PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF KARNATAKA

(UNDER RULE NO: 16/17 of THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – NEERJA SHAH

Case of: Ms DRAKSHAYINI NAGIDER V/s MAX LIFE INSURANCE COMPANY LIMITED

Complaint No: BNG-L-032-1819-0118

Award No: IO/BNG/A/LI/0250/2018-2019

1.	Name & Address of the Complainant	Ms Drakshayini Nadiger No 128, Nadiger House, Hediyal Road Sunakal Bidari, Haveri, Hubli Karnataka – 581115 (M): 9964037951
2.	Policy No: Type of Policy: Name of the Policy: Commencement of Policy Policy Period/ Premium Paying Term	307037101 Life Max Life Monthly Income Advantage Plan 06.07.2017 25/15 years
3.	Name of the Insured Name of the Policyholder	Mr. Nagaraj Nadiger (DLA)
4.	Name of the Respondent Insurer	Max Life Insurance Company Ltd
5.	Date of Repudiation/Rejection	09.03.2018
6.	Reason for repudiation/Rejection	Non-Disclosure of Material Facts
7.	Date of receipt of Annexure VI-A	10.07.2018
8.	Nature of complaint	Repudiation of death claim
9.	Amount of claim	₹.9,13,928/-
10.	Date of Partial Settlement	Nil
11.	Amount of relief sought	₹.9,13,928/-
12.	Complaint registered under Rule No:	13 (1) (b) of Insurance Ombudsman Rules, 2017
13.	Date of hearing/place	02.01.2019/Bengaluru
14.	Representation at the hearing	
	a) For the Complainant	Self
	b) For the Respondent Insurer	Mr. Chandrashekar – Sr. Manager
15.	Complaint how disposed	Dismissed
16.	Date of Award/Order	02.01.2019

17. Brief Facts of the Case:

The complaint emanated from repudiation of death claim by the Respondent Insurer (RI) for not disclosing the material information at the time securing the policy. In spite of her representation to the Grievance Redressal Officer (GRO) of the RI, her claim was rejected. Therefore, the Complainant approached this Forum for consideration of her claim on humanitarian grounds.

18. Cause of Complaint: -

a. Complainant's argument:

The Complainant in her letter dated 24.06.2018 has stated that her late husband obtained the said policy on 06.07.2017 by paying an annual premium of ₹ 52,251/- for a sum assured of ₹ 9,13,928/- through M/S. AXIS Bank Hadadi Branch – Davanagere. Her husband was involved in the business of supplying agricultural seeds to agriculturists. He had high income of around ₹ 3 Lakhs per annum and was also a tax payer. Unfortunately on 25.11.2017 he collapsed in the house due to massive heart attack and expired at his residence itself. Thereafter she filed the death claim with the RI on 19.11.2017. The RI rejected her claim but informed her vide letter dated 24.04.2018 that they had cancelled the said policy and refunded the premium paid by him. But till date she has not received the said premium. It is pertinent here to mention that the officials of the RI, took signature on all the forms while he was alive and issued the said the policy. Consequent upon his death, it is not proper for the RI to cancel his policy and refund the premium. Though she represented her case to G.R.O. of the RI, there was no response from them. Faced with financial difficulties to run the family, she has approached this Forum for settlement of death claim on the said policy.

b. Respondent Insurer's argument:

The RI vide their SCN dated 17.12.2018 has stated that the D.L.A. after understanding the product features of the said policy, submitted the proposal form and other annexures for issue of the same. Accordingly the RI issued the said policy and despatched the same to the D.L.A. and he has received the same. The RI received the death intimation from the Complainant on 19.04.2018. Since it was an early claim, the RI conducted an investigation into bonafides of the claim. During investigations it came to light that the D.L.A. was known case of Chronic Kidney Disease and last Haemodialysis was done on 02.02.2017. In addition the D.L.A. was also suffering from Dilated Cardiomyopathy and Grade 2 M.R. and had previous Anaesthetic Urethroplasty on 26.12.2016. The D.L.A. was under treatment in YENEPOYA Hospital in Mangalore from 01.02.2017 to 10.02.2017 for Urethric Anastomosis, Dysuria, …etc. These hospitalization were prior to commencement of the policy. These were material and relevant information which were never disclosed by the D.L.A. in the proposal form at the time of obtaining the policy. The non-disclosure of these material information has amounted to fraud thereby vitiating the said policy. Even though the RI specifically asked these questions about the health and habits of the D.L.A. in the proposal form, the D.L.A. chose not to disclose the same thereby resulting in non-disclosure of material facts with fraudulent intention. As the Fraud was established by the RI in the form of medical records, the present case was repudiated on the basis of Medical Non-Disclosure of material facts. Upon receipt of the representation from the Complainant the RI refunded the premium paid by the D.L.A. The RI has prayed for dismissal of the present complaint.

19. Reason for Registration of complaint: -

The complaint fell within the scope of the Insurance Ombudsman Rules, 2017 under Sec 13(1)(b) and hence, 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 issue under consideration is, whether the repudiation of the early death claim by RI is in order.
During the personal hearing held on 02.01.2019 both the parties reiterated earlier submissions.

The Forum after deliberations by both the parties and after careful examination of the records placed before the Forum has observed that the D.L.A. availed the said policy and paid one annual premium of ₹ 52,251/- He died on 25.11.2017. Upon receipt of the death claim, the RI conducted investigations into the bonafides of the claim. During investigations it came to light that the D.L.A. was a Known Case of Chronic Kidney Disease, and was on haemodialysis on 02.02.2017. He was also suffering from Dilated Cardiomyopathy and Grade 2 M.R. He was admitted to YENEPOYA Medical College Hospital on 01.02.2017 and was diagnosed as 'Urethric Anastomises, Grade 2 M.R. & Dilated Cardiomyopathy. He was known to have poor urinary stream with Dysuria since Jan 2017. All these diseases are prior to obtaining the said policy. Insurance contract is a special nature of contract which is based on the principle of 'Uberimma Fides' (ut-most Good Faith). It is bounden duty of the proposer/L.A. to disclose all the material information which was well within the knowledge of the Life Assured as the RI cannot be expected to be aware of health and habits of the Proposer/L.A. Non-Disclosure of material information renders the contract void. Had the D.L.A. disclosed these material information the RI would not have issued the said policy. Hence the RI is justified in repudiating the death claim under the said policy.

The RI informed the Forum that they refunded the premium to the Complainant through cheque but the same got returned undelivered and the same would be sent to the Complainant within 1 weeks time.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the Personal Hearing, the decision of the Respondent Insurer is found to be in order as per the terms and conditions of the policy and requires no intervention of at the hands of the Ombudsman.

Hence the complaint is **Dismissed.**

Dated at Bengaluru this 02nd Day of Jan 2019.

(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 – NEERJA SHAH

Case of: Mrs. LATHAMANI.H.R. V/s CANARA HSBC ORIENTAL BANK OF COMMENCE LIFE INSURANCE COMPANY LIMITED

Complaint No: BNG-L-010-1819 -0179

Award No: IO/BNG/A/LI/0266 /2018-2019

1.	Name & Address of the Complainant	Mrs. Lathamani.H.R. W/o Umapathi.C. No 685, Subedar palya, Kenkere past Huliyar Hobli

		Chikkanayakanahalli, Tumkur Dist Karnataka – 572218 (M):9964888123
2.	Policy No: Type of Policy: Name of the policy: Commencement of Policy Policy Period/ Premium Paying Term	900100006/CB63328501 Life – Group Insurance Policy Prime Minister Jeevan Jyothi Bima Yojana 11.06.2015. --
3.	Name of the Insured Name of the Policyholder	Mr C. Umapathy (DLA) Canara Bank
4.	Name of the Respondent Insurer	Canara HSBC, OBC Life Insurance Company limited
5.	Date of Repudiation/Rejection	06.07.2018
6.	Reason for repudiation/Rejection	Premium not deducted from the account holder
7.	Date of receipt of Annexure VI-A	09.08.2018
8.	Nature of complaint	Repudiation of death claim
9.	Amount of claim	₹.2,00,000/-
10.	Date of Partial Settlement	Nil
11.	Amount of relief sought	₹.2,00,000/-
12.	Complaint registered under Rule No:	13 (1) (b) of Insurance Ombudsman Rules, 2017
13.	Date of hearing/place	11.01.2019 - Bengaluru
14.	Representation at the hearing	
	a) For the Complainant	Self
	b) For the Respondent Insurer	Mr. Amith – Manager
15.	Complaint how disposed	Partly Allowed
16.	Date of Award/Order	14.01.2019

17. Brief Facts of the Case:

The complaint emanated from repudiation of death claim by the Respondent Insurer (RI) on the life of beneficiary for the reason that the premium was not deducted by the Master Policy Holder. Though the Complainant approached the Grievance Redressal Officer (G.R.O.) of the RI there was no response from them. Therefore, the Complainant approached this Forum for consideration of her claim on humanitarian grounds.

18. Cause of Complaint: -

a. Complainant's argument:

The Complainant in her letter dated 21.07.2018 stated that her husband i.e. Deceased Life Assured(D.L.A.) enrolled himself for the said life insurance benefit scheme through Canara Bank where he had opened an account. Though they were paying the premium the bank did not deduct the premium from her husband's bank account. Subsequently her husband died and she filed for the death claim with the RI. But her claim was rejected for the reason' premium not deducted' by the bank. Hence she has approached this Forum for consideration of death claim.

b. Respondent Insurer's argument:

The RI vide their SCN dated 17.09.2018 has stated that the D.L.A. enrolled himself for the said group insurance scheme namely 'Pradhan Mantri Jeevan Jyothi Bima Yojana' for a sum assured of ₹.2,00,000/-by paying annual premium of ₹.330/- per anum. Accordingly the RI issued the said policy. To enable the policy to be continued,

the member/beneficiary is required to pay the premium to the RI through the bank account of the life assured by 'auto debit facility'. It was imperative to note that the premium for the year 2017-18 was to be deducted from the bank. Since the premium was not received by the RI through the bank for the year 2017-18, the policy was in lapsed condition and as such nothing was payable as death claim under the said policy. they did not honour the claim. The RI also produced a mail from the bank, wherein the banker has informed the RI that as there was no sufficient balance in the account of the policy holder, they could not deduct the premium from his bank account and remit the same to RI.

As there was no fault of the RI and the complaint is bereft of any merits, the RI has prayed for dismissal of the said complaint.

19. Reason for Registration of complaint: -

The complaint fell within the scope of the Insurance Ombudsman Rules, 2017under Sec 13(1)(b) and so, it was registered.

20. The following documents were placed for perusal: -

d. Complaint along with enclosures,
e. Respondent Insurer's SCN along with enclosures and
f. 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 issue under consideration is, whether the repudiation of the early death claim by RI is in order.

During the personal hearing held on 11.01.2019both the parties reiterated earlier submissions.

After taking closer look at the records placed before the forum and also during the personal hearing, the Forum observes that the D.L.A. was enrolled for 'Prime Minister Jeevan Jyothi Bima Yojana' Scheme on 11.06.2015. The relevant features of the scheme are as follows:-

1. It is a subsidized group insurance scheme where the D.L.A. is covered for a sum assured of ₹.2,00,000/- payable on death.
2. The D.L.A. should have opened a bank account in a nationalized bank and the premium is to be deducted from the bank account of the L.A. through 'auto debit facility' (and not through any other mode) and the same is to be remitted to RI every year on the annual renewal date.
3. The L.A. is required to maintain adequate balance in his bank account, so that the banker will be able to deduct the premium and remit the same to RI.
4. The insurance cover is valid from 10 years t0 55 years of L.A.

In the instant case the Forum observed that the L.A. enrolled himself for the said insurance scheme on 11.06.2015. But it appears that the insurance premium was not deducted for the year 2015-16. However the RI deducted the Insurance premium of ₹.330/- for the year 2016-17. Again the premium for the year 2017-18 was not deducted for PMJJBY policy as there was insufficient balance in the bank account of D.L.A. The Banker

has confirmed vide their mail dated 16.08.2018 that they could not deduct the premium due to paucity of adequate balance in his bank account. The non-recovery of the latest premium due led to lapsation of the said policy for which the RI could not settle the death claim.

The Forum notes that the aforesaid 'Pradhan Mantri Jeevan Jyothi Bima Yojana' has been issued by Canara HSBC OBC Life Insurance Company in English. Had the contract been singed in vernacular language, the Complainant/Life Assured would have ensured adequate balance in the bank account to avail the insurance benefit. Since insurance is a contract it is imperative that the contents of the contract are understood by both the parties. In this case, the Complainant was a villager with no knowledge of English with meagre bank balance.

Therefore the Forum concludes that RI is justified in repudiating the death claim for the reason 'policy is in lapsed condition due to non-recovery of the latest premium due'. However considering the fact that the Complainant expressed extreme financial difficulty in running the family, the RI is directed to refund the total premiums received under the said policy.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the Personal Hearing, the RI is directed to refund the total premiums received under the said policy.

Hence the complaint is **'Partly Allowed'.**

Dated at Bengaluru this 14th Day of January 2019.

(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 – NEERJA SHAH

In the matter of Mr NARASIMHA MURTHY V/s LIFE INSURANCE CORPORATION OF INDIA
Complaint No: BNG-L-029-1819-0117
Award No: IO/(BNG)/A/LI/0271/2018-19

1	Name & Address of the Complainant	Mr Narasimha Murthy S/O Late Chikka Narasimhappa Vychukurahally, Ramapura Post Gowribidanuru Taluk Chikkaballapur Mob: 9482904747
2	Policy No.	363799982

	Type of Policy Name Of Policy Commencement of Risk/ Policy Term/ Premium Paying Term	Life Insurance Market Plus Policy 29.03.2007/05 Yrs / 1 Year
3	Name of the Insured/ Proposer Name of the policyholder	Mr. Chikka Narasimhappa (Late)
4	Name of the Insurer	LIC of India, Divisional Office- II, Bangalore
5	Date of Repudiation/Rejection	22.05.2012
6	Reason for Repudiation	Claim settled according to the Option selected
7	Date of receipt of Annexure VI A	11.01.2019
8	Nature of complaint	Denial of Death Claim.
9	Amount of claim	₹.2,00,000/- + Interest
10	Date and amount of Settlement	07.07.2018 & ₹.78186/-
11	Amount of relief sought	₹.2,00,000/- + Interest
12	Complaint registered under Rule no:	13 (1) (b) of Insurance Ombudsman Rules, 2017
13	Date of hearing/place	11.01.2019/Bengaluru
14	Representation at the hearing	
	a) For the Complainant	Self
	b) For the Respondent Insurer	Mr D K Gandhi, Manager (Claims)
15	Complaint how disposed	Allowed
16	Date of Award	18.01.2019

17. Brief Facts of the Case:

The dispute has arisen on account of rejection of death claim payment by Respondent Insurer (hereinafter referred as RI). The GRO of RI has not responded to his request. Hence, the Complainant has approached this Forum for justice.

18. Cause of Complaint:

a. Complainant's arguments:

The Complainant stated that his father Mr Chikka Narasimhappa (late) has availed the aforesaid policy from RI. Complainant further stated that on 22.05.2012 the Life Assured (LA) died and he being the nominee in the policy approached the RI for settlement of death claim.

The Complainant contested that instead of settling death claim the RI has started paying annuity at the rate if ₹ 950/- per month, though he had submitted the discharge voucher, original policy document and request letter for paying the death claim amount on the aforesaid policy on, RI has acted otherwise. He stated that RI had not responded to the many request letters written by him for settling the death claim instead of annuity payment. He further submitted that the GRO of RI had not responded to his complaint.

Aggrieved, the Complainant registered his complaint with this Forum for justice.

b. Respondent Insurer's Arguments:

The Respondent Insurer has not submitted the Self contained note. However, on 07.07.2018 vide email they have informed that they have admitted the death claim and an amount of ₹ 78,186/- was paid after deducting the annuities amount already paid from the total death claim amount.

19. Reason for Registration of complaint:

The complaint falls within the scope of the Insurance Ombudsman Rules, 2017.

20. The following documents were placed for perusal:

a. Complaint along with enclosures

21. Result of the personal hearing with the RI (Observations & Conclusions):

The issue which requires consideration is whether payment made by RI is in order.

During the course of personal hearing, RI submitted that the policy vested in March 2012 and they started paying annuity to the LA. After receiving the death intimation from the Complainant (May 2012), the servicing branch has forwarded the necessary documents to RI's pension cell. During this process a wrong option form was sent along with the documents. The RI pension cell started paying the annuity to the Complainant as he is Nominee of the aforesaid policy. After the receipt of the complaint from this Forum about the settlement of death claim from the Complainant they have identified the error and rectification action was taken by settling the death claim after making necessary deductions.

Complainant stated that the death claim is to be settled in the May, 2012 as per terms and conditions of the policy and he is at loss due to the part annuity payments and late settlement of death claim by the RI.

The Forum notes that the LA availed LIC's Market Plus Policy on 29.03.2007 by paying single premium of ₹ 1,00,000/- for a term of 5 years in Growth Fund. Date on which the annuity vests is 29.03.2012. As per the policy schedule the benefit payable on vesting is "An amount equal to the Fund Value of the units held in the Policyholder's Unit account at the vesting date, after allowing for an option to commute a maximum of one-third of the Fund Value of units held in the Policyholder's Unit Account, shall be compulsorily utilised to provide a pension based on the then prevailing immediate annuity rates and other terms and conditions either from the Corporation or from any other Life Insurance Company"

The Forum further notes that RI could not provide the option form given by the LA before vesting date 29.03.2012 where as the RI was required to seek the Option of the LA six months prior to the date of vesting. This is found not to have been done by the RI. The LA died on 22.05.2012, the RI asked the Complainant to submit the Option form, which they had to obtain from the LA. Clearly the action of the RI was not in line with the terms and conditions of the policy. This is a clear service deficiency.

RI made death claim process even more complicated by wrongly ratifying the Option Form as 'I' Option – "Annuity for Life with a provision for 100% of the annuity to the spouse on death of the annuitant" where as the option Opted by Complainant is 'F'- "Annuity for life with return of purchase price". RI started to pay annuity of @ ₹ 950/- per month up to October,2016 which is neither mentioned in the Option form 'I' or 'F'.

The Forum after going through the records available found that RI has paid an amount of ₹.52,250/- vide 55 monthly annuity payments and an additional amount of ₹.78,186/- as death claim in July,2018. But as per terms and conditions of the policy the RI is supposed to settle the death claim in May, 2012 as per the option form given by LA. In the absence of the same they misguided the Complainant and made him run from pillar to post to get the death claim which is rightfully due to him since May, 2012. Hence RI is liable to pay the death claim as on May, 2012 with interest as mentioned below.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the Personal Hearing, the RI is directed to arrive at death claim amount as on May, 2012 with interest at applicable Bank Rate + 2% Penal interest as laid down in Regulation 14 of IRDAI (Protection of Policy Holders Interest) Regulations, 2017 after deducting the amount already paid to him.

The complaint is **Allowed**.

22. Compliance of Award:

The attention of the Complainant and the Respondent Insurer is hereby invited to Rule 17(6) of the Insurance Ombudsman Rules, 2017, where under the Respondent Insurer shall comply with the award within 30 days of the receipt of the Award and shall intimate compliance of the same to the Ombudsman.

Dated at Bengaluru on the 18th day of January, 2019

(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 – Mrs NEERJA SHAH

In the matter of Shri RAGHAVENDRA MJ V/s HDFC STD LIFE INSURANCE COMPANY LIMITED
Complaint No: BNG-L-019-1819-0010
Award No.: IO/(BNG)/A/GI/0273/2018-19

1	Name & Address of the Complainant	Sri Raghavendra MJ Sri Raghavendra Computers Opp: Union Park, PB Rd., Chitradurga, Karnataka 577 501 9342310018 Email: raghavendra.src@gmail.com

2	Policy /Cert. No. Type of Policy Date of Commencement/Term Sum Assured & Annual Limit	90256496 HDFC LIFE HEALTH ASSURE PLAN 29.03.2013, Term: Whole Life subject to payment Of Annual Premium. ₹ 3,00,000
3	Name of the Insured/ Proposer Name of the policyholder	Shri Jagadeesh MG deceased
4	Name of the Respondent Insurer	HDFC Std Life Ins Co Ltd.,
5	Date of repudiation/rejection	01.12-2016, 07.02.2017 (By TPA), 07.02.17 BY RI.
6	Reason for repudiation	Non-disclosure of material information.
7	Date of receipt of Annexure VI-A	16.04.2018
8	Nature of complaint	Rejection of Health Insurance claim
9	Amount of claim	₹.2,80,840/- and refund of renewal premium ₹. 13,579/- collected after death of the Assured
10	Date of Partial Settlement	NA
11	Amount of relief sought	₹.2,80,840/-
12	Complaint registered under Rule no:	13 (1) (b) of Insurance Ombudsman Rules, 2017
13	Date of hearing/place	16.01.2019/ Bengaluru
14	Representation at the hearing	
	a) For the Complainant	Self
	b) For the Insurer	Vinay Prakash Sr. Manager Legal
15	Complaint how disposed	**Allowed**
16	Date of Award/Order	23.01.2019

17. Brief Facts of the Case:

The complaint emanates from repudiation of Health Insurance claim of hospitalisation expenses of the deceased LA, by the TPA of RI, on the ground that the incorrect health declaration was given and had not disclosed the pre existing ailments. The Complainant approached the GRO of the Respondent Insurer (RI), but no response by the RI. Hence, the Complainant has approached this Forum to direct the RI to settle the claim.

The Complaint was earlier submitted by Smt. Vanamala MJ the wife of the DLA. Subsequently Mr. Raghavendra MJ Son of the DLA submitted the complaint with all necessary requirements.

18. Cause of Complaint:

a. Complainant's arguments:

The DLA was insured with the above RI from 29.03.2013. On 27th November 2016 he was admitted to BGS Global Hospital Bengaluru with complaint of suffering from dry cough since 1 month. On 28th November 2016 Hospital Insurance desk confirmed that approval has been taken from the Insurance Company for cashless treatment. Subsequently the claimants came to know that cashless facility was rejected by the TPA. Life assured died on 1st December 2016 in the hospital itself. Vide email dated 1.12.16 E-MEDITEK INS TPA Ltd informed that cashless claim was rejected for incorrect information and non disclosure of pre-existing ailment. The complainant stated that her husband was having diabetes from 2 years only before his death and submitted claim papers to HDFC Std Life Bellary but received claim rejection letter dated 7.2.17 by the TPA.

On 28.2.2017 vide a representation Claimant appealed to the Claims Review Committee of the RI but RI has not responded. Though the claim was rejected and the patient died the RI had collected next due premium and after one year again they have sent renewal notice for premium due in March 2018. The complainants have approached this forum for justice.

b.Respondent Insurer's Arguments:

The RI vide their Self Contained Note dated 28.11.2018 deny all the allegations. They stated that the Complainant Mr. Raghavendra is not the nominee under the said policy as such, the complaint is not tenable under law and requested for dismissal of the same.

Further, the RI Confirm that the DLA had taken said Health Assure policy effective from 07.03.2013 by filling the proposal form based on which the policy was issued to him. Regarding rejection of claim, the RI stated that they had investigated the said claim and found that the DLA was suffering from type-II Diabetes since last 9 years. This material information which was very much relevant in issuing the policy was not disclosed by the DLA. Had he disclosed the material information they would not have issued the policy to him. In support of their statement the RI had produced Xerox copies of Initial Assessment Form of BGS Global Hospitals, Bengaluru and discharge summary issued by Hospital in Chitradurga (Name of the Hospital not visible). In view of suppression of material facts the claim was not admitted as per the terms and conditions of the policy and has been rightly denied. The RI requested the forum to dismiss the complaint. In support of their stand the RI had submitted certified copies of proposal forms dated 13.02.2013, Claim Rejection letter dtd 7.2.17 and Policy document certified copy (28 pages).

19. Reason for Registration of complaint:-

The complaint falls within the scope of the Insurance Ombudsman Rules, 2017.

20. The following documents were placed for perusal.

b. Complaint along with enclosures,
c. Respondent Insurer's SCN along with enclosures and
d. Consent of the Complainant in Annexure VIA & and Respondent Insurer in VII A

21. Result of personal hearing with both the parties (Observations & Conclusions):

This Forum has perused the documentary evidences available on record and the submissions made during the personal hearing by both the parties. The dispute is with regard to rejection of claim under the policy on the ground of misrepresentation of material facts.

The Complainant reiterated contents in his complaint and stressed that denial of claim is not in order.

RI has raised objection that since the complaint was filed by Mr Raghavendra MJ who is not the nominee under the policy the same is not tenable in law. As per the Ombudsman Rules 2017 Section 14 (1) any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, can make a complaint. In this case Mr. Raghavendra MJ is son of the DLA and Smt. Vanamala MJ the Nominee, and is the legal heir of both. As such the contention of the RI that the complaint is not tenable in law is wrong and not accepted.

The Forum observes that-

the DLA aged 68 years was admitted to BGS Global Hospitals on 27.11.2016 with complaint of dry cough for 1 month, worsened since 1 week, poor effort tolerance for 15-20 days, pain in abdomen and chest while coughing since few days, fever with chills 4-5 days, constipation and pain while defecating for 2 days etc., and was under treatment. On 30.11.2016 he suddenly had a cardiac arrest, suffered 3 more episodes of sudden bradycardia and hypotension and suffered cardiac arrest – Asystole at 8.30 and died on 1.12.2017 – cause of death as per death summery is *Febrile Illness – Bilateral Pneumonitis – Acute Respiratory Distress Syndrome – Respiratory Failure – Refractory Hypotension – Metabolic Acidosis with High Lactate – Acute Kidney Injury – Diabetes Mellitus*.

Prior to his admission in BGS Global Hospital, Bengaluru, the DLA was admitted in a hospital in Chitradurga on 22.11.2016 for cough since 20 days and fever since 5 days and discharged on 27.11.2016

TPA of the RI had investigated the said claim and found that the DLA was suffering from Type-II Diabetes since 9 years. Accordingly the TPA on behalf of RI had rejected the claim stating that the DLA had conveniently suppressed his past illness prior to the date of risk under the policy. In support of denial the RI has produced photo copies of Hospital records wherein it is mentioned that the DLA was a known case of Type II DM since 9 years as per BGS Global Hospital and 5 years as per Chitradurga Hospital.

RI has issued HDFC LIFE HEALTH ASSURE PLAN with whole life cover, date of Commencement being 29th March 2013. The DLA was hospitalised from 27.11.2016 to 01.12.2016. The claim has arisen after 3 years, 8 months and 2 days.

As per the certified copy of the policy document submitted by RI, Part F, Policy clause 6 , page No. 16, this policy has been covered with the provisions of Section 45 of the Insurance Act 1938. The relevant provisions of Section 45 of Insurance Act 1938 duly amended on 23rd March 2015 are as under-

"45. (1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later."

Further in the "Key Features of the Policy Document" Page 23, Sl.No. 11, under the title "Non Disclosure" the RI had once again reiterated that the Section 45 of Insurance Act 1938 will be applicable to the said policy in case of non-disclosure.

If Section 45 is applied the RI cannot call in question the policy since the policy has run for more than 3 years as on the date of happening.

The Forum notes that Section. 45 of Insurance Act is not applicable to Health Insurance Policies. However, RI made provisions of Section 45 to this health policy.

Further, the TPA of RI has rejected the Claim on behalf of the RI. TPA is not the Insurer. As per IRDAI guidelines Insurer only can repudiate a claim. It is observed that in spite of an appeal made by the Nominee to the Claims Review Committee of the RI, as suggested by TPA in the letter of rejection, RI have not bothered to respond to the appeal made by the Nominee. As such, the Forum observes deficiency of service on the part of the RI, on this count.

