.2020 and discharged on 09.08.2020 once the Covid-19 report turned out to be negative. The total amount that was incurred towards hospitalization was Rs.3,83,786/- out of which Rs.2,20,998/- was approved under cashless. However, Rs.1,62,788/- was deducted although there was no capping in his policy of SI of Rs.10 lacs. Due to this deduction, the hospital has also not refunded his deposit amount. They informed him that the TPA has done short payment, hence they will not refund the deposit since they have adjusted the same. Aggrieved by the deduction in the claim, the complainant approached this Forum for seeking relief in the matter.

The Forum scheduled a joint hearing of the parties concerned to the dispute on 28.04.2021 at 03.30 p.m. However, in the meantime, the Forum was informed by the Respondent during the hearing that they have agreed to settle the deducted claim amount for Rs.1,22,817/- to resolve the grievance. The Forum directed the Respondent to also consider Bio-Medical Waste Charges of Rs.12,000/- since these are essential for the treatment of Covid-19 considering the hygiene and cleanliness required to be maintained right through the hospitalization. The settlement to be made subjection to submission of receipt of Rs.1,02,304/-. The complainant was communicated about the settlement and consented to the same via email dt.03.04.2021.

In view of the above, the within mentioned complaint of the complainant stands closed at this Forum.

Dated at Mumbai this 3rd day of May 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR PRADEEP KASAT
VS
RESPONDENT : MANIPAL CIGNA HEALTH INSURANCE CO LTD

COMPLAINT NO : MUM-H-053-2021-1704
AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the complainant	**Mr Pradeep Kasat** **Mumbai 400 104**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**PROHLR0104365** **ManipalCigna ProHealth Insurance** **31.12.2019 – 30.12.2020** **Rs.25,00,000/- + CB Rs.3,75,000/-**
3	Name of Insured Name of the policy holder	**Mr Pradeep Kasat** **- do -**
4	Name of Insurer	**Manipal Cigna Health Insurance Co Ltd**
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	**25.01.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.1,45,787/-**
10	Date of Partial Settlement	**02.12.2020**
11	Amount of relief sought	**Rs.87,412/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**26.04.2021, 04.00 pm**

14	Representation at the hearing	
	a) For the complainant	**Mr Pradeep Kasat**
	b) For the insurer	**Mr Jaswinder Shekhawat**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant was admitted to Gems Super Speciality Hospital, Kandivali West, Mumbai from 09.09.2020 to 15.09.2020 for treatment of Covid-19. He approached this Forum with a complaint against short-settlement by the Respondent, Manipal Cigna Health Insurance Co Ltd of a claim lodged under the policy for the said hospitalization

Contentions of the complainant : The complainant appeared and deposed before the Forum. He submitted that he lodged a claim for Rs.1,45,787/- but the same was settled for Rs.58,375/- only deducting Rs.87,412/-. He argued that the Insurance Product opted by him clearly mentions about room charges, laboratory/pathology charges, CT Scan etc. "Coverage is till the limit of SI" opted and his basic SI is Rs.25 lacs plus cumulative bonus. This heavy deduction was not acceptable to him, citing reason as "Approved as per GIC in which there is per day package depending on availed room category and type of hospital and its location which include room rent, nursing, doctors fees, investigations, pharmacy and hence charges over above the package is non-payable. He pointed out that if the hospital has not adhered to the package, it was unfair to penalize him since he had genuinely incurred hospitalization expenses and had paid all the charges billed by the hospital. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his balance claim amount.

Contentions of the Respondent : It was contended on behalf of the Respondent that the Insured lodged a reimbursement claim for Rs.1,45,787/- incurred for the treatment taken at Gems Super Speciality Hospital due to Covid-19. After due scrutiny of the claim documents, the Co. settled the claim as per the policy terms and conditions and after making deductions in accordance with the ceiling provided by General Insurance Council (GIC). Hence, Rs.58,375/- was paid to the Insured deducting Rs.1,150/- towards non-medical/non-admissible expenses as per the policy terms and conditions. The deduction of Rs.86,262/- was made as per the GIC rates. The Respondent clarified that the claim was approved as per GIC, in which there is per day package depending on availed room category and type of hospital and its location, which include room rent, nursing, doctor fee, investigations, pharmacy and thus any charges over and above that is non payable. They further added that to maintain transparency, parity and standardization of philosophy amongst insurers, GIC has published rates as reference points for settling Covid-19 claims. The rates have been arrived at by GIC after detailed analysis of the country's healthcare model and would be applicable to both cashless and reimbursement Covid-19 claims in States/Union territories/cities where any Government Authority has not published standard charges for Covid-19 treatment. Subsequently, the Insured approached the grievance cell of the Company for reconsideration of the deductions. After careful evaluation of his request, the Company informed the complainant through email dt.10.12.2020 stating "We would like to inform you that Covid-19 is a new illness with no established protocols and

standardized treatment costs. In order to allay the fears of all insurance policyholders and to bring complete clarity and transparency in the treatment of Covid-19 insurance claims, the GIC, in discussion with expert medical professionals employed by member insurance companies, has brought about a Schedule of rates for Covid-19 claims being filed with its member insurance companies."

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the Insured's coverage is till the limit of SI opted, i.e.Rs.25 lacs plus Cumulative Bonus. The complainant has paid the hospital charges as per the hospital bill on which he has no control. The GI Council Guidelines were issued in June 2020 and the instant hospital should have adhered to it. However, it appears that the hospital has not adhered to the same and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the balance hospitalization expenses barring non-medical items and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Manipal Cigna Health Insurance Co Ltd is directed to settle the balance claim deducted barring the non–medical expenses, if any, in favour of the complainant for his hospitalization in September 2020, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR DAYABHAI R PATEL
VS
RESPONDENT : THE ORIENTAL INSURANCE CO LTD

COMPLAINT NO : MUM-H-050-2021-1576
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the complainant	**Mr Dayabhai R Patel** **Mumbai 400 086**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**131300/48/2021/192** **Mediclaim Insurance Policy (Individual)** **09.04.2020 – 08.04.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**Mr Dayabhai R Patel** - **do** -
4	Name of Insurer	**The Oriental Insurance Co Ltd**
5	Date of Repudiation	**-**
6	Reason for repudiation	**-**
7	Date of receipt of the complaint	**08.01.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.1,79,482/-**
10	Date of Partial Settlement	**21.11.2020**
11	Amount of relief sought	**Rs.35,042/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**23.04.2021, 03.30 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Daybhai R Patel**
	b) For the insurer	**Mrs Rohini Satheesh Kumar, Asst Manager**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant was admitted to Harilal Jaichand Doshi Ghatkopar Hindu Sabha Hospital from 20.06.2020 to 30.06.2020 for treatment of Covid-19. Complainant approached this Forum with a complaint against short-settlement by the Respondent The Oriental Insurance Co Ltd of a claim lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant appeared and deposed before the Forum. He submitted that a claim for Rs.1,79,482/- for the treatment of Covid-19 (positive) undergone by him was settled by the Respondent for Rs.1,35,715/- only, with a deduction of Rs.43,767/-. He stated that out of the deductions, he was not agreeable to the deduction of Doctor's Fees of Rs.4,250/- out of Rs.9,200/-, Investigation Charges Rs.2,470/- (Rs.470 CBC, Rs.1500 X-ray) out of Rs.12,745/- and Medication Charges Rs.28,322/- out of Rs.86,387/-. He was loyal customer of the Insurance Co since 30-35 years for SI of Rs.5 lacs. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the deductions of Rs. 35,042/- were made as per Government Notification No. CORONA-2020/C.R.97/Aro-5 dt.19.05.2020 wherein the charges are included in the package provided in Annexure – C of above the notification, hence not payable. The deductions were made for Doctor Fees Rs.4,250/, Investigation Charges Rs.2,470/- and Medicine Charges Rs.28,322/- = Rs.35,042/-.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant has taken treatment in the Co.'s PPN hospital. The Maharashtra Regulations were issued in June 2020 and the instant hospital should have adhered to it. However, it appears that the hospital has not adhered to the same and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the Doctor Fees Rs.4,250/, Investigation Charges Rs.2,470/- and Medicine Charges Rs.28,322/- = Rs.35,042/- and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The Oriental Insurance Co Ltd is directed to settle the balance claim amounting to Rs.35,042/- in favour of the complainant for his hospitalization in June 2020, towards full and final settlement of the complaint, within 30 days from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.
Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT -: MR KRUNAL VIRENDRA SHETH
VS
RESPONDENT :STAR HEALTH& ALLIED INSURANCE CO LTD

COMPLAINT REF: NO: MUM-H-044-2021-1724
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Mr Krunal Virendra Sheth Mumbai 400 097
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	P/171149/01/2021/003626 Corona Rakshak Policy 24.07.2020 to 05.05.2021 Rs.2,50,000/-
3	Name of Insured Name of the policy holder	Mr Krunal Virendra Sheth - do -
4	Name of Insurer	Star Health and Allied Insurance Co Ltd
5	Date of Repudiation	22.10.2020
6	Reason for partial repudiation	Not fulfilling the criteria of Corona Rakshak Policy
7	Date of receipt of the complaint	31.12.2020
8	Nature of complaint	Total repudiation of claim
9	Amount of claim	Rs.2,50,000/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.2,50,000/-

12	Complaint registered under Indian Ombudsman Rules 2017	13 (b)
13	Date of Hearing	22.04.2021 -04.15 pm
14	Representation at the hearing	
	a) For the complainant	Mr Krunal Virendra Sheth
	b) For the insurer	Dr ArvindThakkar
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainant was diagnosed with Covid-19 and admitted to NESCO Jumbo Covid Centre, MCGM from 31.08.2020 to 09.09.2020 and treated for the same. Complainant approached this Forum with a complaint against the total repudiation by the Respondent, Star Health & Allied Insurance Co Ltd of the claim lodged under the policy in respect of the said hospitalization.

Contentions of the complainant: The complainant appeared and deposed before the Forum. He submitted that he had purchased the Corona Rakshak Policy covering himself and his mother. This policy is a lumpsum benefit plan for Corona. He was hospitalized in August 2020 for Covid-19 in NESCO Covid Centre (run by MCGM) for 10 days, however the Insurance Co rejected his claim on the grounds that a Covid Care Centre is not a hospital and that he had a mild infection and was given only oral medication. He argued that he had infection and was given 6 injections in the Covid Centre and to this day, he is on medication for blood clots. He was not agreeable to the repudiation and therefore, requested the Forum to intervene for settlement of his genuine claim.

Contentions of the Respondent: It was submitted on behalf of the Respondent that the Insured claimed an amount of Rs. 2,50,000/- towards the Lump sum benefits of Covid -19 positive. On scrutiny of claim documents, it was observed that as per submitted medical record of the above hospital that the Insured patient was admitted in Covid care centre. As per Policy Clause 4.1, **"COVID Cover Lump sum benefit equal to 100% of the sum insured shall be payable on positive diagnosis of Covid, requiring hospitalization for minimum continuous period of 72 hours. The positive diagnosis of Covid shall be form a government authorized diagnosis centre."** They further clarified that a**s** per submitted discharge summary there is no active medical line of treatment and the patient was treated with oral medications only. The Indoor Case Record (ICP) of the treating hospital states that the insured patient is afebrile, vitals stable, asymptomatic and has been maintaining oxygen saturation throughout the admission and also mainly treated with oral medications. Hence, the insured could have been managed self-isolated by home quarantine. Hence, the claim was repudiated and communicated to the Insured vide letter dated 22.10.2020.

Forum's Observations/Conclusion: The Forum observes in this case that the complainant was diagnosed with Covid-19 as per SRL Diagnostics report which is a government recognized

diagnostic centre and was admitted to NESCO Covid Centre which is run by MCGM. These centres were opened since hospitals were not in a position to admit patients since several patients were getting admitted for Covid19. The complainant took treatment in the Covid Centre for 10 days. Hence, he has fulfilled the two conditions of the Benefit Plan Policy, namely, Corona Rakshah policy, i.e. positive diagnosis of Covid and minimum 72 hours of continuous hospitalization. From the foregoing, the complainant is entitled to full claim under the policy. The decision of the Respondent is therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Star Health and Allied Insurance Co. Ltd. is directed to settle the lumpsum payment of Rs.2,50,000/-, in favour of the complainant, Mr Krunal V Sheth towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.
Dated: This 30th April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI-MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - DR MAHESH BAKSHI
V/S
RESPONDENT : THE NEW INDIA ASSURANCE CO LTD

COMPLAINT REF: No: MUM-H-049-2021-1641
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Dr Mahesh Bakshi** **Mumbai 400 052**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**14030034199500005117** **New India Mediclaim Policy** **11.08.2019 - 10.08.2020** **Rs.3,00,000/- + CB Rs.20,000/-**
3	Name of Insured Name of the policy holder	**Late MrsBharati M Bakshi** **Dr Mahesh Bakshi**
4	Name of Insurer	**The New India Assurance Co Ltd**
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	**28.09.2020**
8	Nature of complaint	**Short settlement of claim-Proportionate deductions**
9	Amount of claim	**Rs.2,77,712/-**
10	Date of Partial Settlement	
11	Amount of relief sought	**Rs.21,000/-**
12	Complaint registered under Insurance Ombudsman Rules,2017	**Under Rule 13(b)**
13	Date of Hearing	**22.04.2021 – 03.45 p.m.**
14	Representation at the hearing	
	a) For the complainant	**MrHemangBakshi, complainant's son**
	b) For the insurer	**Mrs Josephine Lemos, AO assisted by DrKomal S Shinde, M/s MediAssist Ins TPA Pvt Ltd**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant's wife, MrsBharati M Bakshi was admitted to Hinduja Healthcare Ltd., Khar West, Mumbai on 09.02.2020 with c/o disorientation for 2 days with

restlessness and aggressive behavior , in ICU and diagnosed with Sepsis, B/L Lower Cellulitis, Arterial Sore Left Medial Malleolus, Uncontrolled DM, ACS, LVF, PVD and underwent conservative management, shifted to ward and expired on 14.02.2020. Complainant approached this Forum with a complaint against short settlement by the Respondent, The New India Assurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization.

Contention of the complainant : The complainant and his son, MrHemangBakshi, duly authorized by the complainant, appeared and deposed before the Forum. He submitted that his wife, late MrsBharatiBakshi was admitted to Hinduja Healthcare Hospital, Khar West, on 09.02. 2020 early morning and expired on 14.02.2020. As per tariff of the hospital, (applicable table was w.e.f. 04.04.2019) it does not charge anything including consulting charges and investigation and lab charges depending on whether the patient is in a regular room or in the ICU. All charges remain the same irrespective of whether the patient was for some days is in the regular room or in the ICU. The rates are fixed depending on which plan from the tariff table one chooses. Only the ICU bed charges are different when the patient is in the ICU and no other charges are different. Hence, it can be seen from the claim and the hospital bill submitted to the Insurance Co that, even though his wife was in the ICU for four days and in the regular room for 3 days, as per the hospital's bill and break-up provided by them, only the ICU bed charges were differently charged and that too, was as per their tariff table. All other charges including consulting and investigation and lab charges were charged uniformly for all the days and not charged differently for the four days she was in the ICU and three days in the regular room. However, the Insurance Co has deducted consulting, investigation and lab charges proportionately for the days she was in the ICU–capping it in relation to the regular room rate. The complainant pointed out that if the consulting charges, investigation and lab charges were billed at different rates when she was in the ICU and when she was in the regular rooms, such capping could have been justifiable and not under this case as Hinduja Healthcare's charging system is different than other hospitals and the insurance company has erred in capping as other hospitals charge differently when the patient is in the ICU and differently when the patient in the regular room. The complainant was agreeable to the deductions made on room rent as per his entitlement and non medical expenses but the other charges, i.e. proportionate deductions on Investigation, Consultation and Physiotherapy Charges deducted arbitrarily were disputed by him.

Contentions of the Respondent : It was contended on behalf of the Respondent that the Insured was kept in ICU room rent @ Rs.8,750/- (ICU Rs.6,000/- + Intensive Care Charges Rs.2,750/-) which was above her eligibility, hence proportionate deductions were applied on the final bill as per Clause 3.1(b) which states, **"Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus Buffer, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus Buffer. Subject to this, we will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy."** 3.1 (b) "**Intensive Care Unit (ICU)/Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2% of the Sum Insured per day." and Clause 3.2**

which states,"Proportionate Deduction - Reimbursement/payment of Room Rent, boarding and nursing expenses incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such expenses shall not exceed 2% of the Sum Insured per day. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges." The Respondent stated that the rest of the deductions were on grounds of Non Medical Items as per Annexure -2 of the Policy Clause. The

Respondent was directed to verify if the ICU charges were same as per Twin-sharing. They responded that there is no class based billing system in Hinduja Healthcare Ltd, Khar West, so proportionate deduction will not be applicable on Doctor Fees and Investigation Charges.

Forum's Observations/Conclusion: On hearing the deposition advanced on behalf of both the parties to the dispute and analysis of the documents produced on record, the Forum noted that the complainant has furnished the Hospital Tariff (w.e.f. 04.04.2019) wherein the instant hospital does not charge anything including consulting charges and investigation and lab charges depending on whether the patient is in a regular room or in the ICU. All charges remain the same irrespective of whether the patient for some days is in the regular room or in the ICU. In view of the same, while disallowance of room rent in excess of the insured's eligibility and non-medical expenses being as per policy terms and conditions was in order, reducing other charges in proportion to the entitled room category in the absence of a class-based tariff is not justified and is against IRDAI guidelines in this regard. Under the circumstances, the Respondent was directed to pay the balance admissible hospitalization expenses, which was deducted from the claim amount on proportionate basis. The decision of the Respondent is thus intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co Ltd is directed to pay the balance admissible hospitalization expenses deducting non medicals, if any, in favour of the complainant's deceased wife, MrsBharati M Bakshi, in full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI &GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of the Insurance Ombudsman Rules, 2017)
OMBUDSMAN : MR MILIND KHARAT
CASE OF COMPLAINANT - MR HITENDRA A CHUDASAMA
VS
RESPONDENT : STAR HEALTH & ALLIED INSURANCE CO LTD
COMPLAINT REF: NO : MUM-H-044-2021-1751
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr Hitendra A Chudasama** **Mumbai 400 097**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**P/171132/01/2019/010083** **Family Health Optima Policy** **05.10.2020 to 04.10.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**Mrs Ragini A Chudasama** **Mr Hitendra A Chudasama**
4	Name of Insurer	**Star Health & Allied Insurance CoLtd**
5	Date of Repudiation	**25.12.2020**
6	Reason for repudiation	**Excluded Provider Hospital**
7	Date of receipt of the complaint	**03.02.2021**
8	Nature of complaint	**Total repudiation of claim**

9	Amount of claim	**Rs.2,29,875/-**
10	Date of Partial Settlement	**-**
11	Amount of relief sought	**Rs.2,29,875/-**
12	Insurance Ombudsman Rules, 2017	**13(b)**
13	Date of Hearing	**27.04.2021 at 03.30 p.m.**
14	Representation at the hearing	
	a) For the complainant	**Settled before the hearing**
	b) For the insurer	**Settled before the hearing**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief Facts of the Case : Complainant submitted that her mother, Mrs Ragini A Chudasama had Menopausal Bleeding and lower abdominal pain while urinating in February 2020 and visited Aastha Maternity Hospital where the doctor suggested PAP Smear Test which was negative. However, again in October, she felt shooting unbearable pain in lower abdomen, so they decided to take second opinion with other gynaecologists who advised DNC and Colonoscopy. The same revealed Cervical Cancer and hence opinions of other Oncologists, specialized in Gynaec Ca, i.e.Dr Prachi Thakkar of Sun Super Speciality Hospital and Dr Yogesh Kulkarni of Kokilaben Dhirubhai Ambani Hospital was sought. They opined treatment as soon as possible since it was life threatening and she would not be able to pass urine or stool, if immediate action was not taken. Hence, she was admitted to Sun Super Speciality Hospital, Borivali (West) on 16.11.2020 wherein she underwent Radical Hysterectomy on 17.11.2020 and discharged on 23.11.2020. A claim for reimbursement of hospitalization expenses was preferred and the same was rejected on grounds that the instant hospital did not come under their list under the policy. Not agreeable to the repudiation of the claim, the complainant approached this Forum for seeking relief in the matter.

The Forum scheduled a joint hearing of the parties concerned to the dispute on 27.04.2021 at 03.30 p.m. However, in the meantime, the Respondent informed the Forum that they were agreeable to the settlement of the claim and the complainant consented to the same.
In view of the above, the within mentioned complaint of the complainant stands closed at this Forum.
Dated at Mumbai this 30th day of April 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of the Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT - MR PRADEEP SARAF

VS

RESPONDENT : UNITED INDIA INSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-051-2021-1657

AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr Pradeep Saraf** **Mumbai 400 002**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	0212002819P109560484 Individual Health Insurance Policy 19.10.2019 – 18.10.2020 Rs.5,00,000/-
3	Name of Insured Name of the policy holder	Ms Jaylaxmi P Saraf **Mr Pradeep Saraf**
4	Name of Insurer	United India Insurance Co Ltd
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	22.02.2021
8	Nature of complaint	Short settlement of claim
9	Amount of claim	Rs.1,62,409/-
10	Date of Partial Settlement	11.12.2019
11	Amount of relief sought	Rs.1,21,042/-

12	Complaint registered under Insurance Ombudsman Rules,2017	Under Rule 13(b)
13	Date of Hearing	22.04.2021 – 03.30 p.m.
14	Representation at the hearing	
	a) For the complainant	**Mr Pradeep Saraf**
	b) For the insurer	Ms Sangeeta Gawde, Administrative Officer
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainan's daughter, Ms Jaylaxmi P Saraf was admitted to Sunshine Hospital, Nerul, Navi Mumbai on 09.11.2019 with c/o nasal blockage, breathing difficulty and recurrent cold since 2 months and diagnosed with Deviated Nasal Septum to Left Internal Nasal Valve Blockage and underwent Open Approach Septoplasty with Repair of Internal Nasal Valve with Costal Cartilage performed under general anesthesia and discharged on 11.11.2019. Complainant approached this Forum with a complaint against short-settlement by the Respondent, United India Insurance Co Ltd of a claim lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant appeared and deposed before the Forum. He submitted that the claimed amount was Rs.1,62,409/- but the amount settled was only Rs. 36,407/- and Rs. 1,21,042/- wrongly deducted under reason Usual and Customary-As per PPN Package." He pointed out that he was unaware of the details of the agreement between the hospital and the Insurance Co. He stated that the treatment and surgery charges levied depend on the basis of the condition and the line of treatment. Neither the TPA nor the Insurance Co can decide the treatment charges to be given to any patient as only doctors can decide about the treatment according to the condition of the patient and the type of surgery. He added that each hospital and doctors charge differently for the same treatment accordingly to his skill, expertise and experience. He furnished Dr Arun Panda's certificate dt. 13.12.2019 clarifying the details of the complicated surgery performed and the line of treatment of the surgery. He also stated that his daughter is covered under the policy since 20 years. When the claim was intimated to the Insurance Co, they did not inform him that the said hospital is a PPN hospital. Moreover, nowhere in the policy it is specified that one has to

go to a PPN hospital and that a reimbursement claim will be settled as per GIPSA PPN package. He, therefore, requested for settlement of the balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that Sunshine Hospital, Nerul where the Insured was admitted is under PPN and hence the total claim was settled for Rs.39,907/- for lodged amount of Rs.1,62,409/- as per the package rate. It was also observed that Septoplasty surgery was performed for which 24 hours hospitalisation is not required as per record. As per treating doctor's opinion, the patient was on IV only on 09.11.2019 and was treated rest of 2 days only with oral tablets. Therefore, the claim was settled as per Clause 2.41 which states, **"Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved."** and Clause 2.30 which states, **"NETWORK PROVIDER means the hospital/nursing home or health care providers enlisted by an insurer o r b y a T P A and insurer together to provide medical services to an insured on payment by a cashless facility. The list of Network Hospitals is maintained by a n d available with the TPA and the same is subject to amendment from time to time. PPN-Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person."**

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant had taken treatment in the Co's network hospital. However, it appears that the hospital has not adhered to PPN rates and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the balance hospitalization expenses barring non-medical items and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The decision of the Respondent is therefore intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United Indi Insurance Co Ltd is directed to settle the balance admissible claim amount barring non-medical expenses and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital, in favour of the complainant for her daughter's hospitalization in November 2019, towards full and final settlement of the complaint, within 30 days from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI &GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of the Insurance Ombudsman Rules, 2017)
OMBUDSMAN : MR MILIND KHARAT
CASE OF COMPLAINANT - MRS VIJAYA D SHETTY
VS
RESPONDENT : STAR HEALTH & ALLIED INSURANCE CO LTD
COMPLAINT REF: NO : MUM-H-044-2021-1708
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mrs Vijaya D Shetty** **Mumbai 400 068**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**P/171100/01/2020/015647** **Family Health Optima Policy** **27.02.2020 to 26.02.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**Mrs Vijaya D Shetty** **Mr Devraj S Shetty**
4	Name of Insurer	**Star Health & Allied Insurance CoLtd**
5	Date of Repudiation	**21.12.2020**

6	Reason for repudiation	**Excluded Provider Hospital**
7	Date of receipt of the complaint	**25.01.2021**
8	Nature of complaint	**Total repudiation of claim**
9	Amount of claim	**Rs.1,03,850/-**
10	Date of Partial Settlement	**-**
11	Amount of relief sought	**Rs.1,03,850/-**
12	Insurance Ombudsman Rules, 2017	**13(b)**
13	Date of Hearing	**22.04.2021 at 04.00 p.m.**
14	Representation at the hearing	
	a) For the complainant	**Mrs Vijaya D Shetty**
	b) For the insurer	**Dr Arvind Thakkar**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**30.04.2021**

Brief facts of case :

Complainant was admitted to Goel's Krishna Nursing Home, Dahisar (E), Mumbai on 28.11.2020 with severe Menorrhagia and Dysmenorrhea and diagnosed with multiple fibroids wherein she underwent Total Abdominal Hysterectomy and B/L Salpingo-oophorectomy and discharged on 01.12.2020. She approached this Forum with a complaint against the total repudiation by the Respondent, Star Health & Allied Insurance Co Ltd of the claim lodged under the policy in respect of the said hospitalization.

Contentions of the complainant :

The complainant appeared and deposed before the Forum. She stated that she was in a critical state with heavy bleeding and so admitted to Goel's Krishna Nursing Home and the doctor planned an emergency surgery for the same. The doctor, Dr (Mrs) V M Goel is well known for her services. The complainant stated that she has been insured with the Insurance Co for 5-6 years and had claimed for the first time. Her genuine claim was rejected due to the reason "treatment taken in exclude provider hospital" but she was unaware of the same. She had intimated about the hospitalization, the next day and even then she was not conveyed that the hospital is not in their network list of hospitals. At the time of admission, she was in hospital and her son intimated Star Health & Allied Insurance Co Ltd and he was informed that since the instant hospital was not a cashless hospital, they would have to apply for reimbursement of claim. Not agreeable to the repudiation of her claim, she approached this Forum for settlement of her genuine claim.

Contention of the Respondent :

It was contended on behalf of the Respondent that the Insured had reported the claim in the 5th year of the Medical Insurance Policy. On scrutiny of the claim records, it was observed that

the insured patient was admitted and treated in an excluded provider hospital wherein the expenses incurred towards treatment are not admissible. She was admitted on 28.11.2020 and the claim was intimated to them on 30.11.2020, a day before the discharge. If the Insured would have intimated the claim at the time of admission, they would have informed about the Excluded Hospital. The Respondent clarified that the referred hospital was excluded from the Provider List since 2017 and the same was informed to the Insured and published in the Website. As per Exclusion No.(11) **"Excluded Providers, the expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim."** Hence, the claim was repudiated and the same was communicated to the insured vide letter dated 21.12.2020.

Forum's Observations/Conclusion: On scrutiny of the documents produced on record and after hearing the depositions of both the parties, the Forum noted that when the Insured had given intimation about hospitalization, it was the duty of the Respondent to give her adequate information about the Excluded Provider Hospital. The surgery was an emergency and the Insured got admitted to a hospital close to her residence. The complainant also informed the Forum that when intimation was given to the Respondent about the hospitalization, she was informed that since the hospital is not a cashless one, she could opt for reimbursement of claim after discharge. Hence, the Respondent's denial of the claim on grounds of that the instant hospital is an Excluded Provider Hospital was not found to be in order. From the foregoing, the Respondent was directed to pay the admissible claim deducting non payables, if any, to the complainant. The decision of the Respondent is therefore intervened by the following Order:

AWARD

Under the facts and circumstances of the case, Star Health & Allied Insurance Co Ltd is directed to pay the admissible claim deducting non-payables, if any, in favour of the complainant for her hospitalization in November 2020, towards full and final settlement of the complaint within 30 days from issuance of this order so as to avoid penal interest chargeable as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.
Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR PARESH B SHAH
VS
RESPONDENT : MANIPAL CIGNA HEALTH INSURANCE CO LTD

COMPLAINT NO : MUM-H-053-2021-1681
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the complainant	**Mr Paresh B Shah** **Mumbai 400 067**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**PROHLR010483365** **ProHealth - Protect** **01.03.2020 – 28.02.2021** **Rs.5,50,000/- Rs.55,000/-**
3	Name of Insured Name of the policy holder	**Mr Paresh B Shah** - **do** -
4	Name of Insurer	**Manipal Cigna Health Insurance Co Ltd**
5	Date of Repudiation	-
6	Reason for repudiation	-
7	Date of receipt of the complaint	**16.02.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.3,11,433/-**

10	Date of Partial Settlement	**04.12.2020 and 11.01.2021**
11	Amount of relief sought	**Rs.66,295/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**16.04.2021, 03.30 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Paresh B Shah**
	b) For the insurer	**MsSwethaNai**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**23.04.2021**

Brief Facts of the Case : Complainant was admitted to Dr Chirag Mehta's Health Centre from 24.10.2020 to 26.10.2020 and shifted to United Multispecialty Hospital from 26.10.2020 to 02.11.2020 for treatment of Covid-19 Pneumonitis. Complainant approached this Forum with a complaint against short-settlement by the Respondent, Manipal Cigna Health Insurance Co Ltd of two claims lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant appeared and deposed before the Forum. He submitted that he was admitted to 3 different hospitals over a period of 10 days and underwent Covid-19 Pneumonitis treatment. He made 3 reimbursement claims totaling to Rs.3,11,433/- to Insurance Co by providing all the details and original documents. The settlements of the claims were made as below:

Sr. No.	Claim Number	Claimed	Processed	Deduction
1	23216774	Rs. 46,406	Rs. 34,986	Rs. 11,420
2	23216683	Rs, 6,000	Rs. 6,000	0.00
3	23268967	Rs.2,59,027	Rs.1,33,796	Rs.1,25,231
Total		**Rs.3,11,433**	**Rs.1,74,782**	**Rs.1,36,651**

After multiple follow-ups regarding the deductions, he was reverted with a mail from them mentioning that there are no established protocols and standardized treatment costs for Covid-19 insurance claims and that General Insurance Council (GIC) in consultation with expert medical professionals have brought a schedule of rates applicable and this rate will be applicable to both cashless and reimbursement claims. It went on to further mention that the deductions on his claims were made in line with GIC rates in line with the GIC circular dated 20.06.2020. The circular clearly mentioned **"proposed charges"** and in the terms and conditions of the circular, it clearly states that it does not interfere with the line of treatment suggested by the treating doctor. He further brought to their notice, certain facts as stated by IRDAI in the circular dt.13.01.2021, Circular No.IRDAI/HLT/REG/CIR/011/01/2021 stating that the GIC rates are to be used only for reference/guidance purposes and specifically when the claim is a cashless claim. Additionally, even for cashless claims, health insurers are required to make agreement with health providers (hospitals) using GIC rate as reference/guidance only. GIC is neither a regulatory authority nor the claim was a cashless one, in his case. It also states that, all insurers are directed to ensure that the "**Reimbursement claims"** under a health policy shall be settled as per the terms and conditions of the respective policy contract. The complainant pointed out that nowhere in his policy contract there is mention of GIC circular. Once the IRDAI circular was shared with Manipal Cigna team, they made a miscellaneous one-time payment of Rs.16,158 against it. The complainant, further, added that when he made a complaint to IRDAI and this Forum, they promised to make a further payment of Rs.54,198/-. Hence out of the total claimed amount of Rs.3,11,433/- they have settled Rs.2,45,138/- with a deduction of Rs.66,295/-. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his balance claim amount.

Contentions of the Respondent : It was contended on behalf of the Respondent that on 09.11.2020 a reimbursement claim was lodged for hospitalization of Mr Paresh B Shah due to Covid-19 Pneumonitis in Dr Chirag Mehta's Health Centre from 24.10.2020 to 25.10.2020. After due evaluation of the total claim of Rs.46,406/- was settled for Rs.34,986/- after a deduction of Rs. 11,420/-. Out of the total deductions, Rs. 6,118/- was deducted on account of non-medical expenses and Rs. 5,302/- was deducted on proportionate basis as the Insured availed a room category higher than his eligibility under the policy. As per the plan opted, he was eligible for single private room, whereas he availed a deluxe room. Hence, the charges for single private room as per hospital tariff were paid. On 18.11.2020, he lodged another reimbursement claim for his hospitalization in United Multispecialty Hospital, Mumbai from 26.10.2020 to 02.11.2020 due to Covid-19 Pneumonitis. The claim was for the reimbursement of Rs.2,59,027/- and after scrutiny, the same was settled for Rs.1,33,796/- after deducting charges of Rs.1,25,231/- in excess of GIC rates and non-medical expenses as per policy terms. Subsequently, upon being requested by the Insured, the Respondent reopened the claim and paid additional amount Rs.16,158/- for the actual cost of medicines. He, further, requested for re-assessment of claim basis which, the Respondent reopened and re-evaluated the claim as per policy terms and conditions. As an exception, they paid an additional amount of Rs.54,198/- as per policy terms. It was submitted that out of the total claimed amount of Rs.2,59,027/-, they paid Rs.2,04,152/- as per the policy terms and conditions. The total deduction was Rs.54,875, out of which Rs.36,550/- is

in respect of non-medicals and Rs.18,325/- for proportionate deduction for the room rent since the Insured was admitted in higher room category than his eligibility. The Respondent stated that the Insured availed deluxe room whereas as per the plan opted; he was eligible only for single private room. Hence, both the claims were dealt as per the policy terms and no further amount is payable under the claims. The Respondent was asked during the hearing for clarification regarding room rent, i.e. difference between a single private room and Deluxe room. It was explained that the Insured alleged that he stayed in a single private room whereas the nomenclature given by the instant hospital is 'Deluxe'. Semi-Deluxe refers to Twin-sharing whereas the higher categories are Deluxe and Super-Deluxe. The Respondent has considered the highest room category, i.e. Super-Deluxe Rs.4,500/- per day (hospital has inflated it to Rs.5,500/- per day) hence only Rs.1,000/- was deducted. The settlement for room rent was as under :

2 days Twin-sharing (Semi-Deluxe)	Rs.3000 x 2 days = Rs.7,000/- Paid in full
6 days Super-Deluxe	Rs.4,500 x 6 days = Rs.27,000/- out of Rs.5,500/- per day, hence Rs.6,000/- deducted

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that thedeductions made by the respondent towards room rent as as per policy terms.The Complainant has paid the hospital charges as per the hospital bill on which he has no control. From the foregoing, the Forum is, therefore, of the view that the complainant is entitled to the balance claim deducted under non–medical expenses, i.e. Bio-Medical Waste, Sanitization Expenses and Covid Handling Expenses under both the hospitalizations. The decision of the Respondent is ,therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, Manipal Cigna Health Insurance Co Ltd is directed to settle the balance claim deducted under non–medical expenses, i.e. Bio-Medical Waste, Sanitization Expenses and Covid Handling Expenses from both the hospitalizations, in favour of the complainant for his hospitalizations in October 2020, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 23rd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT - MR NEVILLE H LACCA
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-049-2021-1662
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**Mr Neville H Lacca** **Mumbai 400 102**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**14200034209500000816** **New India Mediclaim Policy** **28.05.2020 to 27.05.2021** **Rs.5,00,000/- + CB Rs.2,50,000/-**
3	Name of Insured Name of the policy holder	**Mr Neville H Lacca** **-** **do** **-**
4	Name of Insurer	**The New India Assurance Co Ltd**
5	Date of Repudiation	**Various**

6	Reason for repudiation	**Administration of Inj.Herceptin for Malignant Neoplasm of stomach is not listed in day care and less than 24 hours hospitalization.**
7	Date of receipt of the complaint	**25.01.2021**
8	Nature of complaint	**Total repudiation of claims (4 claims)**
9	Amount of claim	**Rs.1,61,597/-**
10	Date of Partial Settlement	**-**
11	Amount of relief sought	**Rs.1,61,597/-**
12	Complaint registered under The Insurance Ombudsman Rules 2017	**13 (b)**
13	Date of Hearing	**16.04.2021, 04.00 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Neville H Lacca**
	b) For the insurer	**Mr Ashok Nikam, Asst Manager**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**20.04.2021**

Brief Facts of the Case: Complainant was diagnosed with CA since last 22 months and his first claim for his treatment was in May 2019 and subsequent 3 claims have been settled. Thereafter, he had been advised to take Inj.Herceptin three times and the 4th claim was for Stent Removal under day care procedure.All the 4 claims were repudiated by the Respondent, The New India Assurance Co Ltd stating such treatments were not covered under day care procedure and also does not require hospitalization and hence, were beyond scope of the policy.