Further, while taking repudiation action the TPA has relied on the remarks made in the hospital records that the DLA was a known case of DM Type II for 9 years/ 5 years. The said remarks might be recorded based on the statement made by the DLA or his relatives at the time of admission into Hospital. The statement recorded by Chitradurga Hospital is 5 years and

BGS Hospital 9 years. It cannot be ascertained as to which statement was correct. Mere statement made by the DLA or his relatives at the time of admission cannot be a conclusive proof to show that DM Type II was onset 9 years ago. Except the above noting in Hospital records RI has not submitted any documentary evidence to show as to when and where the Type II DM was diagnosed or who had treated him for DM Type II and treatment details. As such, repudiation action by TPA on behalf of the RI is not in order and the RI is liable to pay the claim amount with Bank Rate of interest @ ₹7.75% for delayed settlement of claim + Penal Interest @ ₹ 2%.

The Forum also directs the RI to refund the Premium with interested at the above stated rate, inadvertently collected from the claimants for the Premium due 3/2017 since insurance cover was not in existence due to death of the assured on 1.12.2016.

Complaint is hereby allowed.

A W A R D

Taking into account of the facts and circumstances of the case, the documents the oral submissions made by both the parties, this Forum is of the opinion that the decision of the Respondent Insurer is found to be not order.

This Forum directs the Respondent Insurer to settle the claim as above as per the terms and conditions of policy along with interest @ 7.75% + 2% from the date of receipt of last necessary documents to the date of payment of claim, as per regulation 14 of Protection of Policy holders' Interests of IRDA Regulations, 2017 issued vide notification dated 22.06.2017.

RI is also hereby directed to refund the premium collected after the death of assured, alongwith the interest at the rates specified rates as above.
Hence, the complaint is **ALLOWED.**

22) Compliance of Award:

The attention of the Complainant and the Respondent Insurer is hereby invited to Rule 17(6) of the Insurance Ombudsman Rules, 2017, where under the Respondent Insurer shall comply with the Award within 30 days of the receipt of the Award and shall intimate compliance of the same to the Ombudsman.

Dated at **Bangalore** this 16th day of January, **2019.**

(NEERJA SHAH)
INSURANCE OMBUDSMAN
FOR THE STATE OF KARNATAKA

PROCEEDINGS BEFORE - THE INSURANCE OMBUDSMAN, STATE OF M.P. & C.G.
(UNDER RULE NO: 16(1)/17 OF THE INSURANCE OMBUDSMAN RULE 2017)

Mrs. Lalita Bai ……..Complainant

V/S

Shri Ram Life Insurance Co.Ltd.……..……. Respondent

COMPLAINT NO: BHP-L-043-1819-0172 Order No. IO/BHP/A/LI/ 0304 /2018-2019

1.	**Name & Address of the Complainant**	**Mrs.Lalita Bai, Gram Kolari, PO- Lolari Ich Kannod Dist.Dewas (MP)**
2.	**Policy No: Type of Policy Duration of policy/DOC**	**NP161606004667 Non Ulip Policy 13.06.2016**
3.	**Name of the insured Name of the policyholder**	**Mr.Beel Singh -same-**
4.	**Name of the insurer**	**Shri Ram Life Insurance Co.Ltd.**
5.	**Date of Repudiation/Rejection**	**27.03.2018**
6.	**Reason for repudiation/Rejection**	**Non disclosure of Material facts**
7.	**Date of receipt of the Complaint**	**26.07.2018**
8.	**Nature of complaint**	**Repudiation of Death Claim**
9.	**Amount of Claim**	**Death claim amount**
10.	**Date of Partial Settlement**	**-**
11.	**Amount of relief sought**	**Death Claim Amount**
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) of Ins.Ombudsman Rule 2017**
13.	**Date of hearing/place**	**10.01.2019 at Bhopal**
14.	**Representation at the hearing**	
	a) For the Complainant	**Absent**
	b) For the insurer	**Mr. Abhinav K. Tripathi, Sr.Legal Executive**
15.	**Complaint how disposed**	**Dismissed**
16.	**Date of Award/Order**	**10.01.2019**

- Mrs. Lalita Bai (Complainant) has filed the complaint against Shri Ram Life Insurance Co.Ltd. (Respondent) alleging repudiation of Death Claim.
- **Brief Facts of the Case-** The Complainant has stated that above policy was taken by her husband from the respondent company. After the death of her husband she lodged the death claim before the respondent company but no reply was given. The complainant approached this forum for payment of death claim.

- The respondent has stated in their SCN that the policy was issued on the basis of proposal form submitted by the Life Assured. The nominee under the policy intimated the company that LA died on 15.09.2016. Since the death claim arouse within a period of 3 months 2 days from the date of commencement, it was entrusted for investigation to know its veracity. On investigation it was revealed that DLA was suffering from Cancer and was taking treatment for the same prior to signing of the proposal form dated 25.05.2016. The respondent further stated that LA had taken treatment at Gujrat Cancer and research institute Ahmedabad on 03.05.2016 vide registration no. G66012. Further LA taken treatment on 18.05.2016 in the same hospital and was diagnosed with "Ca tongue + Pril neck node". The DLA belonged to Antyodaya Family and did not possess any substantial income as stated in proposal form i.e. Rs.2,50,000/- while in his medical records the monthly income is mentioned as Rs. 1,500/- per month. Further LA has suppressed the material facts with respect to his medical history.

- The complainant has filed complaint letter, Annex VI A and correspondence with respondent while respondent have filed SCN with enclosures.
- Complainant remained absent during hearing. I have heard respondent's representative at length and perused paper filed on behalf of the complainant as well as the Insurance Company.
- Respondent has filed a copy of registration card no.G66012 dated 03.05.2016 of the Gujrat Cancer and Research Institute, Ahmedabad which shows that Mr. Beel Singh S/o Buddhuram Barela was registered in the above hospital in surgical unit. The Gujrat Cancer and Research Institute (MP Shah Cancer Hospital, Asarva) Ahmedabad-16 is the specific institute for cancer. In registration card provisional diagnosis is mentioned as CA B.O.T. OP growth involving whole tongue (7 months) with multiple neck node is mentioned in clinical history. In this record also Tongue cancer (advanced) is mentioned. In progress note dated 03.05.2016 also tongue cancer is mentioned. In biopsy report dated 04.05.2016 squanous cell carcinoma is mentioned. Treatment paper dated 18.05.2016 also shows diagnosis as Ca Tongue + pril neck node. Registration card is of 03.05.2016 while policy inception date is 13.06.2016, hence diagnosed ailment and registration in Cancer institute is prior to the proposal. In proposal form DLA has answered regarding personal medical history, question "Have you ever suffered from Cancer," as 'NO'. In proposal form above statement shows that DLA had not disclosed his

cancer disease at the time of inception of policy. Respondent in rejection letter has mentioned that had they been informed correctly about the health problem at the time of proposal, it would have influenced their decision in issuing the policy. In proposal form annual income of insured is mentioned as Rs.2,50,000/- while in medical registration card monthly income is mentioned as Rs.1,500/-. Hence, it is clear that DLA had concealed his correct health status & true income at the time of inception of policy.

- In view of the above facts and circumstances, I come to the conclusion that the DLA had concealed material information at the time of inception of the policy with respect of his previous ailment and hence respondent has not erred in repudiating the claim. Therefore I am of the opinion that there is no reason to interfere with the decision of respondent company and hence complaint is liable to be dismissed.
- The complaint filed by Mrs. Lalita Bai stands dismissed herewith.
- Let copies of Award be given to both the parties.

Dated : January 10, 2019 **(G.S.Shrivastava)**
Place : Bhopal **Insurance Ombudsman**

Mr. Rafiq Khan……..…….…….. Complainant

V/S

Birla Sun Life Insurance Co.Ltd.……...……..……Respondent

COMPLAINT NO: BHP-L-009-1819-0178 ORDER NO: IO/BHP/A/LI/0305 /2018-2019

1.	**Name & Address of the Complainant**	**Mr. Rafiq Khan, Subhash Nagar, Aashta, Near Chhatrawas, Sehore (MP)**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**006719226 Vision Endowment Plus Plan 20.03.2015**
3.	**Name of the insured Name of the policyholder**	**Mrs. Shanno Bi -same-**
4.	**Name of the insurer**	**Birla Sun Life Insurance Co.Ltd.**
5.	**Date of Repudiation/ Rejection**	
6.	**Reason for Repudiation/ Rejection**	**Policy declared as Void ab initio**
7.	**Date of receipt of the Complaint**	**02.08.2018**

8.	**Nature of complaint**	**Non settlement of Death Claim**
9.	**Amount of Claim**	**-**
10.	**Date of Partial Settlement**	**-**
11.	**Amount of relief sought**	**-**
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) Ins. Ombudsman Rule 2017**
13.	**Date of hearing/place**	**10.01.2019 at Bhopal**
14.	**Representation at the hearing**	
	a) For the Complainant	**Absent**
	b) For the insurer	**Mr. Ajay Choubey, Mr.Manager Legal**
15.	**Complaint how disposed**	**Allowed**
16.	**Date of Award/Order**	**10.01.2019**

- Mr. Rafiq Khan (Complainant) has filed a complaint against Birla Sun Life Insurance Co. Ltd. (Respondent) alleging non settlement of death claim.
- **Brief facts of the Case -** The complainant has stated that above policy was taken by his wife Mrs. Shanno Bi from the respondent company. After the death of his wife, he lodged the death claim before the respondent company but his claim was not settled by the respondent company and no reply was given to him. The complainant approached this forum for payment of death claim of his wife.
- The respondent in their SCN have stated that policy was issued on the basis of information furnished by Life Assured in the application form. The policy was issued on 20.03.2015 and dispatched on 23.03.2015 through speed post and same was delivered on 27.03.2015 to the LA. An investigation was done, in which it was established that there was non disclosure of medical facts. As per investigation report cause of death of LA is hepathic encephalopathy (Hepatic encephalopathy is the occurrence of confusion altered level of consciousness and coma as a result of liver failure. In the advanced stages it is called hepatic coma or coma hepaticum. It may ultimately lead to death). LA was suffering from the aliment since 2014 before issuance of policy. Discharge paper show that LA hemoglobin, SGOT/SGPT was elevated to an extent that cannot be a sudden effect showing liver failure. The above facts clearly indicate of active concealment of material facts and information by the LA. Null and Void letter dated 07.09.2016 was sent to the customer and a refund cheque of premium amount was also dispatched on 10.09.2016. Later a death claim was intimated by the claimant under the policy

on 27.01.2018. As the policy was already declared as Null & Void, hence the said claim could not be entertained.

- The complainant has filed complaint letter, Annex. VI A and correspondence with respondent, while respondent have filed SCN with enclosures.
- Complainant remained absent during hearing. I have heard respondent's representative at length and perused paper filed on behalf of the complainant as well as the Insurance Company.
- Above policy under Vision Endowment Plus Plan was issued on the life of Mrs. Sanno Bi with risk commencement date as 20.03.2015. After death of insured on 10.06.2015, death claim was intimated by the nominee on 27.01.2018. As per SCN of respondent company it appears that after discreet check conducted by respondent on 26.06.2016 a detailed investigation was called by the respondent and investigation report was received on 19.11.2016. It is evident from record that after discreet check report dated 27.07.2016, an order dated 07.09.2016 was passed by the respondent by which respondent has discontinued the coverage and declared policy as Void ab inito. According to respondent as the policy was declared void ab inito on 07.09.2016, hence claim was not entertained by the respondent.
- Representative of the respondent have argued that in detailed investigation it was established that insured was suffering from Hepatic Encephalopathy which in advance stage is called as hepatic coma or coma hepaticum. Respondent further argued that as per investigation, insured was having above ailment since 2014 and this fact was not disclosed at the time of inception of the policy and there was concealment of material fact. Respondent has filed annexure 3 with photocopy of 23 medical papers. Discharge summary of City Care Multi Speciality Hospital, Sehore reveals that insured was admitted in the above hospital on 03.06.2015 and was discharged on 10.06.2015 due to death. She was diagnosed with Hepatic Encephalopathy with viral hepatitis. At the time of admission she was having loss of appetite since 8-10 days and was also suffering from fever. Respondent have also filed blood report dated 03.06.2015, 05.06.2015, 07.06.2015 and urine report dated 03.06.2015 with above medical papers. Respondent have stated that her ailment was since 2014. In investigation report dated 19.11.2016, it is mentioned by investigator that Hepatic Encephalopathy problem was from 2014 before issuing of policy. No medical record with respect that she was suffering with above ailment since 2014 has been filed by respondent, hence nothing is on record to show that

insured was having above ailment since 2014. It was also argued on behalf of respondent that discharge paper shows elevation of LA's hemoglobin, SGOT/SGPT to an extent which cannot be a sudden effect. In medical papers filed by the respondent, past history of illness has not been mentioned. In absence of any medical record showing ailment since 2014, above argument of respondent is based on possibilities only and argument is not at all acceptable.

- Policy was declared as null and void vide letter of respondent dated 07.09.2016. Letter addressed and sent to Mrs. Sanno Bi dated 07.09.2016 is on record in which cause of void declaration of policy is shown as, that details of policy owner/ Life insured provided in the proposal form were found to be incorrect. As per respondent after receiving special investigation report dated 27.07.2016 above order declaring policy as null and void was passed. In special investigation report dated 27.07.2016 (annexure-2) date of death of insured as 10.06.2015 due to medical illness has been mentioned. As the date of death of insured was well within the knowledge of respondent company on 27.07.2016, then why letter dated 07.09.2016 was addressed and sent to the deceased insured. Besides this, if it was also in the knowledge of respondent that insured was died due to medical illness, then cause of medical illness must be written in above letter. These facts create a reasonable doubt towards this letter. As per available records, on the date 07.09.2016 respondent was having no concrete evidence of cause of declaring the policy as null and void. Besides this no evidence of insured's ailment since 2014 is also not led by respondent. Hence, declaration of policy as null and void by respondent is not justified.
- In view of the above discussion I arrive at the conclusion that the respondent has erred in declaring the policy as null and void and also in not settling the death claim under above policy. Hence the complaint is allowed and an award is passed with direction to the respondent insurance company to allow the claim under policy no. 006719226 according to terms & conditions of the policy.
- The award shall be implemented within 30 days on receipt of the same. The compliance shall be intimated to this office for information and record.
- Let copies of Award be given to both the parties.

Dated : January 10, 2019 **(G.S.Shrivastava)**
Place : Bhopal **Insurance Ombudsman**

Mr. Shiv Prasad Rajput…….…..……....……. Complainant

V/S

Life Insurance Corporation of India……...……Respondent

COMPLAINT NO: BHP-L-029-1819-0216 **Order No. IO/BHP/A/LI/ 0317 /2018-2019**

1.	**Name & Address of the Complainant**	**Mr. Shiv Prasad Rajput** **Gram Meharkhedi, Post Bheelkhedi,** **Tehsil Shujalpur**
2.	**Policy No:** **Type of Policy** **Duration of policy/DOC**	**354534706** **Jeevan Mitra** **02.06.2013**
3.	**Name of the insured** **Name of the policyholder**	**Mr. Hemraj Singh Rajput** **-same-**
4.	**Name of the insurer**	**LIC OF INDIA**
5.	**Date of Repudiation/Rejection**	**-**
6.	**Reason for repudiation/Rejection**	**-**
7.	**Date of receipt of the Complaint**	**20.08.2018**
8.	**Nature of complaint**	**Repudiation of Death Claim**
9.	**Amount of Claim**	**Death Claim amount**
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	**Death Claim amount + bonus**
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) of Ins. Ombudsman Rule 2017**
13.	**Date of hearing/place**	**29.01.2019 at Bhopal**
14.	**Representation at the hearing**	
	c) For the Complainant	**Mr.Shiv Prasad Rajput**
	d) For the insurer	**Mrs. Manisha Bhatnagar, Manager (CRM)**
15.	**Complaint how disposed**	**Dismissed**
16.	**Date of Award/Order**	**29.01.2019**

- Mr. Shiv Prasad Rajput (Complainant) has filed a complaint against the decision of Life Insurance Corporation of India (Respondent) alleging repudiation of death claim.
- **Brief facts of the Case -** The complainant has stated that the above policy was purchased by his brother Mr. Hemraj Singh Rajput. His brother died on 31.10.2016, thereafter he lodged the death claim before the respondent but his claim was repudiated by the respondent. The complainant approached this forum for payment of death claim amount with interest.

  The respondent in their SCN have stated that DLA was suffering from Tongue Cancer (Squamous Cell Carcinoma Grade-I) and underwent wide excision of tongue carcinoma prior to

revival date 26.12.2014 but he did not disclose the same in DGH dated 26.12.2014. The LA had suppressed material fact regarding his sickness tongue cancer at the time of revival. Death claim repudiated on the grounds of suppression of material facts and refund of premium allowed as per policy conditions.

- The complainant has filed complaint letter, annex. VI A, policy copy, correspondence with respondent while respondent filed SCN with enclosures.
- Efforts for mediation failed. I have heard both the parties at length and perused papers filed on behalf of the complainant as well as the Insurance Company.
- The policy No. 354534706 was issued in favour of LA on 02.06.2013 which was lapsed on account of non payment of premiums. Above policy was revived on 26.12.2014 on the basis of Declaration of Good Health. Claim was repudiated on the ground that DLA was suffering from tongue cancer and underwent wide excision prior to revival date 26.12.2014 which was not disclosed in DGH. Respondent has filed OPD paper and histopathology report of Jawaharlal Nehru Cancer Hospital & Research Centre, Bhopal. In Histopathology report dated 09.06.2014 in impression column, it is mentioned that 'wide excision of tongue with lymph node excision reveal a growth at lateral border of tongue exhibiting features of invasive well differentiated keratinizing squamous cell carcinoma (Grade 1). Hence, it is clear that DLA was suffering from Tongue Carcinoma since 09.06.2014. DGH form dated 26.12.2014 taken at the time of revival of policy is on record which shows that LA had answered regarding health related question (any illness) negatively. He also mentioned that he is completely healthy. In DGH form above statement shows that LA had not disclosed his disease tongue cancer. Medical papers clearly shows that LA had not disclosed above ailment and concealed his correct health status at the time of revival of the policy which LA should furnish mandatorily.
- In view of the above facts & circumstances, I come to the conclusion that the DLA had concealed material information at the time of revival of policy with respect of his previous ailment. Therefore, I am of the considered opinion that there is no reason to interfere with the decision of respondent company and hence complaint is liable to be dismissed.
- The complaint filed by Mr. Shiv Prasad Rajput is dismissed herewith.

- Let copies of Award be given to both the parties.

Dated : January 29, 2019 **(G.S.Shrivastava)**
Place : Bhopal **Insurance Ombudsman**

Mr. Balram Meena …….…..……...……. Complainant

V/S

Bharti Axa Life Insurance Co.Ltd. ……...……Respondent

COMPLAINT NO: BHP-L-008-1819-0228 Order No. IO/BHP/A/LI/ 0319 /2018-2019

1.	**Name & Address of the Complainant**	**Mr. Balram Meena Vidhakhedali Tehsil Baroda Dist Sheopur (MP)**
2.	**Policy No: Type of Policy Duration of policy/DOC**	**501-6482878 Elite Advantage 19.12.2017**
3.	**Name of the insured Name of the policyholder**	**Mr. Sugreev Meena -same-**
4.	**Name of the insurer**	**Bharti Axa Life Insurance Co.Ltd.**
5.	**Date of Repudiation/Rejection**	**27.04.2018**
6.	**Reason for repudiation/Rejection**	**LA had expired before signing the proposal form**
7.	**Date of receipt of the Complaint**	**29.08.2018**
8.	**Nature of complaint**	**Repudiation of Death Claim**
9.	**Amount of Claim**	**Death Claim amount**
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	**Death Claim amount**
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) of Ins. Ombudsman Rule 2017**
13.	**Date of hearing/place**	**30.01.2019 at Bhopal**
14.	**Representation at the hearing**	
	e) For the Complainant	**Mr. Balram Meena**
	f) For the insurer	**Mr. Manoj Kumar Pandagre, Executive**
15.	**Complaint how disposed**	**Allowed**
16.	**Date of Award/Order**	**30.01.2019**

- Mr. Balram Meena (Complainant) has filed a complaint against Bharti Axa Life Insurance Co. Ltd. (Respondent) alleging repudiation of death claim.
- **Brief facts of the Case -** The complainant has stated that the above policy was purchased by his father Mr.Sugreev Meena. His father had expired on 31.12.2017 due to sudden heart attack,

thereafter he lodged the death claim before the respondent but his claim was repudiated by the respondent. It is further stated that after lodging the claim respondent investigation officer came to his house and told that your case is genuine but you will have to pay 20% bribe of total sum assured, I will keep 10% and 10% will give to my boss who assigns cases to me. When complainant didn't give money to investigation officer, he furnished forged report and documents. The complainant approached this forum for payment of death claim.

The respondent in their SCN have stated that above policy was issued on 19.12.2017. The LA Mr. Sugreev Meena had expired on 31.12.2017 and death claim intimation was received by the company on 04.04.2018. The death claim was an early claim, hence company has referred the matter for investigation. During investigation it was revealed that as per the death register the date of death is 26 July 2017 which is prior to signing of the proposal form i.e.09.12.2017. It is further stated that during investigation it was also revealed that the DLA was a chronic alcoholic person and unemployed and there was no shop in the name of Meena General Store while as per proposal form the DLA was a business owner. In investigation it was also found that DLA was having below 10^{th} grade qualification while in proposal form he has mentioned as 12^{th} Pass.

- The complainant has filed complaint letter, annex. VI A, policy copy, correspondence with respondent while respondent filed SCN with enclosures.
- Efforts for mediation failed. I have heard both the parties at length and perused papers filed on behalf of the complainant as well as the Insurance Company.
- It is accepted by the respondent in their SCN that above policy Elite Advantage was issued on the life of DLA in which policy issue date was 19.12.2017 and sum assured was Rs. 5,35,968/-. It is also accepted by the respondent that proposal date of said policy was 09.12.2017 and DLA had expired on 31.12.2017. The claim intimation was given on 04.04.2018. It is also accepted in SCN that the policy holder was enrolled under the policy based on the document executed by him and all the policy documents were forwarded to him. Claim was repudiated by the respondent on the ground that DLA had expired prior to signing the proposal for insurance. In the papers filed by the respondent, death certificate issued on 25.01.2018 with registration number D-2018:23.00155.000002 has been filed, which is also produced by the complainant alongwith the complaint. This death certificate has been issued by Sub-Registrar (Birth &

Death) Gram Panchayt, Baasod on form no.6. Nothing has been produced by the respondent against the genuineness of this certificate. Representative of the respondent during hearing has stated that in the register of death maintained by Anganbadi of Panchayat date of death of DLA is mentioned as 26.07.2017. A photocopy of death register marked as annexure 'C' has been filed by the respondent with their SCN. This photocopy bears no signature of any authority. During hearing representative of the respondent has stated that besides this he is having no evidence with regard to death as on 26.07.2017. Besides this, no evidence has been filed by the respondent showing DLA's death on 26.07.2017. Besides death certificate issued on 25.01.2018 by sub-registrar (Birth & Death) Gram Panchayat Basod, a letter of certification issued by Sarpanch, Gram Panchayat Basod, Jan.Pancha. Sheopur (MP) with photocopy of Anganwadi Register has been filed by complainant in which date of death of DLA is mentioned as 31.12.2017. Photocopy of Anganwadi register is signed by Ramdhara Bai (Anganwadi Karykarti) and mentions date of death of DLA as 31.12.2017. With SCN photocopy of notarial affidavit (annexure B) was also filed by the respondent which was furnished by the nominee/ complainant to the respondent in which also date of death is mentioned as 31.12.2017. Photocopy of death register filed by respondent is not at all acceptable till other corroborative evidence is being filed by respondent. Respondent had not filed any such corroborative evidence with respect to date of death as 26.07.2017. Death certificate dated 25.01.2018, registration number D-2018:23.00155.000002 bearing date of death as 31.12.2017, is issued by the lawful authority authorized in this behalf and is acceptable.

Most Important question arises whether any policy can be issued by the respondent after the death and without identification of policy holder. Declaration by confidential report of the licensed sales person was obtained by the respondent at the time of proposal i.e. on 09.12.2017 is on record. In this report it is mentioned by Mr.Naresh Kumar Life/F.A./Specified person of corporate agent/broker and Mr. Vivek Anand Area Manager/ MOAS/Branch Head/ Sr. Manager Sales, that they have verified the identity, current and permanent residential address of the proposer, the nature of his/her business and his/ her financial status and they have explained the product brochure and the benefit illustration to the proposer. In this form it is also mentioned that life insured is not physically handicapped or in mental disorder. Hence,

with this report it is ample clear that at the time of proposal financial advisor and area manager of respondent were satisfied with the identity of the proposed insured. Besides this in paragraph 19 of SCN it is mentioned by respondent that policy holder was enrolled under the policy based on the document executed by him. Thus it is clear that the insured was identified as true by the respondent, at the time of proposal i.e. on 09.12.2017.

In SCN it is mentioned by the respondent that on investigation it was found that DLA was a chronic Alcoholic, unemployed, having no shop in the name of Meena General Store and educational qualification of DLA was below 10^{th} grade. No evidence with respect to above has been filed by the respondent. No said investigation report has also been filed by respondent.

- In view of above facts and circumstances, I come to the conclusion that the Insurance Company has erred in repudiating the death claim under policy and respondent should have allowed the claim. In the result complaint is allowed and respondent is directed to allow the death claim in accordance with terms and conditions of the policy.

- Let a copy of award be sent to complainant and respondent insurance company for compliance within 30 days.

Dated : January 30, 2019 **(G.S.Shrivastava)**
Place : Bhopal **Insurance Ombudsman**

Mrs. Savita Agrawal ……..……...……. Complainant

V/S

Life Insurance Corporation of India…….....……Respondent

COMPLAINT NO: BHP-L-029-1819-0236 Order No. IO/BHP/A/LI/ 0321/2018-2019

1.	**Name & Address of the Complainant**	**Mrs. Savita Agrawal, Navgaon Road, Katghora, Dist-Korba**
2.	**Policy No: Type of Policy Duration of policy/DOC**	**358998307 Jeevan Saral 09.07.2013**
3.	**Name of the insured Name of the policyholder**	**Mr. Vijay Kumar Agrawal Mr. Vijay Kumar Agrawal**
4.	**Name of the insurer**	**LIC OF INDIA**

5.	**Date of Repudiation/Rejection**	**20.09.2016**
6.	**Reason for repudiation/Rejection**	**Concealment of material fact about previous illness**
7.	**Date of receipt of the Complaint**	**14.08.2018**
8.	**Nature of complaint**	**Repudiation of Death Claim**
9.	**Amount of Claim**	
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) of Ins. Ombudsman Rule 2017**
13.	**Date of hearing/place**	**31.01.2019 at Bhopal**
14.	**Representation at the hearing**	
	g) For the Complainant	**Mrs. Savita Agrawal**
	h) For the insurer	**Mr. S.L.Bhoi, Manager (CRM)**
15.	**Complaint how disposed**	**Dismissed**
16.	**Date of Award/Order**	**31.01.2019**

- Mrs. Savita Agrawal (Complainant/Nominee) has filed a complaint against Life Insurance Corporation of India (Respondent) alleging repudiation of death claim.
- **Brief facts of the Case -** The complainant has stated that the above policy was taken by her husband Mr.Vijay Kumar Agrawal. Her husband died on 16.08.2015, thereafter she lodged the death claim before the respondent but her claim was repudiated by the respondent. The complainant approached this forum for payment of death claim.