Contentions of the Complainant: The complainant appeared and deposed before the Forum in the joint hearing with the Company. He submitted that he has been paying insurance premium for over 27 years and had claimed for the first time in April 2019 when he was diagnosed with Stage-3 C Adenocarcinoma of the Antrum and Pylorus of the stomach. He underwent a supramajor surgery for the same where more than half of his stomach was removed and post the operation he had been taking an aggressive FLOT 5 chemotherapy treatment. His Oncologist, Dr BomanDhabbar, an eminent Oncologist advised him to undergo a test called HERS 2 which is a naturally occurring protein in the body which when found in excess proportions is the chief cause of rapid growth of cancer cells. He tested positive for this protein, hence proving that his cancer was extremely aggressive, life threatening and had an extremely high chance of recurrence. The complainant explained that Herceptin is the injection which is prescribed for preventing this kind of recurrence. Hence his Oncologist prescribed this injection to be taken once every 21 days which is a well-recognised cancer treatment known as targeted therapy, though not included in the day-care list of procedures. He, further, stated that he was required to take this injection for 2 to 3 years or more depending on the recurrence of the disease, post-surgery, in order to prevent the cancer from increasing, spreading (Metastasis) or

recurring. His first claim for the above was in May 2019 and subsequent claim have been settled. Even in the previous year, he had claimed for this treatment along with chemotherapy and his claim was also settled. Thereafter, he had been advised to take 3 Inj. Herceptin and 4th claim was for Stent Removal under day care procedure. However, the current rejection had come as a big surprise to him and has left him extremely disappointed and disheartened. His Oncologist strictly forbade him from stopping the treatment owing to the aggressive nature of the cancer. The complainant pointed that the instant claims form part of his cancer treatment.

Contentions of the Respondent: It was contended on behalf of the Respondent that Mr Neville Lacca was a patient of Ca and was administered Injection Herceptin on 04.06.2020 at BND Onco Centre, on 25.06.2020 and 16.07.2020 at Masina Hospital and on 29.09.2020 at Criticare Hospital & Dialysis Centre for Chemoport Removal on OPD basis. The said procedure was not listed under daycare, hence the claims were repudiated under Clause 1, Clause 2.10 which reads, **"Day Care treatment refer to medical treatment or Surgery which are undertaken under general or local anesthesia in a hospital/day care centre is lessthan 24 hours because of technological advancement and which would otherwise require a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition." and Clause 2.16 which reads, " HOSPITALIZATION means admission in a Hospital for a minimum period of twenty four consecutive hours of Inpatient Care except for specified procedures / treatments as mentioned in Annexure I, where such admission could be for a period of less than twenty four consecutive hours. Note: Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than twenty four consecutive hours."**

Forum's Observations/Conclusion : It is noted that cancer is a multifactorial disease and is one of the leading causes of death worldwide. The contributing factors include specific genetic background, chronic exposure to various environmental stresses, and improper diet. All these risk factors lead to the accumulation of molecular changes or mutations in some important proteins in cells that contribute to the initiation of carcinogenesis. Chemotherapy is an effective treatment against cancer but undesirable chemotherapy reactions and the development of resistance to drugs which results in multi-drug resistance are the major obstacles in cancer chemotherapy. So, alternative formulations are in practice these days which are liposomes, resistance modulation, hormonal therapy, cytotoxic

chemotherapy and gene therapy. One of the most fundamental changes found in cancer cells is the presence of mutations in the genes that are responsible for causing cell growth (oncogenes). The defective proteins produced by these altered genes are prime candidates for targeted therapy. Targeted therapy is one of the major modalities of medical treatment for cancer. As a form of molecular medicine, targeted therapy blocks the growth of cancer cells by interfering with specific targeted molecules needed for carcinogenesis and tumor growth, rather than by simply interfering with all rapidly dividing cells (e.g. with traditional chemotherapy). Targeted cancer therapies are expected to be more effective than older forms of treatments and less harmful to normal cells. Monoclonal antibodies (MABs) are a specific

type of therapy made in a laboratory. They can be used as a targeted therapy to block an abnormal protein in a cancer cell. They can also be used as immunotherapy. MABs work by recognizing and finding specific proteins on cancer cells.

Each MAB recognizes one particular protein. Hence, different MABs have to be made to target different types of cancer. They work in different ways depending on the protein they are targeting and some work in more than one way. This Forum has received a number of complaints against non-settlement of claims for such injections. It is noted that some companies are paying claims for treatment by way of these injections even when given in isolation while some other Companies who were also paying such claims earlier have now taken a stand that it is admissible only when given as a part of chemotherapy/radiotherapy or as pre and post hospitalization expenses for related hospitalization. The basic ground for denial of these claims is that it is an OPD procedure and hence beyond the scope of the policy. On an examination of all the facts/documents produced before the Forum by the Complainant and the Company, the Forum is of the view that:

● As per information collected from various websites, both chemotherapy and targeted therapy are two effective methods for cancer therapy. Chemotherapy is a type of cancer treatment that uses one or more anti-cancer drugs (chemotherapeutic agents) as part of a standardized chemo-therapy regimen. It may be given with curative intent. However, while chemotherapy can also kill the normal cells when eliminating the cancer cells, the normal cells can survive the targeted therapy, when the growth of cancer cells is limited.

● In the instant case, Injection Herceptin is used alone or with other medications to treat certain types of breast cancer. The types of cancers Herceptin is used to treat are tumors that produce more than the normal amount of a certain substance called HER2 protein. This medication is called a monoclonal antibody. It works by attaching to the HER2 cancer cells and blocking them from dividing and growing. It may also destroy the cancer cells or signal the body (immune system) to destroy the cancer cells.

● The antibodies used in cancer therapy are engineered to specifically target certain types of cancer cells. When such antibodies are copied over and over in a lab, the result is a monoclonal antibody therapy, a treatment consisting of millions of identical antibodies aimed at the same molecules on tumor cells. As researchers have found more antigens linked to cancer, they have been able to make MABs against more and more cancers. Thus, the treatment undergone by the patients seems to be one of the advancement of medical technology in as much as over the past couple of decades, more than a dozen monoclonal antibodies have been approved by the Food and Drug Administration to fight cancer, particularly breast, head and neck, lung, liver, stomach, bladder, and melanoma skin cancers, as well as Hodgkin lymphoma.

● Insurance Companies are denying the claims stating that this procedure does not require hospitalization. At the same time, it is also noted that it is not an ordinary injection that can be taken on an OPD basis but is given as an intravenousinfusion in a sterile environment by a specialist and requires monitoring of the patient’s condition for some time thereafter.

● The various certificates issued by the medical practitioners indicate that the treatment is similar to chemo-therapy which is paid for by the Companies as a day care procedure.

● It is pertinent to note that basically these injections are a part of cancer treatment. Targeted therapy is generally preferred by doctors when cancer does not respond to other therapies, has spread, or is inoperable. Treatment of cancer patients with antibodies when used alone or in combination with chemotherapy and radiotherapy, or conjugated to drugs or radioisotopes, prolongs overall survival in cancer patients.

The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology where a minimum of 24 hours of hospitalization is not required. Even IRDAI has come out with a recent circular stating that Insurance Companies cannot deny claims for modern treatments. In view of the above, Respondent is ordered to pay the admissible hospitalization expenses after deductions of non-medicals as per policy terms and conditions. The Respondents decision is, therefore, set aside by the following order of the Forum:

AWARD

Under the facts and circumstances of the case, The New India Assurance Co Ltd is directed to settle the four claims lodged for treatment of CA taken by Mr Neville Lacca at BND Onco Centre, Masina Hospital and Criticare Hospital and Dialysis Centre for the admissible amount less non-medical, if any, as per terms and conditions of the policy, subject to availability of Sum Insured towards full and final settlement of the complaint towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 20th day of April 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR VAIBHAV M PATIL
VS
RESPONDENT : THE NEW INDIA ASSURANCE CO LTD

COMPLAINT NO : MUM-H-049-2021-1622
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the complainant	**Mr Vaibhav M Patil** **Mumbai 400 016**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**11140034209500005960** **New India Mediclaim Policy** **16.12.2020 – 15.12.2021** **Rs.2,00,000/- + CB Rs.50,000/-**
3	Name of Insured Name of the policy holder	**Mr Vaibhav M Patil** - **do** -
4	Name of Insurer	**The New India Assurance Co Ltd**
5	Date of Repudiation	**-**
6	Reason for repudiation	**-**
7	Date of receipt of the complaint	**28.01.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.1,07,508/-**
10	Date of Partial Settlement	**04.01.2021**
11	Amount of relief sought	**Rs.24,024/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**20.04.2021, 04.15 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Vaibhav M Patil**
	b) For the insurer	**Mrs Mansi Pawar, Deputy Manager**

15	Complaint how disposed	**Award**
16	Date of Award/Order	**26.04.2021**

Brief facts of the case : Complainant was admitted to S L Raheja Hospital on 21.12.2020 with c/o Right Leg DM wound and underwent Right Foot Split Skin Grafting with VAC applied on 22.12.2020 and discharged on 26.12.2020. Complainant approached this Forum with a complaint against short settlement by the Respondent, The New India Assurance Co Ltd of a claim lodged under the policy in respect of the said hospitalization.

Contentions of the complainant : The **c**omplainant appeared and deposed before the Forum. He submitted that the final hospital bill was Rs.1,07,508/- out of which Rs.77,641/- was settled under cashless deducting Rs.24,804/-. The complainant pointed out the deductions Rs.7,392/- was deducted towards Drainage Kit Charges which he claimed was not for dressing. He was not agreeable to the deductions and requested for the settlement of his balance claim.

Contentions of the Respondent : It was contended on behalf of the Respondent that out of the total bill of Rs.1,07,508/-, the TPA settled Rs.77,641/- under cashless and deducted Rs.2,700/- towards Nursing and RMO Charges which are included in the room charges, while the hospital has charged excess amount towards the same and Rs.23,837/- was deducted from Non-medical expenses out of which Rs.7,392/- was towards Drainage Kit charges. The deductions were made under Clause 4.4.17 which states, **"Any expense incurred on Domiciliary Hospitalization and as per policy terms and conditions admission charges, non-medical items are not payable as per Annexure II (Item No.180-Any kit not specified)."**

Forum's Observations/Conclusion: On hearing the contentions put forth by both the parties and perusal of the documents produced on record, the Forum opined that out of the deduction of Rs.24,804/- as sought by the complainant, Rs.7,392/- pertains to non medical expenses, i.e.Drainage Kit which is not payable as per Annexure II (Item No.180). In view of above, the Respondent's stand as regards the settlement of the claim is in order. Hence, the Forum does not find any valid reason to intervene in the decision of the Respondent, consequently no relief can be granted to the complainant.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr Vaibhav M Patil against the short settlement of the claim for his hospitalization at S L Raheja Hospital in December 2020 does not sustain. There is no order for any other relief. The case is disposed of accordingly.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated at Mumbai this 26th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of the Insurance Ombudsman Rules, 2017)
OMBUDSMAN : MR MILIND KHARAT
CASE OF COMPLAINANT - MS HEMA SACHDEV
VS
RESPONDENT :HDFC ERGO GENERAL INSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-018-2021-1609
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	**MsHemaSachdev** **Mumbai 400 061**
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	**2952201639500700000/1** **Health SurakshaPolicy** **20.01.2019 to 19.01.2021** **Rs.5,00,000/-**
3	Name of Insured Name of the policy holder	**MsHemaSachdev** **- do -**
4	Name of Insurer	**HDFC Ergo General Insurance Co Ltd**
5	Date of Repudiation	**NA**
6	Reason for repudiation	**NA**
7	Date of receipt of the complaint	**25.01.2021**
8	Nature of complaint	**Premium refund due to increase**
9	Amount of claim	**NA**
10	Date of Partial Settlement	**NA**
11	Amount of relief sought	**Premium refund of past 2 years policies**
12	Complaint registered under Insurance Ombudsman Rules 2017	**Rule 13(f)**
13	Date of Hearing	**20.04.2021,03.30 pm**
14	Representation at the hearing	
	a) For the complainant	**MsHemaSachdev**
	b) For the insurer	**MrNeerajShivangikar**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**23.04.2021**

Brief Facts of the case : Complainant was covered under HealthSuraksha Policy right from 20.01.2017till 19.01.2021 without any break and paying the premium two yearly, regularly. Complainant approached this Forum with a complaint against exorbitant increase in premium for the current year policy, i.e. 20.01.2021 to 19.01.2023 by the Respondent, HDFC Ergo General Insurance Co Ltd and refund of the previous years' policies premia.

Contentions of the complainant: The complainant appeared and deposed before the Forum. She submitted that she had purchased a Health Suraksha Policy Gold Plan for SI of Rs.3 lacs. She stated that in January 2017 one of the HDFC sales person called her and sold her the policy with a premium of Rs 12,759/- for 2 years. Before the renewal of the policy,she got to know that the premium has increased drastically to more than Rs.18000/-. When she enquired about the same, she received a reply mentioning change in policy terms for better facilities, but she had not asked for it,hence why make changes and increase the premium. She pointed out that she has been a loyal customer since 20 years and shefelt cheated. She also called up the customer care and she was asked to fill a cancellation form online and was assured that someone would call and sort her queries when she asked for the refund of previous premia.

Contentions of the Respondent : It was contended on behalf of the Respondent that they had issued Health Suraksha Policy for the period 20.01.2017 to 19.01.019 and the said policy got renewed for a further period of 20.01.2019 to 19.01.2021 subject to the term/s and/or condition/s incorporated and to the extent of limits mentioned in the said Policy. The Respondent stated that they had decided to revise their product keeping in mind the evolving health care needs of the current times and to simplify the policy serving requirements. The Health Suraksha Policy was revised as my:health Suraksha and was filed with IRDAI under the File and Use Procedure. The said product was approved by IRDAI wherein Product UIN was allotted for the said product (UIN - HDFHLIP20049V41920) vide its letter dt.19.08.2019. They clarified that they had sent a Renewal Notice dated 21.11.2020 to Insured wherein they had intimated that her current policy was due for renewal on 19.01.2021 and their policy will be renewed as "my: health Surakha" under Classic plan and the premium was charged accordingly. The Respondent reiterated that a new policy comes with a host of new added features, keeping in mind the current situation. The Insured is demanding refund of premium of expired policies, however, it should be noted that till the expiry of the policy, i.e. 19.01.2021, risk of the Insured was covered and as such the question of refund of premium does not arise.

Forum's Observations/Conclusion: The Forum advised the Respondent to guide the Insured properly about the increase in premium and give justification for the same or suggest them to opt for other suitable Policy. The Forum informed the complainant that increases in premiums are duly vetted by the Regulators and approved by them. It is based purely on the claims experience of the HealthProduct. It was further added that all changes are looked at by the Regulator and only after going through the Co.'s calculation, the premium rates are approved by the Regulator. The Forum stressed that the Insurance Cos cannot arbitrarily charge the

premium and it is only after the Regulators ultimate approval. The IRDAI goes through all the submissions made by the Insurance Co. and its impact on the policy holder.

At the instance of the Forum, the Respondent was directed to offer their other reasonable products to the complainant, however, the complainant declined to opt for any of them.

In view of the above although the Forum appreciates the difficulties of the complainant, since the premiacharged are duly approved by the Regulators, the Forum does not find any valid reason to intervene with the decision of the Respondent, consequently no relief can be granted to the complainant.

AWARD

Under the facts and circumstances of the case, the complaint lodged by MsHemaSachdev against the increase in premium and refund of the same, is dismissed.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the laws of the land against the Respondent Insurer.

Dated: This 23rd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : MR MILIND KHARAT

CASE OF COMPLAINANT – MR LAXMICHAND M GIANANI
VS
RESPONDENT : UNITED INDIA INSURANCE CO LTD

COMPLAINT NO : MUM-H-051-2021-1592
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the complainant	**Mr Laxmichand M Gianani** **Mumbai 400 052**
2	Policy No: Type of Policy Duration of Policy/Period Sum insured	**0221002819P115968642** **Individual Health Insurance Policy** **14.03.2020 – 13.03.2021** **Rs.6,25,000/-**
3	Name of Insured Name of the policy holder	**Late Mrs Radharani L Gianani** **- do -**
4	Name of Insurer	**United India Insurance Co Ltd**
5	Date of Repudiation	**-**
6	Reason for repudiation	**-**
7	Date of receipt of the complaint	**14.01.2021**
8	Nature of complaint	**Short settlement of claim**
9	Amount of claim	**Rs.4,14,327/-**
10	Date of Partial Settlement	**26.09.2020**
11	Amount of relief sought	**Rs.1,83,674/-**
12	Complaint registered under Insurance Ombudsman rules 2017	**13(b)**
13	Date of Hearing	**20.04.2021, 03.45 pm**
14	Representation at the hearing	
	a) For the complainant	**Mr Kumar L Gianaani, complainant's son**
	b) For the insurer	**Mrs Vidisha Parab, Administrative Officer**
15	Complaint how disposed	**Award**
16	Date of Award/Order	**23.04.2021**

Brief Facts of the Case : Complainant's wife, Mrs Radharani L Gianani was admitted to S L Raheja Hospital on 19.09.2020 for treatment of Covid-19 wherein she succumbed on 26.09.2020. Complainant approached this Forum with a complaint against short-settlement by the Respondent, United India Insurance Co Ltd of a claim lodged under the policy for the said hospitalization.

Contentions of the complainant : The complainant's son, duly authorized by him appeared and deposed before the Forum. He submitted that the hospitalization expense of Rs.4,14,327- was authorized for Rs.2,30,653/- by the Respondent, with a deduction of Rs.1,83,674/-. He stated that his deceased mother was admitted in a twin sharing room. He pointed out that they had completely deducted Pathology Charges Rs.15,000/-, Ward Medicine Rs.74,727/-, Ward Disposables Rs.15,029/-, Pharmacy Charges Rs.34,701/-, Ventilator Charges Rs.9,509/-, CT Scan Rs.13,000/-, Cardiology Charges Rs.3,803/- and Bedside Charges Rs.8,580/-. He added that he had also to submit the pre-hospitalization bills for reimbursement. The complainant's son

explained that the claim settlement was made as per the Maharashtra Govt Circular which he was not agreeable. Not agreeable to the short settlement, the complainant approached this Forum for settlement of his balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the excess charges of Rs.1,83,674/- billed by the hospital were disallowed from the claim as per the Public Health Dept Circular No.CORONA 2020/C.R.97/Arogya-5 which were out of the package rand the claim was settled for an amount of Rs.2,30,653/-.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, the Forum observed that the complainant had taken treatment in the Co.'s PPN hospital. The Maharashtra Regulations were issued in June 2020 and the instant hospital should have adhered to it. However, it appears that the hospital has not adhered to the same and has overcharged the patient in violation of their Agreement with the Respondent. Nevertheless, it would not be fair to penalize the complainant for the same as he has genuinely incurred the expenses and has paid the charges as billed by the hospital. The Forum is, therefore, of the view that the complainant is entitled to be reimbursed the deducted amount totaling to Rs.1,83,674/- barring the non-payables, if any, and the Respondent may seek refund of the amount billed in excess of agreed rates directly from the hospital. The decision of the Respondent is ,therefore,intervened by the following Order.

AWARD

Under the facts and circumstances of the case, United India Insurance Co Ltd is directed to settle the balance claim amounting to Rs.1,83,674/- barring the non-payables, if any, in favour of the complainant's deceased wife, Mrs Radharani L Gianani for her hospitalization in September 2020, towards full and final settlement of the complaint, within 30 day from issuance of this order so as to avoid penal interest as per guidelines of the IRDAI. There is no order for any other relief. The case is disposed of accordingly.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 23rd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE
(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - MR DHIREN B MEHTA

VS

RESPONDENT : THE NEW INDIA ASSURANCE CO LTD

COMPLAINT REF: NO:MUM-H-049-2122-0012

AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	Mr Dhiren B Mehta Mumbai 400 054
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14030034182800008604,140300341928000089 39 New India Floater Mediclaim Policy 25.03.2019– 24.03.2020 & 25.03.2020-24.03.2021 Rs.8,00,000/-
3	Name of Insured Name of the policy holder	Mrs Komal D Mehta Mr Dhiren B Mehta
4	Name of Insurer	The New India Assurance Co Ltd
5	Date of Repudiation	Various
6	Reason for repudiation	Injection Eyelia (less than 24 hours hospitalization) – Clause 2.15 (Policy 2019-20), Clause 2.16 (Policy 2021-21)
7	Date of receipt of the complaint	26.02.2021
8	Nature of complaint	Repudiation of claim (5 claims)
9	Amount of claim	Rs.4,17,440/-
10	Date of Partial Settlement	-
11	Amount of relief sought	Rs.4,17,440/-
12	Complaint registered under Ombudsman Rules, 2017	Under Rule 13(b)
13	Date of Hearing	20.04.2021 – 4.30 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr Dhiren B Mehta
	b) For the insurer	Mrs Josephine Lemos, Admn Officer assisted by Dr Komal Shinde, M/s Medi Assist India TPA Pt Ltd
15	Complaint how disposed	Award
16	Date of Award/Order	22.04.2021

Brief Facts of the Case : Complainant's wife was administered Intravitreal Injection Eyelia on 04.12.2019, 01.01.2020, 29.01.2020, 28.02.2020 and 11.05.2020 at Agarwal Eye Hospital, Malad (West) for the treatment of Right Eye Idiopathic Polypoidal Choroidal Vasculopathy (IPCV) and Choroidal Neovascular Membrane (CNVM) for which he lodged five claims under the policy. Respondent, The New India Assurance Co Ltd rejected the claims under the Exclusion Clause of the policy stating that the administration of eye injection was not payable since it was not listed under day care as per policy terms and conditions.

Contentions of the Complainant: The complainant appeared and deposed before the Forum. He contended that his wife was treated for her Right Eye in which injection was necessary as she had blurred vision and was seeing floaters, hence, this treatment was needed. He preferred five claims with the Insurance Co for total of Rs.4,17,440/- however, they repudiated the same on grounds that Eyelia Injection and hospitalization for less than 24 hours was not payable as per policy terms and conditions. Further, they stated that the procedure was not forming part of their day care list of surgeries and the patient could have been treated on OPD basis which did not require hospitalization. The complainant stated that in his wife's instant case, 24 hours hospitalization was not required and it was a day care treatment, despite this, the claim was repudiated. He pointed out that due to advancement in technology, one can take treatment and go home in 2 hours and there is no need of hospitalization. The complainant was not agreeable to the decision of the Insurance Co and requested for settlement of his wife's claims.

Contentions of the Respondent: It was contended on behalf of the Respondent that on scrutiny of the claim documents it was observed that the Insured had submitted claim for RE Eyelia Injection and hospitalization for less than 24 hours. As per policy clause 2.16, expenses on hospitalization for minimum period of 24 hours are admissible. Further, the procedure is not forming a part of day care list of surgeries and the patient could have been treated on OPD basis which didn't warrant hospitalization. As per policy terms and conditions, any ailment that can be treated on OPD basis is not admissible even if converted to IPD or day care. Hence, the claim was not admissible and repudiated.

Forum's Observations/Conclusion: This Forum has received a number of complaints against non-settlement of claims by way of such Anti VEGF injections and has made a detailed analysis of all the facts related to the treatment vis-à-vis the Company's stand in dealing with these claims which have been elaborated in the Awards issued by the Forum in similar cases heard earlier. During the hearing of these cases the complainants have submitted to the Forum certificates from leading Ophthalmologists mentioning the fact that this procedure is not a surgical intervention but is to be carried out in Operation theatre to maintain a sterile environment. The Company has also produced certificates from qualified Ophthalmologists. The various certificates issued by the eye specialists indicate **divided opinion** amongst the doctors regarding the procedure being an inpatient or outpatient one.

The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology where minimum of 24 hours of hospitalization is not required. Based on the deposition of the complainants, the Forum notes that the treatment is

a prolonged one wherein depending upon the prognosis,the patient has to be administered more number of injections. Though the Forum is also able to appreciate the case of the complainant in expecting the Insurer to settle the claims in as much as the treatment being a prolonged one and repetitive in nature but for the reasons stated above, it would be reasonable that the complainant bears a part of the expenses. Accordingly, taking a practical view of the facts of the case, which have been brought to the notice of this Forum, it has come to the conclusion that the cost of the treatment is to be shared equally between the complainant and the Company. The decision of the Respondent is ,therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, the Respondent, The New India Assurance Co Ltd is directed to pay 50% of Rs.4,17,440/-, in favour of the complainant's wife, Mrs Komal D Mehta, as full and final settlement of the complaint.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 22nd day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN
MUMBAI & GOA
METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI. MILIND KHARAT

CASE OF COMPLAINANT - Mr. Tarun M. Desai
VS
RESPONDENT : United India Insurance Co. Ltd.

COMPLAINT REF: NO:MUM-H-051-2021-1575
AWARD NO: IO/MUM/A/HI/ /2020-2021

1	Name & Address of the Complainant	Mr. Tarun M. Desai Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	021400281P103267686 Individual Mediclaim Policy 13.06.2019 to 12.06.2020 Rs.75,000/- + CB
3	Name of Insured Name of the policy holder	Mrs. Vimla Desai Mr. Tarun Desai
4	Name of Insurer	United India Insurance Co. Ltd.
5	Date of Repudiation	……-…….
6	Reason for repudiation	.....-…….
7	Date of receipt of the complaint	14.01.2021
8	Nature of complaint	Product withdrawn
9	Amount of claim	……..-……
10	Date of Partial Settlement	……..-……
11	Amount of relief sought	……-……..
12	Complaint registered under The Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	08.04.2021 @ 12.30 pm
14	Representation at the hearing	
	a) For the complainant	Mr. Tarun Desai
	b) For the insurer	Mrs. Meeta
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief facts of the case : Complainant's mother Mrs. Vimla Desai is covered with the Respondent for more than 12 years under the above Individual Mediclaim Policy. The said policy does not

have any limit on room charges. This policy has been always renewed in time with appropriate payment of premium. He received a notice from the Respondent dt.29.11.2019 that the above product would be withdrawn effective next renewal and he was offered option to migrate to Individual Health Insurance Policy or Family Medicare policy of comparable sum insured. The Complainant was not agreeable with the said decision.

Contentions of the Complainant: Complainant submitted during the hearing that his mother is covered under the Individual Mediclaim Policy for Rs.75,000/- sum insured with CB since 12 years. The Respondent vide their notice dt. 29.11.2019 informed the complainant that that the above product would be withdrawn effective next renewal and he was offered option to migrate to Individual Health Insurance Policy or Family Medicare policy of comparable sum insured of Rs.1.25 lakh. The Coverage offered under Individual Health Insurance policy is meaningless when compared to individual Mediclaim policy due to room rent being limited to 1% of sum insured in Individual Health Insurance Policy or Family Medicare Policy. He added that premium for the offered policy is Rs. 14048 as against withdrawn policy's premium was of Rs. 6150. He had also (under RTI Act) asked respondent company to share financial summary and other documents related to withdrawan product, which he did not get it.

Contentions of the Respondent : Respondent submitted during the hearing that as per their Head Office Circular dated 07/02/2021, the Individual Mediclaim Policy has been withdrawan with effect from 29/02/2021, since it was not sustainable and financially inviable to continue this product. Accordingly they had sent notice dated 29.11.2019 to all policyholders. The complainant also acknowledged that he had received their notice dated 29/11/2019. They had offered him two alternative products for continuation. Also under Sect 8 (1) d of RTI Act, it was not possible for them to share the information sought by him under RTI Application.

Observation and Conclusion : The Forum observes in this case that the Respondent has informed the withdrawal of above product to all the policy holders and the insurance intermediaries. The 90 days' notice of withdrawal of above product and option to take new product with its terms & conditions was given to all the policyholders. In above case the Complainant admitted that he had received the above notice.

It is observed that whenever any products are withdrawn or new products introduced, they are done with approval of the Regulatory Authority (IRDAI). In this case after withdrawal of product, the Insurance Company has also given option to migrate to other available products of the Company. Hence the complaint lodged by the complainant does not sustain under the circumstances.

The Forum therefore does not find any valid ground to intervene with the decision of the Respondent and pass the following order.

AWARD

Under the facts and circumstances of the case, the complaint lodged by Mr. Tarun M Desai against The United India Insurance Co. Ltd. does not sustain.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for him/her, if he/she so decides to move any other Forum/Court as he/she may consider appropriate under the Laws of the Land against the Respondent Insurer.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE

(Under Rule No. 15 (1)/16 of Insurance Ombudsman Rules 2017)

OMBUDSMAN : SHRI MILIND KHARAT

CASE OF COMPLAINANT - Mr. Unnikrishnan N Nair

VS

RESPONDENT : The New India Assurance Co. Ltd.

COMPLAINT REF: NO:MUM-H-049-2021-1632

AWARD NO: IO/MUM/A/GI/ /2020-2021

1	Name & Address of the Complainant	Mr. Unnikrishnan N Nair Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	11120034209500003076 New India Mediclaim Policy 22.08.2020 to 21.08.2021 Rs.1,00,000/- + Rs. 42,500/- (CB)
3	Name of Insured Name of the policy holder	Mr. Unnikrishnan N Nair
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	20.11.2020
6	Reason for repudiation	Policy Exclusion Clause - Diagnostic purpose
7	Date of receipt of the complaint	19.01.2021
8	Nature of complaint	Total repudiation of claim
9	Amount of claim	Rs. 50000/-
10	Date of Partial Settlement	……-……..
11	Amount of relief sought	Rs.50000/-
12	Complaint registered under Insurance Ombudsman Rules 2017	13 (b)
13	Date of Hearing	15.04.2020 @ 12.5 pm

14	Representation at the hearing	
	a) For the complainant	Mr. Unnikrishnan Nair
	b) For the insurer	Mr. ShailendraKeny, DM
15	Complaint how disposed	Award
16	Date of Award/Order	30.04.2021

Brief Facts of the Case : Complainantwas admitted at Holy Spirit Hospital from 01.09.2020 to 01.09.2020 for the complaint of stroke and on the advice of the doctor, he was investigated and treated with oral medicines. Due to Covid situation there was no bed available. Complainant lodged a claim for Rs.50000/-. Respondent repudiated the claim on the ground that only investigation and oral medicines were given on OPD basis and there was no active line of treatment given hence the claim was not payable as per policy clause no. 2.16 The complainant is not agreeable with the decision of the Company.

Contentions of the Complainant : The Complainant submitted during the hearing that he had gone to hospital for treatment of stroke. However due to covid pandemic there was no bed available hence he was examined by Neurologist Doctor and as per his advice he was advised to take treatment at home. He was treated with complete bed rest and given injections, tablets etc at home Complainant lodged a claim for approx Rs.50000/-, however; Respondent repudiated the claim on the ground that the said treatment could have been given on OPD basis.

Contentions of the Respondent: The Respondent submitted that patient visited the hospital with complaints of stroke. The attending Doctor examined him by some investigation and advised him to take treatment at home. On scrutiny of the claim documents it is observed that there is no hospitalization and only investigation and consultation were done on OPD basis.. No active line of treatment was given to the patient hence the claim was not payable as per policy exclusion clause no. 2.16.

Observations/Conclusion : The Forum observes in this case that patient visited hospital with intention of in-patient treatment of stroke. As per attending Doctor's certificate, since thre was no bed available due to COVID PANDEMIC he was examined and advised treatment at home.

Though the line of treatment administered was only oral medicines, however due to covid pandemic situation and on the basis of condition of the patient,the doctor advised him to take further treatment at home under his guidance. Therefore,the Company's stand of repudiating the above claim on the ground of Policy Clause 2.16 for diagnostic purpose is not sustainable and the Company is ,hereby,directed to pay the admissible claim amount less non-medical items, if any,

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the above claim for the admissible claim amount less non-medical items, if any in favour of the Complainant towards full and final settlement of the claim.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules 2017 :

a) As per Rule 17(6) of the said rules the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.
b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated at Mumbai this 30th day of April, 2021.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN: SHRI MILIND KHARAT

CASE OF COMPLAINANT: - MR. PRANAV DESAI

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1670

AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	Mr. Pranav Desai, Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	14060034199500007064 New India Mediclaim Policy 05.12.2019 to 04.12.2020 Rs.15,00,000/-,
3	Name of Insured Name of the proposer	Mrs. Aalisha P. Desai
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	------
6	Reason for repudiation	------
7	Date of receipt of the complaint	18.02.2021
8	Nature of complaint	Short settlement of claim
9	Amount of claim	Rs.1,68,434/-

10	Amount of Partial Settlement	Rs.1,14,375/-
11	Amount of relief sought	Rs.54,059/-
12	Complaint registered under Insurance Ombudsman Rules	Under Rule 13(b)
13	Date of Hearing	15.04.2021 at 4.00 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. Pranav Desai
	b) For the insurer	Mrs.poonamAdvani, Asst.. Manager
15	Complaint how disposed	Issuing Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant,Mr. Pranav Desai,is covered under New India Mediclaim Policy bearing No. 14060037199500007064 for the period 05.12.2019 to 04.12.2020 for a Sum Insured of Rs.15,00,000/-.

Complainant's wife,Mrs. Aalisha Desai was admitted to Breach Candy Hospital from 19/10/2020 to 23/10/2020 for the treatment of Conservative Covid 19 infection. The complainant approached this Forum with a complaint against short-settlement by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy for the said hospitalization.

Contentions of the Complainant: The complainant Mr. Pranav Desai appeared and deposed before the Ombudsman in the joint hearing with the Company on 15th April, 2021 at 4.00 pm. The Forum asked the Complainant to brief about the case to which he submitted that his wife was admitted to Breach Candy Hospital from 19.10.2020 to 23.10.2020 for treatment of the Covid-19 positive infection.

The total claim was lodged for Rs.1,68,434/- for his wife's hospitalization in October 2020, with the company. The Company had settled the claim for Rs.1,14,375/- and deducted an amount of Rs.54,059/- citing the Reasonable & Customary Charges Clause of the policy by adhering to the guidelines on rates issued by the Government of Maharashtra which was not acceptable to him. He requested the Forum for settlement of the balance claim amount.

Further, he submitted that his own claim under Covid-19 positive for said hospitalization was settled by the Respondent in the month of March.2021. He, therefore, requested for settlement of his balance claim amount.

Contentions of the Respondent: It was contended on behalf of the Respondent that the Insured was diagnosed as Conservative Covid 19 infected and underwent medical management for the same. As per policy T&C, Insured claimed a total of Rs.1,68,434/- which they settled for Rs.1,14,375/-. They had, however, deducted Rs.54,059/-as Reasonable customary charges compared with Maharashtra Government and GICguidelines. The hospital is not under the PPN network. The TPA has processed the above-mentioned claims as per Guidelines received from their Head office for processing claims. According to the guideline of GI Council rate list, the excess charges billed by the hospital were disallowed out of the claimed amount.

Forum's Observations/Conclusion: After scrutiny of the documents produced on record coupled with the depositions of both the parties, it is observed that the claim of the complainant has been settled by the Respondent based on Government guidelines. However, it appears that the hospital has not adhered to Government guidelines and has overcharged the patient.

Respondent has not sought any clarification from the hospital in this regard. Under such circumstances, it would not be fair to penalise the complainant for the same as he has genuinely paid the charges as billed by the hospital and is adequately covered under the policy. The Forum is, therefore,of the view that the complainant is entitled to be reimbursed the entire hospitalization expenses barring non-medical items and the Respondent may seek a refund of the amount billed in excess of stipulated rates, directly from the hospital, if deemed fit. The decision of the Respondent is, therefore, intervened by the following Order.

AWARD

Under the facts and circumstances of the case, The New India Assurance Co. Ltd. is directed to settle the admissible balance claim amount of Rs.54,059/- barring non-medical expenses in favour of the complainant Mr. Pranav Desai for his wife's hospitalization, towards full and final settlement of the complaint of the complaint within 30 days from the issuance of this order so as to avoid penal interest as per guidelines of the IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING NAVI MUMBAI & THANE

(Under Rule No. 16/17 of Insurance Ombudsman Rules, 2017)

OMBUDSMAN: SHRI MILIND KHARAT

CASE OF COMPLAINANT: - MR. PRAFUL P. KARIA

VS

RESPONDENT: THE NEW INDIA ASSURANCE CO. LTD.

COMPLAINT REF: NO: MUM-H-049-2021-1686

AWARD NO: IO/MUM/A/HI/ /2021-2022

1	Name & Address of the Complainant	Mr. PrafulKaria, Mumbai
2	Policy No: Type of Policy Duration of Policy/Period Sum Insured	13130034199500006017 New India Mediclaim Policy 06.02.2020 to 05.02.2021 Rs.15,00,000/-, CB Rs.62,500/-
3	Name of Insured Name of the proposer	Mrs. Ila PrafulKaria
4	Name of Insurer	The New India Assurance Co. Ltd.
5	Date of Repudiation	18.01.2021
6	Reason for repudiation	Home treatment claim not payable
7	Date of receipt of the complaint	18.02.2021
8	Nature of complaint	Non Settlement of claims
9	Amount of claim	Rs.82,271/-
10	Amount of Partial Settlement	---
11	Amount of relief sought	Rs.82,271/-
12	Complaint registered under	Under Rule 13(b)

	Insurance Ombudsman Rules	
13	Date of Hearing	15.04.2021 at 1.15 p.m.
14	Representation at the hearing	
	a) For the complainant	Mr. PrafulKaria
	b) For the insurer	Mrs.MadhuriPawar, Dy. Manager
15	Complaint how disposed	Issuing Award
16	Date of Award/Order	30.04.2021

Brief facts of the case: Complainant's wife,Mrs. Ila Karia slipped in the bathroom on 25th March, 2020 and got injured with spine fracture on L1 Vertebrae. He approached the KLS Memorial Hospital, but she could not get admission due to declaration of lockdown from 24th March,2020 because of Covid-19,due to which, she could not be hospitalised. Dr. Ashish B. Jain who was attached with the KLS Memorial hospital advised for complete bed rest and necessary treatment at home with medication. Under the pandemic situation and being a sr.citizen, she was under stress of corona infection. She was left with no option, but to follow the doctor's advice and start treatment and medication at home for three months from 25th March, 2020 onwards,

The Complainant approached this Forum with a complaint against repudiation by the Respondent The New India Assurance Co. Ltd. of a claim lodged under the policy for the said home treatment on the ground that treatment taken as outpatient and expenditure incurred thereupon was excluded from the scope of policy.

Contentions of the Complainant: TheComplainant appeared and deposed before the Ombudsman in the joint hearing with the Company held on 15th April, 2021 at 1.15 Pm. The Forum asked Mr. PrafulKaria the reasons for his wife's grievance. He submitted that his wife slipped in the bathroom and got injured with spine fracture on L1 Vertebrae. Due to unavailability of bed in the hospital, she had taken domiciliary home treatment under guidance of Dr. Ashish B.Jain. He submitted that his wife was under home treatment for 3 months. He further submitted a Certificate from treating doctor Ashish B. Jain , which clearly stated for complete bed rest and necessary treatment at home with medication. He lodged two claims for Rs.59915/- & Rs.22356/- totalling to Rs.82271/-. However, his claim was repudiated by the Respondent. He argued that before getting home treatment, he has made so many correspondence s with MDI TPA and Insurance Company but no response was received from

their end. Aggrieved by the decision of the Respondent, the complainant approached this Forum seeking relief in the matter.

Contentions of the Respondent: The Forum asked the Company the reasons for repudiation of the above claim. The company submitted that patient presenting with complaints of spine fracture on L1 Vertebrae and was treated at home with two intra-muscular injections were given, prescribed medicines for 10 days and advised vitamins / supplementary for 2-3 months with "Complete Bed rest". Further, it was observed that the patient was managed only with oral medication anddidn't qualify for Domiciliary Hospitalization . Such kind of treatment is excluded from the scope of coverage in the policy.

Hence, the claim stood repudiated as per the policy terms and conditions clause 4.4.18 domiciliary hospitalization.

Observations/Conclusion: The Forum observes in this case that patient Mrs. IlaKaria was on home treatment with history of spine fracture on L1 Vertebrae. She was initially under the treatment of Dr. Ashish B. Jain with presenting symptoms of severe Vertigo. As she could not be hospitalised due to declaration of lockdown from 24th March, 2020 on account of pandemic Covid-19, the patient was managed with oral medicines and investigations during home treatment which were normal and all the vitals were also normal under guidance of Dr. Ashish B. Jain.

The treatment was on the basis of medical advice and considering the circumstances,the Company's denial of above claim on the ground that this treatment could have been done on OPD basis is not sustainable and the Company is directed to settle the above claim for the admissible amount of Rs.82,271/- deducting non-medical expenses, if any. The decision of the Respondent is therefore,intervened by the following order:

AWARD

Under the facts and circumstances of the case, The New India Assurance Company Ltd; is directed to settle the above claim for admissible amount of Rs.82.271/- less non-medical items if any, in favour of the complainant Mr. Praful P. Karia, towards full and final settlement of above complaint within 30 days from the issuance of the order so as to avoid penal interest 2% above the Banks' rate as per guidelines of IRDAI.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of the Insurance Ombudsman Rules, 2017:

a) As per Rule 17(6) of Insurance Ombudsman Rules, 2017, the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

b) As per Rule 17(8) the award of Insurance Ombudsman shall be binding on the Insurers.

Dated: This 30th day of April, 2021 at Mumbai.

(MILIND KHARAT)

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
MUMBAI (MUMBAI METRO & GOA)
(Under rule no. 16(1)/17 of the insurance ombudsman rules, 2017)

OMBDUSMAN: – SHRI MILIND KHARAT

Complaint No: MUM-H-003-2021-1667
Award No: IO/MUM/A/HI/ 00 /2020-21
Complainant: Mrs. Jyoti A. Parikh
Respondent: HDFC Ergo General Insurance Company Limited
Nature of Complaint: Short settlement of Covid-19 claim.

Brief Facts of the Case : Mrs. Jyoti Ashok Parikh is covered with HDFC Ergo Health Insurance vide Policy No. AA00204021-05. Complainant Mrs. Jyoti Ashok Parikh was admitted to United Multispecialty Hospital Kandivali West, Mumbai from 22.08.2020 to 29.08.2020 for treatment of Covid-19. The total claim lodged under the policy for reimbursement was of Rs.1,82,708/-. The claim was settled for Rs.61,732/- and balance amount of Rs.1,20,976/- was disallowed.

Aggrieved, she approached this Forum requesting relief in the matter of settlement of the balance claim.

Records were perused and a joint hearing of the parties to the dispute was scheduled on 12th April, 2021. Meanwhile, it was informed by the Insurance Company vide e-mail dated 12th April, 2021 that they have reconsidered the case and settled the claim for Rs.1,20,976/-.

The Complainant also agreed, and expressed her willingness to withdraw the complaint vide his e-mail dated 12th April, 2021.

AWARD

In view of settlement of the claim by the Insurance Company and pursuant withdrawal of the complaint by the complainant, the complaint stands closed at this Forum. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this 12th day of April, 2021.

(MILIND KHARAT)
INSURANCE OMBUDSMAN

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI

(Under Rule 13 r/w 17 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Gurjit Singh Ahuja versus The Oriental Insurance Company Ltd.

Complaint Ref. No.: DEL-H-050-2122-0002

1.	Name & Address of the Complainant	ShriGurjit Singh Ahuja, C-36, Panchsheel Enclave, New Delhi-110017
2.	Policy No. Type of Policy Policy term/policy period	212703/48/2020/4377 Happy Family Floater Policy 06.03.2020 to 15.03.2021
3.	Name of the insured Name of the policy holder	Gurjit Singh Ahuja Gurjit Singh Ahuja
4.	Name of insurer	The Oriental Insurance Company Ltd.
5.	Date of repudiation	18.11.2020
6.	Reason for grievance	Non-settlement of Mediclaim
7.	Date of receipt of the complaint	02.03.2021
8.	Nature of complaint	Non-settlement of Mediclaim
9.	Amount of claim	Rs.53966/-
10.	Date of partial settlement	N.A.
11.	Amount of partial settlement	N.A.
12.	Amount of relief sought	Rs.53966/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules 2017	Rule 13(1)(b)- Any Partial or total repudiation of claims by an Insurer
14.	Date of hearing	13.04.2021
	Place of hearing	Delhi, Online via Cisco WebEx
15.	Representation at the hearing	
	For the Complainant	Shri Gurjit Singh Ahuja, the Complainant

	For the Insurer	Shri Sukhpal Singh, Administrative Officer
16.	Date of Award/Order	Award under Rule 17/ 13.04.2021

17. Brief Facts of the Case: ShriGurjit Singh Ahuja (hereinafter referred to as the complainant) has filed this complaint against the decision of The Oriental Insurance Company Ltd. (hereinafter referred to as the Insurer or the Respondent Insurance Company) allegingwrong rejection of Mediclaim.

18. Cause of Complaint:

a) Complainant's Argument:The Complainant suffered an attack of Covid-19on 26.06.2020 and was placed under Home Treatment & Quarantine by doctors of Max Hospital, giving the line of treatment of COVID-19. After his recovery, he submitted his mediclaim with all the supporting documents to TPA but his claim was rejected on the ground that home quarantine expense was not payable as per policy terms and conditions. He was home treated & quarantined on doctor's advice to save him from exposure to more serious infections in the hospitals and also not to occupy the already limited beds in the hospital for very serious cases. He approached the Grievance Department of the Insurance Company but his claim was not settled.

b) Insurer's Argument: The Insurance Company, vide Self Contained Note dated 05.04.2021, have stated that on scrutiny of claim documents, it was observed that the patient Shri Gurjit Singh Ahuja has submitted the documents for the reimbursement of expenses for the home

quarantine treatment. As Home Quarantine expenses are not payable as per Clause 4.24 of the policy terms & conditions, the claim was repudiated and informed to the Complainant.

19. Reason for registration of Complaint: Non-settlement of Mediclaimvide para 18 (a) above.

20. The following documents were placed for perusal:

a) Copy of policy.
b) Copy of GRO Letter, consultation papers, reports, rejection letter.
c) SCN of the Insurers along with enclosures.

21. Result of hearing with the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments as noted in Para 18 above.

I have examined the arguments and the evidence submitted by both the parties.

The Policy Clause 3.13 provides for reimbursement of domiciliary hospitalization only if either (a) the condition of the patient is such that he/she cannot be removed to the hospital, or (b) non-availability of a room in the hospital.

In the present case, neither of the two conditions were satisfied and the Complainant had on his own decided to undergo domiciliary treatment, while obtaining the advice for medicines and tests from the doctors by way of visits to OPD or through phone calls etc. Further, OPD treatment is not admissible, vide Clause 4.24 of the Policy. Therefore, this claim was inadmissible for OPD treatment under Clause 4.24 and under domiciliary hospitalization under Clause 3.13.

In the above background, the Insurers were justified in repudiating the claim. Pursuantly, the complaint shall deserve rejection.

Award
The complaint is rejected.

(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 13, 2021

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI

(Under Rule 13 r/w 16 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Krishan Kant Tiwari Versus The National Insurance Company Ltd.

Complaint Ref. No.: DEL-H-048-2122-0005

1.	Name & Address of the Complainant	Shri Krishan Kant Tiwari House No. 197, Block G, KH No. 28/14, Mange Ram Park, Near Som Bazar Road, Budh Vihar, Delhi-110086
2.	Policy No: Type of Policy Duration of policy/Policy period	360804501910004605 Parivar Mediclaim Policy 03.01.2020 To 02.01.2021
3.	Name of the insured Name of the policy holder	Krishan Kant Tiwari Krishan Kant Tiwari
4.	Name of the insurer	The National Insurance Company Ltd.
5.	Date of repudiation	03.09.2020
6.	Reason for repudiation	Mis-representation, mis-description or non-disclosure of material facts (Clause 5.1)
7.	Date of receipt of the complaint	11.01.2021
8.	Nature of complaint	Repudiation of Claim
9.	Amount of claim	Rs.97382/-
10.	Date of partial settlement	N.A.
11.	Amount of partial settlement	N.A.
12.	Amount of relief sought	Rs. 97382/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules, 2017	Rule 13(1)(b) – any partial or total repudiation of claims by an insurer
14.	Date of hearing/place	16.04.2021, Delhi, Online, Via WebEx
15.	Representation at the hearing	
	For the Complainant	Shri Krishan Kant Tiwari, the Complainant
	For the insurer	Shri Ramesh Sood, Branch Manager, Alipur
16.	Complaint how disposed/ Date of Award/Order	Recommendation under Rule 16 16.04.2021

17. Brief Facts of the Case:

Shri Krishan Kant Tiwari (hereinafter referred to as the Complainant) has filed this complaint against the decision of The National Insurance Company Ltd. (hereinafter referred to as the Insurers or the Respondent Insurance Company) alleging wrong repudiation of mediclaim.

18. Cause of Complaint:

a) Complainant's Argument: The Complainant was admitted in Santom Hospital, Rohini, Delhi for treatment of fever and burning sensation in urine. During the hospitalization period from 09.04.2020 to 17.04.2020, he incurred total expense of Rs. 97382/-, for which he filed a claim for reimbursement. One investigating officer of TPA came to him and took written statement saying that his claim would be settled very soon. But insurers

rejected his claim citing Policy Clause 5.1. He wrote to GRO on 18.11.2020 but the insurers did not reimburse his claim amount. He has now approached this forum for relief.

b) Insurer's Argument: The Insurer in their SCN dated nil has stated that Shri Krishan Kant Tiwari is an employee of Santom Hospital and is working as Medical Record In-charge in the hospital. He was

admitted in Santom Hospital on 09.04.2020 with c/o fever, burning to urine and discharged on 17.04.2020. Neither family member/hospital informed TPA/Insurer about the hospitalization TPA undertook investigation of the case and as per findings of TPA based on the records of hospital, it was concluded that patient was working at Santom Hospital and manipulated documents showing treatment which was not supported during investigation made, payment received by hospital in cash from its own employee, charging of standard room rate and other charges without any staff discount and treatment for a prolonged period of 8 days, not supported by proper diagnosis and treatment protocols, clearly proves their suspicion. Santom Hospital was on PPN List but in a fraud case, their cashless facility was suspended, because of involvement in case of fraud and abuse. Hence based on all the above, insurers have noticed discrepancies and lapses in the claim documents on the basis of which claim has been repudiated under Clause-5.1 “Duty of Disclosure.”

19. Reason for registration of Complaint: Repudiation of Mediclaim.

20. The following documents were placed for perusal:

a) SCN
b) Discharge
c) GRO

21. Result of hearing of the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments as noted in Para 18 above.

At this stage, the Insurers offer to review the claim and take a decision afresh within one month. The Complainant agrees to this offer and assures to provide all the required documents to the Insurers as are available with him. Thus an agreement of conciliation could be arrived at between the Complainant and the

Insurers, which I consider as fair and reasonable for both the parties.

Award
The complaint is resolved in terms of the agreement of conciliation arrived at between the Complainant and the Insurers. Accordingly, the Insurers shall review the claim and take a decision afresh. The Complainant shall provide to the Insurers all the required documents as are available with him. Parties should implement this agreement within 30 days.

(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 16, 2021

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI
(Under Rule 13 r/w 17 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Vishnu Kumar Versus The National Insurance Company Ltd.
Complaint Ref. No.: DEL-H-048-2122-0004

1.	Name & Address of the Complainant	Shri Vishnu Kumar House No. 53, Ext-3, Nangloi, Delhi-110041
2.	Policy No: Type of Policy Duration of policy/Policy period	360801501810004884 Parivar Mediclaim Policy 16.10.2018 To 15.10.2019
3.	Name of the insured Name of the policy holder	Vishnu Kumar Vishnu Kumar
4.	Name of the insurer	The National Insurance Company Ltd.
5.	Date of repudiation	11.12.2019
6.	Reason for repudiation	Exclusion Clause 4.16- Non-Allopathic Treatment
7.	Date of receipt of the complaint	12.03.2021
8.	Nature of complaint	Repudiation of Claim
9.	Amount of claim	Rs. 67795/-
10.	Date of partial settlement	N.A.
11.	Amount of partial settlement	N.A.
12.	Amount of relief sought	Rs. 67795/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules, 2017	Rule 13(1)(b) – any partial or total repudiation of claims by an insurer
14.	Date of hearing/place	16.04.2021, Delhi, Online, Via WebEx
15.	Representation at the hearing	
	For the Complainant	Shri Vishnu Kumar, the Complainant

	For the insurer	1. Shri Rajender K Papneja, Administrative Officer, DO-34 2. Smt. Bhawana Bisht, Administrative Officer, DO-34
16.	Complaint how disposed/ Date of Award/Order	Award under Rule 17 16.04.2021

22. Brief Facts of the Case:

Shri Vishnu Kumar (hereinafter referred to as the Complainant) has filed this complaint against the decision of The National Insurance Company Ltd. (hereinafter referred to as the Insurers or the Respondent Insurance Company) alleging wrong repudiation of mediclaim.

23. Cause of Complaint:

c) Complainant's Argument:

The Complainant was admitted in Arya Vaidya Sala Kottakkal Ayurvedic Hospital & Research Centre, Kochi for treatment of multiple joint pain with stiffness especially in knee joints, elbows, shoulders and wrist joints, etc. During the hospitalization period 08.09.2019 to 16.09.2019, the total expenses was Rs. 67795/- for which he filed a claim for reimbursement of claim amount, but the insurers rejected his claim stating that Parivar Mediclaim policy does not cover non allopathic treatment as per Policy Exclusion Clause-4.16. Complainant wrote to GRO ON 15.08.2020. But Insurers denied again with the same reason. He has now approached this forum for relief.

d) Insurer's Argument:

The Insurers in their SCN have stated that patient Vishnu Kumar took treatment at Arya Vaidya Sala Kottakkal Ayurvedic Hospital & Research Centre, Kochi from 08.09.2019 to 16.09.2019 and preferred reimbursement of claim for an amount Rs. 67795/- but the claim was not payable under the Policy Exclusion Clause 4.16, which excludes Non Allopathic Treatment. Hence the claim was rightly repudiated.

24. Reason for registration of Complaint: Repudiation of Mediclaim.

25. The following documents were placed for perusal:

d) SCN
e) Discharge
f) GRO

26. Result of hearing of the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments as noted in Para 18 above.

The Insurers had repudiated the claim, which was for an ayurvedic treatment, citing Clause 4.16, which specifically excludes non-allopathic treatments. The Complainant states that the Insurers had reimbursed an earlier claim for the same treatment in 2016. The Insurers state that the reimbursement made in 2016 by the

TPA was in error and was liable for recovery from the TPA, but cannot be cited as a precedence for reimbursement of this claim.

Upon examination of the arguments and the evidence submitted by the parties, I conclude that this claim was inadmissible for reimbursement per Clause 4.16. Pursuantly, the complaint shall deserve to be rejected.

Award
The complaint is rejected.

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(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 16, 2021

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI
(Under Rule 13 r/w 16 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Saurav Chuni Versus Manipal Cigna Health Insurance Company Ltd.
Complaint Ref. No.: DEL-H-053-2122-0007

1.	Name & Address of the Complainant	Shri Saurav Chuni A-212, West Vinod Nagar, Street No. 9, Delhi-110092
2.	Master Policy No. Type of Policy Duration of Master Policy	PROHLR410046176 Manipal Cigna ProHealth Insurance 06.12.2019 To 05.12.2020
3.	Name of the insured Name of the policy holder	Saurav Chuni Saurav Chuni
4.	Name of the insurer	Manipal Cigna Health Insurance Company Ltd.
5.	Date of repudiation	03.04.2020
6.	Reason for repudiation	Pre-existing Disease
7.	Date of receipt of the complaint	04.01.2021
8.	Nature of complaint	Repudiation of Mediclaim
9.	Amount of claim	Rs. 198868/-
10.	Date of partial settlement	N.A.
11.	Amount of partial settlement	N.A.

12.	Amount of relief sought	Rs. 198868/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules, 2017	Rule 13(1)(b) – any partial or total repudiation of claims by an insurer
14.	Date of hearing/place	20.04.2021, Delhi, Online, Via WebEx
15.	Representation at the hearing	
	For the Complainant	1. Shri Saurav Chuni, the Complainant 2. Smt. Anuradha Kapoor, w/o the Complainant
	For the insurer	Dr. Gayatri Subramanian, Asst. Manager (Claims)
16.	Date of Award/Order	Recommendation under Rule 16/ 20.04.2021

27. Brief Facts of the Case:

Shri Saurav Chuni (hereinafter referred to as the complainant) had filed the complaint against the decision of Manipal Cigna Health Insurance Company Ltd (hereinafter referred to as the Respondent Insurance Company) alleging wrong repudiation of mediclaim.

28. Cause of Complaint:

e) Complainant's Argument: The Complainant was admitted on 05.02.2020 at Shanti Mukund Hospital for angioplasty. During hospitalization period from 05.02.2020 to 08.02.2020, total expense was Rs.198868/- for which he filed a claim for reimbursement. But the Insurers repudiated his claim on 03.04.2020 stating that pre-existing disease of BP and related complications are not admissible under the policy for a period of 36 months. He wrote to GRO on 17.05.2020 for reimbursement of claim amount but the Insurers still did not reimburse the amount with the same reason. He has now approached this forum for relief.

f) Insurer's Argument: The Insurers in their SCN dated 09.04.2021 have stated that the Complainant was hospitalized in SHM Cardiac Centre from 05.02.2020 to 08.02.2020 for complaints of acute AWMI, CAG:DVD, PTCA+Stent, HTN, acute on chronic renal disease. He filed a claim for reimbursement of Rs. 198868/-, which he incurred, during hospitalization. However, as he was

having the pre-existing disease of Hypertension, which was disclosed at the time of taking policy and was subject to a waiting period of 36 months, hence the claim was repudiated.

19. Reason for registration of Complaint: Repudiation of Mediclaim.

20. The following documents were placed for perusal:

g) SCN
h) Letter to GRO
i) Discharge Summary

21. Result of hearing of the parties (Observations and Conclusion):

Case called. Parties present and recall their arguments as noted in Para 18 above.

At this stage, the Insurers offer to settle the claim, except of the HTN related expenses (Rs. 650) and Surgeon consumable charges (Rs. 51,789), by reimbursing for the following 10 items:

(1) Procedure for stent: Rs. 27,000, (2) CAG Rs. 15000, (3) Stent & balloon Rs. 53584, (4) Investigation charges Rs. 8910, (5) Cardiologist consultation charges Rs. 4800, (6) ECG & Echo Rs. 3950, (7) Pharmacy Rs. 7808 (against claim of 8438), (8) Emergency consultation Rs. 1200 (Pre=400, Post=800), (9) Cathlab charges Rs. 8587, and (10) Room rent Rs. 22,500.

As regards the Surgeon consumable charges (Rs. 51789), the Insurers offer to review and settle the same as per the policy terms & conditions within 2 weeks, if the Complainant submits the break up duly attested by the hospital. The Complainant agrees to do so within one week.

Thus an agreement of conciliation could be arrived at between the Complainant and the Insurers, which I consider as fair and reasonable for both the parties.

Award

The complaint is resolved in terms of the agreement of conciliation arrived at between the Insurers and the Complainant. Accordingly, the Insurers shall settle the claim in respect of the 10 items as mentioned above. Additionally, the Insurers shall review and settle the claim in respect of the Surgeon consumable charges (Rs. 51789) as per the policy terms & conditions within 2 weeks, if the Complainant submits the break up duly attested by the hospital within one week.

Parties should implement this agreement within 30 days.

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(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 20, 2021

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI

(Under Rule 13 r/w17 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Jaswanti Rani versus Star Health and Allied Insurance Company Ltd.

Complaint Ref: DEL-H-044-2122-0011

1.	Name & Address of the Complainant	Smt. Jaswanti Rani House No. 4116/2, Jagjiwan Niwas, Regharpura, Karol Bagh, Delhi-110005
2.	Policy No. Type of Policy Policy term/policy period	P/700002/01/2020/054652 Star Comprehensive Insurance Policy 28.02.2020 to 27.02.2021
3.	Name of the insured Name of the policy holder	Hemant Kumar Hemant Kumar
4.	Name of insurer	Star Health and Allied Insurance Co. Ltd.
5.	Date of repudiation	09.12.2021
6.	Reason for grievance	Non-settlement of Mediclaim
7.	Date of receipt of the complaint	07.04.2021
8.	Nature of complaint	Inadequate settlement of Mediclaim
9.	Amount of claim	Rs.187505/-
10.	Date of partial settlement	N.A
11.	Amount of partial settlement	N.A
12.	Amount of relief sought	Rs.187505/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules 2017	Rule 13(1)(b)- Any Partial or total repudiation of claims by an Insurer
14.	Date of hearing	28.04.2021
	Place of hearing	Delhi, Online Video Conferencing via Cisco WebEx
15.	Representation at the hearing	

	For the Complainant	1. Smt. Jaswanti Rani, the Complainant 2. Shri Mahinder Kumar, F/o the DLA
	For the Insurer	1. Dr. Madhukar Pandey, Sr. Manager (Claims) 2. Shri Mantosh Kumar, Manager (Claims)
16.	Date of Award/Order	Award under Rule 17/ 28.04.2021

19. Brief Facts of the Case: Smt. Jaswanti Rani (hereinafter referred to as the Complainant) has filed this complaint against the decision of Star Health and Allied Insurance Company Ltd. (hereinafter referred to as the Insurers) alleging wrong rejection of Mediclaim.

20. Cause of Complaint:

a) Complainant's Argument: The Complainant had stated that her husband Late Shri Hemant Kumar was having mediclaim policy with the Insurers and suffered from low BP. The doctor advised him for insertion of AICD instrument, as his heart beat was not stable. He was admitted in the GB Hospital on 12.08.2020 and was operated on 14.08.2020 but his BP was still low. Then he had a cardiac attack and he passed away. She submitted all the claim papers to the Insurance Company but her claim was rejected on the ground that the disease was pre-existing and heart was working at 25%. She approached the Grievance Deptt. of the Insurance Company but her claim was not settled.

b) Insurer's Argument: The Insurance Company, vide its Self Contained Note dated, has stated that the insured Late Shri Hemant Kumar was admitted on 12.08.2020 at GB Pant Hospital and

declared dead on 15.08.2020 due to Dilated Cardiomyopathy. As per documents/OP registration dated 08.08.2020 submitted, it was observed that the insured patient had history of recurrent VT and ECHO shows findings of severe LV dysfunction and EF-25%. Additionally the insured person has not submitted letter from the treating doctor about the exact duration of cardiac disease, past treatment records and investigation reports for cardiac disease, which amounts to non-cooperation. The insured had longstanding cardiac disease prior to date of commencement of first year policy which was from 28.02.2020 to 27.02.2021 and the same was not declared at the time of taking the policy. Hence, the claim was repudiated as per Policy condition No.6 "Disclosure of information norms: The policy shall become void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material facts by the policy holder".

19. Reason for registration of Complaint: Non-settlement of Mediclaim.

21. The following documents were placed for perusal.

d) Copy of policy.
e) Copy of GRO Letter, discharge summary, bill, claim form, rejection letters. OPD card, requirement letter.
f) SCN of the Insurers along with enclosures.

22. Result of hearing with the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments, as noted in Para 18 above.

The Subject Policy was issued on 18.02.2020 for covering the life of the deceased life assured (DLA), who was admitted on 12.08.2020 at GB Pant Hospital and expired there on 15.08.2020 due to Dilated Cardiomyopathy. Neither party has submitted the detailed death summary. However, the OPD Paper dated 08.12.2020 of the same hospital states the medical condition of the DLA as recurrent VT (ventricular tachycardia). The Insurers state that they made efforts with the family of the DLA to secure his past medical history, but without success. The Insurers deputed investigator to the hospital, who submitted report confirming the recurrent VT as the medical background of the DLA.

Upon examination of the arguments and the evidence submitted by the parties, it is concluded that the deceased life assured had not disclosed his longstanding cardiac disease at the time of taking the policy. Therefore, the Insurers were justified in repudiating the claim as per Policy condition No. 6 cited in Para 18b above. Pursuantly, the complaint would deserve rejection.

Award
The complaint is rejected.

(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 28, 2021

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PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI

(Under Rule 13 r/w17 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Narender Kumar Galhotra versus The United India Insurance Company Ltd.

Complaint Ref. No.: DEL-H-051-2122-0010

1.	Name & Address of the Complainant	ShriNarender Kumar Galhotra 178, Hakikat Nagar, Kingsway Camp, Delhi-110009
2.	Policy No. Type of Policy Policy term/policy period	2227002819P111642378 Family Medicare Policy 06.12.2019 to 05.12.2020
3.	Name of the insured Name of the policy holder	Narender Kumar Galhotra Narender Kumar Galhotra
4.	Name of insurer	The United India Insurance Company Ltd.
5.	Date of repudiation	14.11.2020
6.	Reason for grievance	Inadequate settlement of Mediclaim
7.	Date of receipt of the complaint	23.02.2021
8.	Nature of complaint	Inadequate settlement of Mediclaim
9.	Amount of claim	Rs.39000/-
10.	Date of partial settlement	N.A
11.	Amount of partial settlement	N.A
12.	Amount of relief sought	Rs.39000/-
13.	Complaint registered under Rule No of the Insurance Ombudsman Rules 2017	Rule 13(1)(b)- Any Partial or total repudiation of claims by an Insurer
14.	Date of hearing	28.04.2021
	Place of hearing	Delhi, Online Video Conferencing via Cisco WebEx

15.	Representation at the hearing	
	For the Complainant	Shri Narender Kumar Galhotra, the Complainant
	For the Insurer	Shri Gulshan Rai, Dy. Manager, DO-27, Wazirpur
16.	Date of Award/Order	Award under Rule 17/ 28.04.2021

21. Brief Facts of the Case: Shri Narender Kumar Galhotra (hereinafter referred to as the Complainant) has filed this complaint against the decision of The United India Insurance Company Ltd.(hereinafter referred to as the Insurers) alleging inadequate settlement of hisMediclaim.

22. Cause of Complaint:

c) Complainant's Argument:The Complainant was admitted in Fortis Hospital from 07.11.2020 to 13.11.2020 for Covid-19 treatment. During discharge, the TPA has sent four different authorization letters with different settlement amount. He was confused and nobody was listening to him. Ultimately he was discharged from the hospital after paying Rs.39000/ from his pocket. He approached with the Grievance Cell of the Insurers but his balance claim was not settled.

b) Insurer's Argument: The Insurance Company, vide Self Contained Note dated 22.04.2021, have stated that the patient was admitted in Fortis Hospital for Covid-19 from 07.11.2020 to 13.11.2020 with claim amount of Rs.177125/- and TPA settled cashless claim for Rs.130463/- subject to the limits and terms of the policy. The package rates per day were as per the GI Council rates/State Govt. rates which includes lab charges, pharmacy, PPE Kits & other charges. Mainly the deduction was of Inj. Redyx (Remdesivir), which was not payable as per Delhi Govt. Circular Sl. No.4. Hence, the claim was settled as per policy clause 3.32 of Reasonable and Customary charges & the detail of deductions were informed to the Complainant accordingly.

19. Reason for registration of Complaint: Inadequate settlement of Mediclaim.

22. The following documents were placed for perusal.

g) Copy of policy.
h) Copy of GRO Letter, discharges summary, bills, claim form, settlement letters, award copy of Insurance Ombudsman, Goa.
i) SCN of the Insurers along with enclosures.

23. Result of hearing with the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments, as noted in Para 18 above.

Both parties agree that the complaint should be examined only in respect of the cost of the 8 dozes of Injection Remdesivir costing Rs. 42120 in all.The Complainant has argued that it was administered by the Hospital as per his medical requirement and should therefore be reimbursed. The Insurers had relied on the order dated 20.06.2020 of the Delhi Government that had fixed the package rates for Covid related treatment to be charged by the private hospitals in the NCT of Delhi. The package ratewas all-inclusive, covering the cost for bed, food, doctor & nursing charges, food, oxygen, blood, medicines etc., but had specifically excluded Remdesivir.

Upon examination of the arguments and the evidence submitted by the parties, it is concluded that once a reimbursement is made as per a package,then any item specifically excluded from the package would not be eligible for reimbursement. Therefore, the Insurers were justified in disallowing the cost of Remdesivir. Pursuantly, the complaint would deserve rejection.