  The respondent in their SCN have stated that policy was issued on 09.07.2013 and DLA died on 16.08.2015. The policy has run for 2 years 1 month and 4 days and comes under early claim category, therefore company had conducted investigation which reveals that the DLA was suffering from Grade-1 fatty infiltration of liver and cholelithiasis and CLD prior to taking the policy and this fact was not disclosed by the DLA in proposal form. The death claim has been repudiated on the grounds of suppression of material facts.
- The complainant has filed complaint letter, annex. VI A, policy copy, correspondence with respondent while respondent filed SCN with enclosures.
- Efforts for mediation failed. I have heard both the parties at length and perused papers filed on behalf of the complainant as well as the Insurance Company.
- The policy No. 358998307 was issued in favour of LA on 09.07.2013. The death claim was repudiated by respondent on the ground that DLA was suffering from Grade-1 fatty infiltration of liver and cholelithiasis and chronic liver disease prior to taking the policy. An Ulrta Sound

report of Apollo Hospital, Bilaspur dated 17.03.2012 is on record which shows that insured was suffering from Grade 1 fatty infiltration of liver and cholelithiasis. During hearing complainant has also admitted that LA was treated in Apollo Hospital, Bilaspur in 2012 for petty ailment. Clinical pathology report, hematology report dated 17.03.2012 is also on record. Ultra sound dated 17.03.2012 clearly reveals that DLA was having grade 1 fatty infiltration of liver and cholelithiasis on 17.03.2012. Proposal form was filled on 09.07.2013 in which LA has answered regarding health related question "Are you suffering from or have you ever suffered from ailments pertaining to Liver, Stomach, Heart, Lungs, Kidney, Brain or Nervous System?", negatively. In proposal form above statement shows that LA had not disclosed his above disease. Respondent in SCN has stated that had the DLA discloses the above fact in the proposal form, the underwriting decision of the insurer would have been different. Medical paper clearly shows that LA was suffering from Grade 1 fatty infiltration of liver and cholelithiasis prior to risk commencement date and LA had not disclosed above ailment and concealed his correct health status at the time of inception of the policy which LA should furnish mandatorily.

- In view of the above facts & circumstances, I come to the conclusion that the DLA had concealed material information at the time of inception of policy with respect of his previous ailment. Therefore I am of the considered opinion that there is no reason to interfere with the decision of respondent company and hence complaint is liable to be dismissed.
- The complaint filed by Mrs. Savita Agrawal is dismissed herewith.
- Let copies of Award be given to both the parties.

Dated : January 31, 2019 **(G.S.Shrivastava)**
Place : Bhopal **Insurance Ombudsman**

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Sri Gyana Ranjan Jena –V- Aviva Life)
COMPLAINT REF: NO: BHU-L-004-1718-0242
AWARD NO: IO/BHU/A/LI/ 054/2017-2018

1.	**Name & Address of the Complainant**	**Sri Gyana Ranjan Jena, Gopalpur, Sial Parikudagarh, Puri**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**10265268** **Life** **08.01.2016**
3.	**Name of the insured** **Name of the policyholder**	**Smt. Kuni Jena** **-----do-----**
4.	**Name of the insurer**	**Aviva Life**
5.	**Date of Repudiation**	**18.03.2017**
6.	**Reason for repudiation**	**Misrepresentation of spouse insurance cover.**
7.	**Date of admission of the Complaint**	**10.08.2017**
8.	**Nature of complaint**	**Rejection of claim by the Insurer.**
9.	**Amount of Claim**	**Rs.2,60,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.2,60,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**28.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	i) For the Complainant	**Gyana Ranjan Jena**
	j) For the insurer	**Priyabrata Pattanaik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case:- The mother of the complainant took the aforesaid policy from the present Insurer during January 2016 for a term of 10 years with sum assured of Rs.2,60,000/-, annual premium being Rs.19,038/-. Unfortunately she died on 05.05.2016. The claim papers were submitted by the complainant but it was rejected by the Insurer on 18.03.2017 on the ground that the LA has misstated some material fact. A category 3 lady should have sufficient spouse insurance for availing insurance on her own life. She had mentioned in the proposal form that her husband had an insurance of 6 lakh on the basis of which she was also sanctioned an insurance of SA 260000/-. The Insurer submitted that the Life Assured had misrepresented the material fact of "Spouse insurance details" at the proposal stage for which the claim was repudiated. But Finding no other alternative, he approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The claimant argument was that the claim was repudiated on the ground of mis statement of material fact i.e spouse insurance details. He expressed his innocence in this regard. According to the claimant the information regarding spouse insurance might have been generated by the concerned agent only.

b) Insurers' argument:- Insurer's argument was that the deceased LA had given false information regarding her spouse insurance. Investigation has revealed that there was no such coverage on the life of her spouse. Also the document submitted was found to be forged and fabricated. In the absence of spouse insurance, no cover would have been granted to the insured. Profile of the life assured was taken in to consideration while assessing the risk. The life assured was a category 3 self employed lady with educational qualification up to 5th pass. Hence, the underwriter considered her as housewife and raised additional information for proof of spouse insurance and policy was issued on the basis of spouse insurance only. When, it was proved that actually the spouse do not have any insurance on his own life the claim was repudiated. Hence, the case should be dismissed.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):-After going through the documents and argument of both the parties in detail it is admitted that the deceased Life assured had provided wrong information about spouse insurance. The receipt of the policy no 587705777 provided by the LA as a proof of the spouse policy is also forged and fabricated. The said policy is in the name of a different person than the husband of the deceased. But, it appears that the deceased LA had no interest in providing false information regarding her spouse insurance. This was only the handiwork of the concerned agent to complete a proposal of high sum assured and earn commission. The proposal was also not filled up by the LA as evident from the signature in the proposal form. Hence, the Insurer's submission that the LA made some misrepresentation regarding her spouse insurance is incorrect and unacceptable. Hence, this forum is of the opinion that the Insurer should admit the claim and pay the due amount to the claimant.

Taking into account the facts and circumstances of the case and the submissions made by both the parties during the course of hearing, a SUM of Rs.260000/- is hereby awarded to be paid by the Insurer to the Complainant as full and final settlement of the claim.

Hence, the complaint is treated as allowed 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 the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**
b. **As per 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 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 the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Sebati Mohanta–V- Bajaj Allianz, Life)
COMPLAINT REF: NO: BHU-L-006-1718-0343
AWARD NO: IO/BHU/A/LI/ 056 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Sebati Mohanta, W/O- Late Gangadhar Mohanta, At-Chilida, PO- Kantol, Via-Kankadahad, Dist- Dhenkanal.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**303015757, 300705470, 300704301.** **Life** **20.07.2013, 13.05.2013, 12.05.2013.**
3.	**Name of the insured** **Name of the policyholder**	**Late Gangadhar Mohanta.** **- do-**
4.	**Name of the insurer**	**Bajaj Allianz Life.**
5.	**Date of Repudiation**	**19.07.2013**
6.	**Reason for repudiation**	**Pre-existing disease of leukemia before taking policy.**
7.	**Date of admission of the Complaint**	**27.09.2017**
8.	**Nature of complaint**	**Nonpayment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.15,00,000/- + Bonus + 18% interest + other benefits.**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.15,00,000/- + Bonus + 18% interest + Other benefits.**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**28.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	k) For the Complainant	**Sebati Mohanta**
	l) For the insurer	**Saswata Banerjee**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case-: The husband of the complainant took the aforesaid three policies from Insurer during May & July 2013. Unfortunately he died on 11.05.2016. The claim forms were submitted by the nominee but rejected by the Insurer on 19.07.2016 stating that the life assured was having pre existing leukemia before taking proposal i.e since 2009. Then the case was referred to grievance officer but previous decision was upheld. Being dissatisfied with the decision of the Insurer, he approached this Forum for Redressal.

On the other hand the Insurer submitted SCN stating that the claim was repudiated due to non-disclosure of Hospitalization/ Treatment as a diagnosed case of chronic Myeloid Leukemia since 2009 confirmed on 2011. The decision was relied on the discharge certificate from SCB Medical college Hospital where LA was admitted on 28.07.2009 and discharged on 02.08.2009 with diagnosis of Chronic myeloid leukemia with malaria fever with bronchitis. Hence the case may be dismissed.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant's argument was that her husband had purchased 3 policies from the present insurer on different dated and premium was also paid regularly as per the terms and conditions of the policy. But when claim arouse due to death of her husband, the Insurer denied to pay on the ground of mis statement regarding health of LA which is unfair and arbitrary.

b) Insurers' argument:- The Insurer argued that the claim was repudiated due to non-disclosure of Hospitalization/ Treatment as a diagnosed case of chronic Myeloid Leukemia since 2009 confirmed on 2011. The decision was relied on the discharge certificate from SCB Medical college Hospital where LA was admitted on 28.07.2009 and discharged on 02.08.2009 with diagnosis of Chronic myeloid leukemia with malaria fever with bronchitis.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties in detail, it is observed that the policies were revived in Sept. 2015 and March 2016 and death took place on 11.05.2016. As it was a early claim the Insurer went for investigation. The claim was repudiated by the Insurer on the ground of non-disclosure of Hospitalization/ Treatment. The LA was diagnosed as a case of Chronic Myeloid Leukemia since 2009 which was confirmed in 2011. The Insurer also submitted various hospitalization records of the LA prior to the commencement of the policy. This fact was in the knowledge of the LA prior to making the proposal for Insurance which was deliberately concealed. As per the document submitted by the Insurer, the LA was admitted in SCB Medical College and Hospital on 28.07.2009 and was discharged on 02.08.2009 and was diagnosed as suffering from Chronic myeloid leukemia with malaria. Had the previous health history been disclosed at the time of proposal, the Insurer would not have taken the risk. Hence, this forum is of the opinion that the case may be dismissed on the ground of concealment of material fact.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

d. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

e. As per 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 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 the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Damayanti Upadhyaya–V-Bajaj Allianz Life)
COMPLAINT REF: NO: BHU-L-006-1718-0396
AWARD NO: IO/BHU/A/LI/ 055 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Damayanti Upadhyaya, W/O- Late Sadasib Upadhyaya, At- Krushnapur, PO- Bahanaga, Dist- Balasore, Odisha.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**0186630914** **Life** **NA**
3.	**Name of the insured** **Name of the policyholder**	**Sridhar Malik (Assignor)** **Sadasib Upadhyaya (Assignee)**
4.	**Name of the insurer**	**Bajaj Allianz Life.**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**25.10.2017**
8.	**Nature of complaint**	**Nonpayment of death claim by the Insurer.**
9.	**Amount of Claim**	**Death claim value.**
10.	**Date of Partial Settlement**	**Rs.70,251/-**
11.	**Amount of relief sought**	**Rs.70,251/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**28.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	m) For the Complainant	**Damayanti Upadhaya**
	n) For the insurer	**Saswat Banerjee**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case-: The complainant's husband, Late Sadashiba Upadhyaya, was assigned with the aforesaid policy by assignor Sri Sridhar Malik on 28.07.2011. The policy was in the name of Sri Sridhar Mallik. The deceased(Sadashiba Upadhayaya) had paid all the premium after assignment. Unfortunately he died on 24.11.2016 due to accident. When the wife of the assignee submitted the death claim form she was paid the surrender value of

the policy amounting to Rs.70,251/- 0nly on 21.02.2017. Being dissatisfied with the decision of the Insurer, She approached this Forum for Redressal.

On the other hand the Insurer submitted SCN that death claim is admitted on the death of life assured not the Assignee. In this case LA is still alive hence no death claim is payable. Therefore, the case may be dismissed.

18) Cause of Complaint:

a) Complainant's argument:- Complainant's argument was that as the policy was assigned to her husband, hence her husband was the legal title holder of the policy. Hence, when her husband died, she must have received the benefit under the policy.

b) Insurers' argument:- Insurer argued that assignee is not the life assured in the policy. Death claim is payable only when the LA (Life Assured) had expired and not the assignee as per the contract of assignment. Hence, in this case the Insurer has rightly paid the surrender value to the claimant.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- after going through the documents and argument of both the parties in detail, it is observed that the claim by the claimant is not genuine. Assignment of a policy is governed by Sec.38 of Insurance act. As per this act, after assignment of a policy the assignee is the sole beneficiary of the policy. That means, his claim is only limited to the maturity/death claim proceeds of the policy. In this case assignor is the Life Assured not the assignee. Death claim is payable when the life assured had expired and not the assignee. In assignment only rights to the policy changes not the ownership. In this case the Insurer has rightly paid the surrender value after the death of the assignee. Hence, this forum is of the opinion that the case is to be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

g. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.
h. As per 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 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 the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE

THE INSURANCE OMBUDSMAN, STATE OF ODISHA

(UNDER RULE NO: 16(1)/17 of

THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – SHRI I SURESH BABU

CASE OF (Smt. Bijayalaxmi Swain –V- Bharati Axa Life)

COMPLAINT REF: NO: BHU-L-008-1718-0394

AWARD NO: IO/BHU/A/LI/ 070 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Bijayalaxmi Swain, At- Suryapur Bagada, Baladevjew Kendrapada, Dt- Kendrapada, Odisha.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**501-1824991** **Life** **11.03.2014**
3.	**Name of the insured** **Name of the policyholder**	**Lipsa Priyadarshini.** **Late Manoranjan Jena.**
4.	**Name of the insurer**	**Bharati Axa Life**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**26.10.2017**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer.**
9.	**Amount of Claim**	**Rs.15,56,266/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.15,56,266/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**

13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	o) For the Complainant	**Bijayalaxmi Swain**
	p) For the insurer	**Santosh Panigrahi**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case:-The complainant's husband took the aforesaid policy on the life of his daughter from the present Insurer during March 2014. Unfortunately her husband died on 11.09.2015 due to accident. She submitted the claim to the Insurer on 15.02.2017 but did not get any response. Finding no other alternative, she approached this Forum for Redressal.

The Insurer on the other hand has submitted SCN on 30.10.2017 stating that the company was unable to consider the request of the complainant as the death claim under any insurance policy is paid only after the death of Life Insured and not the proposer. In this policy Lipsa Priyadarshini (Daughter) was the Life insured and Manoranjan Jena (deceased) is the proposer. Hence as per the terms and conditions of the policy nothing is payable.

18) Cause of Complaint:

a) Complainant's argument:- Complaint argued that her husband had taken a policy on the life of her daughter and after death of her husband the Insurer denied to pay the claim. After the death of her husband the income of the family has come to an end and she does not have any income of her own to pay the premium also. Hence she requested the insurer to at least refund the premium paid by her husband if the claim is not admitted.

b) Insurers' argument:- The Insurer on the other hand argued that the company was unable to consider the request of the complainant as the death claim under any insurance policy is paid only after the death of Life Insured and not the proposer. In this policy Lipsa Priyadarshini (Daughter) was the Life insured and Manoranjan Jena (deceased) is the proposer. Hence as per the terms and conditions of the policy nothing is payable.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties it is observed that, the policy in question was issued on the life of the child where father was the proposer. It is admitted that the claim is not payable on the death of the proposer. But some provision should be there in the policy for stop payment of premium after the death of the proposer as the income of the family ceases. The Insurer should have suggested/persuaded the proposer to opt for premium waiver benefit rider at the time of proposal. After death of the only earning member of the family, there is no possibility for payment of premium against the policy. As per the statement of the complaint her husband had deposited 2 premiums @ Rs.99999.42 before death. Hence, this forum is of the opinion that the complaint is to be refunded the total premium paid against the said policy and the policy is to be treated as null and void after that.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complainant is to be refunded whatever premium paid against the policy by the Insurer towards full and final settlement against the claim.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

j. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

k. According to the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Smt Gitanjali Jena –V-Birla Sun Life)
COMPLAINT REF: NO: BHU-L-009-1718-0431
AWARD NO: IO/BHU/A/LI/077 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Gitanjali Jena, Sec-6, H-Block, Bhagabati Palli, Rourkela-769002.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**006623879** **Life** **05.11.2014**
3.	**Name of the insured** **Name of the policyholder**	**Prafulla Kumar Jena** **-do-**
4.	**Name of the insurer**	**Birla Sun Life**
5.	**Date of Repudiation**	**13.04.2017.**
6.	**Reason for repudiation**	**Active concealment of material facts regarding health during revival.**
7.	**Date of admission of the Complaint**	**21.11.2017**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer.**
9.	**Amount of Claim**	**Rs.2,50,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.2,50,000/- + Interest**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	q) For the Complainant	**Gitanjali Jena**

	r) For the insurer	**Aparajita Bagchi**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The complainant's husband took the aforesaid policy from present Insurer on 05.11.2014. Unfortunately her husband died on 05.11.2016. Being the nominee she lodged the death claim but it was repudiated by Insurer on the ground of misrepresentation regarding the condition of health at the time of revival i.e on 13.07.2016. The cause of death was due to septicemia. The Life Assured was diagnosed to be suffering from Type-II Diabetes Mellitus, Hypertension, Chronic Kidney Disease and Urinary Tract infection for which Life Assured had undergone investigations and treatment much prior to the commencement of Insurance. Finding no other alternative, she approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The claimant argued that the Insurer repudiated the death claim against policy on the life of her husband showing false allegation that he was suffering from Diabetes. Hypertension, chronic Kidney disease prior to the commencement of the policy. Her husband was in good health prior to the commencement of the policy. Hence, death claim should be admitted and paid as per rules.

b) Insurers' argument:- The Insurer on the other hand stated that although the policy in question commenced on 05.11.2014 the 2nd premium was not paid in time. It was revived on 13.07.2016 by paying the 2nd premium with late fee. After 5 months and 29 days from the date of revival, death claim intimation along with necessary documents were filed with the Insurer. After vivid investigation it was found that the policy holder died due to sepsis and shock. Investigation revealed that the deceased LA was suffering from Diabetes mellitus, Kidney disease and ulcer prior to reinstatement of the policy. Hence, the claim against the said policy was liable for repudiation.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):- After a careful scrutiny of the documents submitted by both the parties it was observed that the policy was revived on 13.07.2016 by giving a declaration of good health. But he was suffering from Diabetes, Hyprtension etc prior to the date of revival of the policy. The Insurer has also collected various documents to prove regarding the ill heath of the LA. As per Section 45(2) of Insurance Act, a policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of revival of the policy on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived. But in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, except on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be refunded to the insured or the legal representatives or nominees or the assignees of the insured within a period of ninety days from the date of such repudiation. Hence, this forum is of the opinion that whatever premium paid by the deceased LA against the policy in question should be refunded to the claimant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, it is awarded that all the premiums paid in the said policy be refunded by the Insurer to the claimant as full and final settlement of the claim.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

l. **According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**

m. **As per 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 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**

n. **As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Kamal Tarai -V- SBI Life)
COMPLAINT REF: NO: BHU-L-019-1718-0271
AWARD NO: IO/BHU/A/LI/ 093/2017-2018

1.	**Name & Address of the Complainant**	**Mr. Kamal Tarai.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**18518074** **Life** **17.06.2016**
3.	**Name of the insured** **Name of the policyholder**	**Smt. Benga Dei.** **- do-**
4.	**Name of the insurer**	**HDFC Standard Ins. Company.**
5.	**Date of Repudiation**	**25.02.2017**
6.	**Reason for repudiation**	**Suppression of previous insurance history in the proposal.**
7.	**Date of admission of the Complaint**	**23.08.2017.**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.1,30,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.1,30,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**31.01.2019 / Bhubaneswar**

14.	**Representation at the hearing**	
	s) For the Complainant	**Absent**
	t) For the insurer	**Koyel Ghosh**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.01.2019**

17) Brief Facts of the Case:- The mother of the complainant took a policy from the Insurer. The life assured died on 07.08.2016. The complainant as nominee lodged a death claim but claim was rejected by Insurer on 25.02.2017 on the ground suppression of previous insurance history at the time of proposal. Being dissatisfied with the decision of the Insurer the claimant approached this Forum for Redressal.

On the other hand, the insurer submitted SCN stating that the policy was completed on the basis of some material information supplied by the LA at the time of proposal. While purchasing the policy she had stated that her age was 54 years. But after investigation it was found that the actual age was 66 years as evident from voter ID card. In addition to it she had also not disclosed regarding her previous policies taken from other insurers. From the SCN of the Insurer it is also clear that the deceased LA had purchased insurance of huge amount from different Insurers during the month of June 2016 where death occurred on 07.08.2016 just within 2 months after. This amounted to deliberate misrepresentation of material facts affecting the underwriting decision of the Insurer. Hence, the claim was repudiated.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant was absent in the hearing on 31.01.2019

b) Insurers' argument:- The Insurer stated that the Complainant has approached the Court of Permanent Lok Adalat (PSU), Khurda for redressal on the same subject matter. A copy of PLA notice was also produced by the Insurer. Hence, the case may be dismissed.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- As the complainant has moved to Permanent Lok Adalat, Khurda for redressal, this forum is of the opinion that the complaint is to be dismissed at our end.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

o. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

p. As per 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 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.

q. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Sarojini Parida -V- Exide Life)
COMPLAINT REF: NO: BHU-L-025-1718-0428
AWARD NO: IO/BHU/A/LI/065 /2017-2018

1.	**Name & Address of the Complainant**	**Mrs. Sarojini Parida, At- Bijadihi, PO- Aluajharan, Via- Kamakhya Nagar, Dist- Dhenkanal.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**02633989,02633961.** **Life** **27.02.2013, NA.**
3.	**Name of the insured** **Name of the policyholder**	**Late purastam Panda.** **- do-**
4.	**Name of the insurer**	**Exide Life**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**21.11.2017**
8.	**Nature of complaint**	**No response by Insurer regarding settlement of death claim.**
9.	**Amount of Claim**	**Monetary Loss**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**NA**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**
13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	u) For the Complainant	**Sarojini Parida**
	v) For the insurer	**R Sree Ram**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case:- The complainant's husband took a policy from the present Insurer during February 2013. Unfortunately the Life assured died on 20.05.2013.The complainant as nominee lodged the complaint. But

neither the company paid the claim nor responded in the matter. Finding no other alternative, she approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- As per the complainant, she had claimed the death insurance claim proceeds to the Insurer, which is not paid till date.

b) Insurers' argument:- Insurer's argument was that although death of the LA took place on 20.05.2013 the claimant had not submitted any claim papers with the Insurer till date. The claim will be settled as soon as the all the relevant papers are submitted with the Insurer.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the argument of both the parties in detail it is observed that all the relevant claim papers are not submitted to the Insurer by the claimant till date. Unless claim papers are produced with the insurer the Insurer is helpless to settle the claim. Hence, this forum advised the claimant to submit the papers in detail to the Insurer and if it is not settled in time the she should approach Ombudsman for settlement.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complainant is advised to submit the claim papers to the Insurer for payment of death claim proceeds.

Hence, the complaint is treated as admitted.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

- **r. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**
- **s. As per 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 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.**
- **t. According to the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 29th Jan.2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Sunil Kumar Sahoo –V- LIC OF INDIA,Bhubaneswar DO)
COMPLAINT REF: NO: BHU-L-029-1718-0293
AWARD NO: IO/BHU/A/LI/078 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Sunil Kumar Sahoo, EH-25, Sec-6, Rantpur, BHEL, Haridwar, Uttarakhanda-249403**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**587298050** **Life** **28.05.2009**
3.	**Name of the insured** **Name of the policyholder**	**Late Pramila Sahoo** **- do-**
4.	**Name of the insurer**	**LIC OF INDIA, Bhubaneswar DO**
5.	**Date of Repudiation**	**31.03.2015**
6.	**Reason for repudiation**	**Incorrect information withholding correct information regarding health at the time of proposal.**
7.	**Date of admission of the Complaint**	**31.08.2017**
8.	**Nature of complaint**	**Repudiation of death claim by Insurer.**
9.	**Amount of Claim**	**Rs.75,000/- (SA)+ Bonus**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**SA + Bonus**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	w) For the Complainant	**Sunil Kumar Sahoo**
	x) For the insurer	**D Naik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.01.2019**

17) Brief Facts of the Case-: The complainant's mother took a policy with the present Insurer during 2009. Unfortunately she died on 17.11.2014. Death claim forms were submitted. But the claim was repudiated on the ground of suppression of material fact on health in the proposal form submitted by the deceased. The nominee being dissatisfied with the decision of the Insurer approached this Forum for Redressal.

On the other hand Insurer submitted SCN/Counter pleading that the deceased took a policy on 31.08.2009. The policy was revived on 28.01.2014. The life assured died on 17.11.2014 due to CRTD. Although she had mentioned that her health was good at the time of taking insurance, in fact, she was treated at care hospital from 25.02.2009 to 12.03.2009 prior to taking the policy in question. So the claim was repudiated on the ground of withholding material information regarding health with no payment liability.

18) Cause of Complaint:

a) Complainant's argument:- The complainant argued that the Insurer arbitrarily repudiated the claim against the said policy on the ground of mis representation of material fact as per section 45 of Insurance Act. According to the claimant no policy can be called in question on the ground of mis-statement after 2 years of commencement. Here in this case the DOC was 28.05.2009 and date of death was 17.11.2014. Hence, full liability is to be paid under the said policy.

b) Insurers' argument:- The insurer on the other hand argued that at the time of proposal DLA declared that her health was good and during the last 5 years she had not undergone any operation or not suffered from any ailments pertaining to heart. But all these answers were false as there was evidence that she was treated at Aditya Care Hospital, Bhubaneswar from 25.02.2009 to 12.03.2009 for CRT device implantation. The DLA did not disclose this fact in the proposal. It is therefore evident that the DLA had made incorrect statements and withhold correct information regarding her health at the time of proposal. So, the claim was repudiated with no payment liability under the policy and all moneys that have been paid in consequences stands forfeited.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties it is observed that the CRT device was implanted in DLA's heart during 2009 which was prior to the commencement of the policy. But the policy was discontinued and revived on 28.01.2014 after which death occurred on 17.11.2014 almost ten months after revival. Here in this case the health conditions of the DLA was very much in her knowledge and she did not disclose it at the time of proposal. As per Sec.45 of the Insurance Act, 1938 (pre-revised) no policy of life insurance after the expiry of 2 years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or a referee, or friend of the insured, or any document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose. But in case of revival, as per Law Commission of India, 112th report on section 45 of insurance act 1938, the period of 2 years has to be calculated from the date on which the policy was originally effected. Here the commencement of the policy is 28.05.2009. The Insurer has not pointed about the misrepresentation of material fact within a period of 2 years. Hence, this forum is of the opinion that the claim is to be admitted in favor of the claimant and Sum Assured along with bonus is to be paid as per rules.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, it is awarded that the Sum Assured of Rs.75000/- (Rupees Seventy five thousand only) along with bonus is to be paid by the insurer to the claimant as full and final settlement of claim.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

u. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.
v. As per 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 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

w. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri Suresh Babu
CASE OF (Sri Bibhabasu Dash –V- LIC OF INDIA, Cuttack DO)
COMPLAINT REF: NO: BHU-L-029-1718-0295
AWARD NO: IO/BHU/A/LI/086 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Namita Prava Das, W/O- Late Sushanta Kumar Mohapatra, At- Garjanpur, P.O-Madanpur, Kendrapara.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**588319808,588995440,597975592,583511283.** **Life** **28.03.2009, 06.02.2010,28.07.2010,15.03.2000.**
3.	**Name of the insured** **Name of the policyholder**	**Late Sushant Kumar Mahapatra.** **- do-**
4.	**Name of the insurer**	**LIC OF INDIA, Cuttack DO**
5.	**Date of Repudiation**	**12.03.2015**
6.	**Reason for repudiation**	**Withholding material information regarding health at the time of proposal.**
7.	**Date of admission of the Complaint**	**01.09.2017**
8.	**Nature of complaint**	**Repudiation of death claim by Insurer.**
9.	**Amount of Claim**	**Rs.11,00,000/- Sum Assured**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.11,00,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019/ Bhubaneswar**
14.	**Representation at the hearing**	
	y) For the Complainant	**Namita prava Das**
	z) For the insurer	**R C Bhadra**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case-: The husband of the complainant had taken 4 policies as stated above. Unfortunately he died 17.06.2013. The complainant lodged the claim to Insurer but the Insurer repudiated the liability on 12.03.2015 on the ground that the deceased insured had withheld material information regarding health at the time of revival

of the policies. The deceased had taken 41 days leave on medical ground (as alleged by the Insurer) but actually he was attending the process of "Mantra Sidha" as a devotee at Satsikhya Mandir of Swami Nigamananda Ashram, Bhubaneswar during that period. The complainant represented to the grievance officer of the Insurer on 25.04.2016 but decision was kept upheld by grievance officer. Finding no other alternative, she approached this Forum for Reddressal.