Award
The complaint is rejected.

(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 28, 2021

PROCEEDINGS OF THE INSURANCE OMBUDSMAN, DELHI
(Under Rule 13 r/w 16 of the Insurance Ombudsman Rules, 2017)

Ombudsman: Shri Sudhir Krishna

Case of Jyoti Versus The Reliance General Insurance Company Ltd.
Complaint Ref. No.: DEL-H-035-2122-0003

1.	Name & Address of the Complainant	Smt. Jyoti D1/1/2-A, Gali No. 17, Rama Vihar, Delhi -110081
2.	Master Policy No:/ Policy Certificate No. Type of Policy Duration of Master Policy/ Certificate Period	920292028520000092 / 131592028521011750 Reliance Covid-19 Protection Insurance 25.04.2020 To 30.05.2020 / 20.05.2020 To 19.05.2021
3.	Name of the insured Name of the policy holder	Jyoti Jyoti
4.	Name of the insurer	The Reliance General Insurance Company Ltd.
5.	Date of repudiation	24.08.2020
6.	Reason for repudiation	Repudiation under Specific exclusion related to Section-3(ii) Cohabitation Clause of policy
7.	Date of receipt of the complaint	05.03.2021
8.	Nature of complaint	Repudiation of Covid-19 Mediclaim
M	Amount of claim	Rs. 200000/-
10.	Date of partial settlement	N.A.

11.	Amount of partial settlement	N.A./-
12.	Amount of relief sought	Rs. 200000/-
13.	Complaint registered under Rule No. of the Insurance Ombudsman Rules, 2017	Rule 13(1)(b) – any partial or total repudiation of claims by an insurer
14.	Date of hearing/place	29.04.2021, Delhi, Online, Via WebEx
15.	Representation at the hearing	
	For the Complainant	1. Smt. Jyoti, the Complainant 2. Shri Deendayal, H/o the Complainant
	For the insurer	Dr. Amit Srivastava, Corporate Manager Health Claims
16.	Complaint how disposed/ Date of Award/Order	Recommendation under Rule 16 29.04.2021

29. Brief Facts of the Case:

Smt. Jyoti (hereinafter referred to as the Complainant) has filed this complaint against the decision of The Reliance General Insurance Company Ltd. (hereinafter referred to as the Insurers or the Respondent Insurance Company) alleging wrong repudiation of Covid-19 Mediclaim.

30. Cause of Complaint:

g) Complainant's Argument: The Complainant was infected with Covid-19 and found Positive on 11.06.2020 as per Covid Test Report of Path Kind Lab, Gurgaon. She went for Home Isolation from 11.06.2020 to 28.06.2020 and discharged from Home Isolation as per discharge certificate of Chief District Medical Officer. She filed a claim to insurers for Rs. 200000/-, but insurers repudiated her claim stating that no claim shall be payable where the insured person was living with and sharing the same address as that of a person who was diagnosed with Covid-19 or quarantined at the time of proposal. Complainant is working in Savitri Hospital but Covid patients are not admitted or treated there. She wrote to GRO on 19.08.2020 but still did not receive her claim. She has now approached to this forum for relief.

h) Insurer's Argument: The Insurers in their SCN dated 12.04.2021 have stated that as per the policy Proposal Form, the insured did not declare at the time of taking the policy her occupation that she was working as Health worker in Savitri Hospital (Covid-19 Designated Place). Hence her claim was repudiated on Co-habitation Clause, which is Specific exclusion related to Section-3(ii) which states that No claim shall be payable where the insured person was living with and sharing the same address as that of person(s) who were diagnosed with Covid-19 or quarantined at the time of proposal. This is also a case of non-disclosure and misrepresentation which is Section-6 General Exclusion: (viii). Therefore the claim has rightly been repudiated.

31. Reason for registration of Complaint: Repudiation of Motor Claim.

32. The following documents were placed for perusal:

j) Covid-19 Detective Report

k) GRO
l) GRO Reply

33. Result of hearing of the parties (Observations and Conclusion):

Case called. Parties are present and recall their arguments as note in Para 18 above.

The insurers had repudiated the claim on the ground that the Complainant was working in a hospital that was treating Covid patient. However, the Complainant has submitted a certificate issued by the Hospital stating that this hospital is neither a Covid Hospital nor does it treat Covid patients. However, this certificate is undated and the Insurers deny having seen it before. The Insurers offer to verify this certificate and if it is found to be correct for the relevant claim period, they would settle the claim within 30 days of the receipt of this Award. The Complainant accepts this offer. Thus an agreement of conciliation could be arrived at between the Complainant and the Insurers, which I consider as fair and reasonable for both the parties.

Award
The complaint is resolved in terms of the agreement of conciliation arrived at between the Complainant and the Insurers. Accordingly, the Insurers shall verify the certificate to confirm if the Savitri Hospital, where the Complainant was working, was either a Covid Hospital or it was treating Covid patients during the relevant claim period and if the certificate is found to be correct, then they would settle the claim as per the terms and conditions of the policy within 30 days of the receipt of this Award.

(Sudhir Krishna)
Insurance Ombudsman, Delhi
April 29, 2021

AWARD NO.IO/KOC/A/HI/0001/2021-2022

PROCEEDINGS OF

THE INSURANCE OMBUDSMAN, KOCHI

(UNDER RULE NO. 13 1(b) READ WITH RULE 14 OF

THE INSURANCE OMBUDSMAN RULES, 2017)

Complaint No. KOC-H-044-2021-0895

PRESENT: Ms. POONAM BODRA

INSURANCE OMBUDSMAN, KOCHI.

AWARD PASSED ON 27.04.2021

1.	**Name and Address of the complainant**	**:**	**Mr. Sreekumar R** **House no.10/409, Sreedurga, Eroor South, Tripunithura 682306**
2.	**Policy Number**	**:**	**P/181211/01/2021/005458**
3.	**Name of the Insured**	**:**	**Mr. Sreekumar R**
4.	**Name of the Insurer**	**:**	**STAR HEALTH AND ALLIED INS. CO. LTD.**
5.	**Date of receipt of Complaint**	**:**	**17.02.2021**
6.	**Nature of complaint**	**:**	**Part payment of mediclaim**
7.	**Amount of relief sought**	**:**	**--**

8. Date of hearing : 22.04.2021

9. Parties present at the hearing

a) For the Complainant : Mr. Sreekumar R (online)

b) For the Insurer : Mr. Manu Mohan (Online)

AWARD

This is a complaint filed under Rule 13 1(b) read along with Rule 14 of the Insurance Ombudsman Rules, 2017. The complaint is regarding partial rejection of mediclaim. The complainant, Mr. Sreekumar R is the policyholder.

1. Averments in the complaint are as follows:

The Complainant stated that he is the holder of Family Health Optima Insurance of the respondent since 30.9.18. The present coverage limit is Rs.6.75,000/-(SI-Rs.5lacs + Bonus –Rs.1.75lacs). The complainant had an accidental fall while playing and underwent surgery at the MOSC hospital on 29.12.20 at the MOSC Hospital, Kolencherry. Out of the bill amount of Rs.1,47,332/- only an amount of Rs.1,06,289/- was approved. Balance Rs.41.043 /- solicited. Policy period -30.9.20 to 29.9.21.

2. The Respondent Insurer entered appearance and filed a self contained note. It is submitted that they had received a request for cashless treatment from M.O.S.C Medical College Hospital, Ernakulam on 23/12/2020 stating that the complainant was planned for an admission at the hospital on 28/12/2020 and was provisionally diagnosed with medial meniscus post horn tear, Lateral meniscus Anterior horn tear & ACL Tear Right Knee . On receiving the pre-authorization request form, an amount of Rs.20,000/-, was initially authorized on 23/12/2020. After the treatment, the hospital authorities had forwarded the discharge summary along with a copy of the final bill of Rs. 1,47,332/-. On verification of the claim documents, an amount of Rs. 1,06,289/-, was approved on 01/01/2021, as per terms and conditions of the policy . While processing, it was noticed that the insured had not submitted the balance cash paid receipt till this date. The calculation details are as follows:-

Sl.No:	Particulars	Total Claimed Amount	Deducted items and amount	Total Admissible amount
1	DISPO MATERIAL	Rs.7,706/-	Disposable Gown Not payable: Rs. 1048/-, Drape not payable : Rs.1382/-, Swab Not	Rs.4,533/-

			payable : Rs. 32/-. Trolley sheet not payable: Rs. 81/-, Towel not payable: 43/-, Apron not payable : Rs. 58/-, Skin marker not payable : Rs. 63/-, Gloves not payable : Rs. 466/-	
2	ANESTHESIA CHARGE	Rs.12,900/-		Rs.12,900/-
3	LAB	Rs.5,601/-	CROSS MATCHING & BLOOD GROUP NOT PAYABLE: Rs.902/-	Rs.4,699/-
4	Cardiac Monitoring	Rs.148/-		Rs.148/-
5	DRESSING	Rs.240/-		Rs.240/-
6	NURSING	Rs.2,980/-		Rs.2,980/-
7	NURSING PROCEDURE	Rs.390/-	Additional injection charges not payable : Rs.390/-	
8	OT charges(Theater & operation & ACL Procedure)	Rs. 40,688/-		Rs. 40,688/-
9	OXYGEN	Rs.172/-		Rs.172/-
10	MEDICINE	Rs.9,122/-	Wipes , under pad and Bandage not payable : Rs. 1125/-	Rs.7997/-
11	PHYSIOTHERAPY	Rs.882/-		Rs.882/-
12	PROCEDURE	Rs.5,053/-	Already considered full OT charges . Hence additional Instruments charges not payable : Rs.5053/-	
13	PROFESSIONAL	Rs.13,100/-		Rs.13,100/-
14	ROOM	Rs.3,580/-		Rs.3,580/-
15	LAB	Rs.423/-		Rs.423/-

16	TREATMENT	Rs.42913/-	Knee immobilizer, Knee brace , crutches, Plastic box not payable : Rs. 3908/-	Rs. 39,005/-
17	XRAY	Rs.860/-		Rs.860/-
18	MATERIAL	Rs.64/-	Cotton and Gauze not payable : Rs.64/-	
19	DIETRY	Rs.510/-	Dietary charges not payable : Rs.510/=	
			Total Claimed Amount	Rs. 1,47,332/-
			Non payable amount	Rs. 15,125/-
			Total Admissible amount	Rs. 1,32,207/-
			Already approved Amount (Cashless time)	Rs.1,06,289/-
			Balance payable amount (the complainant has not submitted balance paid receipt , if he submits the same the balance payable amount would be Rs. 25,918/-	Rs.25,918/-

If the complainant had submitted the balance cash paid receipt, the respondent insurer would have been ready to pay the balance amount of Rs.25,918/-.

3. I heard the Complainant and the Respondent Insurer. The Complainant submitted that he had an accidental fall while playing badminton injuring his right knee and underwent surgery at the MOSC hospital, Kolencherry. Ernakulam Dist. on 29.12.20 . All bills/records were submitted to the respondent insurer. Out of the claim bill amount of Rs.1,47,332/-, an amount of Rs.1,06,289/-, only was approved. He prayed for settling the balance claim amount which he is eligible. The Respondent Insurer submitted that while processing, they had noticed that the complainant had not submitted the balance amount paid receipts till date. If the complainant submits the balance cash paid receipt, the respondent insurer is ready to pay the balance admissible amount of Rs.25,918/-.

4. I heard the complainant and the respondent insurer and had gone through the records . In this complaint where the complainant claimed for the short fall in the claim amount for the surgery he underwent for his right knee following an accidental fall while playing badminton, the respondent insurer was directed to recalculate the claim amount by admitting disposal gown & glove charges as a special case due to the present Covid pandemic situation and also to include additional injection charges under the head nursing.

Total Claim Amount :Rs.1,47,335.00

Claim Amount Settled :Rs.1,06,289.00

The recalculation of the claim amount submitted by the respondent insurer are as follows:-

Sl.No:	Particulars	Total Claimed Amount	Deducted items and amount	Total Admissible amount	Remarks
1	DISPO MATERIAL	Rs.7,706/-	Drape not payable : Rs.1382/-, Swab Not payable : Rs. 32/-. Trolley sheet not payable: Rs. 81/-, Towel not payable: 43/-, Apron not payable : Rs. 58/-, Skin marker not payable : Rs. 63/-,	Rs.4,533/- +Rs.1,048/- +Rs.466/- =Rs.6,047/-	Disposable Gown payable: Rs. 1048/- & Gloves payable : Rs. 466/- due to the present Covid scenario
2	ANESTHESIA CHARGE	Rs.12,900/-		Rs.12,900/-	
3	LAB	Rs.5,601/-	CROSS MATCHING &	Rs.4,699/-	

			BLOOD GROUP NOT PAYABLE: Rs.902/-		
4	Cardiac Monitoring	Rs.148/-		Rs.148/-	
5	DRESSING	Rs.240/-		Rs.240/-	
6	NURSING	Rs.2,980/-		Rs.2,980/-	
7	& NURSING PROCEDURE	Rs.390/-	-	Rs.390/-	Additional injection charges payable
8	OT charges(Theater & operation & ACL Procedure)	Rs. 40,688/-		Rs. 40,688/-	
9	OXYGEN	Rs.172/-		Rs.172/-	
10	MEDICINE	Rs.9,122/-	Wipes , under pad and Bandage not payable : Rs. 1125/-	Rs.7,997/-	
11	PHYSIOTHERAPY	Rs.882/-		Rs.882/-	
12	PROCEDURE	Rs.5,053/-	Already considered full OT charges. Hence additional Instruments charges not payable : Rs.5053/-		
13	PROFESSIONAL	Rs.13,100/-		Rs.13,100/-	
14	ROOM	Rs.3,580/-		Rs.3,580/-	
15	LAB	Rs.423/-		Rs.423/-	
16	TREATMENT	Rs.42,913/-	Knee immobilizer,	Rs. 39,005/-	

			Knee brace , crutches, Plastic box not payable : Rs. 3908/-		
17	XRAY	Rs.860/-		Rs.860/-	
18	MATERIAL	Rs.64/-	Cotton and Gauze not payable : Rs.64/-		
19	DIETRY	Rs.510/-	Dietary charges not payable : Rs.510/=		
			Total Claimed Amount	Rs. 1,47,332/-	
			Non payable amount	Rs. 13,221/-	
			Total Admissible amount	Rs. 1,34,111/-	
			Already approved Amount (Cashless time)	Rs.1,06,289/-	
			Balance payable amount	Rs.27,822/-	

The respondent insurer has to pay the balance admissible claim amount of Rs.27,822/- to the complainant as per the policy terms & conditions.

4. In the result, an award is passed, directing the Respondent Insurer to pay an amount of Rs. 27,822/- , as per the policy terms & conditions , within the period mentioned hereunder. No cost.

As prescribed in Rule 17(6) of Insurance Ombudsman Rules, 2017, the Insurer shall comply with the award within 30 days of receipt of the award and intimate compliance of the same to the Ombudsman.

Dated this the 27th day of April 2021.

Sd/-

(POONAM BODRA)

INSURANCE OMBUDSMAN

AWARD NO.IO/KOC/A/HI/0002/2021-2022

PROCEEDINGS OF

THE INSURANCE OMBUDSMAN, KOCHI

(UNDER RULE NO. 13 1(b) READ WITH RULE 14 OF

THE INSURANCE OMBUDSMAN RULES, 2017)

Complaint No. KOC-H-044-2021-0879

PRESENT: Ms. POONAM BODRA

INSURANCE OMBUDSMAN, KOCHI.

AWARD PASSED ON 27.04.2021

1.	**Name and Address of the complainant**	**:**	**Mr. Aboobacker A K** **Aimanakudy House, Kaithakkadu kara, Pattimattom P O, Pin-683562**
2.	**Policy Number**	**:**	**P/181219/01/2021/004127**
3.	**Name of the Insured**	**:**	**Mr. Aboobacker A K**
4.	**Name of the Insurer**	**:**	**STAR HEALTH AND ALLIED INS. CO. LTD.**
5.	**Date of receipt of Complaint**	**:**	**10.02.2021**
6.	**Nature of complaint**	**:**	**Rejection of mediclaim**
7.	**Amount of relief sought**	**:**	**--**
8.	**Date of hearing**	**:**	**22.04.2021**
9.	**Parties present at the hearing**		
	a) For the Complainant	**:**	**Mr. Aboobacker A K (Online)**
	b) For the Insurer	**:**	**Mr. Manu Mohan (Online)**

AWARD

This is a complaint filed under Rule 13 1(b) read along with Rule 14 of the Insurance Ombudsman Rules, 2017. The complaint is regarding rejection of mediclaim. The complainant, Mr. Aboobacker A K is the policyholder.

1. Averments in the complaint are as follows:

The Complainant 50 years old male stated that he was covered under the Corona Rakshak Policy taken by his spouse for the period 25.7.20 to 6.5.21, for a SI of Rs.2lacs. On 3.10.20, the complainant was admitted in the MOSC hospital, Kolencherry, Ernakulam Dist., after testing Corona Positive and was discharged on 10.2.20. The claim when put up with the respondent insurer was denied.

2. The Respondent Insurer entered appearance and filed a self contained note. It is submitted that the complainant was covered under the Corona Rakshak Policy for the period 25.7.20 to 6.5.21, for a sum insured of Rs.2lacs. The complainant was admitted at MOSC Hospital, Kolencherry on 3.10.20 for the treatment of Mild Covid Infection, HTN, T2DM, DLP, OSA and after treatment was discharged on 10.10.20. The discharge summary from the hospital dated 12.10.19, revealed that the patient was treated for Severe OSA, Acute Allergic Trachebronchitis, T2DM, DLP & HTN. Based on the available medical records, it was evident that the patient had a history of OSA, T2DM, DLP & HTN, prior to the inception of the policy, which was not revealed in the proposal form. The complainant therefore had willfully suppressed the PED in the proposal form. The respondent insurer repudiated the claim based on suppression of material facts.

3. I heard the Complainant and the Respondent Insurer. The Complainant submitted that he was covered under the Corona Rakshak policy of the respondent insurer. His claim for the treatment for Covid was denied. The Respondent Insurer submitted that the complainant was admitted at MOSC Hospital, Kolencherry on 3.10.20, for the treatment of Mild Covid Infection, HTN, T2DM, DLP, OSA and after treatment was discharged on 10.10.20. On scrutiny, the discharge summary dated 12.10.19, from the hospital revealed that the complainant was treated for Severe OSA, Acute Allergic Trachebronchitis, T2DM, DLP & HTN. It was therefore evident that the patient had a history of OSA, T2DM, DLP & HTN, prior to the inception of the Corona Rakshak policy(policy period:-25.7.20 to 6.5.21), which was not revealed in the proposal form. The claim was therefore repudiated on suppression of material facts.

4. I heard the complainant and the respondent insurer and had gone through the records submitted. In this case where the claim under the Corona Rakshak Policy of the respondent insurer was denied, the tenable arguments put forth by the respondent insurer were that: 1).the complainant took a Corona Rakshak Policy for the period 25.7.20 to 6.5.21 2). He was admitted in the MOSC Medical College, Kolencherry, for the period 3.10.20 to 10.10.20, on testing positive. 3). The claim put up on discharge was denied as on scrutiny it was observed that the complainant did not disclose the pre existing disease in the proposal form while taking the Corona Rakshak Policy. 4). The discharge summary dated 12.10.19, from the same hospital revealed that the complainant was treated for Severe OSA, Acute Allergic Trachebronchitis, T2DM, DLP & HTN which were not disclosed while taking the Corona Rakshak

Policy and hence the claim was denied on suppression of material facts. I therefore do not want to interfere in the decision of the respondent insurer in denying the claim.

In the result, an AWARD is passed for Dismissal of the complaint.

Dated this the 27th day of April 2021.

Sd/-

(POONAM BODRA)

INSURANCE OMBUDSMAN

AWARD NO.IO/KOC/A/HI/0003/2021-2022

PROCEEDINGS OF

THE INSURANCE OMBUDSMAN, KOCHI

(UNDER RULE NO. 13 1(b) READ WITH RULE 14 OF

THE INSURANCE OMBUDSMAN RULES, 2017)

Complaint No. KOC-H-044-2021-0880

PRESENT: Ms. POONAM BODRA

INSURANCE OMBUDSMAN, KOCHI.

AWARD PASSED ON 27.04.2021

1.	**Name and Address of the complainant**	**:**	**Mr. Jojo Joseph** **Pinakkattu House, Parapuzha P.O, Thodupuzha 695102**
2.	**Policy Number**	**:**	**P/181215/01/2020/004095**
3.	**Name of the Insured**	**:**	**Mr. Jojo Joseph**
4.	**Name of the Insurer**	**:**	**STAR HEALTH AND ALLIED INS. CO. LTD.**
5.	**Date of receipt of Complaint**	**:**	**12.02.2021**
6.	**Nature of complaint**	**:**	**Rejection of mediclaim**
7.	**Amount of relief sought**	**:**	**--**
8.	**Date of hearing**	**:**	**22.04.2021**
9.	**Parties present at the hearing**		

c) For the Complainant : Mr. Jojo Joseph (online)

d) For the Insurer : Mr. Manu Mohan (Online)

AWARD

This is a complaint filed under Rule 13 1(b) read along with Rule 14 of the Insurance Ombudsman Rules, 2017. The complaint is regarding rejection of mediclaim. The complainant, Mr. Jojo Joseph is the policyholder.

1. Averments in the complaint are as follows:

The Complainant aged 41 years holding health insurance cover with the respondent insurer stated that he is a rubber tapper & contractor for the last 15years. For slaughter tapping one has to climb up to 10 to 12 feet using ladder. On 14.4.20, while in the said work, the ladder slipped from the tree and met with an accident causing wrist injury. On consulting a traditional Marma Chikalsak, it was confirmed that he had a wrist fracture. The complainant therefore got admitted in the Apollo Hospital, where the orthopedic surgeon examined and treated. X-ray/MRI confirmed wrist fracture. On 5.5.20, surgery was performed. The claim when submitted was denied under Pre Existing disease.

2. The Respondent Insurer entered appearance and filed a self contained note. It is submitted that the complainant had taken Medi Classic Health Insurance Policy for the period commencing from 18/11/2019 to 17/11/2020 for the Sum Insured of Rs. 5,00,000/-. The proposal form is the basis and integral part of the contract, on the basis of which the policy is issued. The policy is issued strictly according to the terms and conditions only and it is a settled law that the parties to the insurance contract are bound by the terms and conditions of the policy issued. The complainant was admitted at Apollo Adlux Hospital , Ernakulam on 04/05/2020 for the treatment of Right Wrist injury-Carpal Instability, Dorsal Intercalated Segment Instability and after the treatment he was discharged on 07/05/2020. On discharge the complainant submitted the claim form with discharge summary alongwith bills of Rs. 86542/- and reports. As per the MRI Scan report of the complainant:

- Extensor compartment tenosynovitis with background osteoarthritis changes.
- Cystic fluid signal lesions in the triquetral, scaphoid, capitate and trapezoid -? Degenerative/intraosseous ganglion cysts
- Subtle bone edema noted in the radial styloid process- fracture

The Dorsal Intercalated Segment Instability is an isolated injury to the scapholunate ligament may progress to abnormal joint mechanics and degenerative cartilage changes. Treatment for scapholunate instability is aimed at arresting the degenerative process by restoring ligament continuity and normalizing carpal kinematics. Since this condition was chronic in nature, the company repudiated the claim. Based on the

available records, it was confirmed that the ailment for which the complainant had undergone treatment was pre-existing. Since the ailment was pre existing, the insurer repudiated the claim based on waiting period No:3(iii) of the policy i.e., pre existing disease.

3. I heard the Complainant and the Respondent Insurer. The Complainant submitted that while slaughter tapping on 14.4.20, the ladder which he climbed slipped from the tree and had an accident fall causing wrist injury and was treated under the orthopedic surgeon in the Apollo Adlux Hospital, Ernakulam. On 5.5.20, surgery was performed. The claim was denied. The Respondent Insurer submitted that the complainant was admitted at Apollo Adlux Hospital, Ernakulam from 04.05.2020 to 7.5.20 for the treatment of Right Wrist injury-Carpal Instability, Dorsal Intercalated Segment Instability . On verification of the medical records, it was understood that this condition was chronic in nature and also confirmed that the ailment for which the complainant underwent treatment was pre-existing. Hence the claim was repudiated.

4. I heard the complainant and the respondent insurer and had gone through the records submitted by them. This is complainant wherein the a slaughter tapper was involved in an accidental fall while engaged in the job, fracturing his Right Wrist. On analyzing the nature and situation of the accidental injury, I have decided to award the complaint in favor of the complainant. The respondent insurer therefore has to pay the admissible amount of Rs.70,656/-, to the complainant as per the policy terms and conditions.

In the result, an award is passed, directing the Respondent Insurer to pay an amount of Rs. 70,656/- , within the period mentioned hereunder. No cost.

As prescribed in Rule 17(6) of Insurance Ombudsman Rules, 2017, the Insurer shall comply with the award within 30 days of receipt of the award and intimate compliance of the same to the Ombudsman.

Dated this the 27th day of April 2021.

Sd/-

(POONAM BODRA)

INSURANCE OMBUDSMAN

AWARD NO.IO/KOC/A/HI/0005/2021-2022

PROCEEDINGS OF

THE INSURANCE OMBUDSMAN, KOCHI

(UNDER RULE NO. 13 1(b) READ WITH RULE 14 OF

THE INSURANCE OMBUDSMAN RULES, 2017)

Complaint No. KOC-H-023-2021-0900

PRESENT: Ms. POONAM BODRA

INSURANCE OMBUDSMAN, KOCHI

AWARD PASSED ON 28.04.2021

1.	**Name and Address of the complainant**	**:**	**Mr. Chandrasekharan Pillai** **Kailasam Cheravally, Kayamkulam (M), Kerala 690502**
2.	**Policy Number**	**:**	**H0363754**
3.	**Name of the Insured**	**:**	**Mr. Chandrasekharan Pillai**
4.	**Name of the Insurer**	**:**	**IFFCO-TOKIO Genl. Insc. Co. Ltd.**

5.	**Date of receipt of Complaint**	**:**	**18.02.2021**
6.	**Nature of complaint**	**:**	**Rejection of mediclaim (Covid)**
7.	**Amount of relief sought**	**:**	**--**
8.	**Date of hearing**	**:**	**22.04.2021**
9.	**Parties present at the hearing**		
	a) For the Complainant	**:**	**Mr. Chandrasekharan Pillai (Online)**
	b) For the Insurer	**:**	**Dr Balasubramaniyan C (online)**

AWARD

This is a complaint filed under Rule 13 1(b) read along with Rule 14 of the Insurance Ombudsman Rules, 2017. The complaint is regarding rejection of mediclaim (Covid). The complainant, Mr. Chandrasekharan Pillai is the policyholder.

1. Averments in the complaint are as follows:

The Complainant, 48years male, stated that he was holding a corona rakshak policy of the respondent insurer. He was tested covid positive on 16.10.20 from the recognized DDRC Lab and was admitted at the Madhava Hospital Haripad(Govt. Quarantine Centre) on 24.10.20 and was discharged on26.10.20. His claim was rejected .The SI is 2 lacs .

2. The Respondent Insurer entered appearance and filed a self contained note. It is submitted that the complainant was issued a Corona Rakshak Benefit Policy with a Sum Insured of Rs.2lacs, for the period 10.8.20 to 21.5.21. On scrutiny of the medical documents it was concluded that the patient was admitted only for isolation purpose for Covid with Asymptotic status. The patient stayed in designated isolation ward of first line treatment center which was set up by the government, ministry of health and family welfare, Govt. of India, for isolation/quarantine purpose only. The isolation cannot be considered as hospitalization. Hence the claim was denied as per the policy terms and conditions{ policy clauses 3.7(Hospitalisation),3.8(in patient care),3.9(covid cover)}.

3. I heard the Complainant and the Respondent Insurer. The Complainant submitted that he was admitted at the Madhava Hospital Haripad(Govt. Quarantine Centre) on 24.10.20 and was discharged on26.10.20, upon testing covid positive on 16.10.20, from the recognized DDRC Lab. His claim under the Corona Rakshak policy was rejected. The Respondent Insurer submitted that The patient stayed in designated isolation ward of first line treatment center which was set up by the government, ministry of health and family welfare, Govt. of India, for isolation/quarantine purpose only. The isolation cannot be considered as hospitalization. Hence the claim was denied as per the policy terms.

During the hearing, the complainant stated that he had received the said policy through the Bank but the policy conditions were not received. The respondent insurer was therefore directed to verify and report the same in a day. The respondent insurer informed through mail dated 26.4.21, that the concerned policy was issued through the online link via bancassurance channel (Esaf Bank). The Policy was issued by the Esaf employee on hand. Moreover, the Corona Raksha Benefit policy (CRB) wording's are designed by IRDA which is common for all insurance company, It's available in public domain for knowledge . The Reason for Rejection: Hospitalization criteria - 72 hours hospitalization not completed (i.e - 24/10/2020 to 26/10/2020 - Treated in CFLTC).

4. I heard both the parties and had gone through the records submitted by them. In this case where the complainant`s Covid claim under the Corona Rakshak policy was denied, the argument put forth by the respondent insurer was that the complainant on testing Covid positive was kept in designated isolation ward of first line treatment center which was set up by the government, ministry of health and family welfare, Govt. of India, for isolation/quarantine purpose only. The isolation cannot be considered as hospitalization and 72 hours hospitalization was not completed and hence the claim was rejected stands admissible. I therefore do not want to interfere in the decision of the respondent insurer in denying the claim.

In the result, an AWARD is passed for Dismissal of the complaint.

Dated this the 28th day of April 2021.

Sd/-

(POONAM BODRA)

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN – VINAY SAH

CASE OF Mr. Anil Shripat Karande Vs. The New India Assurance Company Ltd.

COMPLAINT NO: PUN-H-049-1920-0141

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Kunal Anil Karande 703, Bldg. No.5, Shankeshwar Palms, Near Khandoba Mandir, Kumbharkan Pada, Dombivili (W), 421201 (M.S.)
2.	Policy No: Type of Policy:	13150034189500003059 New India Mediclaim Policy
3.	Policy period:	20/06/2018 to 19/06/2019
4.	Sum Insured/IDV	Rs.2 lakhs
5.	Date of inception of first policy:	04/06/2009
6.	Name & age of the Insured: Name of the Policyholder:	Mr. Anil Shripat Karande – Age: 61 years Same as above
7.	Name of the Insurer:	The New India Assurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	1st claim –24 hour hospitalization not present. 2nd claim – Liver Cirrhosis due to alcohol.
9.	Date of receipt of the Complaint:	01/04/2019
10.	Nature of complaint:	Rejection of entire health claim
11.	Amount of Claim:	Rs.3,23,704/- for 2 claims
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	**29/01/2021 (Online)**
14.	Representation at the hearing	
	a) For the Complainant:	Absent
	b) For the insurer:	Mr. Raj Kamal Singh
15.	Complaint how disposed:	Allowed
16.	Date of Award:	31/03/2021

Contentions of the Complainant:

Complainant's parents were insured with the Respondent Insurer (RI) under the above policy for the period 20/06/2018 to 19/06/2019 for a SI of Rs.2 lakhs each. The insured patient aged 61 years was hospitalized two times at SRV Mamata Hospital, Dombivili for treatment of Hepatic Encephalopathy and NASH induced CLD.

After the claim documents of the insured patient, were submitted to the RI for reimbursement, the RI after going through the records, rejected the claim on the grounds that there was no 24 hour hospitalization and the treatment taken was also not listed in Day Care. In the second

claim, the claim was rejected stating that the treatment was being taken for Cirrhosis of Liver which was due to intake of alcohol all these years.

The insured patient was admitted at SRV Mamata Hospital on 2 occasions as under:

1. From 17/09/2018 to 18/09/2018 and
2. From 10/12/2018 to 22/12/2018 (expired).

The complainant was brought to the hospital on 10/12/2018 and he expired on 22/12/2018. The cause of death is septic shock with hepatic coma in k/c/o of Cirrhosis of liver **– NASH*** induced.

NASH - Nonalcoholic fatty liver disease (NAFLD) is a condition in which fat builds up in your liver. Nonalcoholic steatohepatitis (NASH) is a type of NAFLD. If you have NASH, you have inflammation and liver cell damage, along with fat in your liver.

Aggrieved with the decision of RI, the complainant has approached the forum for resolution of his grievance.

Contentions of the Respondent Insurer (RI):

The RI has stated that the insured patient was admitted to SRV Mamata Hospital, Dombivili for treatment of Hepatic Encephalopathy and NASH induced CLD. The patient was diagnosed with NASH induced CLD with Diabetes Mellitus with Upper GI Bleed. The patient was admitted with complaints of myoclonic jerks, abdominal discomfort, constipation, and general weakness. The RI rejected both the claims citing the following grounds / clauses under the policy:

1st admission from 17/09/2018 to 18/09/2018

Exclusion Clause 2.16 – 'HOPITALISATION means admission in a Hospital for a minimum period of twenty consecutive hours of Inpatient Care except for specific procedures / treatments as mentioned in Annexure 1, where such admission could be for a period of less than twenty four consecutive hours".

Exclusion Clause 2.10 – DAY CARE TREATMENT – "Day care treatment refers to medical treatment, and/or Surgery which are:

-Undertaken under General or Local Anesthesia in a Hospital / Day Care Centre in less than twenty four hours because of technological advancement, and

-Which would have otherwise required a Hospitalization of more than twenty four hours. Treatments normally taken on an out-patient basis is not included in the scope of this definition".

2nd admission from 10/12/2018 to 22/12/2018 –

Exclusion Clause 4.4.6 – Convalescence, general debility, 'Run-down' condition or rest cure, obesity treatment and its complications, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, venereal disease, intentional self-injury and Illness or Injury caused by the use of intoxicating drugs / alcohol".

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **29/01/2021 (Online)** RI representative reiterated company's stand.

From the available documents, forum notes that:

1. In respect of the first claim, forum agrees with the rejection of the claim as the hospitalization was not for 24 hours as required for admission of any hospitalization claim other than day care treatment.

2. In respect of second claim, the rejection is on the basis of alcoholism. But, there is no documentary evidence in the entire claim docket in support of RI's contention. It is observed that the insured expired on 22/12/2018. The discharge summary mentions k/c/o NASH induced CLD. Meaning 'Non Alcoholic Steato Hepatitis'. During the second admission, the rejection is entirely based on the assumption that cause of liver cirrhosis is alcohol only. Whereas, the treatment papers clearly mention it as NASH induced. Incidentally, the RI does not have any proof / medical document to substantiate the fact that the insured patient was alcoholic. During the hearing also, the RI was told to submit the proof of alcoholism, but they failed to provide till this date.

In view of the above and documents submitted, forum finds that the rejections of the second claim is not on valid grounds and with substantial proofs. In view of this, the complaint for the second claim is allowed.

The complainant has not mentioned the amount of claim in this respect, but has submitted a copy of the final bill of Rs. 2.30 Lakhs. The RI is advised to process this claim for payment. Complaint is partially allowed. Award follows:

AWARD

Under the facts and circumstances of the case, the Respondent insurer is directed to settle second claim of the complainant towards full and final settlement of his complaint maximum upto the available sum insured and CB if any.

The Award shall be settled within one month from the date of award failing which it will attract interest at the prevailing bank rate plus 2% additional interest from the date of rejection till the date of payment of the Award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: on 12th April, 2021 at Pune

V**INAY SAH**
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF Mr:Chetan Vasudev Choudhary v/s Religare Health Insurance Company Limited.

COMPLAINT NO: PUN/ H-037/19-20/0093

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr.Chetan Vasudev Choudhary, Flat No.9, Jayteerth Co-op Housing Society Limted, Opp-Sharada Arcade, Near D Mart, Vijay Sales, Pune Satara Road, Pune-411009
2.	Policy No: Type of Policy:	12093391 Mediclaim Care Policy.
3.	Policy period:	14/01/2018 to 13/01/2020 2 years policy
4.	Sum Insured/IDV	Rs.5,00,000/-
5.	Date of inception of first policy:	14/01/2018
6.	Name & age of the Insured: Name of the Policyholder:	Mr.Chetan Vasudev Choudhary Mr.Chetan Vasudev Choudhary
7.	Name of the Insurer:	Religare Health Insurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Name of daughter is not incorporated in the policy in time.
9.	Date of receipt of the Complaint:	29/05/2019
10.	Nature of complaint:	Name of daughter is not incorporated in the policy in time hence complainant has to bear medical expenses.
11.	Amount of Claim:	Rs.27400/-
12.	Rule of IO Rule under which the Complaint was registered:	13(b)
13.	Date of hearing/Place:	22/01/2021
14.	Representation at the hearing	
	c) For the Complainant:	Mr.Chetan Vasudev Choudhary
	d) For the insurer:	Dr.Nisha
15.	Complaint how disposed:	Award

Contentions of the Complainant:

Complainant was a customer of Religare Health Insurance (RHI) since 14/01/2018. He and his wife were the covered members of the said policy which was issued for two years. On 29/01/2018, his wife delivered a baby girl. He requested R I Company to add his baby Kamakshi Chaudhary after 90 days from her birth and as per RHI policy customer executive demanded Birth Certificate. Later, on receipt of Birth Certificate (which he received after 180 days from the Government authorities on 23/09/2018), he again requested the R I to add his daughter's

name, but the request was again rejected on account of expiry of 180 days from the date of her birth. Thus, even after so many requests his baby's name was not added in the policy.

He was having one more policy for his mother. At the time of her policy renewal which was due on 20/01/2019, as he was reluctant to renew it because of their service issues in his policy, the renewal team assured him addition of his daughter's name on special approval. After 20 days from 20/01/2019, he was informed that the special approval for addition of his baby is received and it will take 3 to 4 days for making final payment approval and meanwhile requested him to pay renewal premium for his mother. Relying on them, he paid renewal premium on 3/2/2019.

But actual payment approval for addition for his baby was received on 15/04/2019 and he made the payment on the same day. It took almost 3 months for getting the payment approval. After the payment, till 28/5/2019, his baby was not added to the policy.

Meanwhile his daughter got admitted to hospital on 2nd April 2019 where he incurred expenses of Rs.15,500/-and Rs. 3,000/- respectively. Earlier also, in the month of November 2018 his baby was admitted in the hospital and had incurred medical expenses of Rs.7,400/- and Rs.Rs.1,500/-. He further contended that these expenses would have been covered if the approval received in time for his daughter name addition in the said policy.

Complainant is claiming damages for medical expenses due to this inordinate delay from the RI. And also demanded some action against the R I Company.

Contentions of Respondent Insurer (RI):

Extracts of their SCN are reproduced below:

1. *That post issuance of the Policy, the Complainant approached the Respondent Company with a request for addition of his new born daughter **(Kamakshi Chaudhary)** in the policy coverage. It is pertinent to mention here that the said request was made with complete documents via mail on **21st February, 2019** while the daughter of the Complainant was born on **29th January, 2018**. It is pertinent to mention here that the request for addition of daughter was made post 180 days from the date of birth of the daughter. It is also important to mention here that as per the Company's Underwriting Guidelines, any new born child born during the continuation of the policy (mid-term) can be added only after 90 days of the date of birth but post 180 days from the date of birth fresh underwriting approval was required. Therefore, the said endorsement request of the Complainant was duly answered and the same was informed to the Complainant vide communication dated 22nd February, 2019.*
2. *That post request for endorsement of addition of the Complainant's daughter in the Policy Coverage, the Respondent Company further considered the addition of the Complainant's request after obtaining the underwriting approval. In this respect additional premium was collected by the Respondent Company which was duly received on 16th April, 2019. On receiving the additional premium amount, the Respondent Company assessed the proposal and underwrote the endorsement request as the Complainant's daughter age was more than 180 days, and accordingly endorsed the request of the Complainant by adding the daughter of the Complainant as an insured in*

*the Complainant's Policy. The Complainant was also issued Endorsement Letter dated **28-May-2019** duly depicting the Complainant's daughter as insured.*

3. *It is further pertinent to mention here that as per the complaint the daughter of the Complainant was hospitalized on 2nd April, 2019 and the complainant was alleging the fact on a presumption that "If the company would have added the member in January or February, 2019 then his financial burden would have been reduced."Since the company had honored the request of the customer beyond 180 Days only after taking the due approval from Underwriting and the said fact was already communicated to the customer. Further the hospitalization took place before the premium received date i.e. 16th April, 2019. Therefore Complainant herein is primarily putting the allegations on a mere presumption and on a baseless ground.*

   We would further like to reiterate that as per the Company Underwriting Guidelines a member cannot be added post 180 Days without taking the Underwriter's approval however in the present case company has already allowed the member addition &underwritten the same after taking the said approval.

4. *That the Complainant doesn't have any cause of action to pursue the present Complaint as the endorsement request of the Complainant has already been considered w.e.f. 9th May, 2019 and the excess premium of Rs. 2,038/- from 16thArpil, 2019 to 8th May, 2019 has already been refunded on 31st May, 2019 vide transaction reference number 19448772 into the source account as per company records therefore the Complaint can be dismissed in limine.*

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 22/01/2021 **(through video-conferencing)**, both the parties reiterated their respective stand.

The chronology of events correlated with the RI's submission, with the forum's remarks are as given below:

1. Complainant requested for addition of his new born daughter's name in his existing policy at customer care centre after attaining of her age of 90 days as per the policy norms. He was told to submit the birth certificate.
2. By the time he got the birth certificate, it had crossed 180 days of the child's age. He again approached the RI for her inclusion in the policy. The mail communication done by the RI, dt. 30/10/2018 in reply to his said request, again mis-guided him to wait till the renewal of the policy as the child has crossed the age of 180 days and her inclusion can be done at the time of renewal only. While telling this, RI did not consider that the said policy was issued for the two year's period and do they mean to wait till completion of two years?
3. Again in the month of February 2019, he approached RI for inclusion of his daughter's name in his policy. The reply given by RI vide their mail dt.22/02/2019, was again giving the same reasons of 180 days. In this mail, they have not given any way out also for

inclusion of her name after the age of 180 days. Whereas, in the SCN they have mentioned that after 180 days underwriting approval is required.

4. At last, he received the payment link only on 15/04/19, through which he made payment on the same day. Proposal is dt.26/02/2019.

Complainant has two demands from this forum, viz.

1. To get the policy w.e.f.15/04/2019 and
2. To get reimbursement of hospitalization expenses (Rs.22,900 and medical expenses)

Under the facts and circumstances, forum observes that,

RI has erred in mis-guiding the complainant in non inclusion of his new born baby's name in his existing policy for the following reasons:

i) They could have included her name based on the hospital proof of birth of the child and subsequently could have been replaced with the birth certificate.

ii) They did not give any way out for inclusion of the child in case of crossing the age of 180 days. They gave an incorrect information to wait till the renewal which was due after 2 years period.

iii) It is pertinent to note that the complainant could not have approached any other insurance company also just for inclusion of his new born child. Because, no insurer will issue a policy only for a child. He had no alternative but to wait for inclusion of her name in the existing policy. Because of the delay on the part of the RI, he had to suffer financial loss for which the insurance is mainly done and had to undergo hardship in getting the insurance.

iv) TAT (turn around time) period stipulated by the authority is as stated below:

'Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017

8. PROPOSAL FOR INSURANCE:

6. Insurer shall process the proposals with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to the proposer within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by the insurer.'

v) It is observed that the RI has not followed these guidelines even after their mail of 22nd February 2019. After lapse of two months from this date, after the complainant had approached their CEO, he was sent payment access. Hence, non-deposit of premium was not his fault. Since beginning, he was ready to pay, but he was not given access to pay nor was his proposal rejected. In view of this, it is presumed that the proposal was accepted but the acceptance was not timely conveyed to the complainant. Hence, the liability is considered to be existed from 12/3/2019, i.e. from 16th day of date of proposal 26/02/2019.

vi) From the mail correspondence shared by the RI, as per complainant's mail dt. 5/6/19, he has asked to include his daughter in the existing policy from 15/4/2019 confirming therein that he has paid Rs.3700/- on 15/4/2019, after completing all the procedures and approval.

In view of this, it is inferred that the complainant, being a CA by profession, can understand and agree to the fact that the policy if issued w.e.f. 15/4/2019, will not cover the claims arisen before this date. Hence, his claim for reimbursement occurred on 2/4/2019 cannot be considered. As such, it is practically of no use to have a back dated policy. Moreover, RI has refunded him proportionate premium from 15/04/2019 (date of payment) to 25/05/201/ (Date of endorsement).

For his second demand to penalize for the lapses, this forum cannot give any monetary penalty but can give strictures for prudent underwriting and to avoid such issues in future. RI, vide their mail dt.7/5/2019 have apologized for the inconvenience caused to the complainant. Award follows:

AWARD

Under the facts and circumstances, the RI is advised to be more prudent with the issues of the customers, to guide them properly and avoid such grievances in future.

Complaint is thus closed, with no order as to claim and or compensation.

Dated: at Pune on 16th April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF Mr Darshan Vinod Bagle v/s Future Generali India Insurance Company Limited
COMPLAINT NO: PUN/H-016/2021/0365
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr.Darshan Vinod Bagle, c/o Nilesh B Kabare, 1st Floor Kabare Hospital, Lane No.1, Dhule, Maharashtra-424001
2.	Policy No: Type of Policy:	CRP-2-J-20-7547221-00-000 Corona Rakshak Policy

3.	Policy period:	21/07/2020 to 01/05/2021
4.	Sum Insured/IDV	Rs.2,50,000/-
5.	Date of inception of first policy:	21/07/2020
6.	Name & age of the Insured: Name of the Policyholder:	Mr.Darshan Vinod Bagle, 21 years Mr.Darshan Vinod Bagle
7.	Name of the Insurer:	Future Generali India Insurance Company Ltd
8.	Reason for repudiation/Partial Settlement:	Hospitalization is not justified.
9.	Date of receipt of the Complaint:	28/12/2020
10.	Nature of complaint:	Total repudiation of the claim
11.	Amount of Claim:	Rs.2,50,000/-
12.	Rule of IO Rule under which the Complaint was registered:	13(b)
13.	Date of hearing/Place:	28/01/2021 Online
14.	Representation at the hearing	
	e) For the Complainant:	Mr.Darshan Vinod Bagle
	f) For the insurer:	Dr. Akanksha Saxena
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Mr. Darshan Vinod Bagle (Complainant) had purchased above mentioned Corona Rakshak Policy from Future Generali India Insurance Company (R I Company). The Policy is valid upto 1st of May 2021 from 21/07/2020 for 9.5 months. There is a waiting period of 15 days. As per terms and conditions of the policy Lump Sum benefit equal to Sum Insured of Rs.2,50,000/- is payable on positive diagnosis of Covid-19, requiring indoor hospitalization for minimum period of 72 hours. On 30th August 2020 he was tested Covid-19 positive. He was admitted to Civil

Hospital Dhule on 31/08/2021 and discharged on 06/09/2021. On 28th November 2020 the said claim was repudiated on ground that the indoor admission for this case is not warranted.

According to him the indoor admission is necessary and R I company's contention is wrong. He claimed the amount of compensation as sum insured and damages for harassment.

Contentions of Respondent Insurer (RI):

R I Company contended that discharge summary shows insured was 'mild symptomatic'. All vitals especially SPO2 99% were within normal limits. Not received any active treatment during admission and insured was admitted for isolation purpose only.
As per Circular issued by Govt. MOHFW dt. 17/03/2020, mild symptoms does not require hospitalization. Hence, the claim is repudiated vide letter dt. 28/11/2020.

Result of personal hearing with both the parties (Observations & Conclusions):

A personal hearing on 28/01/2021 (through video-conferencing), was held which was attended by both the parties.

RI representative reiterated that the SPO2 was 99% as per discharge summary. Chest X-ray & HRCT reports are not there. Only rapid antigen test was done.

From the available documents, Forum finds that Dr. Vipul Bafna of Niramay Hospital has given a letter stating, patient is

c/o fever c chills since 2 days
c/o cough
c/o sore throat
GC fair, temp. 101 F, SPO2 92%
And advised RT PCR & SOS admission.

Jilha Rugnalay, Dhule in their case paper has noting that "Mr. Darshan Bagle 21 year old male r/o Dhule was admitted on 31/08/2020 as covid 19 +ve. Pt. with symptoms of fever, chills, sore throat, cough. On examination, he had decreased O2 saturation & fever. It has further notings that on 02/09/2020, his O2 dropped to 93% & **on 05/09/2020, his O2 saturation was 82%.** He was given oxygen therapy, nebulization and oral medications. He was symptomatic on admission and required to be admitted indoor for treatment.

This was pointed out to RI representative during hearing. It seems they were not in receipt of this document. Dr. Akanksha agreed that if O2 level is dropping below 90%, hospital admission is justified.

In view of this, claim is entertainable. Complaint is allowed. Amount payable in this case is a fixed sum insured being a benefit policy.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.2,50,000/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN– VINAY SAH

CASE OF Mr. G. Padmanabhan V/S United India Insurance Company Ltd.

COMPLAINT NO: PUN-H-051-1920-0071

Award No IO/PUN/A/HI/ /2021-2022

1.	Name & Address of the Complainant	Mr. G. Padmanabhan Pune
2.	Policy No: Type of Policy:	1619002817P110667192 Individual Health Insurance Policy – **Gold Plan**
3.	Policy period:	03.11.2017-02.11.2018
4.	Sum Insured	Rs.5,00,000/-
5.	Date of inception of first policy:	03.11.1998
6.	Name of the Insured: Name of the Policyholder:	Mr. G. Padmanabhan, 73 years Same as above
7.	Name of the Insurer:	United India Ins Co Ltd
8.	Reason for repudiation/Partial Settlement:	Various reasons
9.	Date of receipt of the Complaint:	15.05.2019
10.	Nature of complaint:	Claim rejected- Partially(Two claims)
11.	Amount of Claim:	Rs.62,494/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	18/01/2021 **(Online)**
14.	Representation at the hearing	
	For the Complainant:	Insured himself
	For the insurer:	Mr. S.D. Chitanvis
15.	Complaint how disposed:	Allowed
16.	Date of Award:	31/03/2021

Contentions of the Complainant:-

The complainant has taken a policy from the RI for the period 03.11.2017 to 02.11.2018 for a SI of Rs.5 lakhs. The Inception date of the policy is 03/11/1998. The complainant, aged 73 yrs was hospitalized twice in Prayag Hospital 28.08.2018 to 09.09.2018 and the second admission was from 23.10.2018 to 28.10.2018. Both the claims were partially settled by the RI after deduction of some amount. The complainant has stated that Prayag Hospital does not have cashless facility and he has settled both the bills with the treating hospital and lodged reimbursement of hospitalization claim with the RI.

1.28.08.2018 to 09.09.2018 Expenses Rs.1,04,675/- settled for Rs.73,205/-

2.23/10/2018 to 28/10/2018, Expenses Rs.69,395/- settled for Rs.38,371/-

For the partial amount of unpaid claim, complainant has approached this forum.

Contentions of the Respondent Insurer (RI):-

The RI has mentioned that the deductions were done as per the policy term and conditions as under:

- The charges of Rs.12,000/- towards special room charges for 4 days and Rs.3,600/- ICU charges were disallowed as the surgery was done on 04.09.2018 at Ruby hall. Reason given is ICU stay not justified, as per TPA. Hence, the excess or prolonged hospitalization period were not acceptable. Hence the same is disallowed;
- The ICU monitor charges of Rs.6000 is part of ICU hence separately not admissible;
- Syringe pump charges of Rs.1000 were disallowed from claim under policy Clause No. 4.16 – the clause is reproduced as under:

  Clause 4.16 – "External and or durable Medical / Non-medical equipment of any kind used for diagnosis and / or treatment and / or monitoring and / or maintenance and / or support including CPAP, CAPD, Infusion Pump, Oxygen concentrator etc., Ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, slings, braces, stockings, elastocrepe bandages, external orthopedic pads, sub cutaneous insulin pump, diabetic foot wear, Glucometer / Thermometer, alpha/water bed and similar related items etc. and also any medical equipment which are subsequently used at home."

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **18/01/2021 (Online)** both the parties reiterated their respective stand.

From the available documents, forum notes that:

- The complainant was hospitalized twice in the year 2018 and the claim was partially settled by RI after deducting some amount which was not payable as per the policy terms and conditions;
- The complainant has also further stated that the room stay and the nature of medicines administered is not decided by the patient and hence all such charges deducted under non-justifiable should be paid to him. He has submitted hospital certificate justifying his extended ICU stay, consultation charges etc.
- During hearing, the RI was advised to send their fresh calculation sheet after reviewing the deductions done in both the claims and they have sent their admissible amount as under:

Bill Date	Sub category	Bill Amount (Rs.)	Admissible Amount (Rs.)

I Admission			
28/10/2018	Room rent charges	7,000/-	7,000/-
28/10/2018	Consultation / visit charges	3,600/-	3,600/-
28/10/2018	Consultation / visit charges	8,000/-	8,000/-
II Admission			
30/09/2018	Medicine charges	2,800/-	2,800/-
	Total Rs…		**45,640/-**

Forum found this amount as adequately reviewed. The complaint is allowed. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.45,640/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 12th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Ganesh U Murkute V/S Star Health and Allied Ins. co ltd
COMPLAINT NO: PUN-H-044-2021-0367
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Shri Ganesh U Murkute Pune
2.	Policy No: Type of Policy:	P/151124/01/2021/002349 Family Health Optima Ins Plan

3.	Policy period:	06.08.2020 to 05.08.2021
4.	Sum Insured	Rs. 500000
5.	Date of inception of first policy:	03.08.2020
6.	Name and age of the Insured: Name of the Policyholder:	Komal Ganesh Murkute, 25yrs, Wife Shri Ganesh U Murkute
7.	Name of the Insurer:	Star Health and Allied Ins Co Ltd
8.	Reason for repudiation/Partial Settlement:	Stable covid case Hospitalisation not required
9.	Date of receipt of the Complaint:	31.12.2020
10.	Nature of complaint:	Total Rejection full claim amount
11.	Amount of Claim:	64448 (15662 Pre+48686 Hosp+100 Post)
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28/01/2021; Online
14.	Representation at the hearing	
	i) For the Complainant:	Himself
	j) For the insurer:	Dr. Anjali Rathod
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:-

The complainant had taken a policy for entire family from 06.08.2020 to 05.08.2021 from Star health and Allied Ins. Co Ltd under family Health Optima Ins. Plan.

His wife Mrs Komal was detected with Covid 19 and was hospitalized at AIMs Hospital on 27.09.2020 to 01.10.2020. He submitted reimbursement bill of 48686 and pre hospitalization bill of 15662.

The claim was rejected by the company stating that the Insured patient's signs were normal and her general condition were stable throughout the period of hospitalization. As per ICMR guidelines medically claim is not payable.

The complainant has approached the forum for settlement of full claim amount.

Contentions of the Respondent Insurer(RI):-

In the SCN the RI has contended that, initially the insured had requested for cashless treatment with pre auth form which was denied. Subsequently they submitted reimbursement claim. The same was repudiated on 24/11/2020 for the following reasons:

1. As per indoor case papers the SPO2 level of the insured patient at the time of admission was 96%.
   On 28/9/20 it was between 96% to 99%
   On 29/9/20 it was between 96% to 99%
2. As per AIIMS guidelines, the patients with SPO2 level greater than 94% are having only MILD INFECTION. Patients with mild infection are prescribed HOME ISOLATION ONLY.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 28/01/2021 **(through video-conferencing)**, both the parties reiterated their respective stand.

Upon hearing the contentions of both the parties and documents submitted on record, forum has following observations.

From the discharge summary of the hospital, it is noted that at the time of admission the insured patient had complaint of fever, cough, and weakness since 6-7 days. Required medicines were given. Her health was monitored with D-Dimer, CRP & Ferritin tests. On 01/10/2020, the patient was discharged as she was comfortable and was advised to do repeat markers after 2 days.

During the hearing, complainant contended that during that time, his parents and brother were also hospitalized because of covid and his brother's claim is settled by the RI.

In view these facts, forum finds that the claim is payable. The amount of claim assessed by the RI as per their SCN is Rs.37715/-. Pre hospitalization expenses Rs. 15662/- are not allowed as there is no referral letter dated 23/09/2020 for investigations & diagnostics and for medicines.

Complaint is allowed.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 37715/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF Mr. Haresh K Karara v/s Cholamandalam M S General Insurance Company Limited

COMPLAINT NO: PUN/H-012/2021/0362

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr Haresh Kanyalal Karara, Alankar Apartment, B Wing near Venus Cinema, Ulhasnagar, Thane Maharashtra-421004
2.	Policy No: Type of Policy:	2894/00017059/000/00 Corona Rakshak Policy, Chola
3.	Policy period:	04/08/2020 to 15/05/2021
4.	Sum Insured/IDV	Rs.1,50,000/-
5.	Date of inception of first policy:	04/08/2020
6.	Name & age of the Insured: Name of the Policyholder:	Mr Haresh Kanyalal Karara, 35 Years Same as above
7.	Name of the Insurer:	Cholamandalam M S General Insurance Co Limited
8.	Reason for repudiation/Partial Settlement:	In patient hospitalization not justified as vitals were stable with asymptomatic conditions.
9.	Date of receipt of the Complaint:	28/12/2020
10.	Nature of complaint:	Total repudiation of the claim
11.	Amount of Claim:	Rs.1,50,000/-
12.	Rule of IO Rule under which the Complaint was registered:	13 1 (b)
13.	Date of hearing/Place:	28/01/2021 Online
14.	Representation at the hearing	
	k) For the Complainant:	Mr Haresh Karara on voice call
	l) For the insurer:	Mr.Rushabh; Dr.Minal Vinoth
15.	Complaint how disposed:	Disallowed

Contentions of the Complainant:

Mr. Haresh Kanyalal Karara (Complainant) had purchased a Corona Rakshak Policy from Cholamandalam MS General Insurance Company with effective date 19/08/2020 to 15/05/2021. The Cover is for Rs.1,50,000/-. The condition of the policy is if an insured gets detected with corona positive and if he gets admitted in hospital for more than 72 hours, he will get Rs.1,50,000/- as compensation. He was admitted for 11 days in the hospital. But still his claim is rejected with reason that his admission was not necessary.

Complainant refuted the charges made by Insurance Company that he was asymptomatic. He says that he had all the symptoms of Covid 19. i.e. cough, cold, fever, breathing problem, body pain, loss of taste, weakness. He has submitted a case paper dated 09/09/2020 from Dr. Chhotu's clinic which has remark of cough, fever, loss of taste and loss of smell. He further contends that because he was admitted in Government hospital and not incurred any medical expenses, his claim was rejected. Whereas, his friend having same problem and same policy was admitted in private hospital and his claim was passed. Also, he was living with his 65 years old mother, wife and 5 years old daughter in a 1 BHK house. As such, it was not a good idea to get treated at home.

Contentions of Respondent Insurer (RI):

As mentioned in the rejection and their SCN, the reason for rejection is: Inpatient hospitalization of the Insured is not justified as Vitals were stable, patient was asymptomatic with no specific complaint for admission. As per Ministry of Family Welfare guidelines, such members do not require hospitalization and treatment can be done under home quarantine.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 28/01/2021 **(through video-conferencing)**, both the parties reiterated their respective stand.

Upon hearing the contentions of both the parties and documents submitted on record, forum has following observations.

1. The admission of the complainant was in 'covid care center' (Vedanta CCC, Vihtthalwadi) and not in a hospital, as required under the policy terms for admission of liability.
2. There are no day to day case papers to show whether he had breathing problem and/or any other problem as he claims, and what treatment was given. No any remark to this effect on discharge card also.

From the papers it can be inferred that the admission was for isolation only and not for any specific treatment which needs hospitalization. Only admission in a covid care centre for more than 72 hours does not merit getting the claim unless hospitalisation was really required. In view of this, the forum is not of the view to intervene in the decision taken by RI. Repudiation of claim is justified. Complaint is not admissible.

Award follows:

AWARD

Under the facts and circumstances, complaint is devoid of merits. Complaint therefore stands dismissed.

Dated: at Pune this 30th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN – VINAY SAH

CASE OF Mr. Hemant Kumar Shah V/S Star Health and Allied Insurance Company Ltd.

COMPLAINT NO: PUN-H-044-2021-0515

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Hemant Kumar Shah Navi MumbaI
2.	Policy No: Type of Policy:	P/171130/01/2020/011626 Family Health Optima Insurance Plan
3.	Policy period:	30.12.2019 to 29.12.2020
4.	Sum Insured	Rs.5,00,000 + Rs. 1,50,000 Recharge Benefit
5.	Date of inception of first policy:	30.12.2019
6.	Name & Age of the Insured: Name of the Policyholder:	Mr. Hemant Kumar Shah, Age: 45 years Same as above
7.	Name of the Insurer:	Star Health & Allied Insurance Company Ltd.
8.	Reason for repudiation/Partial Settlement:	Partial repudiation of health claim
9.	Date of receipt of the Complaint:	08.02.2021
10.	Nature of complaint:	Settlement of full claim amount
11.	Amount of Claim:	Rs.1,50,317/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	30.03.2021 **(Online)**
14.	Representation at the hearing	
	m) For the Complainant:	Complainant himself
	n) For the insurer:	Dr.Smita Sonawane
15.	Complaint how disposed:	Allowed
16.	Date of Award:	05/04/2021

Contentions of the Complainant

The complainant had Family health optima insurance plan with Respondent Insurer for SI Rs.5,00,000/- . He was admitted to MPCT Hospital with complaints of cough and severe hypoxia with severe presentation of modulator ARDS from 20.09.2020 to 01.10.2020 for Covid 19 positive.

After discharge, he has lodged a claim of self hospitalization in MPCT Hospital for a total hospitalization bill of Rs.4,48,694/- out of which the RI has approved an amount of Rs.2,98,377/- and Rs.6400/- (cash benefit of Rs. 800/- per day for taking shared room instead of eligible single AC room) in the reimbursement, totaling to Rs.3,04,777/-. The complainant is

requesting for full settlement of claim from the RI. The main deduction as per the complainant is of Rs.83,942/- towards Injection Ulicrit under the grounds that the said drug is an unproven therapy. He contends that how can he question the hospital/doctors whether the treatment which they are giving is a proven therapy or not? MPCT hospital is a reputed hospital and they have given him the best treatment to save his life.

The complainant has also represented to the Grievance Cell of the RI but they too have replied that they have settled the maximum payable under the policy conditions and nothing more can be considered. In view of this decision, the complainant has approached the forum for redressal of this grievance.

Contentions of the Respondent Insurer (RI)

After receipt of the claim documents and supporting papers, RI has settled the claim for Rs.2,98,377/- and Rs.6400/- in the reimbursement, totaling to Rs.3,04,777/-, out of a total hospital bill of Rs.4,48,694. The assessment chart provided by the RI is as under:

Nature of deductions along with reasons:

Description	Bill amount	Amount deducted	Amount approved	Remarks
Medicines and consumables	Rs.314380	Rs.136182	Rs.178198	Non medicals, disposables & Ulinatsin / Ulicrit charges not payable
Composite package	Rs.10350	Rs.10350		Excess nursing , BMW Physio charges not payable
Investigation & Consumables	Rs.72314	Rs.3785	Rs.68529	HGT,RBS, not payable
Total deduction		**Rs.150317**		

The RI has stressed the fact that injection Unilastatin is not the part of treatment protocol for ARDS patients in covid pneumonia. Hence, the same is Unconventional/Untested/Unproven/Experimental therapy.

As per exclusion 22 of the policy, " *The company shall not be liable to make any payments under this policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of Unconventional, Untested, Unproven, Experimental therapies*." Hence, the same is not payable which is amounting to Rs.83,942/-.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **30/03/2021 (Online)** both the parties reiterated their respective stand. From the available documents, forum notes that:

1. The complainant has submitted clarification letter from MPCT hospital that '*the patient was clinically deteriorating and patient's O2 (Oxygen) requirement increases and patient went to NIV support and ABG suggestive of hypoxia which is in range to moderate to severe ARDS*. The role of Ulinastatin: it is immune modulator which is used in moderate to severe ARDS.therefore, the patient was started with Ulicrit injn. in required basis of the patient as it is immune modulator which is used in ARDS.*

   **Acute respiratory distress syndrome (ARDS) is a life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body. Most people who get ARDS are already at the hospital for trauma or illness.*

2. During the hearing, complainant narrated the situation at the time of his illness that his lungs were working 75% of its capacity and he was affected with pneumonia too. After 6-7 days he became unconscious and was shifted to Apollo Hospital for further management.

3. The RI representative argued that in Apollo Hospital this disputed injection was stopped by the treating doctor, which itself proves that the injection was not effective.

4. The forum finds that even though the injection was found ineffective, insured patient (complainant) was not in a position to decide the line of treatment, neither can he choose the injection which are to be administered to him, as he is a non-medical person. The complainant has taken the treatment as per his medical condition and as deemed fit to his treating doctor.

In view of above and the documents submitted, forum finds that the cost of injection rejected by the RI is not in order and hence the same to be considered by the RI. The complaint is allowed.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 83,942/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune on 8th day April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN– VINAY SAH

CASE OF Mrs. Kalawati Jain v/s Star Health and Allied Insurance Co Ltd

COMPLAINT NO: PUN-H-044-1920-0100

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Kalawati Jain, Solapur
2.	Policy No: Type of Policy:	P/151125/01/2018/001163 FAMILY HEALTH OPTIMA INSURANCE PLAN
3.	Policy period:	15/3/2018 TO 14/3/2019
4.	Sum Insured	Rs. 500000/-
5.	Date of inception of first policy:	17/11/2016
6.	Name of the Policyholder:	Chetan Jain and Kalawati Jain
7.	Name of the Insurer:	Star Health and Allied Insurance Co. Ltd
8.	Reason for repudiation/Partial Settlement:	Illness falls under two years waiting period hence rejected the claim
9.	Date of receipt of the Complaint:	6/6/2019
10.	Nature of complaint:	Total Rejection of claim
11.	Amount of Claim:	Rs. 125283/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1(b)
13.	Date of hearing/Place:	22/1/2021 Through Video Conferencing
14.	Representation at the hearing	
	o) For the Complainant:	Chetan Jain (H)
	p) For the insurer:	Dr. Anjali Rathod
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

The complainant has health policy with Respondent Insurer (herein after is called RI) from 17/11/2016 to 16/11/2017 thereafter policy is renewed from 15/3/2018 to 14/3/2019.

The Complainant's husband has submitted complaint stating that he is paying for medical insurance to RI for last three years. His wife, Kalawati Chetan Jain, aged 49 yrs, was operated for L5, S1 at Pune Adventist Hospital on 7/2/2019 and was discharged on 12/2/2019. He paid the hospital bill and filed reimbursement claim was with RI.

The hospitalization period is 7/2/2019 to 12/2/2019. Hospitalization was for L5-S1 LAMINACTOMY WITH L5-S1 FIXATION AND REDUCTION WITH BONE GRAFTING.

RI has rejected the claim under section 3(ii) which has 24 months of waiting period for the treatment of Prolapse of Intervertebral Disc.

Complainant has contended that there is no prolapse of intervertebral Disc but there is Laminectomy of L5-S1 Surgical procedure to remove (bone spur) part/all of lamina to relieve pressure. It is also called decompression surgery.

As per the complainant, at the time of treatment, her state of health was so severe that she was not able to stand for 15min also and she required to keep herself in horizontal position only. She could not do her routine work also. Doctor had told that if operation is not done immediately, patient might face severe problems. If power is lost, she might not be able to walk in her lifetime. Hence, the operation was done on emergency basis.

Contentions of the Respondent Insurer (RI):

As per SCN, Its Branch Office –Solapur has issued Family Health Optima insurance Policy vide policy no.

- P/151125/01/2017/000226 -17/11/2016-16/11/2017
- P/151125/01/2018/001163-15/3/2018-14/3/2019

The Complainant has reported the claim for the treatment for L5-S1 LAMINACTOMY WITH L5-S1 FIXATION AND REDUCTION WITH BONE GRAFTING in the 2nd year of the Medical Insurance Policy from inception.

However, they could not entertain the claim as it falls in the waiting period of 24 months as prescribed under the policy as per Exclusion Clause No.3 (ii) (a) of the Policy, which states as:

"*A **waiting period of 24 consecutive months** of continuous coverage from the inception of this policy will apply to the following specified ailments/illness/disease Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, **Diseases related to** Thyroid, **Prolapse of Intervertebral Disc (other than caused by accident),** Varicose veins and Varicose ulcers, Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula, all Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies, all types of Hernia, Benign Tumors of Epididymis, Spermatocele, Varicocele, Hydrocele, Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence and congenital Internal disease/defect*"

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 22/01/2021 **(through video-conferencing)**, both the parties reiterated their respective stand.

From the documents submitted, it is observed that,

The RI has renewed this policy with continuity benefit, though there was 118 days gap, as the gap period was falling within the grace period of 120 days as prescribed in the Renewal clause as quoted below:

'Renewal: The policy will be renewed except on grounds of misrepresentation / fraud committed.

A grace period of 120 days from the date of expiry of the policy is available for renewal. ***If renewal is made within this 120 days period, the continuity of benefits with reference waiting periods stated will be available.*** *Any disease or illness contracted or injury sustained during the grace period will be deemed as Pre existing and will be subject to waiting period as stated under 3iii.*

The clause implies that there will be continuity cover if renewed within grace period. In the present dispute first policy started from 17/11/2016. With this date, the two years waiting period gets over on 16/11/2018. The hospitalization was of dated 7/02/2019, which is falling well beyond 24 months from the first policy inception date.

RI's contention that the insured patient has undergone treatment during the second year of the policy, is not acceptable, because, RI is treating the gap as gap and reducing the gap period from the total policy period since inception. Thus, total period is falling short by about 1½ months to complete 24 months. This is not adhering to the above policy clause.

In view of this, claim is not falling in the waiting period. Hence, found payable. As informed by RI in the SCN, their quantum of liability is Rs.1,01,476/-. This amount seems to be adequate as against the claim amount of Rs.1,25,283/-

Complaint allowed. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 1,01,476/-to the complainant, towards full and final settlement of the complaint.