On the other hand Insurer submitted SCN/Counter pleading that the deceased took 4 policies from present Insurer. While reviving the policies he had declared that he was having good health. But it was found that the DLA was suffering from acid peptic disease and was advised for rest up to 10.04.2011by the Doctor on 01.03.2011 vide OPD no. 23096. The DLA was also on E.L. for that period. The life assured died on 17.06.2013. So the claim was repudiated on the ground of suppression of material fact on health at the time of revival of policies.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant argued that her husband had taken the above 4 policies from the present Insurer. Because of some financial constraints the LA could not pay the premiums in time and all these policies were revived on different dates during the year 2011, 2012 & 2013. But unfortunately LA died on 17.06.2013. But the claim was repudiated on the ground of suppression of material fact on health at the time of revival. This is an arbitrary and unlawful action by the Insurer to get rid of the liability.

b) Insurers' argument:- The Insurer on the other hand stated that all these policies were revived on different dates during the year 2011, 2012 & 2013 and death occurred on 17.06.2013 which is within 3 years from the date of revival. Insurer has also collected evidence to prove that the DLA was suffering from Acid Peptic Disease since 01.03.2011. In addition to it the DLA had availed leave from the employer on the ground of health from 11.03.2011 to 10.04.2011. All these things were not disclosed at the time of revival while submitting DGH. Hence the claim was repudiated.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties it is observed that the death occurred within 3 years from the date of revival. According to the Insurer the DLA did not disclose his health condition at the time of revival. He was suffering from Acid Peptic Disease and was under treatment under a Doctor of UGPHC Pattamundai. But can the acid peptic disease be the cause of death ? The Insurer has collected evidence that the DLA was on leave from 11.03.2011 to 10.04.2011 on health grounds. It was also contradicted by the claimant by showing evidence that he was attending the process of "Mantra Sidha" during that period as a devotee at Satsikhya Mandir of Swami Nigamananda Ashram, Bhubaneswar. The claimant stated that her husband was compelled to apply for leave on health ground only for the purpose of sanction. Had he applied for leave on some other reason, the leave would not have been sanctioned by the competent authority. Further Section 45 of Insurance act 1938 (pre revised) states that no policy can be called in question on the ground of mis-statement after 2 years from the date of it's commencement. As per Law Commission of India 112th Report on Section 45 of insurance act 1938, in case of revival of lapsed policy, the period has to be calculated from the date on which policy was originally effected. Here in this case the period of 2 years has already elapsed. Hence, this forum is of the opinion that the death claims under all the above mentioned policies are to be admitted and paid in favor of the claimant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, it is awarded that death claim in respect of all the 4 policies is to be admitted and paid by the Insurer to the claimant as full and final settlement of the claim.

Hence, the complaint is treated as admitted accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

x. **According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**

y. **As per 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 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**

z. **As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Nirupama Jena –V- LIC OF INDIA,Bhubaneswar DO)
COMPLAINT REF: NO: BHU-L-029-1718-0296
AWARD NO: IO/BHU/A/LI/ 059 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Nirupama Jena, Plot No.2197/9834, Satya Vihar, Rasulgarh, Mancheswar, Bhubaneswar – 751017.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**583239737** **Life** **28.11.2002**
3.	**Name of the insured** **Name of the policyholder**	**Late Khirod Chandra Jena** **- do-**
4.	**Name of the insurer**	**LIC OF INDIA, Bhubaneswar DO**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**01.09.2017**
8.	**Nature of complaint**	**The death claim was not yet settled.**
9.	**Amount of Claim**	**SA + Bonus + Delayed Interest**
10.	**Date of Partial Settlement**	**NA**

11.	**Amount of relief sought**	**SA + Bonus + Delayed Interest**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**
13.	**Date of hearing/place**	**29.01.2019/ Bhubaneswar**
14.	**Representation at the hearing**	
	aa) For the Complainant	**Absent**
	bb) For the insurer	**D K Naik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	

17) Brief Facts of the Case-: The complainant's husband took a policy with the present Insurer during 2002. Unfortunately he died on 22.07.2014. Death claim forms were submitted and reminder was sent on 25.10.2016. But the claim was not yet settled. No reply was also received from the Insurer. Finding no other alternative, She approached this Forum for Redressal.

On the other hand the insurer has submitted SCN 26.10.2017 stating that the claim has already been admitted in favor of the claimant and Rs. 151268.00 was paid on 22.11.2017. Hence, the case may be treated as dismissed.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant was absent.

b) Insurers' argument:- As per the statement of the Insurer, claim has already been admitted in favor of the Claimant and Rs.151268.00 was paid on 22.11.2017 as full and final settlement in respect of the said policy.. Hence, the case may be dismissed.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- The insurer has already admitted the claim and paid the claim proceeds to the claimant on 22.11.2017. Further, the claimant did not attend the hearing as she does not have any further grievance against the Insurer. Hence, this forum is of the opinion that the complaint should be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by the Insurer, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

aa. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

bb. According to the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Binod Pradhan -V-LIC Of India, Bhubaneswar DO)
COMPLAINT REF: NO: BHU-L-029-1718-0395
AWARD NO: IO/BHU/A/LI/067 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Binod Pradhan, At/PO- Dinagaon, Via-Madhyakhanda, Dist- Nayagarh, Odisha.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**588944004** **Life** **07.12.2009**
3.	**Name of the insured** **Name of the policyholder**	**Smt. Atartti Pradhan** **- do-**
4.	**Name of the insurer**	**LIC Of India, Bhubaneswar DO.**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**30.10.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.1,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.1,00,000/- + Interest**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**
13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	cc) For the Complainant	**Binod Pradhan**
	dd) For the insurer	**D K Naik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case:- The wife of the complainant took the aforesaid policy from the present Insurer on 07.12.2009, but unfortunately she died on 20.12.2009 due to Cardiac Arrest. The Nominee, the husband of the deceased have submitted the claim papers but the Insurer was silent on the matter of payment of claim. Finding no other alternative, he approached this Forum for Redressal.

On the other hand the Insurer has submitted SCN in which it has mentioned that the Nominee submitted the claim documents in the Office on 25.02.2016, after a gap of 6 years and four months except death certificate. However, the claimant submitted one attested copy of death certificate on 27.10.2017 in Nayagarh Branch and it was received by DO Bhubaneswar on 17.11.2017. The papers are under scrutiny by the Divisional claim department for consideration of claim..

18) Cause of Complaint:

a) Complainant's argument:- The Complainant's argument was that his wife had taken a policy from the present Insurer on 07.12.2009, but unfortunately she died on 20.12.2009 due to cardiac arrest. He applied for payment of death claim proceeds in the said policy, but the Insurer did not respond yet.

b) Insurers' argument:- On the other hand the Insurer argued that the Nominee submitted the claim documents in the Office on 25.02.2016, after a gap of 6 years and four months except death certificate. However, the claimant submitted one attested copy of death certificate on 27.10.2017 in Nayagarh Branch and it was received by DO Bhubaneswar on 17.11.2017. The papers are under scrutiny by the Divisional claim department for consideration of claim..

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments by both the parties it is observed that the delay in submission of the papers was due to the unhealthy mental conditions of the claimant after death of his wife. He remained absent from his village after wife's death for which there was an inordinate delay in submission of claim papers and requested to condone the delay. But Insurer submitted that there are some discrepancy in the name of the LA. In addition, this was an early claim arising after 13 days after taking the policy, so the claim papers are under scrutiny by the Divisional claim team for consideration of claim. Hence, this forum is of the opinion that the Insurer should process the claim immediately and take necessary steps to settle the claim on the basis of merit of the case.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the Insurer is advised to process the claim immediately and settle the claim on the basis of it's merit.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

cc. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.
dd. Insurers' argument:- Insurer's argument was that although death of the LA took place on 20.05.2013 the claimant had not submitted any claim papers with the Insurer till date. The claim will be settled as soon as the all the relevant papers are submitted with the Insurer.

ee. According to the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Jayakrishna Naik -V-LIC Of India, Sambalpur DO)
COMPLAINT REF: NO: BHU-L-029-1718-0415
AWARD NO: IO/BHU/A/LI/ 072/2017-2018

1.	**Name & Address of the Complainant**	**Sri Jayakrishna Naik, At/PO- Lahanga, Via- Godbhaga, Dist- Bargarh – 768111.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**594687923** **Life** **20.09.2013**
3.	**Name of the insured** **Name of the policyholder**	**Late Manabhanjan Naik.** **- do-**
4.	**Name of the insurer**	**LIC Of India, Sambalpur DO.**
5.	**Date of Repudiation**	**17.03.2016.**
6.	**Reason for repudiation**	**Withholding material information regarding income & occupation.**
7.	**Date of admission of the Complaint**	**13.11.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.5,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.5,00,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019/ Bhubaneswar**
14.	**Representation at the hearing**	
	ee) For the Complainant	**Jayakrishna Naik**
	ff) For the insurer	**J Muna**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**04.02.2019**

17) Brief Facts of the Case:- The son of the complainant took the aforesaid policy for SA Rs.500000/- from the present Insurer during Sep 2013 but unfortunately he died on 07.10.2014. He submitted the claim but it was rejected by the Insurer on the ground of mis-statement regarding occupation & income. But in fact his son was privately employed by a contractor of Adity Birla Company and no salary slip/service record was maintained by the contractor. Being aggrieved by such decision & finding no other alternative, he approached this Forum for Redressal.

On the other hand the Insurer submitted SCN on 04.12.2017 stating that the DLA had made deliberate misstatements and withheld material information from them regarding his occupation and income at the time of

taking the policy. Had he disclosed the material fact and given correct information regarding his income and occupation, he would not have been granted an insurance of such large sum assured and the underwriting decision would have been different. Hence, the case may be dismissed.

18) Cause of Complaint:

a) Complainant's argument:- The complainant argument was that the repudiation of claim by the Insurer on the ground of misrepresentation of material fact was arbitrary and unjust. At the time of insurance, his son was working in Aditya Birla, Jharsududa on temporary basis which was mis-quoted in the proposal by the agent only. He was getting Rs.30000/- per month as salary and in addition to it he had also some other income from agriculture. Hence, the argument of the Insurer that the LA had misstated his occupation & income particulars is wrong.

b) Insurers' argument:- Insurer on the other hand argued that the proposal was accepted under non-medical special scheme as the proposer stated that he was working in Aditya Birla, Jarsuguda. But actually he was working under a contractor and drawing a very less amount than he had mentioned in the proposal.The father of the LA had submitted a written document regarding correct employment and salary of the deceased. It was a deliberate attempt by the deceased LA to withhold some material information which had a bearing on the acceptance of the risk. Hence, as per the terms of policy contracts, the claim was repudiated.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties, it is observed that, the deceased LA had mis stated some material information at the time of commencement of the contract. Actually, the LA was not an employed person . He was working on temporary basis under a contractor and was paid a very nominal salary. As per the report obtained by the Insurer from the father of the deceased, he had only worked under that contractor for 2 months i.e during April and May 2014. Had the proposer given correct information regarding his occupation and income, a policy of such higher Sum assured would not have been sanctioned to him. Rather he gave some false information in the proposal form on the basis of which proposal was accepted. Thus it is evident that he had made deliberate misstatements and withhold material information from the Insurer only to grab the benefits of insurance. Hence, this forum is of the opinion that the contract of insurance should be declared null and void and the case may be dismissed accordingly.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is declared as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

ff. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

gg. As per 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 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) As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurer

Dated at Bhubaneswar on 4th Jan.2019

(I Suresh Babu)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Swarnalata Das -V-LIC Of India, Cuttack DO)
COMPLAINT REF: NO: BHU-L-029-1718-0416
AWARD NO: IO/BHU/A/LI/081 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Swarnalata Das, W/O- Late Prabir Kumar Das, At-Dakhinabandha, PO-Sarankul, Via- Mangalpur, Dt-Jajpur**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**598918038, 598586771.** **Life** **28.06.2012, 28.11.2011**
3.	**Name of the insured** **Name of the policyholder**	**Late Prabir Kumar Das.** **- do-**
4.	**Name of the insurer**	**LIC Of India, Cuttack DO.**
5.	**Date of Repudiation**	**30.09.2016.**
6.	**Reason for repudiation**	**Withholding material information regarding health during revival.**
7.	**Date of admission of the Complaint**	**13.11.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.1,50,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.1,50,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	gg) For the Complainant	**Swarnalata Das**
	hh) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The husband of the complainant took the aforesaid two policies from the present Insurer during June 2012 & November 2011 respectively but unfortunately he died on 16.03.2016. She submitted the claim but it was rejected by the Insurer on the ground of mis-statement regarding health. Being aggrieved by such decision & finding no other alternative, she approached this Forum for Redressal.

On the other hand the Insurer has submitted SCN on 27.11.2017 stating that the competent authority repudiated the claim on the basis of suppression of material facts. According to the Insurer, the DLA was suffering from cancer of Gall Bladder since March 2014 (04.03.2014) as reported by Dr. D K Agarwalla, Acharya Harihar Cancer Center, Cuttack. The policy was revived on 20.03.2014. Hence, LA was very much aware that he was suffering from cancer at the time of revival of the policies for which the claim was repudiated.

18) Cause of Complaint:

a) Complainant's argument:- Complainant argued that her husband had purchased the above policies from the present insurer during Nov.2011 and June 2012. But after the death of the DLA, the claim was repudiated on the ground of mis representation regarding health at the time of revival i.e on 20.03.2014.

b) Insurers' argument:- On the other hand the Insurer argued that the competent authority repudiated the claim on the basis of suppression of material facts. According to the Insurer, the DLA was suffering from cancer of Gall Bladder since March 2014 (04.03.2014) as reported by Dr. D K Agarwalla, Acharya Harihar Cancer Center, Cuttack. The policy was revived on 20.03.2014. Hence, LA was very much aware that he was suffering from cancer at the time of revival of the policies for which the claim was repudiated

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.

a) Photo copies of policy documents.

b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents it is observed that the death of LA occurred on 16.03.2016 and cause of death was Gall Bladder cancer. It was also observed that the DLA was suffering from Cancer of Gall Bladder since March 2014 (04.03.2014) and policies were revived on 20.03.2014. Here, the Section 45 of Insurance Act 1938 (Amended in 2015) will be applicable as the death of the LA was on 16.03.2016. As per this act a policy of Life Insurance may be called in question at any time within 3 years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy on the ground of mis-representation or fraud. Here in this case, the DLA was very much aware that he was suffering from cancer. Inspite of knowing that he was suffering from cancer, he revived the policies by giving declaration of good health. Hence, this forum is of the opinion that, the complaint is to be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is to be treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

- **hh. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.**
- **ii. As per 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 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**
- **jj. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.**

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Mandakini Das -V-LIC Of India, Bhubaneswar DO)
COMPLAINT REF: NO: BHU-L-029-1718-0418
AWARD NO: IO/BHU/A/LI/079 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Mandakini Das, At/PO- Baisingha, PO-Kamakhyanagar, Dist- dhenkanal. Pin-759039**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**587789685** **Life** **12.01.2012**
3.	**Name of the insured** **Name of the policyholder**	**Late Bijaya Kumar Dash** **- do-**
4.	**Name of the insurer**	**LIC Of India, Bhubaneswar DO.**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of admission of the Complaint**	**13.11.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.5,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Death Claim**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	ii) For the Complainant	**Mandakini Dash**
	jj) For the insurer	**D Naik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The complainant was the nominee of the life assured who took a policy from the present Insurer during January 2012. Unfortunately he died on 23.02.2012 due to heart stroke. The complainant lodged the death claim as nominee but no response had been made from the side of the Insurer in spite of her best efforts. Finding no other alternative, she approached this Forum for Redressal.

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18) Cause of Complaint:

a) Complainant's argument:- The complainant's argument was that although she has submitted all the papers in regard to the claim, it is not yet paid

b) Insurers' argument:- On the other hand the Insurer submitted that the payment of claim is delayed because of some requirements which are not complied by the claimant. Last letter written to the claimant for compliance to various requirements was 30.12.2017. As soon as the requirements are complied, the claim will be paid

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After verification of documents and arguments of both the parties it is observed that it was a case of early claim. Death occurred just after one month of availing the policy. The claim was intimated to the insurer in late i.e after a gap of 3 years and 6 months. Although, the claim was intimated it was not settled because of some requirements. The last letter was written on 30.12.2017 by the insurer to the complaint regarding some requirements which is not complied yet. Unless requirements are complied with the insurer expressed it's helplessness to settle the claim. Till date the claim has not been repudiated. Hence, this forum advised the claimant to comply all the requirements asked by the insurer then only claim can settled.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complainant is advised to comply all the requirements asked by the Insurer for early settlement of the case.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

kk. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

ll. As per 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 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

mm. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I Suresh Babu)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Anupama Mohanta -V-LIC Of India, Cuttack DO)
COMPLAINT REF: NO: BHU-L-029-1718-0421
AWARD NO: IO/BHU/A/LI/085 /2017-2018

1.	**Name & Address of the Complainant**	**Smt. Anupama Mohanta, At- Nischintapur, PO- Radhikapur, Via- Ukhunda, PS-Baria, Dist- Kendujhar.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**599559377** **Life** **05.03.2015.**
3.	**Name of the insured** **Name of the policyholder**	**Late Somanath Mohanta.** **- do-**
4.	**Name of the insurer**	**LIC Of India, Cuttack DO.**
5.	**Date of Repudiation**	**09.01.2016.**
6.	**Reason for repudiation**	**Incorrect information and withholding material information regarding health.**
7.	**Date of admission of the Complaint**	**15.11.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.6,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.6,00,000/- + Bonus.**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019/ Bhubaneswar**
14.	**Representation at the hearing**	
	kk) For the Complainant	**Anupama Mohanta**
	ll) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The husband of the complainant took the aforesaid policy from the present Insurer during March 2015 but unfortunately he died when policy was in force i.e on 19.01.2017. The claim is repudiated by the Insurer. As per the letter of the Insurer dated 09.01.2016, the claim was repudiated on health ground. The insurer has the evidence and reasons to believe that the LA was suffering from Type2 DM and was a chronic alcoholic prior to the commencement of the policy. Hence, it is concluded that the insured made incorrect statements and with-held correct information to the insurer only to grab an insurance of high Sum Assured with a mala fide intention. Being aggrieved by such decision & finding no other alternative, she approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant argued thather husband took the aforesaid policy from the present Insurer during March 2015 but unfortunately he died when policy was in force i.e on 19.01.2017. The claim is repudiated by the Insurer on the ground of mis-statement regarding health at the time of proposal. According to her the DLA was in good health at the time of proposal. This was only a plea by the insurer not to accept the liability.

b) Insurers' argument:- According to Insurer the claim was repudiated on health ground. The insurer had the evidence and reasons to believe that the LA was suffering from Type2 DM and was a chronic alcoholic prior to the

commencement of the policy. Hence, it is concluded that the insured made incorrect statements and with-held correct information to the insurer only to grab an insurance of high Sum Assured with a mala fide intention

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):-After going through the documents and arguments of both the parties, it is observed that the death has occurred within 1 year from the date of the commencement of the policy. Insurer's investigation revealed that the DLA was suffering from type2 diabetes prior to the commencement of the policy. In addition to it the DLA was a chronic alcoholic which he had not disclosed at the time of proposal. As per Section 45 of Insurance Act, 1938 (Amended in 2015) a policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy on the ground of mis-representation or fraud. Here in this case the DLA was very much aware that he was suffering from type2 DM which was a material fact for consideration of the risk. Hence, this forum is of the opinion that the claim is to be repudiated and complaint should be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

nn. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

oo. As per 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 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

pp. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Kapila Charan Behera -V-LIC Of India, Cuttack DO)
COMPLAINT REF: NO: BHU-L-029-1718-0429
AWARD NO: IO/BHU/A/LI/089 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Kapila Charan Behera, At- Khadagpur, P.O-Kalasri Gopalpur, Via- Charinangal, Dist- Jajpur.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**599715388** **Life** **28.12.2013.**
3.	**Name of the insured** **Name of the policyholder**	**Late Kanchan Behera.** **- do-**
4.	**Name of the insurer**	**LIC Of India, Cuttack DO.**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**Original driving licence required.**
7.	**Date of admission of the Complaint**	**13.11.2017**
8.	**Nature of complaint**	**Non -payment of death claim by the Insurer.**
9.	**Amount of Claim**	**Rs.5,00,000/- + Bonus for 2 years.**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.5,50,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019/ Bhubaneswar**
14.	**Representation at the hearing**	
	mm) For the Complainant	**Kapila Charan Behera**
	nn) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The wife of the complainant took the aforesaid policy from the present Insurer during December 2013 but unfortunately she died on 11.08.2015. Although all documents had been submitted the claim was not yet settled. Being aggrieved by such decision & finding no other alternative, she approached this Forum for Redressal.

On the other hand the Insurer has submitted SCN dated 12.01.2018 stating that the claim was not paid due to want of some requirements. The claimant was asked to submit the original HSC/ +3 certificate of the deceased for verification at their end. But, the claimant could not submit the same. He was also asked to submit policy bond of previous policies on the same life and on the life of her family members which has also not submitted yet. Hence, there was a delay in the settlement of the claim. As soon as all the requirements are complied by the claimant the matter will be taken into consideration.

18) Cause of Complaint:

a) Complainant's argument:- The complainant argued that he had submitted all the documents related to the death claim of his wife. But till date the claim is not settled. When he was asked to submit the original HSC/ +3 certificate of his wife, he denied to submit as the same is not available. He also expressed his helplessness to submit the same as he was staying outside and non of the wife's relative are alive as on date.

b) Insurers' argument:- On the other hand the Insurer argued that the claim was not paid due to want of some requirements. The claimant was asked to submit the original HSC/ +3 certificate of the deceased for verification at their end. But, the claimant could not submit the same. He was also asked to submit policy bond of previous policies on the same life and on the life of her family members which has also not submitted yet. Hence, there was a delay in the settlement of the claim. As soon as all the requirements are complied by the claimant the matter will be taken into consideration.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and argument of both the parties, it is observed that the payment of claim against the above said policy was delayed because of some requirements. The Insurer had also advised the claimant to submit all the relevant documents like certificate of the DLA, previous insurance details etc for payment of the claim proceeds. But till date the claimant has not submitted these documents for verification by the insurer. Hence, this forum advised the claimant to submit all the requisite papers before payment of claim.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

qq. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

rr. As per 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 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.

ss. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb.2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Smt Sanghamitra Sahoo –V-LIC of India, Cuttack)
COMPLAINT REF: NO: BHU-L-029-1718-0454
AWARD NO: IO/BHU/A/LI/ 075/2017-2018

1.	**Name & Address of the Complainant**	**Smt. Sanghamitra Sahoo, At-Kalakhanda, PO-Ishlampur, Jajpur-755005**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**598601407** **Life** **28.03.2012**
3.	**Name of the insured** **Name of the policyholder**	**Late Pradip Kumar Sahoo** **-do-**
4.	**Name of the insurer**	**LIC of India, Cuttack.**
5.	**Date of Repudiation**	**06.01.2017.**
6.	**Reason for repudiation**	**Suppression of material fact, intent to mis-lead corporation for granting of risk.**
7.	**Date of admission of the Complaint**	**06.12.2017**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer.**
9.	**Amount of Claim**	**Rs.1,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.1,00,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	oo) For the Complainant	**Sanghamitra Sahoo**
	pp) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**04.02.2019**

17) Brief Facts of the Case:- The complainant's husband took a policy(marriage Endowment/ Educational Annuity) from present Insurer on Mar 2012 with Rs.1,00,000/- Sum assured for a period of 19 years. Unfortunately he died on 15.02.2016. The claimant lodged the death claim as nominee but the claim was rejected on the ground that there was suppression material fact regarding health at the time of revival. On subsequent representation to grievance officer the same decision was upheld. Finding no alternative, she approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- Complainant argued that as nominee of the said policy she had applied for payment of death claim after the death of her husband. But the claim was repudiated on the ground of suppression of material fact regarding health at the time of revival. The said policy had commenced on 28.03.2012 and revived on 26.10.2015. Death took place on 15.02.2016. The claimant argued that as the duration of the policy from the commencement was more than 3 years, the claim should be admitted.

b) Insurers' argument:- On the other hand the Insurer argued that although the policy duration was more than 3 years still it was less than 3 years from the date of revival of risk i.e 26.10.2015. From the discharge summary dated

15.01.2015 of KIMS hospital, Bhubaneswar it was detected that he was a kidney patient since 6 months, i.e-well before date of revival. But the life assured had not disclosed it in DGH submitted at the time of revival on 26.10.2015. Since suppression of fact has bearing on grant of revival the claim was repudiated with return of premium. So the claim may be dismissed.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and argument of both the parties it was observed that the policy was commenced on 28.03.2012 and revived on 26.10.2015. Death of LA occurred on 15.02.2016 i.e within one year from the date of revival, for which claim was repudiated. The Insurer has also obtained all the medical reports prior to the date of revival as a support to their decision. As per Section 45 of Insurance Act (Ammened) 2015, the policies where death of life assured has occurred before 26th December 2014, the guidelines in accordance with the amended Section 45 are applicable. The amended act provides that, "a policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud." Here in this case death has occurred within 3 years from the date of revival and it was proved that the LA was suffering from kidney disease prior to revival. Hence, this forum is of the opinion that the complaint should be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

tt. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

uu. As per 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 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

vv. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 4th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Sri Dolagobinda Pradhan –V-LIC of India, Cuttack)
COMPLAINT REF: NO: BHU-L-029-1718-0456
AWARD NO: IO/BHU/A/LI/088 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Dolagobinda Pradhan, H/O- Late Ranjita Pradhan, At- Katabahal, PO-Patamandira, Via- Parjanga, Dt- Dhenkanal - 759120**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**587973417** **Life** **12.10.2010**
3.	**Name of the insured** **Name of the policyholder**	**Late Ranjita Pradhan.** **-do-**
4.	**Name of the insurer**	**LIC of India, Cuttack.**
5.	**Date of Repudiation**	**19.10.2016.**
6.	**Reason for repudiation**	**Claim time barred by limitation.**
7.	**Date of admission of the Complaint**	**07.12.2017**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer.**
9.	**Amount of Claim**	**Rs.1,00,000/- + Interest**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.1,00,000/- + Interest**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	qq) For the Complainant	**Dola Govinda Pradhan**
	rr) For the insurer	**R C Bhadra**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.01.2019**

17) Brief Facts of the Case:- The complainant's wife took a policy from present Insurer on Oct 2010. Unfortunately she died on 21.12.2011. The claimant lodged the death claim as nominee but the claim was rejected on the ground that the death claim was time barred by limitation. Finding no alternative, he approached this Forum for Redressal.