The amount is to be paid within one month of receipt of this award failing which, it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune, this 22nd day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Kaushal Shah Vs. The Oriental Insurance Company Ltd.
COMPLAINT NO: PUN-H-050-1920-0092
Award No IO/PUN/A/HI/ /2021-2022

1.	Name & Address of the Complainant	Mr. Kaushal Shah 34/903, Mir Complex, Seawood Estate, Sector 54, Nerul (W), Navi Mumbai - 400706
2.	Policy No: Type of Policy:	112200/48/2018/1158 Mediclaim Insurance Policy (Individual)
3.	Policy period:	07/12/2017 to 06/12/2018
4.	Sum Insured/IDV	Rs.6 lakhs
5.	Date of inception of first policy:	07/12/2014
6.	Name & age of the Insured: Name of the Policyholder:	Mr. Kaushal Shah – Age: 43 years Same as above
7.	Name of the Insurer:	The Oriental Insurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	Ayurvedic treatment taken is not a Govt. hospital
9.	Date of receipt of the Complaint:	28/05/2019
10.	Nature of complaint:	Rejection of health claim **(Ayurvedic)**
11.	Amount of Claim:	Rs.50,000/-
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	**22/01/2021 (Online)**
14.	Representation at the hearing	
	q) For the Complainant:	Himself
	r) For the insurer:	Ms. Vaishali Khilare
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Complainant was insured with the Respondent Insurer (RI) under the above policy for the period 07/12/2017 to 06/12/2018. The insured patient aged 43 years was hospitalized at Prakruti Ayurvedic Health Resort, Satara from 25/12/2017 to 30/12/2017 for treatment of Lumbar Spondylosis. The claim was rejected by the RI on the grounds that the hospital where the treatment was availed by the insured was not a Govt. Hospital or Govt. recognized hospital.

The insured has incurred hospitalization expenses for an amount of Rs.50,000/- towards treatment of the insured patient which was not settled by the RI. The insured has further mentioned that as per the doctor's certificate dated 30/12/2017 that the patient was treated

for Lumbar Spondylosis. The insured has also submitted the Registration Certificate of the hospital issued by the Health Dept., Satara Zilla Parishad.

Aggrieved with this decision, the complainant has approached the forum for resolution of his grievance.

Contentions of the Respondent Insurer (RI):

The RI has rejected the claim stating that the patient was admitted in a Private Hospital. The claim was rejected as per Clause 1 – Note 1, which is reproduced as under:

Clause 1, Note 1 – "In case of Ayurvedic / Homoeopathic / Unani treatment, hospitalization expenses are admissible only when the treatment is taken as an in-patient, in a Government Hospital or a hospital associated with a Medical College".

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **22/01/2021 (Online)** both the parties reiterated their respective stand.

From the available documents, forum notes that:

3. The insured has submitted a certificate issued by the Satara Zilla Parishad stating that the hospital has been registered under the Bombay Nursing Homes Registration Act, 1949 and had 50 bed facility;

4. The insured has also submitted two assessment sheets wherein claims pertaining to the same hospital were settled by other PSU GI Companies whereas the RI was not settling his claim. Incidentally, all the PSU GI Companies are governed by the uniform guidelines;

5. The insured has approached the RI under RTI for providing a list of Ayurvedic Hospitals recognized by Government but they were not able to provide the same to the insured.

There are two aspects in this case:

1. Why a person will opt for insurance protection, if he is taking treatment in a government hospital, because charges there, are almost nil or very negligible. Insurance protection is needed when the medical expenses go beyond ones individual capacity.

2. Why the policy is differentiating treatments for allopathy and other Indian pathies (Ayush) in its mother land? IRDAI in its all the notifications since 2013, have asked the insurance companies to pay for AYUSH treatments. In the recent notification also IRDAI have made it mandatory to cover Ayush treatments without sub-limits. By putting such impractical conditions of government hospitals insurers are depriving their insured public from availing Ayush treatment.

In view of this discussion, it is found that the clause of the subject clause of insurance company is arbitrary.

Forum therefore comes to the conclusion that as the hospital is registered with Government authorities (Zilla parishad in this case), which fulfils the requirements of a definition given in the clause of 'Hospital', the claim is payable.

It is also pertinent to note that the other two PSU GI Companies have settled claims pertaining to the treatment taken at this hospital.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.50,000/-less non-payable items as per policy clause, if any, towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 12th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Mrs Kiran Rao V/S Star Health and Allied Ins. Co ltd
COMPLAINT NO: PUN-H-044-1920-0309
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mrs Kiran Rao Pune
2.	Policy No: Type of Policy:	P/7000001/01/2019/025445 Sr. Citizen Red Carpet Health Insurance Policy
3.	Policy period:	13.11.2018 to 12.11.2019
4.	Sum Insured	200000

5.	Date of inception of first policy:	13.11.2014
6.	Name & Age of the Insured: Name of the Policyholder:	Kiran Rao, 65 yrs Jeevan Subhash Rao
7.	Name of the Insurer:	Star Health and Allied Ins. co ltd
8.	Reason for repudiation/Partial Settlement:	Mis representation and non disclosure of material fact. Surgery of eye rejected
9.	Date of receipt of the Complaint:	06.08.2019
10.	Nature of complaint:	Full settlement of claim amount
11.	Amount of Claim:	Rs.45,523/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	12.03.2021 Online
14.	Representation at the hearing	
	s) For the Complainant:	Absent
	t) For the insurer:	Dr. Anjali Rathod
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

- The complainant had taken Health insurance policy of self and her husband from Royal Sundaram since 2009. The Company did not provide full cashless facility when operated for Glaucoma and cataract of right eye in the year 2018. They were in search of such insurance company who can provide full cashless facility and treating new policy in continuation of old policy without any waiting /locking period
- They came across Shri Vivin of Star health insurance co ltd. He had suggested to take policy under portability scheme under which new policy will be treated as in continuation of old policy. At that time they had declared that both of them are having BP and she was suffering from Glaucoma also for the past two years.
- She had specifically asked him if the company will provide claim if the surgery of her another eye is undertaken within a month or two. To which he had assured that there would not be any problem in getting cashless facility or claim.
- On 18.05.2019 Surgery of left eye took place in Shankar Netralaya, Chennai. The claim for both cashless and reimbursement was rejected by the RI. Had they known that their claim shall be rejected they would probably have ported the policy. She is aggrieved that their sales person has cheated the old people probably for achieving his target and requested the forum to intervene for release of claim amount.

Result of personal hearing with both the parties (Observations & Conclusions):

On the previous day of hearing, the complainant sent a mail stating that she does not hope to get justice. Therefore, she has decided not to proceed further in the matter and to treat the case as closed.

During the hearing, the RI showed their readiness to settle the claim for Rs.28585/-. As per working sheet provided by them, they have allowed Rs. 15000/- for cataract (as per sub limit) and Rs. 13585/- from 'others' after deducting non-payable items and applying 30% co-pay as per policy conditions.

Complaint admitted.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 28585/-towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Krishnachandra Shukla Vs. Star Health & Allied Insurance Company Ltd.
COMPLAINT NO: PUN-H-044-1920-0089
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Krishnachandra Shukla Room No.3, Mumbreshwar, Mandir Trust Chawl, No. G Shankar Mandir, Mumbra – 400612 (M.S.)
2.	Policy No: Type of Policy:	P/171115/01/2018/012265 Family Health Optima Insurance Plan
3.	Policy period:	13/02/2018 to 12/02/2019
4.	Sum Insured/IDV	Rs.3 lakhs
5.	Date of inception of first policy:	13/02/2017
6.	Name & age of the Insured: Name of the Policyholder:	Ms. Manju Shukla – Age: 51 Mr. Krishnachandra Shukla
7.	Name of the Insurer:	Star Health & Allied Insurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	The patient has undergone treatment for non-traumatic disease during 2nd year of the policy (Waiting period of 2 years applicable)
9.	Date of receipt of the Complaint:	04/06/2019
10.	Nature of complaint:	Rejection of health claim
11.	Amount of Claim:	Rs.77,330/-
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	22/01/2021 **(Online)**
14.	Representation at the hearing	
	u) For the Complainant:	Himself & Manju Shukla (w)
	v) For the insurer:	Dr.Anjali Rathod
15.	Complaint how disposed:	Disallowed.

Contentions of the Complainant:

Complainant and his family were insured with the Respondent Insurer (RI) under the above policy for a SI of Rs.3 lakhs for the period 13/02/2018 to 12/02/2019. The insured patient, Ms. Manju Shukla, aged 45 years was diagnosed and treated for Right Supra Spinatus tear on 03/09/2018 at KEM Hospital and Seth Gordhandas Sunderdas Medical College, Mumbai and discharged on 06/09/2018. The RI rejected the claim stating that claim has been preferred in the 2nd year of the policy and since it has a 2 year waiting period, claim was not paid as per the policy terms and conditions.

After the claim documents were submitted to the RI for reimbursement for an amount of Rs.71,000/-, the RI has rejected the claim on the grounds that the claim has been lodged in the 2nd year of the policy and such claim is payable only after 2 years of continuous coverage.

Contentions of the Respondent Insurer (RI):

The RI has replied that they have rejected the claim vide their letter dated 20/10/2018 on the grounds that from the medical records, there is no history of trauma. The insured patient has undergone treatment for non-traumatic disease related to the ligament which is lodged during the second year of the policy.

The RI has rejected the claim as per ***Clause 3(ii)*** – waiting period which states – *"the company is not liable to make any payment in respect of any expense incurred by the insured person for treatment of the above mentioned disease during the first two years of continuous operation of the insurance cover."*

*As per Waiting Period No.3 (ii) (d) of the policy, "**A waiting period of 24 consecutive months** of continuous coverage from the inception of this policy will apply to the following specified ailments / illness / diseases: All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, **Bones and Joint including Arthroscopy and Arthroplasty** / Joint Replacement (other than caused by accident)."*

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **22/01/2021 (Online)** both the parties reiterated their respective stand.

The dispute here can be resolved by getting cause of the ailment. Liability of the RI can arise only if the ailment is proved to be accidental in view of the exclusion clause mentioned above. Following are the observations, after scrutiny of claim papers, the discussions during the hearing and relative search taken by the forum.

- The insured patient was admitted at the hospital for undergoing treatment of Right Supra Spinatus tear on 03/09/2018 at KEM Hospital and Seth Gordhandas Sunderdas Medical College, Mumbai with complaint of pain over Rt shoulder and difficulty in movement and was discharged on 06/09/2018;
- As per the Diagnosis sheet, it is mentioned that there is no history of direct injury / fall to the insured patient but follow-up treatment chart reveals that Arthroscopic repair done and closed in layers;
- The pre-operative assessment sheet shows the notings in the column of '*Present Complaints: c/o pain over R shoulder since 6 months. Difficulty in movement'.* There is no mention of any accidental injury. In none of the claim documents, the accidental nature of the said ailment is revealed.
- The google search on the said ailment shows results as: *Changes in the rotator cuff that weaken it occur around the age of 30 and increase after that. Many people are unaware of these changes because they don't always cause pain. These changes can't initially be seen without a microscope, but sometimes they can show up on an MRI scan.*

In view of the fact of accidental injury not getting established, the ailment attracts 24 months waiting period. The policy was running only for 19 months approximately. It is therefore observed that the rejection of the claim is in order and done as per the policy terms and conditions.

Complaint is disallowed. Award follows:

AWARD

Under the facts and circumstances, it is found that the decision of repudiation of claim needs no intervention. Complaint therefore stands dismissed.

Dated: at Pune this 19th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN –VINAY SAH
CASE OF Mahesh Dashrath Shinde V/s. Star Health and Allied Insurance Co. Ltd
COMPLAINT NO: PUN-H-044-2021-0516
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Dr. Mahesh Dashrath Shinde, Navi Mumbai
2.	Policy No: Type of Policy:	P/17116/01/2021/006470 Corona Rakshak Policy
3.	Policy period:	02/09/2020 to 14/06/2021
4.	Sum Insured	Rs.2,50,000/-
5.	Date of inception of first policy:	30/10/2020
6.	Name of the Policyholder:	Dr. Mahesh Shinde, Age 34
7.	Name of the Insurer:	Star Health and Allied Insurance Company Ltd.
8.	Reason for repudiation/Partial Settlement:	Rejected as vital parameters were stable and hence hospitalization not justified
9.	Date of receipt of the Complaint:	08/02/2021
10.	Nature of complaint:	Total Repudiation of covid claim
11.	Amount of Claim:	Rs.2,50,000/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the	Rule 13 1(b)

	Complaint was registered:	
13.	Date of hearing/Place:	30/3/2021 **(Online)**
14.	Representation at the hearing	
	w) For the Complainant:	Complainant himself
	x) For the insurer:	Dr. Smita Sonawane
15.	Complaint how disposed:	Dismissed
16.	Date of Award:	19/04/2021

Contentions of the Complainant:

The Complainant is a Doctor by profession, took Corona Rakshak Policy with Respondent Insurer (hereafter is called RI) for himself for SI Rs.250000/- for the period 02/09/2020 to 14/06/2021. The complainant was having fever of 101 degree since the last 3 days. So he consulted another Doctor, Dr. Sonawane and was advised for hospitalization. Accordingly, the complainant got himself admitted in Reliance Hospital Mandake Foundation, Mumbai on 30/10/2020 and was discharged on 05/11/2020. The complainant was administered Inj. Paracetamol (neomal) through IV. As a result, his fever came in control on the date of admission only i.e. on 30th October, 2020. However, RI has rejected the claim stating that the vital signs of the complainant were within the normal limits and that the patient required only Self isolation through home quarantine.

Contentions of the Respondent:

The RI, in their SCN have contended that they had rejected the claim on the grounds that as per medical records, the insured patient is afebrile, vital signs are stable and saturation is maintained in room air; the Investigation Reports are within normal limits and hence as per the guidelines of All India Institute of Medical Sciences, New Delhi, the patient needs only self-isolation by home quarantine and not hospitalization. The claim was denied as per Condition No.6 of the policy, which is reproduced hereunder:

RI has rejected the claim as per the guidelines from All India Medical Sciences, New Delhi and Ministry of Family Health and Family Welfare, Government of India regarding the treatment of COVID 19 patients, the patients with SpO2 level greater than 94% on room air and respiratory rate lesser than 24/min are having only MILD INFECTION. The patient with mild infection are prescribed Home Isolation only. Instead, here the patient is admitted and treated, which is not warranted. Hence, the claim was repudiated vide their letter dated 18/12/2020 and informed to the insured accordingly.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **30/03/2021 (Online)** both the parties reiterated their respective stand.

From the available documents and deliberations had with both the parties during the hearing, forum has following observations:

- Form VI-A is not submitted by the complainant.

- During the hearing also, the RI has contended that the complainant was not having any co-morbidities. His vitals were normal. Home quarantine was sufficient in his case.
- The complainant was asked why he was required to get admitted when the other health parameters were normal, he said, the fever etc. is seen normal in the IPD sheet because, he himself being a doctor by profession, used to take medicines, as and when he found his temperature was rising. This implies that self medication was possible and the situation was under his control and he could have managed himself at home also. Contrary to this, it is observed from the hospital's '*Nursing initial assessment'* form dt.30/10/2020, that it is clearly mentioned therein that ***'Instructed not to administer own medicines unless prescribed.'*** As per this form, it gets established that he has violated the instructions.
- His condition was not at all critical. As such, it is not understood why the Remdesivir injection was required to be administered to him. Forum did not get satisfactory replies regarding this from him. He said, he doesn't know why it was administered. Being a doctor, he should have knowledge of this, as he was self medicating also.
- The certificate submitted stating the need for hospitalization, is not signed by the treating doctor but signed as: '*for Dr. Sandeep Sonawane*.' It does not carry any rubber stamp of the said hospital/ the doctor. Hence, this certificate cannot be treated as an authentic certificate.
- The AIMMS guidelines do not support the admission of the patient in the hospital based on the prevailing health parameters.

The policy benefit wordings are as quoted below:

'Benefit: If during the period of insurance, the insured person is diagnosed with Covid positive requiring hospitalization for minimum continuous period of 72 hours, following medical advice of a duly qualified medical practitioner as per the norms specified by ministry of health & family welfare, Govt. of India, then the Company will pay the lumpsum benefit equal to 100% of sum insured opted.'

As per this clause, the benefit is payable if following two conditions get fulfilled viz.

i. The insured person should be diagnosed with Covid positive and

ii. He requires hospitalization as per the specified norms.

From the above discussions and the documents, it is observed that the requirement of hospitalization is not established beyond doubt in this case. Hence, forum is not of the view to consider the complaint favourably and did not find it necessary to intervene in the rejection of the claim.

Complaint is thus disallowed.

Award follows:

AWARD

Under the facts and circumstances, it is observed that need of hospitalization did not establish. Complaint therefore stands dismissed.

Dated: at Pune on 19th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF MR. MUKESH K. MEHTA V/S THE ORIENTAL INSURANCE COMPANY LTD.
COMPLAINT NO: PUN-H-050-1920-0132
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Mukesh M. Mehta Lakshmi Sadan, Gopal Nagar No.2, 3rd floor, Room No.14, Dombivili (E), 421201 Thane (M.S.)
2.	Policy No: Type of Policy:	121700/48/2018/2921 Happy Family Floater – 2015: **PLAN SILVER**
3.	Policy period:	19/06/2017 to 18/06/2018
4.	Sum Insured/IDV	Rs.3 lakhs
5.	Date of inception of first policy:	19/06/2011
6.	Name & age of the Insured: Name of the Policyholder:	Mr. Mukesh K. Mehta – Age: 59 years Mr. Yash M. Mehta
7.	Name of the Insurer:	THE ORIENTAL INSURANCE COMPANY LTD.
8.	Reason for repudiation/Partial Settlement:	Claim has been settled as per Reasonable & Customary clause
9.	Date of receipt of the Complaint:	03/06/2019
10.	Nature of complaint:	Partial repudiation of health claim **(cataract)**
11.	Amount of Claim:	Rs.23,779/-
12.	Rule of IO Rule under which the	13(1)(b)

	Complaint was registered:	
13.	Date of hearing/Place:	**29/01/2021 (Online)**
14.	Representation at the hearing	
	y) For the Complainant:	Mr. Yash Mehta (S/O Complainant)
	z) For the insurer:	Mr. Pravin Pashte
15.	Complaint how disposed:	Allowed
16.	Date of Award:	22/03/2021

Contentions of the Complainant:

Complainant and his family were insured with RI vide above policy for the period 19/06/2017 to 18/06/2018 for SI of Rs.3 lakhs. He was admitted in Anil Eye Hospital, Dombivili on 12/03/2018 for treatment of cataract of left eye and after treatment he was discharged on the same day. Reimbursement claim for Rs.47,779/- was lodged with the RI but RI has settled the claim for only Rs.24,000/- and have deducted Rs.23,779/- towards reasonable and customary clause of the policy.

Consequent to part settlement of the instant claim, insured has approached the Grievance Cell of the RI for reconsideration of his balance claim but they have they have not responded to his request. Further, he has also lodged an RTI application for informing him the reasons and also the fact that earlier in 2016, the RI has settled his cataract operation claim of right eye by deducting only 10% co-pay and paid Rs. 37433/-. He contends that no sub limit for cataract or any other procedure is mentioned in the policy. The RI has also not sent him the necessary information. Aggrieved with this situation, complainant has approached the forum for resolution.

Contention of Respondent Insurer (RI):

RI has issued Policy No. 121700/48/2018/2921 which is a Happy Family Floater – 2015 Policy for the period 19/06/2017 to 18/06/2018 for a sum insured of Rs.3 lakhs. They have settled the cataract claim partially amounting to Rs.24,000/-. The details as per the assessment sheet is that the hospital bill was for Rs.47,779/- out of which Rs.26,667/- was paid by deducting Rs.21,112/- a reasonable and customary charges and 10% towards co-pay.

The deductions are on account of Clause 3.41 of the policy terms and condition, which is reproduced hereunder:

Clause 3.41 – Reasonable and Customary charges – "means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved".

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 29/01/2021 **(Online)**, both the parties reiterated their respective stand.

From the available documents it is noted that:

1. The policy does not have any capping for cataract surgery.
2. RI has provided comparative rates of 4 hospitals as below, which they say are tertiary care hospitals and conduct the same surgery with same facilities.

   a) Om hospital Rs. 20,000/-

   b) R R hospital unit of Kagzi hospital Rs. 20,000/-

   c) Apex hospital Dombivli Rs. 18,000/-

   d) Arogyam Multispeciality Hospital ICCU Rs. 18,000/-

But, as these are not provided on letterheads of concerned hospitals, Forum cannot accept it.

3. RI has not produced any proof showing any communication made with the complainant of information being given for the ceiling they have decided for cataract claims.

In view of this, to arrive at the certain amount, forum would like to refer the recent health guidelines issued by IRDAI wherein for Catatract Treatment**,** they have suggested maximum Rs40000/-. In view of this, as the expenses are more than this amount, forum considers the claim can be settled for this amount even after considering 10% co-pay.

As RI has already paid Rs.24,000/-, the balance amount payable =Rs.16000/-

Complaint allowed.

Award follows,

AWARD

Under the facts and circumstances of the case, the Respondent Insurer is directed to pay to the complainant Rs.16,000/- towards the full and final settlement of this complaint.

The award is to be complied with one month from the date of receipt of this award failing which it will attract interest at the applicable bank rate plus 2%extra from the date of rejection of claim till the date of payment of this award.

Dated: On 9th of April, 2021 at Pune

VINAY SAH
INSURANCE OMBUDSMAN, PUNE

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF Shri Narendra Narayan Singh v/s The United India Insurance Company Limited

COMPLAINT PUN-H-51-/19-20/0344

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Shri Narendra Narayan Singh, B-708, Progressive Celebrity,Plot No.71, Sector -15, CBD Belapur, Navi Mumbai Maharashtra-400614
2.	Policy No: Type of Policy:	0306002817P113361706, 0306002818P111681097 Super Top up Medical Care Policy.
3.	Policy period:	21/12/2017 to 20/12/2018 21/12/2018 to 20/12/2019
4.	Sum Insured/IDV	Rs.7,00,000/- Threshold Limit Rs.3,00,000/-
5.	Date of inception of first policy:	21/12/2010
6.	Name & age of the Insured: Name of the Policyholder:	Shri Narendra Narayan Singh, 72 Years. Shri Narendra Narayan Singh
7.	Name of the Insurer:	United India Insurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Repudiated the claim as not covered despite approving first course of medication.
9.	Date of receipt of the Complaint:	31/07/2019 at Mumbai
10.	Nature of complaint:	Nonpayment of claim for cancer treatment.
11.	Amount of Claim:	Rs.6,47,266/-
12.	Rule of IO Rule under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	24/03/2021
14.	Representation at the hearing	
	For the Complainant:	Mr. Mayank Singh-son of complainant
	For the insurer:	Ms. Lipika Das
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

The Complainant was a policy holder of Base Policy of National Insurance Company Limited 100200/50/17/10001834 and Top up Policy No. 0306002817P113361706, and 0306002818P111681097 with RI. He was suffering from Renal Urothelial Carcinoma (Cancer). The first occurrence of the disease was October 5th 2017. He entered treatment under Dr. Amol Kumar Patil, Mumbai from 05/10/2017 to 30/10/2017 requiring hospitalization and surgery to remove the diseased kidney. Thereafter he was declared disease free. Then he again started experiencing negative health issues. So follow up PET scan was performed. He was diagnosed with relapse of the disease which had fast progressed to stage 4 Renal Urothelial Carcinoma and advised to get under the care of oncologist. Chemotherapy under day care was

commenced and first dose was given but due to sharp adverse reaction it was discontinued. Alternatively Immunotherapy is the second line of treatment for past two years. The First claim was paid by the United India. But subsequent claims were rejected on recommendations of VIPUL TPA.

Complainant was annoyed with the attitude of TPA VIPUL and United India Insurance Company Limited. According to him even after having continuous base policy for more than 20 years and Top up Policy for 8 years if his genuine claim was not honored, then what is covered in the policy?. He urged to settle the claim with Interest and claimed damages for mental and financial harassment.

Contention of the R I Company:

In their SCN, RI have stated that no claim has been rejected by them on the ground of 'Non approval of the drug ATEZOLIZUMAB' as mentioned in the letter by the insured. They have submitted a list of paid claims under the said policy. RI has contended that the cashless claim was rejected, but.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 24/03/2021 (through video-conferencing), the complainant reiterated his contention. Whereas, the RI conveyed that cashless claim was rejected but thereafter the complainant did not submit the claim under re-imbursement.

- Base Policy was with National Insurance Company. The claims upto their limit stand settled. Under Top up Policy with United India Insurance Company, first claim was settled and subsequent claims were denied.
- Patient is in 4th Stage of Renal Urothelial Carcinoma (Cancer).
- During the hearing, RI conveyed that they are still ready to consider both of the claims on submission of all original claim papers.

Hence, by allowing the complaint, award follows:

AWARD

Under the facts and circumstances, the RI is directed to settle the unpaid claims of the complainant for which the present complaint is filed, upto the available sum insured of the respective policy year.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 22nd day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF Mr Naresh Kathe v/s Star Health and Allied Insurance Company Limited
COMPLAINT NO: PUN-H-044-1920-0133
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Naresh Kathe, 1st Floor, Prakash Niwas, Dombivali(w) Kalyan –Dombivali M. Corporation, Pin 421202, Thane.
2.	Policy No: Type of Policy:	P/171117/01/2018/011751 Mediclassic Individual Insurance Policy
3.	Policy period:	31/10/2017 to 30/10/2018
4.	Sum Insured/IDV	Rs.4,00,000/-
5.	Date of inception of first policy:	31/10/2015
6.	Name & age of the Insured: Name of the Policyholder:	Mrs Sulochana Prakash Kathe Age 51 years Mrs Sulochana Prakash Kathe
7.	Name of the Insurer:	Star Health and allied Insurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Rejection on preexisting medical conditions
9.	Date of receipt of the Complaint:	31/05/2019
10.	Nature of complaint:	Total repudiation of claim-on PED basis
11.	Amount of Claim:	Rs.3,15,849
12.	Rule of IO Rule under which the Complaint was registered:	13 1 (b)
13.	Date of hearing/Place:	22/01/2021 Online
14.	Representation at the hearing	
	aa) For the Complainant:	Mr. Naresh Kathe
	bb) For the insurer:	Dr.Anjali Rathod
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Mrs.Sulochana Prakash Kathe had availed Mediclassic Individual Policy through R I Company's Dombivali branch for Rs.4,00,000/- since 31/10/2015 and policy was running in 3rd year at the time of her hospitalization. She was admitted in Sparsh Hospital in Dombivali on 09/09/2018 and died in the hospital on 18/09/2018. Cause of death was 'aspirated Pneumonia with multiple organ failure associated with Hypertension with COPD'. Her son Mr. Naresh Kathe preferred a claim with R I Company, which was repudiated by the company on 29/10/2018 stating the reason that the policy was running in 3rd year and the preexisting diseases are not covered until completion of 48 months.

Being aggrieved complainant stated that her mother was not having any preexisting medical conditions and requested to R I Company to settle the claim for full amount of Rs. Rs.3,15,849/- but his request was turned down by the R I Company. Hence he has approached to the Forum for solving his issue.

Contentions of Respondent Insurer (RI):

R I , in their SCN have contended that the treatment of the patient insured was for Thalamic Bleed which is a complication of the PED of Hypertension (HTN). She was suffering from HTN prior to the inception of the policy. This was evidenced through the findings of indoor case record, discharge summary of the treating hospital and ECHO report dated 9/9/18. As per ECHO report, the insured had the concentric lt. ventricular hypertrophy which confirms long standing HTN.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 22/01/2021(through video-conferencing), both the parties reiterated their respective stand.

It is observed that the rejection is done by giving the reason that HTN was her PED and her present illness was the complication of HTN, which the complainant is denying. Hence, the dispute can be resolved by getting clarity on whether the patient insured had HTN as her PED or not based on the papers submitted before this forum. On perusal of claim papers submitted by both the parties following points are noted:

1. The complainant had declared diabetes (DM) as her PED while opting for an insurance.
2. RI's contention is that that the 2D ECHO report is suggestive of long-standing HTN. This assumption cannot be taken as a proof of PED as the report is merely suggestive.
3. There is mention in ICP about the pt. being a k/c/o HTN. Also, a certificate given by treating doctor, Dr. Rupali Bhingare that the pt. was under her treatment for HTN & DM since 1½ years. Still it doesn't go to prove that HTN was existing before the commencement of policy and when the diabetes is declared at the time of taking policy, it does not make sense that HTN will not be declared.

In view of the no substantial proof for establishing the fact of PED nature of HTN, the complaint is entertainable. RI in their SCN, have mentioned that maximum quantum of liability under the terms of the policy shall be Rs. 2,73,999/-.

Award is passed accordingly:

AWARD

Under the facts and circumstances of the case, the Respondent Insurer is directed to pay to the complainant Rs. 2,73,999/- towards the full and final settlement of this complaint.

The award is to be complied with one month from the date of receipt of this award failing which it will attract interest at the applicable bank rate plus 2% extra from the date of rejection of claim till the date of payment of this award.

Dated: On 22nd day of April, 2021 at Pune

VINAY SAH
INSURANCE OMBUDSMAN, PUNE

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF Mr.Nauzer P Batha v/s Max Bupa Health Insurance Company Limited
COMPLAINT NO: PUN/ H/031/1920/0099
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Nauzer Batha & Pinky Batha, New Salisbury Park Road, Pune-411037.
2.	Policy No: Type of Policy:	30795829201800 Health Companion Policy.
3.	Policy period:	09/08/2018 to 08/08/2019
4.	Sum Insured/IDV	Rs.10,00,000/-
5.	Date of inception of first policy:	09/08/2018 but continuity of earlier TATA AIG policy has been given since 2012.
6.	Name & age of the Insured: Name of the Policyholder:	Mr. Nauzer Batha 60 years Mr. Nauzer Batha
7.	Name of the Insurer:	Max Bupa Health Insurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Non-disclosure of material facts.
9.	Date of receipt of the Complaint:	03/06/2019
10.	Nature of complaint:	Repudiation of claim in total
11.	Amount of Claim:	Rs.61610/-
12.	Rule of IO Rule under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	22/01/2021 online
14.	Representation at the hearing	

	cc) For the Complainant:	Mrs. Pinky Batha
	dd) For the insurer:	Ms. Shital Patwa
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Complainant had purchased a Max Bupa Policy on 09/08/2018. Prior to that he had policies with Tata AIG since 2012 to 2017 without claim and without break. Porting facility had been completed and porting benefits were granted. Before porting Max Bupa team visited the complainant's house and conducted all the medical checkup. In the February 2019 he was admitted in Ruby Hospital in emergency for bad attack of vertigo. Cashless facility was requested but it was denied on 11/02/2019 as per clause 6.15 Hospitalization is not justified. He was told that first settle the Hospital Bill and then the same will be reimbursed. He submitted the bill for reimbursement on 01/03/2019 but it was also denied on 04/04/2019 after one month's time. The reason given was 'non-disclosure of material facts of past ailment of Hypothyroidism for last 10 years'.

Being aggrieved, the complainant approached Max Bupa Grievance Cell and requested for reconsideration. But the request was turned down by them and the policy was also cancelled. Then he approached ombudsman office for the justice. He further contended that he has informed the Max Bupa Medical team about his past ailment of Hypothyroidism but the team answered that it is now not necessary. They further say that it is not a disease but the hormonal disorder. He informed his agent too about this but he also advised him that is not required. He requested the company that he has no intention to hide any past history and ready to give additional premium to cover this ailment but don't cancel the policy. This request was also turned down.

Contentions of Respondent Insurer (RI):

In the SCN, they have contended that they denied the cashless claim for admission in Ruby Hall clinic on 10/02/2019 stating the reason that the hospitalization was not justified as the patient was admitted solely for physiotherapy, evaluation and investigations purpose only.

Thereafter, a claim bearing no.406334 was filed for settlement of expenses of Rs.61610/-for admission from 10/02/19 to 13/02/19. From the claim papers they found that the patient insured was suffering from hypothyroidism since 10 years, which was not disclosed while opting for insurance. Hence, under non-disclosure, the claim was denied and the policy was also cancelled.

Result of personal hearing with both the parties (Observations & Conclusions):

During the online hearing held on 22/01/2021, both the parties reiterated their contentions.

It is observed that the said policy is ported from TATA AIG and the continuity has been renewed since 2012. Complainant had no intention to hide any past history. In view of this, forum suggested the RI to consider the claim and reinstate the policy. RI representative agreed to settle it for Rs.59210/- and she showed her readiness to reinstate the policy with all the continuity benefits. Complainant agreed to pay the premium for the lapsed period.

Thus, complaint is allowed. Award follows:

AWARD

Under the facts and circumstances of the case, the Respondent Insurer is directed to pay to the complainant Rs. 59210/- and to reinstate the policy for both the complainants with all the continuity benefits by collecting requisite premium for the lapsed period, towards full and final settlement of this complaint.

The award is to be complied with one month from the date of receipt of this award failing which it will attract interest at the applicable bank rate plus 2%extra from the date of rejection of claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: On 19th day of April, 2021 at Pune

VINAY SAH
INSURANCE OMBUDSMAN, PUNE

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/ 17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Mr Nileshkumar S Kadam V/S Manipal Cigna Health Ins. Co Ltd
COMPLAINT NO: PUN-H-035-2021-0368
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr Nileshkumar S Kadam Kalyan (w)
2.	Policy No: Type of Policy:	PROHLR200006211 Prohealth protect (family Floater)
3.	Policy period:	13.08.2020 to 12.08.2021
4.	Sum Insured	Rs. 550000
5.	Date of inception of first policy:	06.07.2017
6.	Name of the Insured: Name of the Policyholder:	Dr Varsha Nileshkumar Kadam 35 yrs Wife Mr Nileshkumar S Kadam
7.	Name of the Insurer:	Manipal Cigna health Ins co ltd
8.	Reason for repudiation/Partial Settlement:	Partial settlement
9.	Date of receipt of the Complaint:	31.12.2020
10.	Nature of complaint:	Partial claim rejected

11.	Amount of Claim:	Rs. 119601
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28.01.2021; Online
14.	Representation at the hearing	
	ee) For the Complainant:	Himself
	ff) For the insurer:	Ms.Shweta Nair; Jaswindersingh Shekhawat; Dr.Rahul Patil
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:-

The complainant had taken a policy from Manipal Cigna Ins. co Ltd for entire family under prohealth–protect (family floater) for SI 550000 for the period from 13.08.2020 to 12.08.2021. His wife Dr Varsha Kadam was admitted in Shwas multispecialty hospital from 08.10.2020 to 13.10.2020 for covid 19. Total amount of the bill came to 156193/- and company settled it for Rs.36592/-

He contends that his wife's brother who was admitted in the same hospital for Covid and was discharged with her only, got reimbursement from Bajaj alliance with only co-pay deduction.

Aggrieved with the short settlement of the claim complainant has asked the forum to intervene and settle the entire claim amount.

Contentions of the Respondent Insurer(RI):-

As per the SCN submitted, they have contended that;

Covid 19 is a new illness with no established protocol and standardized treatment costs. In order to allay the fears of all insurance policyholders and to bring complete clarity and transparency in the treatment of covid 19 claims, the GI council in discussion with expert medical professionals has brought about a schedule of rates for covid 19 claims.

After due scrutiny of the claim documents, the Company settled the claim of the Complainants as per the policy terms and conditions and after making deductions in accordance with the ceiling provided by GIC (Annexure E). Hence, Rs. 34850 towards the hospitalization expenses along with Rs. 1742 (5% for the dependant) was paid to the Complainant through NEFT 120901761GN00009 on 10th December, 2020. Rs. 3098 towards non-medical expenses were deducted as per the terms and conditions of the policy. Further, Rs. 59550 in excess of GIC rates were deducted.

Total amount settled by company	36592
Deducted, Mask, caps, sheet etc.	3098
Misc charges	300
Policy excess deductible (excess of GIC package)	59550

Result of personal hearing with both the parties (Observations & Conclusions):

During the hearing held on 28/01/2021 online both the parties reiterated their respective contentions.

After hearing contentions of both the parties and claim papers submitted on record, the forum has following observations:

1. The tariff given by GI council is not circulated amongst the policy holders nor was the complainant made aware of it at the time of claim intimation.
2. The GI tariff was expected to be reviewed after certain intervals, which never happened after its meeting subsequent to which the referred circular was issued. It does not match with the actual expenses the insured public is spending on covid treatment.
3. As per IRDAI guidelines, the covid claims are to be assessed as per respective policy terms and conditions. The policy does not have any ceiling on any specific head. There is no objection raised by RI on the grounds of reasonability of the bill charged.

In view of this, the revised payable amount is assessed by the forum, as the heavy deductions made by RI applying the GI package rates is not practical, because those rates are not at all matching with the actual rates being charged by the hospitals.

Amount of claim	156193
Less Non payable items	3098
Misc. charges	300
Total amount paid by RI	36592
Balance amount payable	116203

Complaint allowed. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 1,16,203/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF Mr.Pawankumar V Lal v/s Star Health and Allied Insurance Company Limited

COMPLAINT NO: PUN-H-044-1920-0070

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr.Pawankumar V Lal, Quarter No G-30/B, Ajani, Nagpur-440003, Maharashtra.
2.	Policy No: Type of Policy:	P/151116/01/2019/002097 Family Health Optima Insurance-2017
3.	Policy period:	26/06/2018 to 25/06/2019
4.	Sum Insured/IDV	Rs.3,00,000/-
5.	Date of inception of first policy:	28/04/2014
6.	Name & age of the Insured: Name of the Policyholder:	Mr.Pawankumar V Lal Mr.Pawankumar V Lal
7.	Name of the Insurer:	Star Health & Allied Insurance Company Ltd.
8.	Reason for repudiation/Partial Settlement:	Claim documents are fabricated for claim purpose which amount to misrepresentation. Hence the claim is repudiated.
9.	Date of receipt of the Complaint:	21/05/2019
10.	Nature of complaint:	Total rejection of the claim.
11.	Amount of Claim:	1,56,218/-
12.	Rule of IO Rule under which the Complaint was registered:	13 (1)(b)
13.	Date of hearing/Place:	18/01/2021
14.	Representation at the hearing	
	gg) For the Complainant:	Mr. Pawankumar V Lal on voice call
	hh) For the insurer:	Dr. Anjali Rathod
15.	Complaint how disposed:	Disallowed

Contentions of the Complainant:

Mr. Pawankmar had taken a Mediclaim Policy from Star Health and Allied Insurance Company bearing No. P/151116/01/2019/002097. He was admitted at Shree Vighnaharta Hospital, Nagpur from 27/07/2018 to 14/08/2018 for treatment for Accute Viral Hepatitis. Star Health and Allied Insurance Company Limited (RI) had appointed an investigator to find out the details of the case. Based on his report RI Company has repudiated the claim with reason that indoor patient was absconding for two days from hospital and claim is fabricated hence rejected.

Complainant says that the above report is not correct and he was present in the hospital from 27/07/2018 to 14/08/2018. Clarification letter from the hospital is submitted to the forum. This allegation from RI Company is just to avoid the liability. Hence he approached forum for full settlement of the claim.

Contentions of Respondent Insurer (RI):

As per the SCN submitted by RI, the claim was rejected on the basis of discrepancies found in the claim papers, hospitalization period and fabrication of documents, as detailed below:

1. When their Investigator visited the hospital, they found that the patient had gone home during the hospitalization period. In support of this, they have submitted a certificate dt.2/11/21018, from the treating Dr. Shyam Meshram, who has mentioned therein that the patient Mr. Pawankumar Lal was under his treatment from 27/07/2018 to 29/07/2018, after that he went home for 2 days. Then again he was admitted to hospital from 1/8/18 to 14/8/18.
2. They have rejected the claim as per the policy condition no.6 of the policy which says, *'If there is misrepresentation from the insured person, the company is not liable to make any payment in respect of any claim.'*

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 18/01/2021 (through video-conferencing), both the parties reiterated their respective stand.

The complainant was specifically asked about the discrepancies observed in the hospitalization period and his absence noticed by the RI's representative at the hospital during his hospitalization period. He could not give satisfactory reply to this. He said, that he has given hospital's clarification letter after the objection raised by the RI.

The forum perused the claim papers submitted by the parties and noted that,

1. Hospitalization seems to be for too long a period given the nature of ailment.
2. We have treating doctor Shyam Meshram's certificate letter dated 02/11/2018 which clearly mentions that patient had gone home for 2 days and then re-admitted on 01/08/2018.
3. The clarification letter, subsequently submitted by the complainant, though signed by Dr. Shyam Meshram, does not show it as written by him as the wording of it sounds by a third person e.g. *'Mr.Pawan Kumar Lal ….was under treatment (indoor patient) from 27/7/18 to 14/8/18 in our hospital under Dr.Shyam Meshram..'*
   The signature of the doctor does not match with the signature in the earlier certificate dt.2/11/18.
4. The complainant did not cooperate with the investigator in giving proper information about his hospitalization period. When the investigator visited the complainant/patient at his home, patient called his agent and as per his advice, denied to share any details with investigating officer and argued with him.
5. Hospital authority was not ready to share any indoor records saying that it was already sent to Insurance Company many times.
6. There are discrepancies in the hospital bill also. The bill charged is not as per their tariff procured by the RI's investigator.

7. In multiple places on medical papers, forum observed an overwriting in dates. Entries in the ICP and TPR chart are found on the days that he was missing. Blood tests were prescribed, medicines were prescribed and purchased from the usual medical store. Hospital once issues a certificate on Dr. Meshram's letterhead that the patient had gone home for 2 days. Later another certificate again on Dr. Meshram's letterhead is issued albeit with different handwriting and different signature certifying that Shri. Pawan Lal was continuously admitted from 27/07/2018 to 14/08/2018 and that, previous certificate was incorrect due to some misunderstanding and mistake. As such, no any record and document from this hospital seem to be reliable. Forum advises RI to blacklist this hospital.

In view of the above, forum does not want to intervene in the decision of rejection of claim as fabrication of documents is evident in this case.

Complaint is thus disallowed.

Award follows:

AWARD

Under the facts and circumstances, it is found that the decision of repudiation of claim needs no intervention. Complaint therefore stands dismissed.

Dated: at Pune this 30th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Pragnesh Nagda Vs. The Oriental Insurance Company Ltd.
COMPLAINT NO: PUN-H-050-1920-0143
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Pragnesh S. Nagda 4, Janai Bldg., 1st floor, Gupte Road, Near Jain Mandir, Dombivili (W) – 421202 Thane Dist., (M.S.)
2.	Policy No: Type of Policy:	121700/48/2017/14181 Mediclaim Insurance Policy
3.	Policy period:	14/03/2017 to 13/03/2018
4.	Sum Insured/IDV	Rs.1 lakh

5.	Date of inception of first policy:	20/03/2012
6.	Name & age of the Insured: Name of the Policyholder:	Mrs. Veena S. Nagda – Age:52 years Mr. Pragnesh S. Nagda
7.	Name of the Insurer:	The Oriental Insurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	No active line of treatment availed by patient
9.	Date of receipt of the Complaint:	09/07/2019
10.	Nature of complaint:	Rejection of entire health claim
11.	Amount of Claim:	Rs.31,609/-
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	29/01/2021 **(Online)**
14.	Representation at the hearing	
	ii) For the Complainant:	Absent
	jj) For the insurer:	Mr. Pravin Pashte
15.	Complaint how disposed:	Allowed
16.	Date of Award:	22/03/2021

Contentions of the Complainant:

Complainant and his family were insured with the Respondent Insurer (RI) under the above policy for a SI of Rs.1 lakh for the period 14/03/2017 to 13/03/2018. The insured patient aged 52 years was diagnosed for benign paroxysmal positional vertigo and transient ischemic attack and admitted from 22/01/2018 to 24/01/2018 at Apex Hospital, Dombivili. The RI rejected the claim under the grounds that patient underwent diagnostic process but no active line of treatment was given to the patient and hence the claim was not payable.

The insured has submitted a certificate dated 14/07/2018 issued by the treating doctor / hospital that the patient was admitted with h/o giddiness and h/o head injury and treatment was given to her as per the symptoms and that the RIs contention that treatment was not given is baseless.

Contentions of the Respondent Insurer (RI):

The RI has replied that they have rejected the claim based on the indoor cases papers and the medical document obtained by them by invoking Policy clause 4.10 which is reproduced hereunder:

Clause 4.10 – "expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period".

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **29/01/2021 (Online)** RI representative reiterated company's stand.

It is learnt from papers submitted that the insured patient fell down on road on 20/01/2018 while walking. There was active bleeding on lt. side forehead. Stitches were put for the same. She took 2 days OPD treatment, but due to heavy vomiting and giddiness, she was admitted as in patient on 22/01/2018. MRI was done, neurologist opinion was taken. Treating doctor Dr. Jitendra Nisa has given a certificate that the patient was given active treatment as per her symptoms.

To resolve the complaint, it is to be seen whether the policy clause is correctly applied in this case or not. As per the clause 4.10 quoted above, the claim is not payable if the expenses incurred on diagnostic purposes are not followed by active treatment. In view of this, on examining the discharge summary, it is observed that the patient was diagnosed with benign paroxysmal positional vertigo and transient ischemic attack and the treatment given was tab Zifi 200 BD/ Inj PAN 40BD/ Inj Emset 4TDS/Tab Vertin 165 MG TDS. Hence, it is not correct to say that no active treatment was given during the hospitalisation.

Under the facts and circumstances, it is found that the denial of claim is not correct. During the hearing the RI, therefore was advised to convey the payable amount. Accordingly, they have informed vide their mail dt. 29/01/2021, the payable amount to be Rs.26135/-, which the forum feels is reasonable.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 26135/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune on 12th April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN– VINAY SAH

CASE OF Mr & Mrs Pravin and Maithili Bartakke V/S Cholamandalam Gen Ins. Co Ltd

COMPLAINT NO: PUN-H-012-2021-0359

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainants	Mr Praveen Bartakke Mrs Maithili Bartakke Satara
2.	Policy No: Type of Policy:	2894/00032026/000/00 Corona Rakshak Policy,Chola.
3.	Policy period:	18.08.2020 to 30.11.2020
4.	Sum Insured	Rs. 150000 +150000
5.	Date of inception of first policy:	18.08.2020
6.	Name and age of the Insured: Name of the Policyholder:	Mrs Maithili Bartakke,43 yrs Mr. Praveen Bartakke
7.	Name of the Insurer:	Cholamandalam Gen Ins co Ltd
8.	Reason for repudiation/Partial Settlement:	Rejection of claim(within waiting period) Waiting period 18.08.2020 to 01.09.2020
9.	Date of receipt of the Complaint:	23.2.2020
10.	Nature of complaint:	Claim rejected
11.	Amount of Claim:	Rs.1,50,000/- each
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28/01/2021; Online
14.	Representation at the hearing	
	kk) For the Complainant:	Mr & Mrs. Bartakke
	ll) For the insurer:	Mr. Rushabh; Dr. Minal Vinoth
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

The complainants Maithili and Praveen Bartakke had taken Cororna Rakshak policy from Cholamandalam Gen Ins. Co Ltd for SA 150000 each on 18.08.2020. Both were detected Covid 19 positive. Symptoms started on 02.09.2020. Due to non availability of beds in their locality, they got admitted on 04.09.2020. Claim was rejected on the basis that the diagnosis was within 15 days of effective date of first health insurance policy under Chola MS Covid 19 cover Group Policy

The complainants have approached the forum for settlement of full claim amount.

Contentions of the Respondent Insurer (RI):

As per rejection letter as well as their SCN, the reason given for rejection is:
Present ailment is diagnosed within first fifteen days of inception of policy. Hence claim is inadmissible.

Result of personal hearing with both the parties (Observations & Conclusions):

An online hearing was held on 28/01/2021 which was attended by both the parties. RI representatives contended that both the insureds had signs and symptoms within 15 days waiting period. Hence, the claim is not admissible.

The concerned clause in the policy says,

'The Company shall not be liable for any claim arising under the policy within 15 days from the first policy commencement date with us.'

Forum observes that the clause does not say anything about signs and symptoms within 15 days. In this case, neither the disease was diagnosed nor the claim had arisen within 15 days.

On perusal of the claim papers forum has following observations.

As per the policy issue date, the 15 days waiting period gets over on 1/9/2020. Both of them were admitted on 4/9/2020.

The RI has not detailed how the ailment falls in 15 days waiting period. As per discharge summary, the duration written on the date of admission 04/09/2020, as '2 days', which goes back to 02/09/2020. Their positive test is also of the date 02/09/2020. Waiting period written on the policy as: *'18/08/2020 to 01/09/2020.'*

Besides that, the complainants are fulfilling both the criteria of admissibility of claims, which are:

i. Having detected as covid positive and
ii. No objection of RI on requirement of hospitalization for more than 72 hours.

In view of this, claims are admissible. The payable amounts in both the cases is Rs.1,50,000/- each in both the cases.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.1,50,000/-to each complainant towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune, this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Mr Pravin Jadhav V/S New India Assurance Co Ltd
COMPLAINT NO: PUN-H-049-2021-0358
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr Pravin Ramchandra Jadhav Pune
2.	Policy No: Type of Policy:	151700/34/19/27/00000027 New India Asha Kiran Policy
3.	Policy period:	25.09.2019 to 24.09.2020
4.	Sum Insured	200000
5.	Date of inception of first policy:	25.09.2017
6.	Name of the Insured: Name of the Policyholder:	Mrs. Archana Pravin Jadhav,38 yrs wife Pravin Ramchandra Jadhav
7.	Name of the Insurer:	The New India Assurance Co Ltd
8.	Reason for repudiation/Partial Settlement:	Repudiation
9.	Date of receipt of the Complaint:	29.12.2020
10.	Nature of complaint:	Claim rejected- Allopathic treatment by BAMS doctor hence claim not payable
11.	Amount of Claim:	99802
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28/01/2021; Online
14.	Representation at the hearing	
	mm) For the Complainant:	Himself
	nn) For the insurer:	Umeshchandra Upadhyay
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:-

The complainant Shri Pravin Jadhav had taken a policy for self and his family from New India Assurance Ltd from 25.09.2019 to 24.09.2020 for Sum Insured of Rs.200000/- under New India Asha Kiran Policy.

His wife Mrs Archana Pravin Jadhav was diagnosed with Covid 19 with lower Zone Pneumonia and was hospitalized in Ayurved Rugnalay-Sane guruji Arogya Kendra from 18.09.2020 to 26.09.2020.The complainant submitted the bill of Rs 99802 for settlement of claim

The insurance company declined the claim for reason,

Patient had taken Allopathic treatment from BAMS doctor hence as per definition of medical practitioner claim is not payable as per policy term and conditions, hence repudiated.

The complainant has contended that he had tried availability of Covid beds in different hospitals in Pune from 16h Sept 2020 to 18th Sept 2020 (Noble, Sahyadri Hospital), but due to non-availability of bed and patient's critical conditions, he had admitted her in Auyurved Rugnalaya without knowing the degree of the Doctor.

He has also enclosed document of the hospital-Government GR for allowing the hospital to give Allopathic treatment.

Contentions of the Respondent Insurer (RI):-

The SCN not received.

Result of personal hearing with both the parties (Observations & Conclusions):

During the online hearing on 28.01.2021, both the parties reiterated their contentions.

On perusal/scrutiny of above mentioned claim documents the company regretted the claim based on patient had taken Allopathic treatment from BAMS doctor. As per definition of Medical practitioner in their policy, the claim is not payable as per terms and conditions of the policy.

Clause 2.24: *MEDICAL PRACTITIONER means person who holds valid registration from the Medical council of any state or Medical council of India for Medicine or Homeopathy set up by the Govt. of India and is acting within the scope and jurisdiction of his licence.*

In view of this definition, as mentioned in the policy and Maharashtra Govt's notification dt.25/11/1992 the BAMS doctor is also eligible to practice the modern system of medicine which is known as allopathic system of medicine to the extent of training they received in that system.

If RI had objection for his treatment, they should have established that the said doctor had not received sufficient training to practice allopathy.

In view of this, claim is admissible. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.99802/- less compulsory deductibles as per policy terms towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Sachin Bothara Vs. The Oriental Insurance Company Ltd.
COMPLAINT NO: PUN-H-050-1920-0086
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Sachin Shantilal Bothara B-603, Indigo Park, Sadashivnagar, Govindnagar Link Road, Nashik - 422009
2.	Policy No: Type of Policy:	131201/48/2019/856 Happy Family Floater 2015 **(Diamond Plan)**
3.	Policy period:	15/09/2018 to 14/09/2019

4.	Sum Insured/IDV	Rs.12,00,000/-
5.	Date of inception of first policy:	15/09/2013
6.	Name & age of the Insured: Name of the Policyholder:	Mr. Shantilal Bothara – Age: 67 years Mr. Sachin Shantilal Bothara
7.	Name of the Insurer:	The Oriental Insurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	Claim has been settled as per Reasonable & Customary charges
9.	Date of receipt of the Complaint:	20/02/2019
10.	Nature of complaint:	Partial repudiation of health claim
11.	Amount of Claim:	Rs.30,000/-
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	22/01/2021 **(Online)**
14.	Representation at the hearing	
	oo) For the Complainant:	Himself
	pp) For the insurer:	Mr.Vipul Kachare
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Complainant and his family were insured with the Respondent Insurer (RI) under the above policy for a SI of Rs.12 lakhs for the period 15/09/2018 to 14/09/2019. The patient aged 67 years was operated for right eye cataract on 06/12/2018 at Comfort Clinic Nursing Home, Mumbai. The RI settled the claim partially stating that claim has been settled as per reasonable and customary charges clause. The insured has stated that since he has adequate sum insured under the policy, he should get the full reimbursement.

After the claim documents were submitted to the RI for reimbursement for an amount of Rs.54,201/-, the RI settled the claim for Rs.24,201/- and deducted Rs.30,000/- towards doctor's fees.

Aggrieved with this decision, the complainant has approached the forum for redressal of his grievance.

Contentions of the Respondent Insurer (RI):

RI in their SCN have contended that the claim was settled as per the GIPSA PPN Network package available in Hospital as per the agreement between GIPSA department and hospital department for the package of illness purpose. Hence, the tariff given from GIPSA are applied in this claim.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **22/01/2021 (Online)** both the parties reiterated their respective stand. From the available documents it is noted that:

1. The insured has submitted composite hospital bill comprising of Surgeon's professional fees, anesthetist fees, IOL charges amounting to Rs.38,000/-. Incidentally, the RI has

disbursed only the IOL charges and have disallowed the surgeon's fees of Rs.30,000/- and hence the difference has arisen.

2. The RI has not given any proof in support of their contention that they had informed of the GIPSA fixed rates in respect of cataract to the complainant. The same was expected to be done along with the policy document or at least on receipt of the intimation of the said planned surgery. It could have saved the complainant the extra amount he was forced to pay by the hospital.
3. It sounds from the RI's SCN that the subject hospital was listed in their PPN hospitals. In that case, they should have informed the hospital about the receipt of planned surgery of their client-insured-complainant and to restrict their expenses to the amount they have decided in the GIPSA PPN rates. RI may ask refund of amount from the hospital for extra amount charged by them to their customers/policy holders.
4. There is no capping given in the policy for cataract.

In view of this, the forum advises RI to settle the claim for a reasonable amount of Rs.50,000/-. As Rs.24,201/- is already paid, balance amount now payable will be Rs.25,799/-. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.25,799/-towards full and final settlement of the complaint.
The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 19th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN– VINAY SAH

CASE OF Sachin Sanap V/S Star Health and Allied Insurance Co. Ltd.

COMPLAINT NO: PUN-H-035-2021-356

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Shri Sachin P Sanap Amravati
2.	Policy No: Type of Policy:	P/171111/01/2021/007821 Corona Rakshak Policy
3.	Policy period:	09.08.2020 to 21.05.2021 (285 days)
4.	Sum Insured	Rs. 250000
5.	Date of inception of first policy:	09.08.2020
6.	Name of the Insured: Name of the Policyholder:	Mr Sachin Pandurang Sanap, 29 yrs self
7.	Name of the Insurer:	Star Health and Allied Ins Co Ltd
8.	Reason for repudiation/Partial Settlement:	Hospitalization not required
9.	Date of receipt of the Complaint:	31.12.2020
10.	Nature of complaint:	Settlement of full claim amount
11.	Amount of Claim:	2,50,000/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28/01/2021; Online
14.	Representation at the hearing	
	qq) For the Complainant:	Himself
	rr) For the insurer:	Dr. Anjali Rathod
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

The complainant had taken a Corona Rakshak policy from Star health and allied Ins. co ltd. For the period 09.08.2020 to 21.05.2021. He was detected Covid positive on 28.09.2020. He was admitted in Best Multispeciality Hospital from 28.09.2020 to 06.10.2020 for Diagnosis Covid 19 positive c Bilateral Pneumonia.

The company repudiated the claim stating that from the submitted records that the insured patient has only mild symptoms and has no breathing difficulty, SPO2 is maintained. They are unable to settle the claim hence repudiate the same.

He was working as District coordinator in Mahatma Jyotiba Phule Jan arogya Yojana. His job profile involves hospital visit and patient interaction considering risk of Covid 19. Hence he had opted for this special scheme from Star health

As per policy norms important parameter for claim was

1) Covid 19 positive from Govt lab
2) 72 hours hospitalization

Claim was rejected stating SPO2 level .There is no guideline of SPO2 in policy document.

Contentions of the Respondent Insurer (RI):-

As per SCN, their contention is: SPO2 level of the insured patient was 97% at the time of admission and was ranging from 96% to 98% thereafter during hospitalized period.

As per AIIMS and Govt. of India guidelines, a person having SPO2 level above 94% on room air is having only MILD INFECTION and can be treated by home isolation.

Instead, the patient is admitted and treated which is not warranted. Hence, the claim was repudiated and communicated to the insured vide letter dt. 11/12/2020.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 28/0/2021 **(through video-conferencing)**, both the parties reiterated their respective stand.

Upon hearing the contentions of both the parties and documents submitted on record, forum has following observations.

Patient has submitted a letter from Dr. Sohel Bari of Best Multispeciality Hospital dt. 20/12/2020 stating that considering his all the vital parameters and RT PCR report, clinical and physical condition, hospitalization was recommended. To avoid future clinical complications, immediately started with inj. Remdesivir, inj. Piptaz and other important medicines. The treatment was continued for 6 days as patient was gradually recovering with vital parameters.

The IPD papers show that the complainant was treated with Remdesivir every day from 29/9/20 to 4/10/20. As the administration of Remdesivir needs hospitalization, the forum finds that the hospitalization is justified. In view of this, the claim is to be considered as all other parameters of the admission of claim are fulfilled.

Amount of compensation is fixed to sum insured as this being a benefit policy. Complaint is allowed.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.2,50,000/- towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF Mr. Sanjay A Joshi v/s National Insurance Company Limited
COMPLAINT NO: PUN/H-48/1920/0138
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr Sanjay Ashokkumar Joshi, 7 Datta Niwas, Tekri Rasta, LBS Marg,3 Petrol Pump, Thane (West)
2.	Policy No: Type of Policy:	241000/50/18/10001428 Pariwar Mediclaim Policy.
3.	Policy period:	21/07/2018 to 20/07/2019
4.	Sum Insured/IDV	Rs.5,00,000/-
5.	Date of inception of first policy:	20/07/2016
6.	Name & age of the Insured: Name of the Policyholder:	Miss Jiya Sanjay Joshi, 12 years Mr Sanjay Ashokkumar Joshi
7.	Name of the Insurer:	National Insurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Correction of Squint Eye Surgery
9.	Date of receipt of the Complaint:	21/06/2019
10.	Nature of complaint:	Total rejection of the Claim

11.	Amount of Claim:	Rs.67,316/-
12.	Rule of IO Rule under which the Complaint was registered:	13 1(b)
13.	Date of hearing/Place:	29/01/2021 Online
14.	Representation at the hearing	
	ss) For the Complainant:	Mr Sanjay Ashokkumar Joshi
	tt) For the insurer:	Mr. Nitin Pole
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Complainant (along with his wife and two daughters) is a policy holder of National Insurance Company Limited Pariwar Mediclaim Policy. Complainant's daughter Jiya was suffering from Acute Non-Accommodative Acquired Esotropia since February 2018. She was operated for restoration of fusion Stereopsis in jyotirmay Eye Clinic, Thane. The procedure was done under day care due to advancement in the technique and 24 hour admission for this procedure is not required. It is not a cosmetic surgery and it is also not a congenital defect. Potential cause of the disease: Acquired defect in fusional divergence. R I Company repudiated the claim under the Policy clause No.4.6 Cosmetic Surgery for correction of squint and under the clause of 4.9 Congenital anomaly.

Complainant refuted both the charges. According to him this is not the case of Cosmetic Surgery as per Clause No.4.6 and not a congenital anomaly as depicted in R I Company's contention. To support his claim he has submitted Medical statement dated 12/06/2018 issued by Dr.Mihir Kothari who has performed this surgery. He is having few photographs of her daughter and is ready to show it in the hearing scheduled on 29/01/2021 to substantiate his claim that she was not having squint since birth. After the surgery, she started seeing normally again and no squint was observed. He claimed that his claim is admissible and may be paid by RI Company in total without further delay.

Contentions of Respondent Insurer (RI):

R I Company has submitted their SCN on 4th July 2019 and reiterated their stand of repudiation of the claim under clause No. 4.6 for Cosmetic Surgery and 4.9 for congenical anomaly but not submitted any proof or medical paper except these two clause wording.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 29/01/2021 (through video-conferencing), both the parties reiterated their respective stand.

The dispute here can be resolved by ascertaining whether it was a cosmetic surgery or a congenital anomaly or a suddenly aroused ailment. To ascertain most probable cause, forum took the web search on the subject and found following information.

'Esotropia is caused by eye misalignment (strabismus). Some people are born with esotropia. This is called congenital esotropia. The condition can also develop later in life from untreated farsightedness or other medical conditions. This is called acquired esotropia. If you are

farsighted and don't wear glasses, the constant strain on your eyes can eventually force them into a crossed position.'

Complainant in his complaint has contended that his daughter, then 13 years suddenly started seeing squint (L eye). Since it was not by birth, they consulted the specialist Dr. Kothari in this field. He suggested putting patch on R eye to strengthen the muscle of L eye for first 3 months, if not resolved then would go for surgery. She tried putting a patch as suggested by doctor but the issue was not resolved. Doctor then suggested for the surgery. These facts establish that the surgery was not for cosmetic purpose.

To establish the fact that the ailment was not since birth, he submitted her childhood photographs. On its perusal no squint is seen in those snaps. In view of this, complaint is admissible. During the hearing the RI was therefore advised to assess the claim and inform the payable amount to the forum. Accordingly, the amount as assessed by RI is as given below:

Claimed amount:	Rs.67316
Less amount disallowed:	Rs.9900
Amount payable:	Rs.57416

Complaint admitted. Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs.57,416/- to the complainant, towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF Mr.Santosh Dhide v/s The New India Assurance Company Limited

COMPLAINT NO: PUN/H-049/19-20/0090

Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Santosh Dhide, 385,Shaniwar Peth, Pune-411030
2.	Policy No: Type of Policy:	15340034182800001217 New India floater Mediclaim Policy.
3.	Policy period:	25/09/2018 to 24/09/2019
4.	Sum Insured/IDV	Rs.3,00,000/-
5.	Date of inception of first policy:	25/09/2017
6.	Name & age of the Insured: Name of the Policyholder:	Mr.Santosh Dhide, 43 years Mr.Santosh Dhide
7.	Name of the Insurer:	The New India Assurance Company Limited
8.	Reason for repudiation/Partial Settlement:	Claim falls under 2 years waiting period
9.	Date of receipt of the Complaint:	04/06/2019
10.	Nature of complaint:	Total repudiation of the claim
11.	Amount of Claim:	Rs.60,000/-
12.	Rule of IO Rule under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	22/01/2021 Online
14.	Representation at the hearing	
	uu) For the Complainant:	Mr.Santosh Dhide
	vv) For the insurer:	Ms. Sarika Patange
15.	Complaint how disposed:	Disallowed

Contentions of the Complainant:

Complainant availed New India Assurance Mediclaim Policy No. 15340034182800001217 for the period of 25/09/2018 to 24/09/2019 to cover himself and his family for Rs.3,00,000/-. Policy is running in its 2nd year. Complainant was admitted in KEM Hospital, Pune from 04/03/2019 to 06/03/2019 for B/L Sino nasal Polyposis+ Deviated nasal Septum. He approached TPA raksha prior to the admission and obtained approval for the cashless for Rs.60,000/-. Approval sheet is submitted by him. Subsequently complainant submitted the reimbursement claim which was repudiated by the R I Company.

Complainant argued that he had taken permission and approval before admission, and at that time this clause was not considered. He also contended that Agent of the RI never told him about this clause and had the permission and approval not been granted, he would have postponed the treatment. Hence he demanded that, his claim in total should be honored.

Contentions of Respondent Insurer (RI):

Claim is denied in total by R I Company with a reason that the claim is payable only after 24 months from inception and till claim date, 24 months are not completed.

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on 22/01/2021 (through video-conferencing), both the parties reiterated their respective stand.

On perusal of documents submitted and after hearing contentions of both the parties, forum has following observations:

1. From the copy of SMS dt.26/2/2019 submitted by the insured-complainant received from Raksha TPA, it is observed that it is a **provisional approval** for cashless facility. Wordings of the same are as quoted below:

   '*Dear Insured,*

   Cashless facility of Rs.60000/- is provisionally authorized to KEM Hospital, Pune with pre auth no. 9021819423724. Raksha wishes you a speedy recovery.*

   **Subject to Final bill and Discharge summary*.'

   It is thus noted that the approval was not unconditional. In view of this, RI /their TPA has kept a right to deny the claim, based on the discharge summary and final bill. It is possible because the duration of illness/ past history/ details of procedure done, etc. get revealed after receipt of discharge summary only.

2. Forum also confirmed that the **policy exclusion no. 4.3.1** states as:

   '4.3.1 Unless the insured person has continuous coverage in excess of twenty four months, expenses n treatment of the following illnesses are not payable:

   1. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.'

3. RI cannot be asked to honor the wrong cashless approval given by their TPA which is not adhering to policy terms.

4. No doubt, the complainant has suffered monetary loss and also had to face panic situation at the time of discharge. The RI and their TPA are warned to be more vigilant while issuing the cashless approvals. At the same time, the complainant also should get proper information of the policy terms and conditions before and after entering into an insurance contract.

Under the facts and circumstances, the complaint is disallowed.

Award follows:

AWARD

Under the facts and circumstances, it is found that the decision of repudiation of claim needs no intervention. Complaint therefore stands dismissed.

Dated: at Pune, this 30th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Mr. Shivam Kesarwani v/s Apollo Munich Health Insurance Co. Ltd
COMPLAINT NO: PUN-H-003-1920-0102
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Shivam Shyam Kesarwani, Thane
2.	Policy No: Type of Policy:	160400/11119/AA00930171 OPTIMA RESTORE
3.	Policy period:	19/10/2018-18/10/2019
4.	Sum Insured	RS. 300000/-
5.	Date of inception of first policy:	19/10/2018
6.	Name of the Policyholder:	Mr.Shivam Shyam Kesarwani
7.	Name of the Insurer:	Apollo Munich Health Insurance Co. ltd
8.	Reason for repudiation/Partial Settlement:	Rejected for misrepresentation and cancelled the policy
9.	Date of receipt of the Complaint:	12/6/2019
10.	Nature of complaint:	Total Rejection of claim
11.	Amount of Claim:	90654/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1(b)
13.	Date of hearing/Place:	22/01/2021; Online
14.	Representation at the hearing	
	ww) For the	Himself

	Complainant:	
	xx) For the insurer:	Mr. Manoj Prajapati
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

Proposer of the policy is mother, Mrs Deepa Shyam Kesarwani.

The proposer took two policies in the name of her children, Shivam and Shivangi, 1) Optima Restore Individual for sum insured of Rs. 300000/- each and 2) Optima Cash Gold policy for Rs. 3000/- daily cash.

Master Shivam was admitted in Sham Bharti hospital from 05/12/2018 to 09/12/2018 for burning micturition, mild fever on and off, generalized weakness, cold and cough and abdominal pain. His claim for Rs. 90654/- was rejected for misrepresentation. The other claim for daughter who was admitted under Arogya Hospital for 6 days was paid by the RI for daily cash of Rs. 18000/-

As per complaint given by Mr. Shivam, the investigator, Davendar Patil came to his home and asked for the documents of the hospital which the complainant was not having. Then investigator gave him enquiry form. He filled whatever he remembered and submitted to investigator. The company did not pass his claim by giving reasons like medicine in the invoices is not according to his disease etc. he belongs to a middle class family, his mother has borrowed money for paying hospital bills and in such condition, the company is harassing them.

Contentions of the Respondent Insurer (RI):

RI had appointed an investigator in this case. He has found out several discrepancies. As per the tariff obtained from the hospital, the room rent for deluxe room is Rs.1800/- whereas the hospital bill submitted shows Rs.3500/-per day. Patient was given an injection which was highly expensive although he was sensitive to it. His CBC count was very high on 3rd December but post hospitalization, the test was not repeated. Entries in the IPD register were not in the sequence order. Treating doctor did not co-operate with the investigator in explaining the discrepancies observed in treatment also.

Based on this, the RI rejected the claim on misrepresentation and cancelled the policy.

Result of personal hearing with both the parties (Observations & Conclusions):

During the hearing, both the parties reiterated their respective contentions.

The complainant stated that, whatever medicines were administered, are not in his control. It is the lookout of the hospital. Regarding room rent also he stated that, he paid whatever he was told to pay by the hospital.

On hearing both the parties and papers submitted before this forum, it is observed that within a span of two months of the issue of first policy, two claims for both the covered insured members were reported. Out of which, claim of daughter of the policy holder was paid by the RI.

In the current case, in view of the higher rate charged by the hospital in case of Mr. Shivam, forum suggests to compute the claim payable by applying the room rent at Rs.1800/-.