On the other hand the Insurer submitted SCN/Counter stating that while verification of claim it was observed that the claim was intimated to this office on 15.09.2015 while date of death was 21.12.2011, nearly after 4 years and 3 months after the date of death. Hence as per claims manual part1, chapter 2, section 4.2, the claim was barred by limitation. Also from available records, it was found that the there was overwriting in treatment papers. These papers appear to be manufactured just before submitting the claim. So the claim was rejected.

18) Cause of Complaint:

a) Complainant's argument:- The Complaint argued that his wife had purchased the above mentioned policy from the present insurer. She was in good health at the time of proposal. But later due to her illness she was treated in Sun Clinic Balanda, Talcher and was referred for better treatment to SCB Medical College & Hospital, Cuttack . But death occurred on the way to Cuttack on 21.12.2011. However, he submitted all the claim papers to the Insurer on 15.09.2015. The-is late was due to his ignorance about the existence of the policy in the name of his wife. But the claim was repudiated by the Insurer on the ground of late submission.

b) Insurers' argument:- On the other hand the Insurer stated that while verification of claim it was observed that the claim was intimated to this office on 15.09.2015 while date of death was 21.12.2011, nearly after 4 years and 3 months after the date of death. Hence as per claims manual part1, chapter 2, section 4.2, the claim was barred by limitation. Also from available records, it was found that the there was overwriting in treatment papers. These papers appear to be manufactured just before submitting the claim. So the claim was rejected.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties it was observed that the claimant is an illiterate person having no knowledge regarding the existence of an insurance policy on the life of his wife. From the Xerox copy of claim papers submitted by the claimant it was also found that there was no over-witting at any stage, as claimed by the insurer. Death was due to cardiac failure due to severe anemia. Both the report of the Doctor (in claim form 3816) and confession of the claimant proves that the DLA died on the way to SCB Medical College & Hospital. The claimant has also submitted one affidavit with regard to the date and place of death. Hence, this forum is of the opinion that the claim under the policy in dispute should be admitted and benefit to be paid by the insurer to the claimant.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, it is hereby awarded that the death claim is to be admitted by the insurer, for full Sum Assured along with bonus as per terms and conditions of the policy, as full and final settlement against the claim.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

ww. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

xx. As per 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 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.

yy. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Sri Alok Ranjan Patnaik –V-LIC of India, Cuttack)
COMPLAINT REF: NO: BHU-L-029-1718-0459
AWARD NO: IO/BHU/A/LI/071 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Alok Ranjan Patnaik, Plot No-28/1, Siripur, Nuasahi, Khandagiri, Bhubaneswar.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**598843937** **Life** **26.11.2012**
3.	**Name of the insured** **Name of the policyholder**	**Late Nirmala Patnaik.** **----do-----**
4.	**Name of the insurer**	**LIC of India, Cuttack.**
5.	**Date of Repudiation**	**15.02.2017.**
6.	**Reason for repudiation**	**Suppression of material fact relating to assessment of risk on the life of deceased.**
7.	**Date of admission of the Complaint**	**07.12.2017**
8.	**Nature of complaint**	**Non payment of death claim by Insurer.**
9.	**Amount of Claim**	**Rs.2,00,000/- + Bonus + Return of premium Rs.49,470/- + mental agony of Rs.1,00,000/-.**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Death claim amount.**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	ss) For the Complainant	**Alok Ranjan Patnaik**
	tt) For the insurer	**R C Bhadra**

15	Complaint how disposed	Under Insurance Ombudsman Rule 17.
16	Date of Award/Order	04.02.2019

17) Brief Facts of the Case:- The mother of the complainant took a policy from the present Insurer on 26.11.2012. Unfortunately she died on 11.11.2015 due to cardiac shock as per medical report. The death claim was lodged by the nominee but it was rejected by the Insurer on the ground of suppression of material fact which had a bearing on acceptance of risk. The representation to the grievance officer also did not result any fruit. Being dissatisfied with the decision, he approached this Forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The mother of the complainant was the life assured in the said policy. Death was due to cardiac shock, but the claim was rejected on the ground that there was a suppression of material fact i.e the age of the proposer was mis stated. According to the claimant , he had submitted all the documents in the Office except certificate but claim is not settled. He is unable to submit the certificate as it is not available in his house and he had no knowledge regarding her school certificate. The objection raised by the Insurer as per section 45 of Insurance act is not applicable to this case as the policy has already completed 2 years prior to the death of the deceased.

b) Insurers' argument:- On the other hand Insurer argued that age proof submitted by the life assured was school certificate. But the school was non-existent. Copy of the death certificate of the husband indicated that he was dead at the time of wife taking policy which was suppressed by DLA. Age of the deceased was 54 years at the time of proposal where as age of her second son was 43 years as on that date which is inconsistent. So the claim was rejected on the ground of suppression of material fact relating to assessment of risk.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):-After going though the documents and argument of both the parties it is observed that the age of the LA was wrongly mentioned. As per the voter card the age of the LA was 59 years but as per the certificate the LA's age was 54 years. Complainant's argument was that her mother had not submitted any wrong age proof. The age mentioned in the voter card was not correct rather the certificate submitted by her mother was genuine and correct. It is admitted by the complainant that her mother was a widow at the time of proposal and the source of income was pension only. But the proposal paper reveals that her husband was alive at the time of proposal and his annual income was Rs.18000/- per month. It is not clear that why a lady will give false information regarding her marital status at the time of proposal. In no way she was benefited by this. It appears that all these are only the handiwork of the concerned agent. The proposal form was filled up by the agent who had quoted wrong information regarding the age and marital status of the proposer. The poor deceased LA was not at fault. Again, as per section 45 of Insurance act 1938 (prior to amendment) a policy can not be questioned on ground of mis-statement after 2 years. Here in this case the policy had crossed 2 years from the date of commencement. Hence, this forum is of the opinion that the Insurer should pay the Sum assured against the said policy to the claimant with bonus as per rule.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, a Sum of Rs.200000/- (Rupees Two lakh only) with bonus is hereby awarded to be paid by the Insurer to the complainant as full and final settlement of claim.

Hence, the complaint is allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

zz. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

aaa. As per 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 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

bbb. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

.Dated at Bhubaneswar on 4th Feb. 2019

(Sri I Suresh Babu)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – SHRI I SURESH BABU
CASE OF (Sri Alok Ranjan Patnaik –V-LIC of India, Cuttack)
COMPLAINT REF: NO: BHU-L-029-1718-0460
AWARD NO: IO/BHU/A/LI/074/2017-2018

1.	**Name & Address of the Complainant**	**Smt. Jinatun Bibi, W/O-Late Idris Khan, At- Saidabad, PO- Garadapur, Via- M.Nagar, Dt-Bhadrak.**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**598647005,599049666.** **Life** **08.11.2011,27.09.2012.**
3.	**Name of the insured** **Name of the policyholder**	**Late Idris Khan.** **----do-----**
4.	**Name of the insurer**	**LIC of India, Cuttack.**
5.	**Date of Repudiation**	**15.02.2017.**
6.	**Reason for repudiation**	**The claim is not yet repudiated. Claimant has not yet submitted requisite claim form.**
7.	**Date of admission of the Complaint**	**07.12.2017**
8.	**Nature of complaint**	**Non payment of death claim by Insurer.**
9.	**Amount of Claim**	**Rs.70,000/- + Rs.1,10,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.4,00,000/- + Rs.4,00,000/-**

12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(a)**
13.	**Date of hearing/place**	**030.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	uu) For the Complainant	**A Khan**
	vv) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**04.02.2019**

17) Brief Facts of the Case:- The deceased life assured took 2 policies from the present Insurer during Nov 2011 & Sep 2012 respectively. Unfortunately he died on 18.07.2014. Death claim was lodged by nominee on 21.11.2015 at Bhadrak BO with subsequent reminder on 15.12.2016. The claim is not yet settled. So she has approached this Forum for Redressal.

On the other hand, the Insurer submitted SCN/Counter stating that the claimant has not yet submitted the requisite claim forms and the claim is at present pending due to requirement, not submitted by the claimant.

18) Cause of Complaint:

a) Complainant's argument:- Complainant argued that the Life assured had taken 2 policies from the present Insurer. But when she applied for death claim after the death of her husband her request is not heard. Although she has submitted all the papers with the Insurer, the claim has not yet been settled. Claimant stated that her name is Jinatun Bibi and she is the sole legal heir of her husband Idrish Khan the owner of the said policies. She also submitted the legal heir certificate to the Insurer. But till date the claim was not paid.

b) Insurers' argument:- Insurer submitted that claim has been admitted and paid in respect of policy no.599049666. But so far as policy no. 598647005 is concerned payment is delayed as there is a difference in the name of the nominee. In the policy bond the name of nominee was mentioned as Tehera Khatun, but the claimant was Jinatun Bibi. However, they have already paid the claim in respect of policy no. 599049666 where nominee was clean. But in other policy i.e policy no. it was delayed as there is a difference in nominee name in policy bond and the name of claimant. Hence, they have asked the claimant to submit Successor certificate for payment of the claim.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-settlement of claim by Insurer.

20) The following documents were placed for perusal.
a) Photo copies of proposal/policy document.
b) Photo copy of complaint letter and rejection letter by Insurer.

21) Result of hearing with both parties (Observations & Conclusion):- After reviewing the documents and arguments of both the parties, it is admitted that the Insurer has already admitted and paid the claim to the complainant in respect of policy no. 599049666. However, delay was observed in respect of policy no.598647005. This delay was due to the fact that, in this policy some discrepancy was observed in the name of nominee. She opined that, name must be corrected before payment of claim amount. Jinatun Bibi and Tehera Khatun are not the same person. In this case, claim can not be admitted on the basis of legal heir certificate. Hence, this forum is of the opinion that, the claimant is to be advised to produce claim papers along with successor certificate before payment.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complainant is advised to submit Successor certificate for payment of the claim proceeds against policy no.598647005.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

ccc. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

ddd. As per 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 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

eee. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 4th Jan.2019

(I Suresh Babu)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Sanjukta Sahu vs- LIC of India, Cuttack DO)
COMPLAINT REF: NO: BHU-L-029-1819-0476
AWARD NO: IO/BHU/A/LI/ 076 /2018-2019

1.	**Name & Address of the Complainant**	**Smt Sanjukta Sahoo. C/O- Paramananda Moharana, At/Po- Samantarapur, Via- Kabirpur Dist- Jajpur**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**599418940** **Life** **28-03.2013**
3.	**Name of the insured** **Name of the policyholder**	**Late Bulu Kishore Sahoo** **- do-**
4.	**Name of the insurer**	**LIC of India, Cuttack**
5.	**Date of Repudiation**	**31.03.2016**
6.	**Reason for repudiation**	**Claim repudiated on the ground of suppression of material fact**
7.	**Date of admission of the Complaint**	**08.01.2019**
8.	**Nature of complaint**	**Non payment of death claim by the Insurer**
9.	**Amount of Claim**	**Rs.4,00,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.4,00,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	

	ww)For the Complainant	**Sanjukta Sahoo**
	xx) For the insurer	**S Panda**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**04.02.2019**

17) Brief Facts of the Case:- The deceased LA had taken the said policy on 28.03.2013, but unfortunately death occurred on 03.04.2014. Being an early claim the case was referred for investigation. After investigation it was found that the TC submitted by the LA at the time of proposal was not correct. As per the Insurer, the TC was fabricated which was also confirmed by the Headmaster of the concerned school. Hence, the TC submitted by the deceased LA was fake. Again, as per the Voter Identity card the age of the DLA was 51 years at the time of taking the policy where maximum age at entry for the said plan is 45 years. Hence, the competent authority repudiated the said claim. Being aggrieved, the claimant approached this forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant argued that her husband had submitted certificate issued by Head Master Kuansh Primary school along with a driving license as age proof at the time of proposal, in which date of birth was mentioned as 08.06.1968. But unfortunately the LA died on 03.04.2014. The Insurer repudiated the claim on the plea that date of birth is not correct and LA was of higher age as per the voter card.

b) Insurers' argument:- The Insurer on the other hand argued that the deceased LA had submitted a TC issued from "Antara Mahatipur High school, Antara, Balasore dated 14.07.1983 which was a fake one as confirmed by the Head Master of the concerned school. As per the voter identity age of the DLA was 51 years as on the date of proposal. Policy conditions states that maximum age at entry of the said plan is only 45 years. Hence, the claim was repudiated.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the documents and arguments of both the parties, it is observed that the deceased LA had submitted 2 age proofs at the time of proposal in which DOB was mentioned as 08.06.1968. In addition to it the policy was also completed by accepting the same date as DOB. When the deceased LA had submitted a standard age proof the Insurer should not go to refer any other non standard age proof. Secondly, Insurer's argument that the certificate issued by Antara Mahatipur High School is fake is also not acceptable as the claimant produced a certificate issued by Headmaster Kuansh Primary school where DOB was also found to be same i.e 08.06.1968. Hence, it appears that there should not be any doubt in regard to the DOB of the deceased LA and thus this forum is of the opinion that claim should be admitted as per rules.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, it is awarded that the claim to be admitted and the claimant to be paid full Sum assured along with other benefits as per the terms and conditions of the policy as full and final settlement of the claim.

Hence, the complaint is treated as allowed accordingly.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

fff. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

ggg. As per 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 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) As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers

Dated at Bhubaneswar on 4th Feb. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Smt. Rasmita Barik-V- Max Life)
COMPLAINT REF: NO: BHU-L-032-1718-0584
AWARD NO: IO/BHU/A/LI/ 082 /2017-2018

1.	**Name & Address of the Complainant**	**Mrs. Rasmita Barik W/O- Late Tapan Kumar Barik Vill/Po- Kansara, Dist- Kendrapara 754212**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**265658013** **Life** **02.03.2016**
3.	**Name of the insured** **Name of the policyholder**	**Mr. Tapan Kumar Barik** **- do-**
4.	**Name of the insurer**	**Max Life**
5.	**Date of Repudiation**	**31.01.2018**
6.	**Reason for repudiation**	**Non-disclosure of health conditions at the time of proposal.**
7.	**Date of admission of the Complaint**	**12.03.2018**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer**
9.	**Amount of Claim**	**Rs.7,65,000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.7,65,000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**30.01.2019 / Bhubaneswar**

14.	**Representation at the hearing**	
	yy) For the Complainant	**Absent**
	zz) For the insurer	**Surya Rout**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**05.02.2019**

17) Brief Facts of the Case:- The Husband of the claimant had taken a policy of insurance from the present Insurer on 02.03.2016. But unfortunately he died on 07.07.2016. When the wife of the deceased life assured claimed the death benefit against the said policy, the claim was repudiated by the insurer on the ground of non disclosure of material fact regarding health condition and occupation of the LA. As per the proposal form the deceased LA was working under MNREGA scheme, but actually he was an agriculturist. Hence the insurer decided to cancel the policy and refund the premium amount. Finding no other alternative solution, he approached this forum for Redressal.

18) Cause of Complaint:

a) Complainant's argument:- The Complainant was absent

b) Insurers' argument:- Insurer stated that this is a case of mis representation of material fact at the time of proposal. The claim was repudiated on the ground of non-disclosure of material fact regarding health and occupation of LA. But, as a gesture of good will, the insurer has already settled the matter by paying an amount of Rs.764971/- to the claimant. Hence, the case may be closed.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- From the mail of the Insurer dated 29.01.2019 it is observed that the claim has already been settled in favor of the claimant and an amount of Rs.764971?- has been paid to the claimant as a gesture of good will. Hence, this forum is of the opinion that the complaint is to be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

hhh. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

iii. As per 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 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

jjj. As per the rule 17(8), of the said rules the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 5th Feb. 2019

(I SURESH BABU)
INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF ODISHA
(UNDER RULE NO: 16(1)/17 of
THE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Shri I Suresh Babu
CASE OF (Sri Narendra Sahoo-V- LICI Bhubaneswar)
COMPLAINT REF: NO: BHU-L-029-1718-0588
AWARD NO: IO/BHU/A/LI/061 /2017-2018

1.	**Name & Address of the Complainant**	**Sri Narendra Sahoo,**
2.	**Policy No:** **Type of Policy** **Duration of policy/Policy period**	**597221242** **Life** **28.06.2015**
3.	**Name of the insured** **Name of the policyholder**	**Mrs. Kuntala Sahoo** **- do-**
4.	**Name of the insurer**	**LIC of India Bhubaneswar**
5.	**Date of Repudiation**	**25.09.2017**
6.	**Reason for repudiation**	**Non-disclosure of details regarding previous Insurance**
7.	**Date of admission of the Complaint**	**12.03.2018**
8.	**Nature of complaint**	**Non Payment of claim by the Insurer**
9.	**Amount of Claim**	**Rs.200000/-**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.200000/-**
12.	**Complaint registered under Rule no: of Insurance Ombudsman Rules**	**13(1)(b)**
13.	**Date of hearing/place**	**29.01.2019 / Bhubaneswar**
14.	**Representation at the hearing**	
	aaa) For the Complainant	**Narendra Sahoo**
	bbb) For the insurer	**D K Naik**
15	**Complaint how disposed**	**Under Insurance Ombudsman Rule 17.**
16	**Date of Award/Order**	**29.01.2019**

17) Brief Facts of the Case. Wife of the complainant had taken one policy on her own life from the present Insurer for SA of Rs.200000/- on 28.02.2012. But unfortunately she died on 29.09.2015. When all the claim papers were submitted by the nominee for payment of death claim benefit, the Insurer repudiated the claim on the ground of mis statement of material fact. Finding no other solution, he approached this forum for Redressal.

The Insurer on the other hand submitted SCN stating that the deceased LA had suppressed some material fact like her previous insurance, for which the claim was repudiated. The DLA was a category III lady to whom maximum insurance of SA 200000 can only be sanctioned. Her educational educational qualification was 5th class only. But the said lady had another insurance for SA 200000/- vide policy no. 116785768 which was purchased from LIC of India, Neheru Place CBO, New Delhi. Hence, the claim was repudiated with refund of premium paid.

18) Cause of Complaint:

a) Complainant's argument:- The complainant argued that although he had submitted all the papers in regard to the said claim, claim was repudiated by the Insurer on the ground of mis statement of material fact.

b) Insurers' argument:- Insurer on the other hand argued that a category-3 lady can avail insurance up to maximum Rs.200000/- when her educational qualification is up to 8th standard only. Here in this case her educational qualification was up to 5th standard only. Hence, maximum insurance that she can avail is Rs.200000/-. But the same life assured had another insurance for SA of Rs.200000/- vide policy no. 116785768 which was issued from LIC of India Neheru Place CBO, New Delhi against which death claim has already been paid. Hence, the claim was declined.

19) Reason for Registration of Complaint: - scope of the Insurance Ombudsman Rules 2017.
This is a complaint against non-payment of death claim by the Insurer.

20) The following documents were placed for perusal.
a) Photo copies of policy documents.
b) Photo copy of representation to Insurer and its reply.

21) Result of hearing with both parties (Observations & Conclusion):- After going through the argument of both the parties in detail, it was observed that the LA did not disclose regarding her previous insurance while taking further insurance. She had already purchased one insurance of SA Rs.200000/- from LICI Neheru place CBO, New Delhi which she did not disclose. As per rules she can avail maximum insurance of SA Rs.200000/-, being a category-3 lady with educational qualification up to 5th standard. As per the insurer's record and statement of the claimant, death claim in respect of the said policy at New Delhi has already been paid. Hence, this forum is of the opinion no further claim payment is to be made by the Insurer and the case should be dismissed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the complaint is treated as dismissed.

22) The attention of the Complainant and the Insurer is hereby invited to the following provisions of Insurance Ombudsman Rules, 2017:

kkk. According to Rule 17(6) of the Insurance Ombudsman Rule 2017, the Insurer shall comply with the Award within 30 days of the receipt of the award and shall intimate the compliance to the Ombudsman.

lll. As per 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 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.

mmm. According to the said rule, the award of the Insurance Ombudsman shall be binding on the Insurers.

Dated at Bhubaneswar on 29th Jan. 2019

INSURANCE OMBUDSMAN
FOR THE STATE OF ODISHA

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

CASE NO-CHD-L-025-1617-1149
Case of Mr. Sohan lal Vs Exide Life Insurance Co.Ltd.

1.	**Name & Address of the Complainant**	**Mr. Sohan Lal** **VPO- Jakholi, Kaithal,** **Haryana – 136 027** **Mobile No.- 9068583420**
2.	**Policy No: DOC** **Type of Policy** **Duration of policy/Premium**	**03201577 30.09.2015** **Exide Life Guarnteed Income Insurance Plan** **Rs.15525/-**
3.	**Name of the insured** **Name of the policyholder**	**Mr. Mahabir** **Mr. Mahabir**
4.	**Name of the insurer**	**Exide Life Insurance Co.Ltd.**
5.	**Date of Repudiation**	**04.08.2016**
6.	**Reason for repudiation**	**Concealment of facts**
7.	**Date of receipt of the Complaint**	**29.08.2016**
8.	**Nature of complaint**	**Repudiation of death claim**
9.	**Amount of Claim**	**Sum Assured alongwith bonus/benefits**
10.	**Date of Partial Settlement**	**NIL**
11.	**Amount of relief sought**	**Sum Assured alongwith bonus/benefits**
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017**	**13.1.(b)**
13.	**Date of hearing/place**	**14.08.2018 & 11.12.2018 /Chandigarh**
14.	**Representation at the hearing**	
	For the Complainant	**Self**
	For the insurer	**Ms. Vaishali Urs- G M Legal** **Mr. Vignesh Ram- A.M. Legal**
15	**Complaint how disposed**	**Award**

16	**Date of Award/Order**	**10.01.2019**

17) Brief Facts of the case:

On 29.08.2016, Mr. Sohan Lal had filed a complaint against Exide Life Insurance Co.Ltd. in respect of repudiation of death claim under policy bearing no. 03201577. The complainant has stated that his father had taken a policy on his life from above insurance company and he expired suddenly on 06.04.2016 due to chest pain. When he approached the company for payment of death claim it was repudiated by them on grounds of insufficient income of his father which was not mentioned correctly in the proposal forms. Hence feeling aggrieved, he approached this office to seek justice.

The Insurer in their SCN dated 09.08.2017 has stated that the above policy was issued based on the answers statements, documents submitted, and declarations made in the proposal forms and on receipt of death intimation it was found that the deceased life assured belonged to BPL category and it was not disclosed in the proposal forms in which his occupation was mentioned as landlord/agriculturist. Hence the claim was repudiated due to non disclosure of material fact.

18) Cause of Complaint:

Complainant's argument:

Mr. Sohan Lal attended the personal hearing on 14.08.2018 and 11.12.2018, reiterated the contents of complaint. He also submitted that his father was illiterate but had agriculture income and to substantiate he had submitted on 14.08.2018 the ITR of financial year 2014-2015 which was filed by his father with an annual income of Rs. 270000/-.

Insurers' argument:

The Insurer's representative reiterated the contents of SCN and again submitted that the deceased life assured belonged to BPL category and also submitted the job card which was issued to deceased life assured in June 2009.

19) The following documents were placed for perusal:-

a) Copies of the proposal form. b) Complaint to the insurer. c) Reply of company

20) Result of personal hearing with both parties (Observations & Conclusion)

On going through the various documents available in the file and also hearing both the complainant and the representative Insurance Company, it is observed that the above policy was issued in Sept 2015 and the Life Assured died on 06.04.2016. The death claim under the said policy was repudiated by the company on the grounds that the deceased life assured belonged to BPL category and this fact

was not disclosed by the deceased life assured and to substantiate it the insurer has submitted the copy of the job card issued to him in June 2009. On perusal of this job card it was found that name mentioned in job card is 'Mahiver' and father's name is also not mentioned so it cannot be construed upon that the card belonged to deceased life assured, Mr. Mahavir. Moreover the said card was issued way back in June 2009 and the policy was issued in Sept 2015.The complainant has already submitted ITR of financial year 2014-2015 which was filed by his father with an annual income of Rs. 270000/- .While attending the hearing on 14.08.2018 the Insurer's representative requested for next hearing so as to verify the details of said ITR and in the next date of hearing i.e. on 11.12.2018 he did not comment anything about the authenticity of the said ITR.The insurer has repudiated the death claim under the said policy in a haste without verifying the paying capacity of the deceased life assured and the insurer's decision for repudiation merely on the basis of BPL card issued way back in June 2009 to deceased life assured/ different person, is not justified.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, an award is passed with a direction to the insurance company to settle the death claim under the policy bearing no 03201577 along with bonus/benefits payable under the policy.

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:

a. **According to 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 intimate compliance of the same to the Ombudsman.**

Dated at Chandigarh on 10th day of January, 2019

D.K.Verma
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Dr. D.K.Verma
CASE OF Mrs. Sangeeta Batish V/s PNB Met Life India Insurance Co. Ltd.
COMPLAINT REF. No. : CHD-L-033-1718-0811

1.	**Name & Address of the Complainant**	**Mrs. Sangeeta Batish House No.- 481/3, C, Near Surya Theatre, Ajite Nagar, Ludhiana, Punjab- 141001 Mobile No.- 9463883210**
2.	**Policy No: DOC Type of Policy Term of policy /Premium**	**21575653 15.05.2015 Met Loan & Life Suraksha 02 yrs/**
3.	**Name of the insured Name of the policy holder**	**Mr. Nawal Kumar Mr. Nawal Kumar**
4.	**Name of the insurer**	**PNB Met Life India Insurance Co. Ltd.**
5.	**Date of receipt of the Complaint**	**22-08-2017**
6.	**Nature of complaint**	**Repudiation of death claim**
7.	**Date of Repudiation**	**04.07.2017**
8.	**Reason for repudiation**	**Non disclosure of material fact**
9.	**Amount of Claim**	**Rs.356000/-**
10.	**Date of Partial Settlement**	**NIL**
11.	**Amount of relief sought**	**Rs.356000/- alongwith bonus/benefits**
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017.**	**13.1. (b)**
13.	**Date of hearing/place**	**10-12-2018 / Chandigarh**
14.	**Representation at the hearing**	
	ccc) For the Complainant	**Self**
	ddd) For the insurer	**Mr. Rajeev Sharma- Sr. Manager- Legal**
15	**Complaint how disposed**	**Award**
16	**Date of Award/Order**	**04.01.2019**

17) Brief Facts of the Case:

On 22-08-2017, Mrs. Sangeeta Batish had lodged a complaint in this office against PNB Met Life India Insurance Co. Ltd. in respect of Policy bearing No. 21575653. She had stated that her husband has taken the above policy and he was admitted at DMC Ludhiana on 24.09.2016 due to fever and was discharged on 01.10.2016.After that he was again admitted on 21.10.2016 and was diagnosed with suffering from brain tumor

and he died on 18.01.2017 after being treated and discharged from said hospital on 17.01.2017.When she lodged the death claim with the company', it was repudiated by the company stating that her husband has not disclosed in the proposal papers, his previous medical history, Hence, feeling aggrieved, she approached this office to seek justice.

The Insurer in their SCN which was received by us on 04.05.2018, has stated that the deceased life assured had applied for an insurance policy on his life to cover the loan and completely relying upon the declarations, statements, documents, representations and information furnished by the life assured, the company had issued the policy bearing no 21575653 and Life Assured died on 18.01.2017. The death claim was lodged as per death benefit option and during the investigation it was revealed that the said policy was obtained by misrepresenting the true and actual facts pertaining to deceased life assured's medical condition. The insurer has further stated that he has suppressed the material fact that he was suffering from Hypertension since 10-12 years and was taking medication for the same and which was revealed in the discharge summary of the DMC Ludhiana hospital.

18) Cause of Complaint:

Complainant's argument:

Mrs. Sangeeta Batish reiterated the contents of the complaint and submitted that her husband has not taken any treatment before taking above policy and requested for death claim payment under the said policy.

Insurers' argument:

The Insurer's representative reiterated the contents of SCN; however he could not submit any records of treatment taken by the deceased life assured prior to taking above said policy.

19) The following documents were placed for perusal:-

a) Copies of the proposal form. b) Complaint to the insurer.

c) Reply of company d) Discharge summary of Dayanand Medical college &Hospital Ludhiana

20) Result of personal hearing with both parties (Observations & Conclusion)

On going through the various documents available in the file and also hearing both the complainant and the representative Insurance Company, it is observed that the above policy was issued on 15.05.2015. The Life Assured under the said policy was admitted in Dayanand Medical college & Hospital Ludhiana on 24.09.2016.He was again admitted on 21.10.2016 where he was diagnosed with suffering from brain tumor and he died on 18.01.2017 after being treated and discharged from said hospital on 17.01.2017.The death claim was repudiated by the company on the basis of concealment of facts and for repudiating the death claim the company had relied upon discharge summary of Dayanand Medical college & Hospital Ludhiana in which it is mentioned that he was suffering from Hypertension since 10-12 years, whereas to substantiate their decision the company could not submit any corroborative evidence of the treatment taken by the deceased life

assured before taking the above policy. In fact no proper investigation was conducted by the company to prove pre-existing illness and the claim was repudiated on the basis of mere mention of previous illness in the Treatment summary. The company could also not submit any records of pre proposal treatment taken by the deceased life assured.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, an award is passed with a direction to the insurance company to settle the death claim under the policy bearing no 21575653 along with bonus/benefits payable under the policy.

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:

b. According to 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 intimate compliance of the same to the Ombudsman.

Dated at Chandigarh on 04th day of January, 2019.

D.K.Verma

INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Dr. D.K.Verma
CASE OF Mr. Sunil Kumar Bhasin V/s PNB Met Life India Insurance Co. Ltd.
COMPLAINT REF. No. : CHD-L-033-1718-0956

1.	**Name & Address of the Complainant**	**Mr. Sunil Kumar Bhasin** **H.No.- 3280, Swati Society, Sector-49 D,** **Chandigarh- 160047** **Mobile No.- 9814037339**
2.	**Policy No: DOC** **Type of Policy** **Term of policy /Premium**	**21376184 25-08-2014** **Met Endowment Saving Plan** **10 yrs/Rs. 49999/-**
3.	**Name of the insured** **Name of the policy holder**	**Mr. Anil Kumar Bhasin** **Mr. Anil Kumar Bhasin**

4.	**Name of the insurer**	**PNB Met Life India Insurance Co. Ltd.**
5.	**Date of receipt of the Complaint**	**11-10-2017**
6.	**Nature of complaint**	**Rejection of death claim**
7.	**Date of Repudiation**	**04.07.2017**
8.	**Reason for repudiation**	**Policy lapsed since 25.08.2015**
9.	**Amount of Claim**	**Rs.481605/-**
10.	**Date of Partial Settlement**	**NIL**
11.	**Amount of relief sought**	**Payment of death claim**
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017.**	**13.1. (b.)**
13.	**Date of hearing/place**	**10-12-2018 / Chandigarh**
14.	**Representation at the hearing**	
	a) For the Complainant	**Self**
	b) For the insurer	**Mr. Rajeev Sharma- Sr. Manager- Legal**
15	**Complaint how disposed**	**Dismissed**
16	**Date of Award/Order**	**04.01.2019**

17) Brief Facts of the Case:

On 11-10-2017, Mr. Sunil Kumar Bhasin had lodged a complaint in this office against PNB Met Life India Insurance Co. Ltd. in respect of Policy No. 21376184.He had stated that his brother Mr. Anil Kumar Bhasin has taken the above policy in August 2014 and he died on 03.10.2016.When the complainant approached the company for payment of death claim he was informed that nothing is payable under the said policy, Hence, feeling aggrieved, he approached this office to seek justice.

The Insurer in their SCN, which was received by us on 02.05.2018, has stated that the deceased life assured had applied for an insurance policy on his life and completely relying upon the declarations, statements, documents, representations and information furnished by the life assured, the company had issued the policy bearing no 21376184 and Life Assured died on 03.10.2016. The Insurer has further stated that the above policy was issued on 25.08.2014 and renewal premiums due on 25.08.2015 onwards were not paid by the deceased life assured, hence the said policy was rendered lapsed as per terms and conditions of the policy. The life assured died on 03.10.2016 and the policy was in lapsed mode as on date of death, hence the coverage on his life had ceased to operate thus as per terms and conditions of the policy and accordingly claim rejection letter was sent on 28.02.2017.

18) Cause of Complaint:

Complainant's argument:

Mr. Sunil Kumar Bhasin reiterated the contents of the complant and submitted that his brother has taken the above policy in August 2014 and he had complained to the company through mail on 25.08.2015 that he had

opted for 05 years term policy whereas he was issued 10 years term policy. He had also informed the company that he is divorcee and had proposed his brother Mr. Sunil Kumar Bhasin as nominee and not Mrs. Dolly as stated in policy document.

Insurers' argument:

The Insurer's representative reiterated the contents of SCN and further submitted that with reference to said mail dated 25.08.2015 of the deceased life assured, he was replied through their mail dated 27.08.2015 to send duly signed complaint along with copy of the driving license or passport for matching the signatures with the complaint letter already provided, but the company did not receive any signed letter/complaint from the deceased life assured.

19) The following documents were placed for perusal:-

a) Copies of the proposal form. b) Complaint to the insurer (mail dated 25.08.2015)

c) Reply of company (mail dated 27.08.2015)

20) Result of personal hearing with both parties (Observations & Conclusion)

On going through the various documents available in the file and also hearing both the complainant and the representative Insurance Company, it is observed that the above policy was issued on 25.08.2014 with an annual premium of Rs.49999/- and the renewal premiums due from August, 2015 onwards were not paid by the deceased Life Assured. The Life Assured under the said policy expired on 03.10.2016 and the said policy was lying lapsed as on date of death, due to nonpayment of further premiums. The company has also informed vide their letter dated 28.02.2017 to Mrs. Dolly, who is nominee under the policy that death claim liability is regretted. The policy was lying lapsed as on date of death and as per terms and conditions of the policy the death claim is not payable; hence there is no need to interfere with the decision of the company.

ORDER

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, there is no need to interfere with the decision of the insurer and the complaint is dismissed.

Hence, the complaint is treated as closed

Dated at Chandigarh on 04th day of January, 2019

D.K.VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – Dr. D.K.Verma
CASE OF Mrs. Kamlesh Devi V/s PNB Met Life India Insurance Co. Ltd.
COMPLAINT REF. No. : CHD-L-033-1718-0895

1.	**Name & Address of the Complainant**	**Mrs. Kamlesh Devi W/o Late Sh. Narender Kumar Dalal, S/o Sh. Dariyav Singh Dabodha, Kala Dabodha Jhajjar Kaka(s), Bahadurgarh, Haryana- 124507 Mobile No.- 9717885636**
2.	**Policy No: DOC Type of Policy Term of policy /Premium**	**21368062 08-08-2014 Met Smart Platinum**
3.	**Name of the insured Name of the policy holder**	**Mr. Narender Kumar Dalal Mr. Narender Kumar Dalal**
4.	**Name of the insurer**	**PNB Met Life India Insurance Co. Ltd.**
5.	**Date of receipt of the Complaint**	**12-09-2017**
6.	**Nature of complaint**	**Repudiation of death claim**
7.	**Date of Repudiation**	**17.06.2016/29.06.2017**
8.	**Reason for repudiation**	**Non disclosure of material fact**
9.	**Amount of Claim**	**Rs. 07 Lakhs**
10.	**Date of Partial Settlement**	**196117.64**
11.	**Amount of relief sought**	**Payment of full sum assured**
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017.**	**13.1.(b)**
13.	**Date of hearing/place**	**10-12-2018 / Chandigarh**
14.	**Representation at the hearing**	
	a) For the Complainant	**Self**
	b) For the insurer	**Mr. Rajeev Sharma- Sr. Manager- Legal**
15	**Complaint how disposed**	**Dismissed**
16	**Date of Award/Order**	**04.01.2019**

17) Brief Facts of the Case:

On 12-09-2017, Mrs. Kamlesh Devi had lodged a complaint in this office against PNB Met Life India Insurance Co. Ltd. in respect of Policy No. 21368062. She had stated that her husband has taken the above policy and he expired all of sudden. When she lodged the death claim with the company', it was repudiated by the company vide their letter dated 29.06.2017. Hence, feeling aggrieved, she approached this office to seek justice.

The Insurer in their SCN dated 19.04.2018 and received by us on 23.04.2018, has stated that the deceased life assured had applied for an insurance policy on his life and completely relying upon the declarations, statements, documents, representations and information furnished by the life assured, the company had issued the policy bearing no 21368062 and Life Assured died on 10.02.2016. The death claim was lodged as per death benefit option and during the investigation it was revealed that the said policy was obtained by misrepresenting the true and actual facts pertaining to deceased life assured's medical condition. The insurer has further stated that he has suppressed the material fact that he was diagnosed with Hypertension and left MCA aneurysm and underwent craniotomy since 2007 as per medical documents of Maharaja Agrasen Hospital and accordingly the death claim was repudiated vide their letter dated 17.06.2016

18) Cause of Complaint:

Complainant's argument:

Mrs. Kamlesh Devi reiterated the contents of the complaint and submitted that her husband has not taken any treatment before taking above policy and requested for death claim payment under the said policy.

Insurers' argument:

The Insurer's representative reiterated the contents of SCN and further submitted that the fund value of Rs. 196117.64 with unclaimed bonus of Rs. 487.08 accrued has already been paid to the complainant through electronic mode.

19) The following documents were placed for perusal:-

a) Copies of the proposal form. b) Complaint to the insurer c) Reply of company

d) Copies of records of treatment taken from Maharaja Agersen Hospital, New Delhi

20) Result of personal hearing with both parties (Observations & Conclusion)

On going through the various documents available in the file and also hearing both the complainant and the representative Insurance Company, it is observed that the above policy was issued in August 2014 and the Life Assured died on 10.02.2016. The death claim was repudiated by the insurer on the grounds that the deceased life assured has not disclosed the true and actual facts pertaining to his medical condition that he was diagnosed with Hypertension and left MCA aneurysm and underwent craniotomy in 2007 as per medical documents of Maharaja Agrasen Hospital New Delhi and this fact was also admitted by the complainant during the personal hearing. It has been established from the documents submitted by the company that the deceased life assured has taken treatment and was operated in the above said hospital in March 2007 for the above said ailments and this fact was not disclosed while taking the insurance policy in August 2014,

In view of the documentary evidence submitted by the Insurance Company and inability of the complainant to provide any evidence to disprove the same, there is no need to interfere with the decision of the company.

ORDER

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, there is no need to interfere with the decision of the insurer and the complaint is dismissed.

Hence, the complaint is treated as closed

Dated at Chandigarh on 04th day of January, 2019

D.K.VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF CHANDIGARH

(UNDER INSURNCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – Dr. D K Verma

Case of Shri Ram Chander V/S Aviva Life Insurance Company India Ltd.

COMPLAINT REF: NO: CHD-L-004-1718-0967

1.	**Name & Address of the Complainant**	**Shri Ram Chander #255, Vill Burail, Chandigarh**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**FBI0084231/00789194, FBI0082299/00788401 Family Income Builder 12 years**
3.	**Name of the insured Name of the policyholder**	**Late Shri Tonish Kumar**
4.	**Name of the insurer**	**Aviva Life Insurance Company**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of receipt of the Complaint**	**29.09.2017**
8.	**Nature of complaint**	**Death Claim**
9.	**Amount of Claim**	**NA**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs.**
12.	**Complaint registered under Rule no:**	**13.1(d)**
13.	**Representation at the hearing**	
	For the Complainant	**Self**
	For the insurer	**Sh. Ratnesh Keshri, Sr. Manager(Legal)**
14	**Complaint how disposed**	**Dismissed**
15	**Date and Place of Hearing**	**14.01.2019/Chandigarh**

16) Brief Facts of the Case:

On 29.09.2017, Shri Ram Chander had filed a complaint in this office against Aviva Life Insurance Company about non-settlement of death claim under two policies bearing numbers FBI0082299/00788401 and FBI0084231/00789194 purchased on 08.03.2013 and 23.03.2013 for a premium of Rs. 2,97,650/= and Rs. 1,98,467/= to be paid for 12 years each issued in his son's name Shri Tonish Kumar. Shri Tonish Kumar died in an accident on 04.05.2017. When he, the nominee claimed the policy amount, he was told that the benefits would be paid in the period 23.03.2026 to 23.03.2037. Hence, feeling aggrieved, she has approached this forum to seek justice.

17) **Cause of Complaint:**

a) **Complainant's argument:**
The complainant re-iterated the contents of the complaint and said that in the event of the death of his son, it is unreasonable to make the nominee wait for another 9 years to get the claim.

b) **Insurers' argument:**

c) The representative of the Company informed that the policies bearing numbers FBI0082299/00788401 and FBI0084231/00789194 were purchased on 08.03.2013 and 23.03.2013 for a premium of Rs. 2,97,650/= and Rs. 1,98,467/= to be paid for 12 years each. Three premiums were paid under the policies i.e. for 2013, 2014 and 2015. After the grace period, the policies were paid up due to non-payment of premium. The life assured died on 04.05.2017 which was within the revivable period. As per the terms of the policies, the nominee was informed that under policy FBI0082299, the payable amont was rs. 1,45,550 to be paid at the end of each policy year during the payout period from 08.03.2025 to 08.03.2036 and under policy FBI0084231, an amount of Rs. 97,050/= was payable at the end of each policy year during the payout period 23.03.2025 to 23.03.2036.

18) The following documents were placed for perusal :-

a) Complaint to the Company
b) Reply of the Insurance Company

19) Result of personal hearing with both parties (Observations & Conclusion)

I have examined the various documents available in the file including the copy of the complaint, Annexure-VI and the contents of the SCN filed by the Insurance Company. The complainant's trauma on losing his son due to an accident is understandable and hence, his expectation of the payment of claim after the death of his son is justified. However, the Company is also bound by the terms and conditions of the policy according to which the claim would be payable from 20126 to 2037.

Taking into account the facts & circumstances of the case and the submissions made by the Company during the course of hearing, there is no need for any interference and the complaint is dismissed.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 22nd day of January, 2019.

Dr. D K Verma
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF CHANDIGARH
(UNDER RULE INSURANCE OMBUDSMAN RULES, 2017)
OMBUDSMAN – DR. D K VERMA

Case of Ms Kamla V/S Aviva Life Insurance Co. Ltd.

COMPLAINT REF: NO: CHD-L-004-1718-0652

1. On 7.07.2017, Ms Kamla had filed a complaint against Aviva Life Insurance. Co. Ltd. about repudiation of death claim under her son's policies bearing numbers 10256093 and 10257665.

2. On 20.08.2018, the Insurance Company has informed that the complainant had approached Permanent Lok Adalat, Jind, Haryana in 2018. A copy of the application and notice dated 13.06.2018 issued by Permanent Lok Aalat, Jind have been submitted. The same was confirmed by the complainant on 14.01.2019.

3. Hence, in accordance with Rule 14.5 of Insurance Ombudsman Rules, 2017 which states that ***" No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or Consumer Forum or arbitrator"***, the complaint is closed.

Dated at Chandigarh on 15th day of January, 2019

Dr. D K Verma
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)

INSURANCE OMBUDSMAN-Dr. D.K. VERMA
Case of Mrs. Vandana Sharma Vs Birla Sun Life Insurance Co. Ltd.
CASE NO-CHD-L-009-1718-0189

1.	**Name & Address of the Complainant**	**Mrs. Vandana Sharma** **W/o Late Shri Ghyanshyam Sharma,** **Damla, Kishan Pura, Yamuna Nagar,** **Haryana- 135001 Mobile No.- 9416457537**
2.	**Policy No: DOC** **Type of Policy** **Duration of policy/Policy period**	006908879 BSLI Income Assured Plan
3.	**Name of the insured** **Name of the policyholder**	**Mr. Ghyanshyam Sharma** **Mr. Ghyanshyam Sharma**
4.	**Name of the insurer**	**Birla Sun Life Insurance Co. Ltd.**
5.	**Date of Repudiation**	29.06.2016
6.	**Reason for repudiation**	Non – disclosure of material facts
7.	**Date of receipt of the Complaint**	28-04-2017
8.	**Nature of complaint**	Mis-Selling
9.	**Amount of Claim**	Rs.217000
10.	**Date of Partial Settlement**	
11.	**Amount of relief sought**	Rs.217000
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017**	13[1] [c]
13.	**Date of hearing/place**	14-01-2019 / Chandigarh
14.	**Representation at the hearing**	
	eee) For the Complainant	Self
	fff) For the insurer	Mr. Kaveesh, Manager- Legal
15.	**Complaint how disposed**	Dismissed
16.	**Date of Award/Order**	14.01.2019

17. Brief Facts of the case:

On 28-04-2017, **Mrs. Vandana Sharma** had filed a complaint of death claim rejection against **Birla Sun Life Insurance Co. Ltd.** in respect of policy bearing no. 006908879,issued on the life of her husband late Sh.Ghanshyam Sharma.

18. **Cause of Complaint:**

a]Complainant's argument

Mrs. Vandana Sharma the complainant attended the personal hearing and reiterated the contents of the complaint. During the hearing, the complainant argued that the Insurance Company had repudiated the death claim in respect of her husband late Sh.Ghanshyam Sharma. Her husband had taken the policy no. 006908879 with risk commencement date as 31.12.2015 and paid the premium of Rs 48999 for the sum assured of Rs.217625.She further added that her husband unfortunately expired on 27.03.2016 and the death claim was filed with the company. She further submitted that the policy was in force at the time of death. The company has repudiated the death claim on the ground of **concealment of material facts** related to non disclosure of other insurance policies taken from different insurance companies at the time of proposal/ purchasing policy. She had also submitted that her husband had been trapped in hoax calls and allured for high returns and even her husband did not discuss with her /family about taking policies from different companies. She came to know about all these policies only after her husband's death and contested that the insurance company itself should have confirmed, whether the life to be assured is having other policies from other companies through their network. Now after the death of her husband rejecting claim is injustice to her and requested for settlement of the death claim.

b] Insurer's argument

In personal hearing the insurer reiterated the contents of SCN and submitted that the Life Assured was issued the policy bearing no. 006908879 on 31-12-2015 on the basis of information provided by him in the said application and believing the same to be true and correct. The BSLI on 28-04-2016 received a claimant statement from the complainant, being the nominee under the said policy intimating the demise of her husband on 27-03-2016. It may be noted that Claimant has expired within 2 months & 26 days from the date of policy issuance. The investigations have established that prior to the proposal for insurance, the Life Assured has not only procured insurance policies with multiple insurance companies for huge sum assured, but has also applied for simultaneous insurance policies with other insurance companies. All these information was not disclosed in the proposal form for insurance. Moreover, during the investigation, the wife of the deceased stated that he was earning around 2-3 lakhs annually. Whereas in the proposal form the Life Assured has described himself as Business Owner with an annual income of Rs. 500000/- which is also not true and is inconsistent with the written statement of the wife of the deceased.

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19.The following documents were placed for perusal:

a) Complaint to the Company b) Copy of policy document

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

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

On hearing both the parties and examining the various documents available in the file it is evident that the complainant's husband had taken a policy for sum assured of Rs. 217,625 with date of commencement as 31.12.2015 and unfortunately died on 27.03.2016 i.e. within three months of taking the policy. The investigation conducted and the papers submitted by the Insurance Company revealed that the deceased life assured had taken other policies simultaneously from different insurance companies i.e SBI, EXIDE, HDFC, Reliance & Future Generali for huge sum assureds. The fact about

taking other policies was not disclosed at the time of taking policy. Since, it is a clear case of suppression of material facts and against the principle of Uberrima fides (Utmost good faith) the Insurance Company has rightly repudiated death claim as per terms & conditions of the policy. The provision of section 45 of Insurance laws [Amendment] Act, 2015 states that in case claim under a policy is repudiated on the grounds of misstatement or suppression of material facts, the premium collected under the policy till the date of repudiation is to be refunded to the nominee/ claimant/ assignee/ legal heirs, as the case may be, with in a period of ninety days from the date of such repudiation., however, in this case the company has not followed the applicability of section 45.

ORDER

Taking into accounts the facts and circumstances of the case and the submissions made by the both parties during the course of personal hearing, the complaint is dismissed. However, the company is directed to refund the premium with 6% interest from filing of the death claim with insurance company till final payment without deduction of any charges.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 14th day of January 2019.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF CHANDIGARH

(UNDER INSURNCE OMBUDSMAN RULES, 2017)

OMBUDSMAN – Dr. D K Verma

Case of Ms Sawinder Kaur & Shri Hem Raj V/S Reliance Nippon Life Insurance Company Ltd.

COMPLAINT REF: NO: CHD-L-036-1718-1017

1.	**Name & Address of the Complainant**	**Ms Sawinder Kaur & Shri Hem Raj C/o ADGP cum Commandant General Punjab Home Guards & Director Civil Defence, Punjab**
2.	**Policy No: Type of Policy Duration of policy/Policy period**	**40001087 Group Policy**
3.	**Name of the insured Name of the policyholder**	**Late Shri Bhola Singh, Late Sham Lal**
4.	**Name of the insurer**	**Reliance Nippon Life Insurance Company**
5.	**Date of Repudiation**	**NA**
6.	**Reason for repudiation**	**NA**
7.	**Date of receipt of the Complaint**	**27.10.2017**
8.	**Nature of complaint**	**Mis-selling**

9.	**Amount of Claim**	**NA**
10.	**Date of Partial Settlement**	**NA**
11.	**Amount of relief sought**	**Rs. 3 lakhs each**
12.	**Complaint registered under Rule no:**	**13.1(d)**
13.	**Representation at the hearing**	
	a) For the Complainant	**Self, Shri Jatinder Kumar, Supdt., ADG Home Guards**
	b) For the insurer	**Shri GG Padmakar Tripathi, Manager Legal**
14	**Complaint how disposed**	**Agreement**
15	**Date & Place of Hearing**	**17.01.2019/Chandigarh**

16) Brief Facts of the Case:

On 27.10.2017, Punjab Home Guards office had filed a complaint in this office about non-payment of death claim under the group policy of Punjab Home guards bearing number 40001087 in respect of Late Shri Bhola Singh and Late Shri Sham Lal both of who died on 18.12.2015. Punjab Home Guards had the group policy with Reliance life for the period 19.12.2012 to 18.12.2013, 19.12.2013 to 18.12.2014 but erroneously, the policy was issued from 18.12.2014 to 17.12.2015 instead of 19.12.2014 to 18.12.2015. The next year, policy was purchased from LIC of India for the period 19.12.2015 to 18.12.2016. Due to this, Reliance Life did not pay death claim of the two deaths that occurred on 18.12.2015 which was only a clerical mistake. They followed up with the Company but could not get any relief. Hence, they have approached this office to seek justice.

17) At the outset, the Insurance Company offered to settle the Death Claims. In case of Ms Sawinder Kaur, the Company agreed to pay an interest of 6% per anum from the date of filing of claim till the date of its actual payment.

19) The Company's offer is accepted by the Complainants.

20) Accordingly, an agreement was signed between the Company and the complainants on 17.01.2019.

21) The complaint is closed with a condition that the company shall comply with the agreement and shall send a compliance report to this office within 30 days of receipt of this order for information and record.

To be communicated to the parties.

Dated at Chandigarh on 22nd day of January, 2019.

Dr. D.K.VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, CHANDIGARH
(UNDER INSURANCE OMBUDSMAN RULES, 2017)

INSURANCE OMBUDSMAN-Dr. D.K. VERMA
Case of Ms. Vidya Devi Vs SBI Life Insurance Co. Ltd.
CASE NO-CHD-L-041-1718-1111

1.	**Name & Address of the Complainant**	Ms. Vidya Devi W/o Late Sh. Sohan Lal, House No. 713 A, Gali No. 7A, Tafzalpura, Patiala, Punjab, Mobile No.: 8360183925
2.	**Policy No: DOC** **Type of Policy** **Duration of policy/Policy period**	70000018311/ 19.07.2017 SBI Life Rinn Raksha Group Insurance Policy 5 years
3.	**Name of the insured** **Name of the policyholder**	Mr. Sohan Lal Mr. Sohan Lal
4.	**Name of the insurer**	**SBI Life Insurance Co. Ltd.**
5.	**Date of Repudiation**	25.10.2017
6.	**Reason for repudiation**	Non disclosure of material facts
7.	**Date of receipt of the Complaint**	30.11.2017
8.	**Nature of complaint**	Mis-Selling
9.	**Amount of Claim**	Rs. 500000/-
10.	**Date of Partial Settlement**	NA
11.	**Amount of relief sought**	Rs. 500000/-
12.	**Complaint registered under Rule no: Insurance Ombudsman Rules, 2017**	13 [1] [D]
13.	**Date of hearing/place**	23.01.2019/ Chandigarh
14.	**Representation at the hearing**	
	For the Complainant	Self
	For the insurer	Mr. Vashisth & Raman
15.	**Complaint how disposed**	Dismissed
16.	**Date of Award/Order**	23.01.2019

17. Brief Facts of the case:

On 30.11.2017, Ms. Vidya Devi had filed a complaint of repudiation of death claim against **SBI Life Insurance Co. Ltd.** in respect of policy bearing no 70000018311/7007620749 . The policy was issued under the Rinn Raksha Personal Loan Scheme . The deceased life assured had taken personal loan from SBI and policy was issued on 19.07.2017.The life assured unfortunately died on 16.08.2017 and claim was filed with insurer and same was repudiated on the ground of pre existing diseases.

18.a]Complainant's argument

Mrs. Vidya Devi the complainant attended the personal hearing and reiterated the contents of the complaint. During the hearing, the complainant argued that the Insurance Company had repudiated the death claim in respect of her husband late Sh. Sohan Lal. Her husband had taken the policy no700000018311/ 7007620749 with risk commencement date as 19.07.2017and paid the premium of Rs 15124 for the sum assured of Rs.500000.She further added that her husband unfortunately died on 16.08.2017 and the death claim was filed with the company. She further submitted that the policy was in force at the time of death. The company has repudiated the death claim on the ground of **concealment of material facts** related to health of her husband that the pre existing disease has not been disclosed at the time of taking policy, however, she submitted that her late husband had disclosed each and every thing in front of her to the insurer at the time of taking policy. Now after the death of her husband rejecting claim is injustice to her and requested for settlement of the death claim.

b] Insurer's argument:

In personal hearing the insurer reiterated the contents of SCN and submitted that the deceased late Sh. Sohan Lal applied for SBI Life-Rinn Raksha policy through State Bank of Travancore, the master policyholder under master policy no. 70000018311 through membership form no. 7007620749 dated 22.06.2017. The date of commencement of the risk under the policy was 19.07.2017 for the initial sum assured of Rs. 5,00,000/- and the terms of the policy was of 60 months. The DLA was also issued certificate of Insurance as an evidence of his insurance cover. The DLA is reported to have died on 16.08.2017. The policy resulted in an early claim in just 28 days. The SBI Life enquired into the matter and found that the DLA was suffering from Type II diabetes mellitus, coronary artery disease and alcoholic liver disease (ALD) prior to the date of enrollment into the insurance cover. As per the discharge slip of Department of Medicine Unit- 6, Rajendra Hospital Patiala, the DLA was hospitalized from 25.06.2012 to 28.06.2012 and was diagnosed from T2 DM with CAD (DCM) with ALD with OSA and also as per the employer's certificate, the DLA was on medical leave from 25.06.2012 to 12.07.2012. In the membership form for Rinn Raksha Group Insurance Plan, under point no. 5 medical questionnaire, the DLA replied in negative that he did not have any pre existing diseases. The insurer submitted that premium has been refunded to the complainant on 25.10.2017.