Complaint is thus allowed.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to settle the claim of Mr.Shivam under the Optima Restore Policy by applying the room rent @Rs.1800/-per day towards full and final settlement of the complaint.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune, on 22 April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN–VINAY SAH
CASE OF MR. Sukesha Ashok Mendon v/s Cigna TTK Health Insurance Co. Ltd
COMPLAINT NO: PUN-H-053-1920-0101
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Sukesha Ashok Mendon Nigdi Pune
2.	Policy No: Type of Policy:	PROHLR010419321 Cigna TTK Pro Health Insurance
3.	Policy period:	29/05/2018 to 28/05/2019
4.	Sum Insured	Rs10 lacs
5.	Date of inception of first policy:	27/5/2015
6.	Name of the Policyholder:	Ashok Mendon, 63 years
7.	Name and age of the Insurer:	Cigna TTK Health Insurance Co. ltd
8.	Reason for repudiation/Partial	Total Rejection of claim for non-disclosure of the

	Settlement:	PED-HT
9.	Date of receipt of the Complaint:	29/4/2019
10.	Nature of complaint:	TOTAL REJECTION OF CLAIM
11.	Amount of Claim:	Rs. 217724/-
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	13 1(b)
13.	Date of hearing/Place:	22/1/2021 on line hearing
14.	Representation at the hearing	
	yy) For the Complainant:	Mr. Mohnish Mendon
	zz) For the insurer:	Ms. Ashish Kaur; Ms. Gayatri Subramanian
15.	Complaint how disposed:	Allowed

Contentions of the Complainant:

The Complainant was having health policy with Max Bupa for two years i.e. from 26/5/2015 after that policy was ported with Respondent Insurer (herein after is called RI) on 29/5/2017. Policy covers complainant with her husband Mr. Ashok with endorsement for PED of Diabetes Mellitus and no PED for complainant.

Insured, Mr. Ashok was admitted on 9/8/2018 in Asian Cancer Institute for RT Subdural Hematoma having k/c/o acute lymphoblastic Leukemia with DM, HTN, IHD and died there on 13/8/2018.

His hospitalization claim for Rs. 217724/- was rejected by the RI giving reason that he was having HTN since 2013. Aggrieved with the rejection of claim, complainant has filed complaint before this Forum for resolution.

Contentions of the Respondent Insurer:

RI has submitted Self Contained Note (SCN). As per SCN, the complainant's husband, Mr. Ashok Mendon approached the Company for porting of his health policy. The proposal form with portability form was received on 19th May, 2017 wherein Complainant had disclosed regarding his PED of Diabetes Mellitus.

RI issued policy with loading accepting PED Condition of DM. Mr. Ashok Mendon was not included in the policy at the time of renewal -2 in the policy.

The details of Policy are as follow:

Policy no.	PROHLR010419321
Proposer/Insured person	Ashok Mendon –self Sukesha Ashok Mendon(wife)
Policy Period	29/5/2017-28/5/2018 12/11/2018-11/11/2019 29/5/2019-28/5/2020
Sum Insured	Rs. 10 lacs

Status	Expired

The Complainant's husband Ashok Mendon has not disclosed the history of being Hypertensive since 2013. This has been certified by AIMS hospital Pune on 27/7/2018. Hence, they rejected the claim under General Terms and conditions no. VIII which is for Duty of Disclosure-produced below:

"*The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non–disclosure of any material particulars in the proposal form. Personal statement, declaration, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by you or any one acting on your behalf, under this policy. You further understand and agree that we may at our sole discretion cancel the Policy and the premium paid shall be forfeited to us*."

Mr. Ashok was admitted on 29/5/2018 for hypertensive illness and subdural hematoma which is directly related to his pre-existing illness.

AIMS certificate dated 27/7/2018 copied on SCN. As per certificate, duration of HTN and DM are since 2013.

Result of personal hearing with both the parties (Observations & Conclusions):

During the hearing held on 22/01/2021, online, both the parties reiterated their respective stand.

From the documents submitted, it is observed that,

- This is a policy ported from Max Bupa, the first policy of which was issued by them on 26/5/2015. It was for two years, ie. upto 25/5/17.
- Thereafter, it was renewed with RI by porting it on 29/5/2017 onwards under RI's policy plan Pro Health Plus, policy no. PROHLR01419321. Hence, this was their 3rd year policy.
- Policy was renewed further for the period 29/5/2018-28/5/2019 as a 4th continuous renewal.
- A claim was made for Angioplasty in the month of May 2018, in the 4th policy year. The RI had rejected this claim on 1/11/2018 for non-disclosure of HTN since 2013.
- It is noted that after this hospitalization, series of his hospitalisations were started. The details of the same are as noted below:

Sr.No.	Hospitalisation at	Period of Hospitalisation	For treatment of
1	AIMS	24/7/18 to 27/7/18	CAG; PCI to LAD
2	Tata Hospital	6/8/18 to 9/8/18	PRO B ALL-Chemo suggested
3	Asian Cancer Hospital	9/8/18 to 13/8/18 (Patient expired)	Chemotherapy

- Due to multiple Co-morbidities –CNS Involvement, subdural hemorrhage, DM& HT &Coronary Artery Disease, patient was unlikely to tolerate chemotherapy hence advised

to take Palliative Care treatment. Hence patient shifted to Asian Cancer Institute on 9/8/18 and he died there on 13/8/18.

During the hearing it is noted that the complainant also agreed to the fact that the HTN was existing before opting for the first insurance also. The complainant contended that they were misguided by the agent not to declare it.

In view of these facts RI was asked to consider the claim for CA by excluding HTN related expenses, it being as an undisclosed ailment. The RI accordingly conveyed the settlement amount as Rs.77825/- and have confirmed that they have processed for the payment of this amount.

Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay Rs. 77825/- to the complainant, if still pending to be paid, towards full and final settlement of the complaint. If it is not yet paid, it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune, on 22 April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Umesh Gadiya Vs. Star Health & Allied Insurance Company Ltd.
COMPLAINT NO: PUN-H-044-1920-0094
Award No IO/PUN/A/HI/ /2021-2022

1.	Name & Address of the Complainant	Mr. Umesh Uttamchand Gadiya E2/5-4, Kumar Piccaso, Sr. No.201, Sadestra Nali Hadapsar, Near Siddhesh Hotel, Hadapsar, Pune - 411028
2.	Policy No:	P/900000/01/2018/000012

	Type of Policy:	Group Health Insurance (JIO)
3.	Policy period:	31/03/2018 to 30/03/2019
4.	Sum Insured/IDV	Rs.2 lakhs
5.	Date of inception of first policy:	31/03/2017
6.	Name & age of the Insured: Name of the Policyholder:	Mrs. Vijaya U. Gadiya – Age: 69 years M/s Jain International Organization (JIO)
7.	Name of the Insurer:	Star Health & Allied Insurance Company Ltd.
8.	Reason for rejection /Partial Settlement:	Expenses were incurred primarily for Investigation and Diagnostic purpose.
9.	Date of receipt of the Complaint:	30/05/2019
10.	Nature of complaint:	Rejection of health claim
11.	Amount of Claim:	Rs.52,736/-
12.	Rule of IOR 2017 under which the Complaint was registered:	13(1)(b)
13.	Date of hearing/Place:	22/01/2021 **(Online)**
14.	Representation at the hearing	
	aaa) For the Complainant:	Mr.Kiran Gadiya
	bbb) For the insurer:	Dr.Anjali Rathod
15.	Complaint how disposed:	Disallowed.

Contentions of the Complainant:

Complainant and his family were insured with the Respondent Insurer (RI) under the above policy for a SI of Rs.2 lakhs for the period 31/03/2018 to 30/03/2019. The patient aged 69 years was admitted to Villoo Poonawalla Memorial Hospital, Pune from 29/03/2019 to 03/04/2019 with complaints of sudden onset deviation of mouth and slurring of speech. The insured patient was admitted to the hospital for treatment of CVA Rt MCA territory infract, hypertension, rheumatoid arthritis and Hyporitaminosis D and the insured has incurred expenses of Rs.52,735/- towards the treatment taken at the hospital.

The RI has rejected the claim under the grounds that the treatment was done primarily for Investigation and Diagnostic purpose which is not covered under the policy. Aggrieved with this decision, the complainant has approached the forum for redressal of his grievance.

Contentions of the Respondent Insurer (RI):

The RI vide their SCN have informed this forum that on receipt of complaint, they reviewed the claim and a sum of Rs.37,173/- was offered to the complainant towards full and final settlement of the claim. The same was accepted by the complainant vide mail dt.26/09/2019. Hence, the same was settled to the insured vide NEFT transaction no. N2821909490263198 dt. 9/10/2019. Total deduction of Rs. 15562/- was on account of Non payable items Rs. 3171/- and 25% co-pay Rs. 12391/-

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **22/01/2021 (Online)** both the parties reiterated their respective stand.

It is observed from the correspondence sent by the RI that the complainant has given unconditional consent for the settlement of the claim for the offered amount of Rs.37173/-, conveyed by the RI. The complainant had not informed this to the forum, before this. During the hearing the representative of the complainant, agreed that he has received the amount. Actually, after giving consent, complaint is considered as closed. Still, complainant appeared for hearing with the argument on the deduction of 25% of claim based on the PED nature of the ailment treated.

As per the special conditions of the policy, since the insured patient was k/c/o Rheumatoid Arthritis, they have deducted 25% co-pay under PED (Rs.12,391/-). The forum also confirmed this fact from the various readings available on the different web sites. One such reading says,

*'Inflammatory substances called cytokines fuel joint destruction in **RA** and blood vessel damage in CVD. Inflammation causes plaque build-up in the arteries, which slowly narrows blood vessels and blocks blood flow, and is the main cause of **heart** attack and stroke.'*

In view of this, the deduction on account of co-pay is correct. RI has settled the claim to the maximum extent, adhering to the policy terms and conditions and there is no further amount liable for payment. Complaint therefore is disallowed.

Award follows:

AWARD

Under the facts and circumstances, it is found that the RI has paid the claim amount after getting consent from the complainant and also there is no scope of enhancement of amount of settlement. Complaint therefore stands closed.

Dated: at Pune on 19th day of April, 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN– VINAY SAH
CASE OF Mrs. Vanita Shete V/S Future Generali India Ins. Co Ltd
COMPLAINT NO: PUN-H-016-2021-0369
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mrs. Vanita Shete Ahmednagar
2.	Policy No: Type of Policy:	CRP-16-20-7004036-00-000 Corona Rakshak Policy (individual)

3.	Policy period:	07.08.2020 to 04.05.2021 (285 days)
4.	Sum Insured	Rs. 250000
5.	Date of inception of first policy:	23.07.2020
6.	Name of the Insured: Name of the Policyholder:	Mrs Vanita Shete, 31 yrs Self
7.	Name of the Insurer:	Future Generali India Ins co Ltd
8.	Reason for repudiation/Partial Settlement:	Hospitalization was for isolation and observation purpose only
9.	Date of receipt of the Complaint:	31.12.2020
10.	Nature of complaint:	Total Repudiation of claim
11.	Amount of Claim:	Rs. 250000
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	28/01/2021; Online
14.	Representation at the hearing	
	ccc) For the Complainant:	Mr.Rajendra Shete
	ddd) For the insurer:	Dr. Akanksha Saxena
15.	Complaint how disposed:	Disallowed

Contentions of the Complainant:

The complainant had taken a Corona Rakshak Policy (Individual) from Future Generali India Ins. Co Ltd for a period from 23.07.2020 to 04.05.2021. Complainant was tested Covid Positive and was hospitalized in District General Hospital, Ahmednagar from 03.10.2020 to 08.10.2020

Respondent Insurer (RI) repudiated the claim of Rs.250000 stating that the admission was for isolation and observation purpose only and the patient has not received any active line of treatment during admission.

She contends that this policy is a specially designed product – a benefit policy, has no direct link with the line of treatment taken by the policy holder.

According to complainant she was admitted in the hospital on the advice of Taluka Health officer, Panchyat Samiti Akola. The ultimate judgement regarding the treatment lies with the physician and ensuing medical conditions of the patients. She wants justice in settling the genuine hospitalization claim.

Contentions of the Respondent Insurer (RI):-

As per the SCN and expert's opinion on the subject, it is contended that

'*The patient had no co-morbidity*
On scrutiny of documents at hand, hospitalization not justified on basis of
- Admitted only with Covid +ve status, no clinical features mentioned.
- Vitals at admission or later not mentioned.

- No clinical features suggestive of severe Covid disease; hospital course uneventful.
Admission for isolation & observation.
- No test reports Available
- HRCT / Chest x-ray not done
Only supportive treatment given
Entire treatment was free of charge'

Hospitalisation was not needed. Hence the rejection of the claim was done.

Result of personal hearing with both the parties (Observations & Conclusions)

During the hearing on 28/01/2021 held online, both the parties reiterated their contentions.

Upon hearing the contentions of both the parties and documents submitted on record, forum has following observations.

On going through the definition of the said Corona Rakshak policy, **Definition 3.4 Diagnosis** reads as under:

'Diagnosis means diagnosis by a registered medical practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.'

In the current case, HRCT/chest X ray not done. No test reports are available to prove the severity of the disease.

The medical case record shows the provisional diagnosis as: '*Covid 19 positive asymptomatic'.* ICP have daily only one entry at 10 am showing normal readings. This itself is a sufficient document to conclude that hospitalization was not required. Her condition did not warrant any treatment. It was just an isolation as observed from the claim papers.

As such, **exclusion clause 6.1** is applicable here:

'*The company shall not be liable to make any payment under the policy in respect of any expenses related to any admission primarily for diagnostic and evaluation purpose.'*

In view of this, complaint is not admissible.

Award follows:

AWARD

Under the facts and circumstances, it is found that the complaint is devoid of merits, hence dismissed.

Dated: On 30th day of April, 2021 Pune

VINAY SAH
INSURANCE OMBUDSMAN, PUNE.

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE

(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)

UNDER SECTION 17 OF THE INSURANCE OMBUDSMAN RULES-2017

OMBUDSMAN–VINAY SAH

CASE OF MRS. VARDA VAIBHAV GOVEKAR

VS.

UNITED INDIA INSURANCE CO.LTD. IN COMPLAINT NO: PUN-G-051-1920-0126

HDFC ERGO GENERAL INSURANCE CO.LTD. IN COMPLAINT NO: PUN-H-018-1920-0510

ADITYA BIRLA HEALTH INSURANCE CO.LTD.IN COMPLAINT NO: PUN-G-055-2021-0340

Award Nos. IO/PUN/A/GI/ /2021-22

Award Nos. IO/PUN/A/HI/ /2021-22

Award Nos. IO/PUN/A/HI/ /2021-22

Complaint No.	PUN-G-051-1920-0126	PUN-H-018-1920-0510	PUN-G-055-2021-0340
Name of Insurance Co.	UNITED INDIA INSURANCE CO.LTD.	HDFC ERGO GENERAL INSURANCE CO.LTD.	ADITYA BIRLA HEALTH INSURANCE CO.LTD.
Policy No.	1214032616P100367223	2950 2011 3400 1100 001	12-18-0046963-00
Type of Policy	UNI HOME CARE POLICY	SARV SURAKSHA	Activ Secure Plan.
Policy Period	6/4/2016 to 5/4/2036	28/07/2015 to 27/07/2019	04.10.2018 TO 03.10.21
Sum Insured Rs.	14,50,000/-	8,00,000/-	25,00,000/-
Date of inception of first policy:	6/4/2016	28/07/2015	04/10/2018
Name of the Policyholder:	Mr. VAIBHAV GOVEKAR	Mr. VAIBHAV GOVEKAR	Mr. VAIBHAV GOVEKAR
Date of receipt of the Complaint:	24/02/2020	19/11/2019	21/12/2020
Nature of complaint:	Total Repudiation of claim	Total Repudiation of claim	Total Repudiation of claim
Amount of Claim: Rs.	14,50,000/-	8,00,000/-	25,00,000/-
Insurance Ombudsman Rule (IOR)2017 under which the	13(1)(b)	13(1)(b)	13(1)(b)

Complaint was registered:			
Date of hearing/Place:	18/12/2020 Online	18/12/2020 Online	12/03/2021 Online
Representation at the hearing			
eee) For the Complainant:	Mrs. Varda Govekar	Mrs. Varda Govekar	Mrs. Varda Govekar
fff) For the insurer:	Mr. Ashwin Bangar	Mr. Jayesh Sharma; Dr. Ravi	Mr. Kamlesh Ghadge
Complaint how disposed:	Disallowed	Disallowed	Disallowed

Contentions of Complainant:

Husband of the complainant had availed accident policies from the above three insurance companies as a security for his home loan/s. He died in train accident on 6/10/2018. She had filed for the compensation for accident benefit granted against all these policies.

All the above three RIs (Respondent Insurers) have repudiated her claims as per the policy exclusion that 1) The suicidal death is not covered under the policy. 2) The deceased- insured was under influence of alcohol (as found in Post Mortem report).

She has contended that the RIs have rejected the claims stating that it was a suicide as per investigation carried out by them and no details were provided by RI that on what basis it was decided that death of her husband was suicide and not accidental. In all the documents submitted by her, it is clearly mentioned that the death is due to accident. She also contends that her husband was not alcoholic. Hence, RI should not reject the claim based on suspicion.

RI's Investigation officer explained to her that Insured was lying down under the train at Platform no.5 of Kurla Terminus Opposite end of Engine. This is not a route where people normally walk.

The Complainant is requesting to solve the matter as early as possible because EMI of loan was started after the death of the husband i.e. from 11/11/2018 and she is the only bread earner, working in a Private Company, with 2 school going daughters to take care of.

Contentions of the Respondent Insurers (RIs):

The common contentions of all the RIs are as stated below:

1. They have accepted the issuance of policy which covers accidental death of the insured subject to policy terms and conditions.
2. Insured Mr. Vaibhav Govekar suffered death due to Decapitation on 06/10/18 on railway track, as per the Post Mortem Report.

3. An internal investigation was conducted to check the veracity of claim and as per the facts corroborated with the statement of wife of deceased it came into picture that the deceased returned from his work in the evening of 05/10/18 and after reaching home he again left home within 15 minutes and went 25 kms away from his home near LTT Railway Station and there is no reason/justification of the deceased travelling to a distant location. Further, deceased had not carried his mobile phone too along with him. The facts mentioned as per Investigation Report clearly confirm that the deceased had an intention to commit suicide.

4. HDFC ERGO as well as Aditya Birla HI have sought the opinion of an independent MBBS Dr C. H. Asrani who is a specialist in dealing with Insurance claims has been taken and he has given findings on several points which clearly prove that it is a suicidal case. He has explained it with differences in Suicidal Injuries and Accidental Injuries.

5. Also, he has explained that "A case of decapitation is commonly an indication of suicidal attempt and rarely of an accident. As established from available medical documents (PMR), the insured shows severe crush injuries to his neck with fracture of cervical vertebrae. These injuries match to those that would occur in a case of decapitation".

   He has further added that "Injuries in individuals lying across the rails (in case of suicide) are overly characteristics: they are found at the neck, head, legs, and the pelvis; the wounds are parallel, with the scissors-effect of the train wheels and the rails on the body lying across the track. The wounds caused by train wheels have clean, straight margins with parallel lines of bruising. As established from available medical documents, the same kind of injuries (decapitation) with fractured shoulder is seen on the insured. Hence, the injuries on the insured match those with that which would occur in a case of suicide on the railway tract". He has further explained and corroborated the suicide by mentioning "That the suicide is supported by circumstantial evidence that insured:

   a) had no logical reason to be at the accident spot.
   b) did not carry any valid ticket.
   c) had told his family that he will return in 10-15 minutes.
   d) there is no need to cross tracks at LTT.
   e) the trains are just starting/ending there, hence the speed is very low (maybe 5Km/hr).

   He has concluded that "On perusal of available medical documents (statement by Spouse, PMR) and reconstruction of the case, it is opined that the death on the railway track of Mr. Vaibhav D Govekar is suicidal in nature".

6. It is further stated that as per Sec. 124A of Railways Act 1989 the Compensation is granted in case of accidental deaths but in case of suicide or attempted suicide, self-inflicted injury, criminal act, act committed in state of intoxication or insanity. Deaths due to natural cause or disease the compensation is not paid by Railways. In the current case no Compensation has been accorded on the death of Insured.

7. Therefore, relying on the Statement of Deceased's wife, PMR, Investigation Report, Opinion of Specialist it is clear that the deceased had committed suicide. Therefore, the claim was appropriately repudiated as per Terms & Conditions of the Policy. The relevant policy wordings are reproduced hereinafter below for ready reference:

The specific exclusion in all the three policies reads as:

'No Indemnity is available hereunder and no payment will be made by the Company for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Suicide, attempted suicide or self inflicted injury or illness.

In the light of the above captioned facts and relevant Policy conditions, claim was repudiated by each RI.

As contended by RIs, deceased was found dead at a distant location on the track of Platform No.5 from where only express trains cross. The complainant has said that her deceased husband used to take local train from LTT. The HDFC ERGO have investigated on the same and a fact came to knowledge that Local trains do not run from/cross LTT, the fact has been verified through call recording done on Railway Central No.182. They have made a call to the concerned number and they have confirmed the fact that local trains neither run nor cross LTT railway station also there is an app available in Play store as m-indicator wherein the details of all local stations are available. There also no LTT station available as there is no stoppage of it, this clearly portrays that the Complainant has blatantly lied about the presence of her husband at LTT railway station.

More specific contentions of Aditya Birla Health Insurance are as quoted below:

On going through all the medical evidence on record, the complainant's statement and the police record, 3 eventualities seem to be probable, which are elaborated upon herein below:

a. Firstly, on going through the statement of the complainant, it was found that the deceased came from office, and at around 7 p.m. told his father that he is going downstairs for 10 minutes, left his mobile phone back at his home and did not come back. As per the GRP notes, the deceased was found dead on the tracks in Kurla terminus between pillar no. 105 and 106. More importantly, the body was found at around 12:55 am in the night quite far from where the deceased lived. The deceased must have long back realized that he has left his mobile phone at home and that his family must be worried about him as he has not returned home. Such conduct on the part of the deceased raises very strong doubts about the death being suicidal in nature rather than accidental. It is pertinent to mention here at the cost of repetition that the deceased met with this alleged accident just **two days** after personal accident cover policy was issued by the answering Insurance Company. If he did not intend to commit suicide, he would have contacted his family and would have informed them of his whereabouts. As per the sl. no. 3 of Customer Information Sheet given in the policy terms & conditions, a personal accident cover excludes "*Suicide or attempted suicide, intentional self-inflicted Injury, acts of self destruction*". Hence, in such an eventuality, the claim would not be payable.

b. Secondly, the post mortem report clearly states that on examination of the contents of the deceased's stomach, **strong alcoholic smell was perceived**. Section VI (iv) (A) (14) relating to permanent exclusions specific to personal accident cover states that, "*Any event arising from or caused due to use, abuse or a consequence or influence of*

abuse of any substance, intoxicant, drug, alcohol or hallucinogen, whether the Insured Person is medically sane or insane" shall not be covered under the policy. It is noteworthy that midnight is not a peak hour time wherein a person may accidentally, due to too much crowd, fall off a local train on the tracks and die. However, considering the strong alcoholic smell perceived from the stomach contents during the post mortem, it is quite probable that the deceased was inebriated, which ultimately resulted in this fatal accident.

That considering all the above stated points, it is clear that the claim is not payable on multiple grounds. *We would like to take this opportunity to put forth our view that this case requires further detailed investigation at not only the insurance company's end, but also the police as there are many questions left unanswered that raise doubts about the soundness of the conclusions reached by the police. The fact that the complainant filed the claim with the answering Insurance Company 4 months after the fatal accident also deprived the insurance company of the chance to properly investigate the circumstances under which the insured died.*

Moreover, we came to know that the deceased had three other policies from other insurance companies as well. **Section IV** of the policy proposal form specifically asked the deceased to provide information about any other policy that the deceased might have either with the answering insurance company or any other insurance company. However, here once again he decided to answer dishonestly and did not disclose that he already had a ***personal accident policy*** with HDFC Ergo and other insurance policies as well.

It is submitted that Section VIII (2) of the policy proposal form clearly asks the proposer to declare that none of the proposer or the proposed insureds in past had any personal accident cover nor any proposal has been declined, deferred, withdrawn or accepted with modified terms. Here again the deceased did not disclose about his personal accident policy with HDFC Ergo.

"N. Duty of Disclosure

The Policy shall be null and void and no Benefit shall be payable hereunder in the event of an untrue or incorrect statement, misrepresentation, mis-description or non-disclosure of any material particular in the Proposal Form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by the Policyholder or any one acting on their behalf, under this Policy. Under such circumstances We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us."

It is a settled position of law that a deliberate wrong answer, which has a bearing on the Contract of Insurance, if discovered during the process of settlement, may lead to the policy being declared void.

His dead body was found on the tracks at Kurla Terminus between pillar no. 105 and 106. Interestingly, pillar no. 105 and 106 are away from the platform and no local trains run in this particular area of the terminus. Furthermore, this being the starting or the ending point for the trains, the train speed is also quite low here. Hence, it is incomprehensible why a resident of Thane went to Kurla Terminus, which is quite far

from his house, when he promised his father that he would be back in 10 minutes. So, although he tried to make his suicide look like an accident perhaps to ensure that his family may receive insurance from various policies, his death left behind too many questions that have no answer other than that this was a staged accident. Also, the body having been found between pillar no. 105 and 106 where no local trains ply, proves that he did not accidentally fell off any train due to too much crowd or speed of the train. We have no logical answer to the question that how can a man reach the railway tracks at Kurla terminus between pillar no. 105 and 106 and fall off a train when there are no local trains running there. Therefore, the facts and circumstances of this case very strongly point that this was a planned suicide and not an accidental death. The expert opinion obtained from **Dr. C. H. Asrani** in this regard to elaborate and corroborate this point is being enclosed herewith for your kind perusal as **Enclosure A**.

As per a study conducted into proximal risk factors of suicide, it has been established that Proximal risk factors are temporally close to a suicide attempt and exert their influence in the day, hours, or minutes before an attempt (Bagge & Sher, 2008; Hufford, 2001). Acute alcohol use is one such proximal factor that has been shown to increase risk for suicide attempts. An empirical review of published studies finds that a median of 40% of suicide attempts by adults were preceded by ingestion of alcohol (Cherpitel et al., 2004). Controlled studies demonstrate that acute alcohol use confers marked risk for suicide attempt (e.g., Bagge et al., 2013b; Borges & Rosovsky, 1996; Borges et al., 2004; Powell et al., 2001) and that risk is intensified at high drinking levels (Bagge et al., 2013b; Borges & Rosovsky, 1996).

Result of personal hearing with both the parties (Observations & Conclusions):

Hearings were held on 18/12/2020 and 12/03/2021 through video conferencing. For arriving at a decision, submissions of all 3 RIs together is taken into account.

From the documents submitted and the discussions had during the hearing, it is observed that,

1. The deceased insured allegedly met with an accident just 2 days after the policy issuance of Aditya Birla.
2. In all the three hearings, complainant could not give any clue to reach to the conclusion that it was not a suicide but there may be some other reason or an accident for the cause of his death. However, she has submitted SDM verdict that the death is catagorised as 'Accidental' death.
3. The deceased insured had not given correct information of available insurances while filling up the online proposal of Aditya Birla HI. Just within two days of the issuance of the said policy the unfortunate death of the deceased has happened, which gives rise to more doubts of a planned suicidal death.
4. While investigating, the RIs should have gathered information about his financial standing/loan liabilities and its repayments, mental health of the deceased insured person from his contact persons, his work place.
5. The circumstantial evidences and the condition of the dead body as seen beheaded supports the contention that the incidence must be a suicide and not an accident.

Because such types of injuries do not happen in case of accident. To arrive at this conclusion, the forum has taken the scientific assessment done by Dr. Asrani, as submitted by RIs viz. HDFC ERGO and Aditya Birla HI.

The forum has every sympathy with the complainant for the unfortunate incidence she and her family had to undergo. But the forum is unable to give any relief in her favour because of the circumstantial evidences support the suicidal death of her husband. All these policies are personal accident policies and those cover only accidental injuries/death and suicide is a common exclusion in all these policies. All the three complaints are therefore disallowed.

A common award is passed as below:

AWARD

Under the facts and circumstances, as the accidental death of the insured is not proved beyond doubt, which is an essential condition in all the above three policies, forum cannot fasten liability on all the above Respondent Insurers. All the above three complaints are therefore stand dismissed.

Dated: at Pune this 30th day of April 2021

VINAY SAH
Insurance Ombudsman, Pune

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, PUNE
(STATE OF MAHARASHTRA EXCEPT MUMBAI METRO)
UNDER SECTION 16/17 OF THE INSURANCE OMBUDSMAN RULES-2017
OMBUDSMAN – VINAY SAH
CASE OF Mr. Vinayak D Rasal V/S The New India Assurance Company Ltd.
COMPLAINT NO: PUN-H-049-2021-0456
Award No IO/PUN/A/HI/ /2021-22

1.	Name & Address of the Complainant	Mr. Vinayak D Rasal Sangli
2.	Policy No: Type of Policy:	15100134192800000443 New India Floater policy
3.	Policy period:	15.01.2020 to 14.01.2021
4.	Sum Insured	Rs.500000
5.	Date of inception of first policy:	15.01.2016
6.	Name & Age of the Insured: Name of the Policyholder:	Mr. Vinayak D Rasal / Ms. Yukta Rasal Age: 51/18 Same as above

7.	Name of the Insurer:	The New India Assurance Company Ltd.
8.	Reason for repudiation/Partial Settlement:	Domiciliary hospitalization
9.	Date of receipt of the Complaint:	28.12.2020
10.	Nature of complaint:	Rejection of health claim (Covid)
11.	Amount of Claim:	Rs.1,65,045/- (2 claims) (1,20,481+44,564)
12.	Insurance Ombudsman Rule (IOR)2017 under which the Complaint was registered:	Rule 13 1 (b)
13.	Date of hearing/Place:	30.03.2021 **(Online)**
14.	Representation at the hearing	
	g) For the Complainant:	Complainant himself
	h) For the insurer:	Mr. Shrinivas Watve
15.	Complaint how disposed:	Partially Allowed
16.	Date of Award:	19/04/2021

Contentions of the Complainant

The complainant had New India Floater policy with Respondent Insurer for SA Rs.5,00,000/-. He has lodged a claim for himself for his hospitalization at Shwas Lifeline center from 08.08.2020 to 21.08.2020 for Covid 19 Pneumonia and also for his daughter, Ms. Yukta Rasal. The nearby areas were affected by the pandemic and hence he could not visit any hospital or seek help from any medical establishment. The authorities had sealed the premises as a result of which nobody could go out or any help could come in the society premises. The complainant and his daughter had no other way but to take treatment confined to their home.

On fourth day the oxygen level of Mr. Vinayak Rasal went low and hence he consulted Dr. Mandke for HRCT & RTPCR. The doctor has provided oxygen cylinder at home from his ICU and treatment was communicated through whats app and mobile. After the TPA was intimated, they called for photographs of bed, which was submitted to the RI. No room rent, nursing charges are demanded as the treating doctor / hospital has charged only towards consultation and oxygen charges. The complainant has settled the bills with the treating hospital for an amount of Rs.1,65,045/- towards treatment of himself and his daughter.

The RI after receipt of claim documents and supporting papers have repudiated the claim under the grounds that domiciliary hospitalization was not allowed as per the policy terms and conditions.

Contentions of the Respondent Insurer (RI)

The RI has repudiated the claim/s stating that homecare treatment was not admissible as per the policy terms and conditions and hence the claim was denied under Clause 4.4.17 which is reproduced as under:

4. What are the exclusion under this policy?

No claim will be payable under this Policy for the following:

4.4.17 – Domiciliary Hospitalization

Result of personal hearing with both the parties (Observations & Conclusions):

During the personal hearing on **30/03/2021 (Online)** both the parties reiterated their respective stand.

From the available documents, forum notes that:

1. During hearing the complainant has stressed the fact that he wanted to take treatment from hospital but due to sealing of his society premises and movement restrictions imposed by the local authorities due to the pandemic, he had no alternative but to take treatment from his home as he was not in a position to visit any hospital. His doctor helped him by providing oxygen cylinder to stabilize the oxygen level of the complainant and assisted the patients through voice call and whats-app messages regarding the treatment to be taken.

2. During the hearing, the RI representative was specifically asked whether they have any objection in respect of the circumstances as described by the complainant truly existed. He agreed with the prevailing situations in the city that time. From the photographs submitted, the forum also observed that the residential area of the complainant is seen sealed by the local authorities and it was not possible for the people to come out of their house. For covid positive patients it was unfeasible.

    i. In respect of the entertainability of the claim under such situations, which were not in the control of the complainant, forum would like to invoke following circulars of IRDAI, so that the complainant should not remain deprived of the benefits under the health insurance policy, which he had taken to get help in such uncertain/ unpredicted infections and or health conditions.
    ii. IRDAI/HLT/REG/CIR/163/06/2020 dt. 26/6/2020;
    iii. IRDAI/HLT/REG/CIR/163/06/2020 dt. 16/07/2020

Vide these circulars, IRDAI have asked the insurers to cover treatment while home quarantined also in Covid Standard Health Policy. Covid Standard Health Policy was introduced specially to cover the public at large to fight with the pandemic conditions financially, for those people also who might not have regular health policy. Otherwise, IRDAI would not have asked the insurers to entertain the covid cases in normal health policy also. This must be in view of the fact that people having normal health policy would not opt for one more covid special health policy. The government also started introducing make-shift hospital arrangements and home quarantine to cope up with the situation to accommodate the increasing number of covid patients. In this situation, the forum is of the view that considering the unprecedented corona pandemic and resultant hardships to all, by giving some flexibility in the norms, the home care treatment introduced in covid standard health policy should be extended to normal health policies also looking to the genuineness of the each such claim on merits. The above IRDAI circular states as:

'Home Care Treatment Expenses: *Insurer shall cover the costs of treatment of COVID incurred by the Insured person on availing treatment at home maximum up to 14 days per incident provided that:*

a) The Medical practitioner advices the Insured person to undergo treatment at home.

b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
d) Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility are offered under homecare expenses subject to claim settlement policy disclosed in the website of the Insurer.
e) In case the insured intends to avail the services of non-network provider, claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services. Insurer shall respond to approval request within 2 hrs of receiving the last necessary requirement.

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID,

a. Diagnostic tests undergone at home or at diagnostics centre

b. Medicines prescribed in writing

c. Consultation charges of the medical practitioner

d. Nursing charges related to medical staff

e. Medical procedures limited to parenteral administration of medicines

f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer'

Subject to other terms, conditions and exclusions of the policy, expenses payable during the Policy period shall not in aggregate exceed the maximum Sum Insured as specified in the Policy Schedule against this Benefit.

3. From the facts and circumstances, it is observed that the daughter's health was stable as seen from the notings of her oxygen and TPR chart. Hospitalization was not required for her. But considering the emergency situation of Shri. Vinayak Rasal, forum recommends RI to consider his claim for payment keeping aside the strict technicality.

   Award follows:

AWARD

Under the facts and circumstances, the RI is directed to pay the claim of the complainant Shri. Vinayak Rasal as per policy norms towards full and final settlement of the complaint. Claim for daughter is dismissed. Hence the complaint is partially allowed.

The award is to be settled within one month from the date of receipt of this award failing which it will attract interest at the prevailing bank rate plus 2% extra from the date of rejection of the claim till the date of payment of this award.

The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules 2017:

17(6) the insurer shall comply with the award within thirty days of the receipt of the award and intimate compliance of the same to the Ombudsman.

17(8) the award of Insurance Ombudsman shall be binding on the insurers.

Dated: at Pune on 19th day April 2021

VINAY SAH
Insurance Ombudsman, Pune