19) The following documents were placed for perusal:

a) Complaint to the Company b) Copy of policy document

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

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

On hearing both the parties and examining the various documents available in the file it is evident that the complainant's mother had taken a policy for sum assured Rs. 500,000 with date of commencement as 19.07.2017 and the life assured unfortunately died on 16.08.2017 i.e. within a months of taking the policy. The investigation conducted and the papers submitted by the Insurance Company revealed that the deceased life assured remained admitted at Department of Medicine Unit- 6, Rajendra Hospital Patiala from 25.06.2012 to 28.06.2012 and was diagnosed for T2 DM with CAD (DCM) with ALD with OSA. The fact about said ailment and hospitalization was not disclosed at the time of taking policy. Since, it is a clear case of suppression of material facts and against the principle of Uberrima fides (Utmost good faith) the Insurance Company has rightly repudiated death claim as per terms & conditions of the policy, however, the insurer has already refunded the premium as per terms & conditions of the policy

ORDER

Taking into accounts the facts and circumstances of the case and the submissions made by the both parties during the course of personal hearing, the complaint is dismissed.

Hence, the complaint is treated as closed.

Dated at Chandigarh on 23 day of January 2019.

D.K. VERMA
INSURANCE OMBUDSMAN

PROCEEDINGS BEFORE
THE INSURANCE OMBUDSMAN, STATE OF CHANDIGARH
(UNDER INSURNCE OMBUDSMAN RULES, 2017)

OMBUDSMAN –Dr. D.K .Verma
CASE OF Ms. Manju Sharma V/s SBI Life Insurance Co. Ltd.
COMPLAINT REF. No. : CHD-L-041-1617-1469

1.	**Name & Address of the Complainant**	Ms. Manju Sharma House No. 23, New Colony, Near Krishna Hospital, PO- Jandli, Ambala City, Haryana-134003 Mobile No. 9466742308
2.	**Policy No:** **Type of Policy** **Term of policy**	63000000601
3.	**Name of the insured** **Name of the policy holder**	Ms. Manju Sharma Ms. Manju Sharma
4.	**Name of the insurer**	SBI Life Insurance Co. Ltd.
5.	**Date of Repudiation**	nil
6.	**Reason for repudiation**	nil

7.	**Dt of receipt of the Complaint**	30-12-2016
8.	**Nature of complaint**	Misselling
9.	**Amount of Claim**	Rs.
10.	**Date of Partial Settlement**	nil
11.	**Amount of relief sought**	Maturity amount & interest
12.	**Complaint registered under Ombudsman Rules 2017**	13.1 (d)
13.	**Date of hearing/place**	25.09.2018 ,28.12.2018 & 23.01.2019 /Chandigarh
14.	**Representation at the hearing**	
	For the Complainant	Self
	For the insurer	Mr. Vashisth & Raman
15	**Complaint how disposed**	Dismissed
16	**Date of Award/Order**	23.01.2019

17) Brief Facts of the Case:

On 30-12-2016 Ms. Manju Sharma wife of deceased life assured late sh. Amarjeet Sharma had lodged a complaint in this office against SBI Life Ins. Co. Ltd that insurance co is not paying personal accident claim of his husband who unfortunately died on 08.10.2016. The deceased life assured was covered under SBI CARD HOLDERs MASTER POLICY NO. 63000000601.

18. Cause of Complaint

a] Complainant's argument

Mrs. Manju Sharma the complainant attended the personal hearing and reiterated the contents of the complaint. During the hearing, the complainant argued that the Insurance company had not settled death claim in respect of her husband late Sh. Amarjeet Sharma Her husband had taken the SBI Card bearing no.4317575023323877 with insurance cover. She further added that her husband unfortunately died on .08.10.2016 and the death claim was filed with the company.

b[**Insurer Argument**

The insurance company in personal hearing & in SCN submitted that the complainant is regarding death claim benefit under SBI Life master policy no. 63000000601, on the life of Late Shri Amarjeet Singh who was holding SBI Card bearing no. 4317575023323877. The insurance company submitted that the insurance cover under SBI Card bearing no. 4317575023323877 which was issued to Late Mr. Amarjeet Sharma was deactivated with effect from February, 2016 and late Mr. Amarjeet Sharma was not covered as on the date of death i.e. 08-10-2016. Hence, as per the terms and conditions of the policy, the company is not liable to consider any claim under the said Master Policy in view of the fact that the cover was inactive as on the date of the death of the Life Assured. From the Monthly Statements, it is evident that the premium was deducted towards PA cover that is, for personal Accident cover and not for life insurance cover. The personal Accident cover was granted by Royal Sundaram and the Personal Accident cover has already been settled for Rs. 7.50.000/- by Royal Sundaram on 02.01.2017. The said Master Policy 63000000601 was substituted by another master policy no. 72100096702 with date of commencement of risk 01.03.2016. However, the deceased was not covered under this policy.

The Master policyholder, SBI Cards, vide their mail dated 29.12.2016, informed the company that there was no consent in this case from the customer side and only PPI Personal Accident premium was deducted till death .The PPI PA policy is not a part of SBI Life policy. The Master Policyholder SBI Card has confirmed that they have received PPI SBI Life Premium only till 08.02.20169 through their mail dated 26.07.2018.

19. The following documents were placed for perusal.

a) Complaint to the company**.** b) Reply of the insurer

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

On perusal of various documents available in the file and considering the submissions of complainant and representative of the insurance company, it has been observed that the insurer has not received the premium from 01.03.2016 onwards whereas the complainant has received claim for personal accident amounting Rs. 750000/- from Royal Sundaram for which the premium was deducted. Since no premium was collected under the policy from the life assured the decision of insurance company seems to be correct.

ORDER

Taking into accounts the facts and circumstances of the case and the submissions made by the both parties during the course of personal hearing, the complaint is dismissed.
Hence, the complaint is treated as closed.

Dated at Chandigarh on 23 day of January 2019.

D.K. VERMA
INSURANCE OMBUDSMAN

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: A. SAMUNDEESWARI Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0390
AWARD NO: IO/CHN/A/LI/0119/2018-19

1.	**Name & Address of the Complainant**	**Ms A. Samundeeswari** **W/o (late) Arun Kumar,** **Chinnamuthur village,** **Sundekuppam Post, Krishnagiri District-635 101**
2.	**Policy No.** **Type of Policy** **Basic Sum Assured** **DOC of policy & DOC of risk** **Mode of payment** **Instalment Premium** **Policy Term/Prem. Paying term** **Date of death of LA** **Duration of policy from DOC of risk** **Status of the policy** **First unpaid premium** **Total Premiums paid**	**709564507** **New Endowment Plan** **Rs. 2,00,000** **28/03/15 & 31/03/15** **Half-yearly** **Rs. 7,142.00** **15 years** **06/10/16** **1Year 6 Months & 5 Days** **In-force** **September 2016 (Hly)** **Rs. 21,326/-**

3.	**Name of the Life Assured**	**V.ARUN KUMAR**
4.	**Name of the insurer**	**Life Insurance Corporation of India, DO, Salem**
5.	**Date of Repudiation**	**By DO: 28/03/18** **By ZO: 24/07/18**
6.	**Reason for repudiation**	**Suppression of material facts in the proposal**
7.	**Date of registration of the complaint**	**24/09/18**
8.	**Date of receipt of Annexure VI-A**	**05/10/18**
9.	**Nature of complaint**	**Non-settlement of death claim**
10.	**Amount of Claim**	**Sum Assured on death plus Simple Reversionary Bonus plus Final Additional Bonus, if any-Sum Assured on Death is: Higher of Basic Sum Assured or 10 times of Annualized premium) or 105% of all the premiums paid as on the date of death**
11.	**Date of Partial Settlement**	**The DODRC offered to refund Rs. 21,326/- being the refund of premiums paid. The same was settled on 31/03/18. Upon appeal, the ZOCRC of the insurer offered to pay Rs. 50,000/- as ex-gratia, over and above the premiums paid. According to the insurer, the complainant has not yet accepted the ex-gratia payment.**
12.	**Amount of relief sought**	**Full Death claim under the policy**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules, 2017**
14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Ms A.Samundeeswari (Complainant)**
	b) For the insurer	**Shri P.G.Kumaravaidyalingam,** **Manager (Claims), LIC of India, DO, Salem**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

During the year 2015, the Deceased Life Assured (DLA), (late) Arun Kumar, the complainant's husband took a policy (No. 709564507) on his own life from LIC of India, herein the Insurer. The policy was issued under non-medical scheme of the insurer. Within 19 months of commencement of risk, the policy resulted into (death) claim on 06/10/16. Thereupon, Ms A.Samundeeswari, the complainant herein, who is the nominee under the policy, staked her claim under the policy. After processing the claim, the insurer, vide its letter dated 28/03/18, informed the complainant that liability under the policy was repudiated on account of suppression of material facts in the proposal at the time of proposing for insurance. However, in terms of amended provisions of Section 45 of the Insurance Act, 1938, the insurer informed the complainant that it is refunding the premiums paid under the policy in full and final settlement of the claim. Aggrieved, the complainant preferred an appeal to the Zonal Office Claims Review Committee (ZOCRC) of the insurer which, although it

upheld the decision of repudiation, ordered for payment of an ex-gratia of Rs. 50,000/- which is over and above the premiums already refunded. Aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

In her complaint, the complainant stated that at the time of taking the policy the DLA had recovered from his illness after taking treatment for Tuberculosis. Even though the agent who canvassed the business was clearly told about the treatment details, he didn't disclose the same in the proposal form and instead, got the signature of the DLA on a blank proposal form, the complainant further states. The complainant added that she is working in a college on consolidated pay and has a school going son and college going daughter. During hearing, the complainant stated that her husband was normal while taking the policy and there were no serious health issues. She further added that even though he was treated in the year 2014 for TB, he got cured at the time of taking the policy.

b) Insurers' argument:

This is an early claim from the date of commencement of the policy. According to the claimant, herein the complainant, the cause of death was heart attack. Claim Form-B (Medical attendant's certificate) and Claim Form-B1 (Certificate of Hospital treatment) reveal that the DLA died due to acute Myocardial Infarction (MI)/ Multi-Drug Resistant Pulmonary Tuberculosis (MDRPT) & duration of the illness being from March 12. As per the death summary of GHTM, Tambaram, the DLA was a known case of MDR-PT and started on II level TB drugs on 09/03/12.

DMR opines that had the DLA revealed TB-MDRPT, additional reports like Chest Physician's report, Chest PA view, etc. would have been called and referred to Zonal Under writing Section (ZUS) for decision regarding acceptance of the proposal or otherwise. As hospital records clearly prove that the DLA didn't disclose the details of treatments he took prior to proposing for insurance, the DODRC repudiated the claim on grounds of suppression of material fact and refunded the premiums paid to the complainant on 31/03/18. The claimant submitted an appeal against repudiation before the Zonal Office Claims Review Committee (ZOCRC) which after examining the case, awarded Rs. 50,000/- as ex-gratia, while upholding the repudiation.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Proposal form dated 28/03/15
b) Policy document dated 18/04/15
c) Medical Attendant's Certificate (Claim form-B) dated 30/01/17
d) Discharge summary of SIMS Chellum Hospital, Salem
e) Letter dated 08/12/17 of the Superintendent, GHTM, Chennai addressed to insurer (death summary)
f) Repudiation letters dated 28/03/18 & 24/07/18
g) Complaint dated 14/09/18 to the Forum
h) Annexure VI-A dated Nil submitted by the complainant
i) Self Contained Note (SCN) dated 04/10/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions of both the parties made during the hearing and the documents submitted, it is observed as under:

a) The case of the insurer, as per repudiation letter dated 28/03/18, is that the DLA was a known case of MDR-PT, started on II level TB drugs on 09/03/12 and hence, the answers given by the DLA to Q nos. 11(a), (b), (d), (e) and 11(i) of the proposal form dated 28/03/15 were false.

b) The relevant questions where-under the DLA made mis- statements and the replies given by the DLA, as per the repudiation letter dated 28/03/18, are as under:

11(a): During the last 5 years did you ever consult a Medical Practitioner for more than a week? **No**

11(b): Have you ever been admitted to any Hospital or Nursing home for general check-up, observation, treatment or operation? **No**

11(d): Are you suffering from or have you ever suffered from ailments pertaining to Liver, Stomach, Heart, Lungs, Kidney, Brain or Nervous system? **No**

11(e): Are you suffering from or have you ever suffered from Diabetes, Tuberculosis, High Blood Pressure, Low Blood Pressure, Cancer, Epilepsy, Hernia, Hydrocele, Leprosy or any other disease? **No**

11(i): What has been your usual state of health? **Good**

c) In repudiating liability under the policy, the insurer relied upon Claim Form-B, Claim Form-B1, Discharge summary of SIMS Chellum Hospital, Salem & Death summary of Government Hospital of Thoracic Medicine (GHTM), Chennai. The above mentioned hospital records were perused and following are our observations:

d) i) As per the Discharge summary of SIMS Chellum Hospital, the DLA was admitted there on 01/10/16 with complaints of breathing difficulty/cold and cough, etc. and was discharged on 02/10/16 with an advice to visit Tambaram Sanatorium Hospital for further management. There is a mention that the DLA was a known case of TB.

ii) Claim Form-B (Medical attendant's certificate) dated 28/01/17 which was completed by the RMO of Government Hospital for Thoracic Medicine (GHTM), Tambaram, mentions the primary cause (of death) as acute MI whilst MDRPT was the secondary cause (of death). As per the said claim form, duration of the illness, viz. MDRPT , was around 4 years and the symptoms of illness (cough/Sputum/ Breathlessness) were first observed by the deceased in March 2012.

iii) According to Claim Form-B1 (Certificate of Hospital Treatment), the DLA took treatment at GHTM as an in-patient from 04/10/16 to 06/10/16 for complaints of Cough/Sputum and Breathlessness and the "diagnosis arrived at in the hospital", is mentioned as "Acute MI/MDRPT/Respiratory failure". There is a specific mention that the DLA himself reported the history and also, duration of the complaints.

iv) In his letter dated 08/12/17(death summary), addressed to the Branch manager of Krishnagiri Branch of the insurer, the Superintendent of GHTM stated that the DLA was a known case of MDRPT, started on II level TB drugs on 09/03/12 and discontinued after 6 months. The letter contains OP as well as IP numbers in respect of the treatment rendered to the DLA.

v) All these documents prove the following: *Prior to his proposing for insurance, the DLA suffered from MDRPT for which he was treated with II level TB drugs on 09/03/12 and the said treatment continued for at least six months: DLA consulted medical practitioner/s during the said period of treatment:*

vi)Nevertheless, while proposing for assurance, the DLA didn't disclose this material information and instead gave mis-statements to the relevant questions contained in the proposal dated 28/03/15. Apart from this, the DLA falsely claimed that his usual state of health was good. This being so, it is clear that the DLA suppressed material information regarding his health while replying to Q nos. 11 (a), (e) & 11 (i) of the proposal dated 28/03/15.

vii) Principle of utmost good faith (Uberrimae fidei) is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in absolute good faith or belief or trust. ***The person getting insured must***

willingly disclose to the insurer his/her complete true information regarding the subject matter of insurance. As a corollary, the insurer's liability gets void if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

viii) The policy was issued under non-medical scheme and that being so, the DLA was duty bound to disclose true state of his health while proposing for insurance. Since the DLA failed to do so while proposing for the policy and also made mis-statements, in terms of the declaration subscribed to by him in the proposal form dated 28/03/15 & also, in terms of the provisions contained in "Forfeiture in certain other events" clause of the policy, the policy shall become void and as a consequence, all claims to any benefit shall cease.

ix) Based on the above documents and submissions made during the hearing, this Forum is of the view that the insurer proved its stand, with hospital/other records, that the complainant had pre-proposal illness prior to his taking the policy. While so, the insurer's action in repudiating the claim is in accordance with the terms and conditions of the policy.

e) The complainant's contention is that even though details of pre-proposal illness of the DLA were shared with the agent who canvassed the policy, the same were not disclosed by him in the proposal form. It is the considered opinion of this Forum that when the DLA had knowledge about his illness of Tuberculosis, it was his foremost duty to disclose the same in the proposal form especially when the questions were put to him in respect of that disease and thus if the disease was not mentioned, then it would amount to suppression of material facts regarding health & such responsibility could not be thrown on the shoulders of the agent.

f) The policy was issued in the year 2015 which was subsequent to the amendment made to Section 45 of the Insurance Act, 1938. Nevertheless, the policy document contains pre-amended version of Section 45 of the Insurance Act, 1938. The insurer is advised to ensure that the policy document is issued with the terms and conditions which are in vogue at the time of issuance.

g) The claim had arisen on 06/10/16 and the same was intimated to the insurer, vide letter dated 17/11/16 of the complainant. There is a noting in the said letter by an official of the insurer that "forms received on 23/11/16".

Nevertheless, the insurer arranged for an investigation into the bonafides of the claim through one of its officials only on 18/02/17. The Claim enquiry report was received by the insurer on 13/03/17. Thereupon, on 19/05/17, the insurer requested the complainant to produce copies of hospital records

in respect of the treatment taken by the DLA. The DLA complied with the same on 11/07/17. Almost after expiry of 7 months thereof, the insurer, vide its letter dated 28/03/18, informed the complainant about its decision to repudiate the liability under the policy. The insurer took around 18 months to convey its decision which is in violation of the time lines stipulated in the IRDAI's Protection of Policyholders' Interests (PPI) Regulations, 2017. This Forum conveys its strong displeasure over the inordinate time taken by the insurer in conveying its decision.

h) The policy resulted into claim on 06/10/16 which is subsequent to the amendment made to Section 45 of the Insurance Act, 1938. As duration from the date of commencement of risk was less than three years, provisions contained in Section 45 (4) of the Insurance Act, 1938 read with instructions contained in letter dated 28/10/15 of IRDAI (ref: IRDA / Life/ GDL/ MISC/ 186 /10/2015) regarding refund of premiums vis-à-vis repudiation of claim do apply to this case. According to the insurer, three instalments of premiums were received under the policy which amount to Rs. 21,326 and the same was already refunded to the complainant on 31/03/18. Apart from this, taking into account the economic status of the complainant, the insurer offered to pay Rs. 50,000/- as ex-gratia which the complainant has not yet accepted.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's decision to repudiate the liability under Policy (no. 709564507) is justified and does not warrant any interference.

The complainant may, at her discretion, accept the ex-gratia payment of Rs. 50,000/-, awarded by the insurer. Since she has not accepted the insurer's previous offer, she is not entitled to any interest thereon.

The complaint is, therefore, not allowed.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: D.SAKUNTHALA Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0306

AWARD NO: IO/CHN/A/LI/0120/2018-19

1.	**Name & Address of the Complainant**	**Ms D.Sakunthala** **W/o (late) S.Dhanasekaran** **No. 24/6, Pazhani Street, Near New Bus stand,** **Rasipuram,** **Namakkal District-637 408**
2.	**Policy No.** **Sum Assured** **DOC of risk** **Type of Policy** **Mode of payment** **Instalment Premium** **Policy Term** **Premium Paying term** **Date of revival** **Date of death of LA** **Duration of policy @ 26/02/16** **Status of the policy @ 26/02/16** **First Unpaid Premium (FUP)**	**701820343** **Rs. 50,000** **20/12/2003** **Money Back Plan** **Half-yearly** **Rs. 1,794.00** **20 years** **20 years** **26/02/16** **17/03/17** **1Y & 21 D** **In-Force** **20/06/17 (Hly)**
3.	**Name of the Life Assured**	**S.DHANASEKARAN**
4.	**Name of the insurer**	**Life Insurance Corporation of India,** **DO, Salem**
5.	**Date of Repudiation**	**By DO: 17/03/18** **By ZO: 28/09/18**
6.	**Reason for repudiation**	**Suppression of material facts in the Personal Statement regarding Health (DGH)**
7.	**Date of registration of the Complaint**	**17/08/18**
8.	**Date of receipt of Annexure VI-A**	**27/08/18**
9.	**Nature of complaint**	**Partial settlement of death claim**
10.	**Amount of Claim**	**Rs.76, 856. 00 (Nett claim)**
11.	**Date of Partial Settlement**	**Rs. 34,520/- towards Paid-up value plus Bonus Plus refund of premiums paid at the time of revival and up to date of repudiation, settled on 31/03/18**
12.	**Amount of relief sought**	**Rs. 50,000/-**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules, 2017**

14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Ms. D. Sakunthala (Complainant)**
	b) For the insurer	**Shri P.G.Kumaravaidyalingam, Manager (Claims), LIC of India, DO, Salem**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

In the year 2003 the Deceased Life Assured (DLA), (late) S.Dhanasekaran, the complainant's husband, took a policy (No.701820343) from LIC of India, herein the insurer. The policy was issued under non-medical scheme of the insurer. Due to non-payment of premium due on 20/12/14 and onwards, the policy lapsed. On 26/02/16, the policy was revived on submission of Personal Statement regarding Health (DGH) dated 25/02/16. Within a period of 13 months of revival, the policy resulted into death claim on 17/03/17. Thereupon, the complainant who is the nominee under the policy, staked her claim under the policy. The insurer after processing the claim, vide its letter dated 17/03/18, informed the complainant that on account of suppression of material facts in the Personal Statement regarding health (DGH), liability under the policy was repudiated. Notwithstanding, the insurer offered paid-up value accrued prior to revival of the policy and also, refund of premiums paid at the time of revival up to the date of repudiation. Not satisfied with the decision, the complainant preferred representation to the Zonal Office Claims Review Committee (ZOCRC) of the insurer. The ZOCRC too upheld the repudiation decision. Aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

The complainant's stand is that her deceased husband underwent abdomen scan for ordinary stomach pain on 10/09/15 and otherwise, he was in good health. Her stand is that her husband's signature was obtained in the DGH without explaining to him its full contents. Another reason adduced by the complainant is that since the scan was taken only for ordinary stomach pain, he would have decided not to disclose the same in the DGH. She contends that the reason cited by the insurer for repudiation of claim is not acceptable and hence, requested for settlement of full claim to enable her to run the family. During hearing too, she reiterated that her deceased husband was asked to sign the DGH in blank.

b) Insurers' argument:

The policy was in force at the time of death of the life assured. The revival of the policy was done on the basis of DGH. The DLA availed benefits of Chief Ministers Health Insurance Scheme on 21/09/15 for the abdomen scan taken on 10/09/15. As per the Scan report, the DLA was diagnosed of Hypoplastic left lobe liver with recanalised portal vein, Massive Splenomegaly, Multiple Porta systemic collaterals seen at Splenic hilum, Gall blader calculus and Bilateral renal multiple calyceal caculi. Although the DLA underwent scan prior to revival (of the policy), yet, he didn't disclose the same in the DGH dated 25/02/16.

The Divisional Medical Referee (DMR) opines that had he disclosed the same in the DGH, additional reports like physician report, ECG and ECHO would have been called for and referred to Zonal Underwriting Section of the insurer for its decision. This being so, revival done on 26/02/16 was treated as null and void by the Divisional Office Disputes Redressal Committee (DODRC) for suppression of material facts. In view of amended provisions of Section 45 of the Insurance Act, a sum of Rs. 34,520/- was paid to the claimant on 31.03.2018, herein the complainant, towards paid-up value accrued prior to lapse of the policy, accrued bonuses and refund of premiums paid at the time of revival and also, up to the date of repudiation. The Zonal Office Claims Redressal Committee (ZOCRC) examined the appeal of the complainant and decided to uphold the decision of DODRC.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Policy document dated 23/12/03
b) Personal Statement regarding Health (DGH) dated 25/02/06
c) CT Scan Abdomen (oral contrast)-report dated 10/09/15
d) Repudiation letters dated 17/03/18 & 28/09/18
e) Complaint dated Nil to the Forum
f) Annexure VI-A dated nil submitted by the complainant
g) Self Contained Note (SCN) dated 26/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions of both the parties made during the hearing and the documents submitted, it is observed as under:

a) The case of the insurer, as per letter dated 17/03/18, is that the DLA, at the time of reviving the policy gave false answers to Q nos. 2 (a), (b), (c) & 4 of Personal statement regarding health (DGH) dated 26/02/16. The insurer's stand is that the DLA was diagnosed of Hypoplastic left lobe of liver

with recanalised portal vein, Massive Splenomegaly, Multiple Porta systemic collaterals seen at Splenic hilum, Gall blader calculus and Bilateral renal multiple calyceal caculi.

b) The relevant questions where under the DLA made mis- statements in the DGH and the replies given by the DLA, as per the repudiation letter dated 26/02/16, are as under:

2. Since the date of your proposal for the above mentioned policy, have you ever suffered from
a) Any illness/disease requiring treatment for a week or more? **No**
b) Did you ever have any operation, accident or injury? **No**
c) Did you ever undergo ECG, X-ray, Blood, Urine or Stool examination? **No**
4) Are you at present in sound health? **Yes**

c) i) In repudiating liability under the policy, the insurer relied upon the CT Scan abdomen report dated 10/09/15 of Namakkal Scans & Diagnostics Hi-Tech Whole Body Scan Center. The said scan report reveals that the DLA underwent CT scan of abdomen on 10/09/15 and the impression as per the CT study of abdomen shows evidence of Hypoplasia left lobe liver with recanalized portal vein, Massive Splenomegaly (Enlargement of Spleen), Multiple porta systemic collaterals seen at splenic hilum, peri gastric and lieno-renal areas, Gallbladder calculus and Bilateral renal multiple calyseal calculi.

ii) Perusal of the above record reveals the following: a) DLA underwent CT abdomen scan on 10/09/15 which was prior to the revival of the policy & b) Study of abdomen shows evidence of massive Splenomegaly (Enlargement of Spleen), Gall bladder calculus, Bilateral renal multiple calyceal calculi, Hypoplasia left lobe liver with recanalized portal vein and Multiple porta systemic collaterals seen at splenic hilum, peri gastric and lieno-renal areas. It is thus clear that the DLA was indeed suffering from some major ailments/diseases around six months prior to his reviving the policy.

iii) Nevertheless, while reviving the policy on 26/02/16, the DLA didn't truthfully disclose these details while replying to Q no. 2 (c) of the DGH dated 25/02/16, completed by him. It is also the stand of the insurer that by replying "Good" to Q no. 4, viz. "Are you at present in sound health?" the DLA falsely claimed that he was in sound health.

iv) Principle of utmost good faith (Uberrimae fidei) is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in absolute good faith or belief or trust. ***The person getting insured must willingly disclose to the insurer his/her complete true information regarding the subject matter***

of insurance. As a corollary, the insurer's liability gets void if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

v) The DGH is in English and witnessed by an agent of the insurer. The DLA put his signature thereto in English only. Q no. 2 (a) elicits information about any illness, disease requiring treatment for more than a week to which the DLA replied in negative. As per the CT scan report, the DLA, prior to his reviving the policy, suffered from some (major) diseases/ailments. The insurer, however, didn't produce any hospital record (or opinion from its DMR) to show that all these ailments/diseases indeed require treatment for more than a week. In otherwords, the insurer didn't produce any hospital record to prove that the DLA was under treatment for those ailments/diseases for more than a week. While so, the insurer's stand that the DLA gave false answer to Q no. 2(a) is not correct.

vi) Q no. 2 (b) elicits information as to whether the DLA had any operation or accident or injury. For this question also, the DLA replied in negative. It is, however, a fact that the insurer didn't produce any hospital record/other record to prove its stand that the DLA underwent an operation or had an accident or sustained injuries prior to the revival of the policy. While so, the insurer's stand that the DLA gave false answer to Q no. 2(b) is also not correct.

vii) To Q no. 2 (c) also, the DLA replied in negative which elicits information as to whether he underwent ECG, X-ray or Screening, Blood, Urine or Stool examination. As mentioned above, the DLA underwent CT abdomen scan test on 10/09/15. Since **CT scans** use X-ray technology and advanced computer analysis to create detailed pictures of the body, the DLA who underwent this test, was duty bound to answer this question with "Yes" and furnish full details thereof.

viii) It is the contention of the insurer that the DLA availed the benefit (towards CT abdomen Scan test charges) under Chief Ministers Comprehensive Health Insurance Scheme on 21/09/15 and in proof thereto, the insurer has provided soft copy, downloaded from the Portal concerned, evidencing the same.

ix) Based on the above document and submissions made during the hearing, this Forum is of the view that the insurer proved its stand, with documentary evidence, that the complainant had pre-revival illness. While so, the insurer's action in repudiating the claim is in accordance with the terms and conditions of the policy.

d) The date of death being 17/03/17 and duration of the policy being less than 3 years from the date of revival of the policy, provisions of Section 45 of the Insurance Act, 1938, as amended on 26/12/14 squarely apply to the instant case. In terms of IRDAI's instructions dated 28/10/15 and provisions contained in Section 45 (4) of Insurance Act, 1938, the premiums collected under the policy till the date of repudiation shall be refundable within a period of 90 days from the date of repudiation. The insurer has informed that within a month of the date of repudiation, Rs. 34,520/- (sum total of Paid-up value-Rs. 3,500: Vested Bonuses-Rs. 22,050: Premiums refunded-Rs. 8,970) was paid through cheque dated 31/03/18 and hence, no more claim lies under the policy.

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23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's decision to repudiate the liability under Policy no. 701820343 is justified and does not warrant any interference.

The complaint is, therefore, not allowed.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: A. SAMIRAJ Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0310

AWARD NO: IO/CHN/A/LI/0121/2018-19

1.	**Name & Address of the Complainant**	**Shri A. Samiraj** **H/o (late) M.Selvi Regina** **D No. 154, Amman Nagar,** **Thadikombu,** **Dindigul-624 709**
2.	**Policy No.** **Sum Assured** **DOC of risk** **Type of Policy** **Mode of payment** **Instalment Premium** **Policy Term** **Premium Paying term** **Date of revival (DOR)** **Date of death of LA** **Duration of policy @ 24/03/17 (from DOR)** **Status of the policy @ 24/03/17** **First Unpaid Premium (FUP)**	**743246513** **Rs. 50,000** **05/11/2002** **New Money Back Plan** **Quarterly** **Rs. 696.00** **25 years** **25 years** **08/11/2014** **24/03/17** **2Y 4m & 16 D** **Reduced Paid-up (Eligible for extended claim concession)** **05/05/2016 (Qly)**
3.	**Name of the Life Assured**	**SELVI REGINA**
4.	**Name of the insurer**	**Life Insurance Corporation of India, DO, Madurai**
5.	**Date of Repudiation**	**By DO: 07/11/17** **By ZO: 02/04/18**
6.	**Reason for repudiation**	**Suppression of material facts in the Personal Statement regarding Health (DGH)**
7.	**Date of registration of the Complaint**	**21/08/18**
8.	**Date of receipt of Annexure VI-A**	**06/09/18**
9.	**Nature of complaint**	**Non-settlement of claim**
10.	**Amount of Claim**	**Rs. 80,678.80 (Nett claim)**
11.	**Date of Partial Settlement**	**The ZOCRC awarded Rs. 35,000/- as ex-gratia but the complainant has, however, not accepted the same.**
12.	**Amount of relief sought**	**Rs. 2,00,000/- plus interest plus compensation, if any**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules, 2017**

14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Complainant was absent**
	b) For the insurer	**Shri M.Chellappa, Manager (Claims), LIC of India, DO, Madurai**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

In the year 2002, the Deceased Life Assured (DLA), (late) Selvi Regina, the complainant's wife, took a policy (No.743246513) from LIC of India, herein the insurer. The policy was issued under non-medical scheme of the insurer. Due to non-payment of premium due on 05/08/13 (quarterly due) and onwards, the policy lapsed. On 08/11/14, the policy was revived on the strength of Personal Statement regarding Health (DGH) dated 08/10/14, completed by the DLA. Thereafter, within a period of 29 months of revival, the policy resulted into death claim on 24/03//17. The complainant who is the nominee under the policy, staked his claim under the policy. The insurer after processing the claim, vide its letter dated 07/11/17, informed the complainant that on account of suppression of material facts in the Personal Statement regarding health (DGH), liability under the policy was repudiated. Notwithstanding, the insurer offered Rs. 27,225/-, being the Paid-up value accrued prior to revival of the policy. Not satisfied with the decision, the complainant preferred representation to the Zonal office Claims Review Committee (ZOCRC) of the insurer which although it upheld the repudiation decision, however, awarded an ex-gratia of Rs. 50,000 less Rs. 15,000 (two survival benefits already settled on 05/11/07 & 29/11/12). Aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

The complainant's prime contention is that the claim had arisen after 2 years from the date of revival whereas as per Section 45 of the Insurance Act, 1938, no policy shall be called in to question after expiry of two year period. He further states that the DLA was hale and healthy and the agent as well as the Development officer of the insurer made thorough enquiries regarding the DLA's past history and, physical ailments. The complainant admits that the DLA was affected by Graves disease on anti-thyroidism but was completely cured at the time of revival of the policy. The complainant contends that the medical report of Vadamalayan Hospital dated 13/03/14 is very vague and indeed, does not pertain to his wife.

b) Insurers' argument:

The cause of death, as per the claimant's statement, was heart problem. As per the discharge summaries of Meenakshi Mission Hospital and Research Centre (MMHRC), Madurai and Vadamalayan Hospitals, Madurai, the DLA was not in good health at the time of revival. The discharge summaries reveal that the DLA was a known case of Graves disease on antithroidism and was treated from 20/09/12 to 27/09/12. Further, the DLA was a known case of Auto Immune thyroditis, on treatment/DCM/CKD/chronic CRC & Tuberculosis Spondylitis for which she took treatment prior to the proposal. As illness prior to revival (of the policy) was established, claim was repudiated for suppression of material facts. However, it was decided to pay the paid-up value accrued under the policy on the date of its lapse. Action was initiated against the agent.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Policy document dated 10/01/03
b) Personal Statement regarding Health (DGH) dated 08/10/14
c) Discharge summary of Meenakshi Mission Hospitals & Research Centre, Madurai
d) Discharge summary of Vadamalayan Hospitals (P) Limited, Madurai
e) Discharge summary of Apollo Speciality Hospital, Madurai
f) Certificate dated 20/03/17 of Apollo Speciality Hospital, Madurai
g) Medical certificate dated 05/11/12
h) Certificate dated 13/03/14 of Dr.M.Baskar, Vadamalayan Hospitals (P) Limited, Madurai
i) Certificate by Employer
j) Claim Enquiry Report dated 26/08/17
k) Repudiation letters dated 07/11/17 & 02/04/18
l) Complaint dated 31/07/18 to the Forum
m) Annexure VI-A dated nil submitted by the complainant
n) Self Contained Note (SCN) dated 28/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions made by the insurer during the hearing and the documents submitted by the complainant and the insurer, it is observed as under:

a) The case of the insurer, as per letter dated 07/11/17, is that the DLA, at the time of reviving the policy gave false answers to Q nos. 2 (a), (c) & 4 of the Personal statement regarding health (DGH) dated 08/10/14. The insurer's stand is that the DLA, as per the hospital records, was a known case of "Graves disease on antithyroidism" (treated from 20/09/17 to 27/09/17), "Auto Immune Thyroiditis on

treatment", "DCM", "CKD", "chronic CRS" and "Spondylitis" for which she took anti- tubercular drugs prior to revival of the policy.

b) The relevant questions where-under the DLAmade mis-statements in the DGH and the replies given by the DLA, as per the repudiation letter dated 07/11/17, , are as under:

> 2). After the date of your proposal for the above mentioned policy, have you ever suffered from,
>
> a) Any illness/disease requiring treatment for a week or more? **No**
>
> c) Did you ever undergo ECG, X-ray, Blood, Urine or Stool examination? **No**
>
> 4). Are you at present in sound health? **Yes**

c) In repudiating liability under the policy, the insurer relied upon the discharge summaries of Meenakshi Mission Hospital & Research Centre (MMHRC), Madurai, Vadamalayan Hospitals (P) Limited, Madurai & Apollo Hospitals, Madurai and also, Certificate issued by Apollo Hospital, Madurai. Perusal of the above hospital records reveals the following:

d) i) Discharge summary of MMHRC, relating to the period of hospitalization of the DLA from 26/09/12 to 27/09/12 (pre-revival period), mentions that the DLA was a known case of Graves disease on thyroidism, basic investigations revealed elevated renal parameters, Thyroid scan showed evidence of "Graves disease" and T3T4 TSH showed "Hypothyroidism". As regards diagnosis, the discharge summary mentions "Graves disease", "Drug induced Hypothyroidism", "Thyrotoxic Cardiomyopathy" & "complete LBBB EF-40%".

ii) Discharge summary issued by Vadamalayan Hospitals (P) Limited, relating to the period of hospitalization of the DLA from 28/02/15 to 03/03/15 (post-revival period), reveals that the complainant's wife was a known case of "Auto Immune Thyroiditis" on treatment/DCM/CKD/ chronic CRS. With regard to "Final diagnosis", it is mentioned as "Tuberculosis Spondylitits-L5-L1", Chronic Kidney Disease (CKD) and "Dilated Cardio Myopathy (DCM)".

iii) Discharge summary of Apollo Speciality Hospitals, Madurai wherein the DLA was treated from 11/03/17 to 24/03/17 mentions that the DLA was a known case of CKD and Hypothyroidism. As regards diagnosis, the discharge summary mentions "DCM with severe LV Dysfunction and Renal failure".

iv) In his certificate dated 20/03/17 an Interventional cardiologist of Apollo Hospitals, Madurai certified that ECHO cardiogram revealed severe LV dysfunction with EF-20%, possibly severe Myocarditis.

v) It is observed that the discharge summaries of Vadamalayan Hospitals (P) Limited and Apollo Hospitals, even though they mention that the DLA was a known case of "Tuberculosis Spondylitis, "CKD" (Chronic Kidney Disease), "DCM" (Dilated Cardio Myopathy), "CRS" (chronic Rhinosinusitis), "Auto Immune Thyroiditis" etc., however, do not contain any information as to when all those diseases/ailments were diagnosed. In view of this, this Forum has not taken cognizance of the said discharge summaries.

vi) The insurer produced copies of Medical Certificates (MC) in respect of various spells of leave availed of by the DLA commencing from 15/11/11 (pre-revival period). All those certificates were issued by the Civil Assistant Surgeons of Government HQ Hospital, Dindigul. In one such Medical Certificate dated 05/11/12, Dr. V. Thiruloga Chandran, Civil Assistant Surgeon, certified that the DLA was suffering from "Thyrotoxicosis" (excess of thyroid hormone in the body.) and hence, recommended her leave of absence (from duty) for 20 days from 06/11/12.

vii) Dr. M.Baskar, consultant Orthopaedic Surgeon, Vadamalayan Hospitals, Madurai gave a certificate dated 13/03/14 (pre-revival period) certifying that the DLA was a case of "Tuberculosis Spondylitis" (L5-L1 level) and was taking anti-tubercular drugs and hence, advised her bed rest for 15 days.

viii) This being so, it is clear that prior to revival of the policy, the DLA suffered from "Graves disease" and "Tuberculosis Spondylitis" for which she took treatment for a week or more. Discharge summary of MMHRC reveal that the DLA underwent some basic investigations which included "ECHO" also.

ix) Nevertheless, while reviving the policy on 08/11/14, the DLA didn't disclose all these details while replying to Q nos. 2 (a) & 2 (c) of the DGH dated 08/10/14 and instead, gave mis-statements. The fact that the DLA continued to suffer from Hypo Thyroidism even in the year 2017 reveal that the DLA was not in sound health while completing the DGH on 08/10/14. Hence, by replying "Good" to Q no. 4 of the DGH, the DLA falsely claimed that she was in sound health.

x) Principle of utmost good faith (Uberrimae fidei) is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e.

insurer and insured) in absolute good faith or belief or trust. ***The person getting insured must willingly disclose to the insurer his/her complete true information regarding the subject matter of insurance.*** As a corollary, the insurer's liability gets void if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

xi) Based on the above document and submissions made during the hearing, this Forum is of the view that the insurer proved its stand, with documentary evidence, that the complainant had pre-revival illness. While so, the insurer's action in repudiating the claim is in accordance with the terms and conditions of the policy.

e) The complainant's contention that the claim had arisen after 2 years from the date of revival whereas as per Section 45 of the Insurance Act, 1938, no policy shall be called in question after expiry of two year period, is not correct and indeed, mis-conceived. As the claim had arisen on 24/03/17, provisions of Section 45 of the Insurance Act, 1938, as amended on 26/12/14, squarely apply to this case and hence, the complainant's contention is untenable. Another contention of the complainant that the medical certificate (and not report) dated 13/03/14 of Vadamalayan Hospitals (P) Limited was not at all obtained by the policyholder is also not correct. The said certificate bears the signature of the Headmaster, Government Higher Secondary School, Sullerembu, Dindigul District and also seal of the said school. It is noted that all the medical certificates (submitted by the DLA to her employer) which were made available to the insurer, have been counter signed by the Headmaster of the said School and all those signatures tally with the one appearing in the medical certificate dated 13/03/14. This being so, the complainant's contention has no force at all.

f) Section 45 (4) of the Insurance Act, 1938 (as amended on 26/12/14) read with guidelines dated 28/10/15 of IRDAI, stipulates that in case of repudiation on the ground of suppression of material fact (and not on the ground of fraud), premiums collected under the policy at the time of revival to the date of repudiation shall be paid to the insured or legal representative etc. along with the accrued benefits prior to its revival within a period of 90 days of from the date of repudiation. In its first repudiation letter dated 07/11/17, the insurer communicated that it is refunding the paid-up value as on the date of revival of the policy. However, it is silent about refund of premiums paid at the time of revival and up to the date of repudiation. Hence the insurer is obliged to pay an amount of Rs. 34,881 to the complainant being the aggregate amount of the Paid-up value of the policy on date of revival (Rs. 27,225) and the premium paid on revival and post revival (Rs. 7,656). In the opinion of this Forum,

the ex-gratia of Rs. 35,000 offered by the insurer is independent of the obligation of the insurer to pay the amount of Rs. 34,881.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's decision to repudiate the liability under Policy no. 743246513 is justified and does not warrant any interference.

However, the insurer is directed to refund an amount of Rs. 34,881.00 to the complainant in accordance with Section 45(4) of the Insurance Act, 1938 and the guidelines of IRDAI referred to. This amount shall also carry interest as provided under Rule 17(7) of the Insurance Ombudsman Rules, 2017.

The complaint is, therefore, not allowed.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: DEVENTRA CATHERINE Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0311

AWARD NO: IO/CHN/A/LI/0122/2018-19

1.	**Name & Address of the Complainant**	**Ms Deventra Catherine** **D/o Shri A.Samiraj** **D No. 154, Amman Nagar,** **Thadikombu,** **Dindigul-624 709**
2.	**Policy No.** **Sum Assured**	**747795693** **Rs. 2,00,000**

	DOC of risk **Type of Policy** **Mode of payment** **Instalment Premium** **Policy Term & Premium Paying term** **Date of revival (DOR)** **Date of death of LA** **Duration of the policy @ 24/03/17 (from DOR)** **Duration of the policy @ 24/03/17 (from DOC)** **Status of the policy @ 24/03/17** **First Unpaid Premium (FUP)**	**10/11/2014** **New Jeevan Anand Plan** **Quarterly** **Rs. 4,345.00** **16 years** **02/05/16** **24/03/17** **10 Months & 22 Days** **2 Years 4 Months & 14 Days** **In-Force** **10/05/2017 (Qly)**
3.	**Name of the Life Assured**	**M.SELVI REGINA**
4.	**Name of the insurer**	**Life Insurance Corporation of India,** **DO, Madurai**
5.	**Date of Repudiation**	**By DO: 07/11/17** **By ZO: 02/04/18**
6.	**Reason for repudiation**	**Suppression of material facts in the Proposal as well as in the Personal Statement regarding Health (DGH)**
7.	**Date of registration of the Complaint**	**21/08/18**
8.	**Date of receipt of Annexure VI-A**	**06/09/18**
9.	**Nature of complaint**	**Non-settlement of claim**
10.	**Amount of Claim**	**Rs. 2,69,114.48 (Nett claim)**
11.	**Date of Partial Settlement**	**The ZOCRC awarded Rs. 13,035/- as ex-gratia (being the refund of premiums paid) but the complainant has not accepted the same.**
12.	**Amount of relief sought**	**Rs. 2,00,000/- plus interest plus compensation, if any**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules, 2017**
14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Complainant was absent**
	b) For the insurer	**Shri M.Chellappa,** **Manager (Claims), LIC of India, DO, Madurai**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

In the year 2014, the Deceased Life Assured (DLA), (late) Selvi Regina, the complainant's mother, took a policy (No.747795693) on her own life from LIC of India, herein the insurer. The policy was issued under non-medical scheme of the insurer. Due to non-payment of premium due on 10/08/15 (quarterly due) and onwards, the policy lapsed. On 02/05/16, the policy was revived on the strength of

Personal Statement regarding Health (DGH) dated 02/05/16, completed by the DLA. Thereafter, within a period of 11 months of revival, the policy resulted into death claim on 24/03//17. The complainant who is the nominee under the policy, staked her claim under the policy. The insurer after processing the claim, vide its letter dated 07/11/17, informed the complainant that on account of suppression of material facts in the Proposal form & also, Personal Statement regarding health (DGH), liability under the policy was repudiated. Not satisfied with the decision, the complainant made a representation to the Zonal office Claims Review Committee (ZOCRC) of the insurer which while upholding the repudiation decision, awarded an ex-gratia of Rs. 13,035/- being premiums paid under the policy. Aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

In her complaint dated 31/07/18, the complainant simply stated that she is making a final appeal for rendering final justice. She, however, added that all her arguments and counters made to the insurer (earlier in the form of appeal) may be taken into account while considering her complaint. In her undated appeal to the insurer, she stated that the points raised by her father in his appeal dated 14/01/18 shall apply *mutatis mutandis* to her case also. The complainant's father who is the complainant under complaint No. CHN-L-029-1819-0310, in his appeal to the Zonal Manager of the insurer contended that the claim had arisen after 2 years from the date of revival whereas as per Section 45 of the Insurance Act, 1938, no policy shall be called in to question after expiry of two year period. He further stated that the DLA was hale and healthy and the agent as well as the Development officer of the insurer made thorough enquiries regarding the DLA's past history and also, her physical ailments. The complainant's father, however, admitted that the DLA was affected by Graves disease on anti-thyroidism but was completely cured at the time of revival of the policy. He contends that the medical report of Vadamalayan Hospital dated 13/03/14 is very vague and indeed, does not pertain to his wife.

b) Insurers' argument:

The cause of death, as per the claimant's statement, was heart problem. As per the discharge summaries of Meenakshi Mission Hospitals & Research Centre (MMHRC), Madurai and Vadamalayan Hospitals, Madurai, the DLA was not in good health at the time of revival. The discharge summaries reveal that the DLA was a known case of Graves disease on anti-thy roidism and was treated from 20/09/12 to 27/09/12. Further, the DLA was a known case of Auto Immune

Thyroditis, on treatment/DCM/CKD/chronic CRC & Tuberculosis Spondylitis for which she took treatment prior to the proposal. As illness prior to revival (of the policy) was established, claim was repudiated for suppression of material facts. However, it was decided to refund the premiums paid up to the date of revival on ex-gratia basis in full and final settlement of all claims under the policy. Action was initiated against the agent.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Policy document dated 18/11/14
b) Personal Statement regarding Health (DGH) dated 02/05/16 and proposal dt. 10/11/2014c)
Discharge summary of Meenakshi Mission Hospitals & Research Centre, Madurai
d) Discharge summary of Vadamalayan Hospitals (P) Limited, Madurai
e) Discharge summary of Apollo Speciality Hospital, Madurai
f) Certificate dated 20/03/17 of Apollo Speciality Hospital, Madurai
g) Medical certificate dated 05/11/12
h) Certificate dated 13/03/14 of Dr.M. Baskar, Vadamalayan Hospitals (P) Limited, Madurai
i) Certificate by Employer
j) Claim Enquiry Report dated 26/08/17
k) Repudiation letters dated 07/11/17 & 02/04/18
l) Complaint dated 31/07/18 to the Forum
m) Annexure VI-A dated nil submitted by the complainant
n) Self Contained Note (SCN) dated 28/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions made by the insurer during the hearing and the documents submitted by the complainant and the insurer, it is observed as under:

a) The case of the insurer, as per letter dated 07/11/17, is that the DLA, at the time of reviving the policy gave false answers to Q nos. 2 (a), (c) & 4 of the Personal Statement regarding Health (DGH) dated 02/05/16. The insurer's stand is that the DLA, as per the hospital records, was a known case of "Graves disease on anti-thyroidism" (treated from 20/09/17 to 27/09/17), "Auto Immune Thyroiditis on treatment", "DCM", "CKD", "chronic CRS" and "Spondylitis" for which she took anti- tubercular drugs prior to revival of the policy.

b) The relevant questions where-under the DLA made mis- statements in the DGH and the replies given by the DLA, as per the repudiation letter dated 07/11/17, are as under:

> 2). After the date of your proposal for the above mentioned policy, have you ever suffered from,

a) Any illness/disease requiring treatment for a week or more? **No**

c) Did you ever undergo ECG, X-ray, Blood, Urine or Stool examination? **No**

4). Are you at present in sound health? **Yes**

c) In repudiating liability under the policy, the insurer relied upon the discharge summaries of Meenakshi Mission Hospital & Research Centre (MMHRC), Madurai, Vadamalayan Hospitals (P) Limited, Madurai & Apollo Hospitals, Madurai and also, Certificate issued by Apollo Hospital, Madurai. Perusal of the above hospital records reveals the following:

d) i) Discharge Summary of MMHRC, relating to the period of hospitalization of the DLA from 26/09/12 to 27/09/12 (pre-revival period), mentions that the DLA was a known case of Graves disease on anti-thyroidism, basic investigations revealed elevated renal parameters, Thyroid scan showed evidence of “Graves disease” and T3T4 TSH showed “Hypothyroidism”. As regards diagnosis (arrived at), the Discharge Summary mentions “Graves disease”, “Drug induced Hypothroidism”, “Thyrotoxic Cardiomyopathy” & “complete LBBB EF-40%”.

ii) Discharge Summary issued by Vadamalayan Hospitals (P) Limited, relating to the period of hospitalization of the DLA from 28/02/15 to 03/03/15 (post-revival period), reveals that the complainant’s mother was a known case of “Auto Immune Thyroiditis” on treatment/DCM/CKD/ chronic CRS. With regard to “Final diagnosis”, it is mentioned as “Tuberculosis Spondylitits-L5-L1”, Chronic Kidney Disease (CKD) and “Dilated Cardio Myopathy (DCM)”.

iii) Discharge Summary of Apollo Speciality Hospitals, Madurai wherein the DLA was treated from 11/03/17 to 24/03/17 mentions that the DLA was a known case of CKD and Hypothyroidism. As regards diagnosis, the discharge summary mentions “DCM with sever LV Dysfunction and Renal failure”.

iv) In his certificate dated 20/03/17 issued by an Interventional cardiologist of Apollo Hospitals, Madurai, the cardiologist certified that ECHO cardiogram revealed severe LV dysfunction with EF-20%, possibly severe Myocarditis.

v) It is observed that the discharge summaries of Vadamalayan Hospitals (P) Limited and Apollo Hospitals, simply mention that the DLA was a known case of “Tuberculosis Spondylitis, “CKD”

(Chronic Kidney Disease), “DCM” (Dilated Cardio Myopathy), “CRS” (chronic Rhinosinusitis), “Auto Immune Thyroiditis” etc. But those discharge summaries do not contain any information as to when all those diseases/ailments were diagnosed.

In view of this, this Forum has not taken cognizance of the discharge summaries of Vadamalayan Hospitals (P) Limited, Madurai and Apollo Speciality Hospitals, Madurai.

vi) The insurer produced copies of Medical Certificates (MC) in respect of various spells of leave availed of by the DLA commencing from 15/11/11 (pre-revival period). All those certificates were issued by the Civil Assistant Surgeons of Government HQ Hospital, Dindigul. In one such Medical Certificate dated 05/11/12, Dr. V. Thiruloga Chandran, Civil Assistant Surgeon, certified that the DLA was suffering from “Thyrotoxicosis” (excess of thyroid hormone in the body.) and hence, recommended her leave of absence (from duty) for 20 days from 06/11/12.

vii) Dr. M.Baskar, consultant Orthopaedic Surgeon, Vadamalayan Hospitals, Madurai gave a certificate dated 13/03/14 (pre-revival period) certifying that the DLA was a case of “Tuberculosis Spondylitis” (L5-L1 level) and was taking anti-tubercular drugs and hence, advised her bed rest for 15 days.

viii) This being so, it is clear that prior to revival of the policy, the DLA suffered from “Graves disease” and “Tuberculosis Spondylitis” for which she took treatment for a week or more. Discharge summary of MMHRC reveal that the DLA underwent some basic investigations which included “ECHO” also.

ix) Nevertheless, while reviving the policy on 02/05/16, the DLA didn’t disclose all these details while replying to Q nos. 2 (a) & 2 (c) of the DGH dated 02/05/16 and instead, gave mis-statements. The fact that the DLA continued to suffer from Hypo-thyroidism even in the year 2017 reveals that the DLA was not in sound health while completing the DGH on 02/05/16. Hence, by replying “Good” to q no. 4 of the DGH, the DLA falsely claimed that she was in sound health.

x) Principle of utmost good faith (Uberrimae fidei) is a very basic and first primary principle of insurance. According to the principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in absolute good faith or belief or trust. ***The person getting insured must willingly disclose to the insurer her/her complete true information regarding the subject matter of insurance.*** As a corollary, the insurer's liability gets void if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

xi) Based on the above document and submissions made during the hearing, this Forum is of the view that the insurer proved its stand, with documentary evidences, that the complainant had pre-revival illness. While so, the insurer's action in repudiating the claim is in accordance with the terms and conditions of the policy.

d) The complainant's contention that the claim had arisen after 2 years from the date of revival whereas as per Section 45 of the Insurance Act, 1938, no policy shall be called in to question after expiry of two year period, is not correct and indeed, mis-conceived. As the claim had arisen on 24/03/17, provisions of Section 45 of the Insurance Act, 1938, as amended on 26/12/14, squarely apply to this case and hence, the complainant's contention is untenable. Another contention of the complainant that the medical certificate (and not report) dated 13/03/14 of Vadamalayan Hospitals (P) Limited was not at all obtained by the policyholder is also not correct. The said certificate bears the signature of the Headmaster, Government Higher Secondary School, Sullerembu, Dindigul District and also seal of the said school. It is noted that all the medical certificates (submitted by the DLA to her employer) which were made available to the insurer, have been counter signed by the Headmaster of the said School and all those signatures tally with the one appearing in the medical certificate dated 13/03/14. This being so, the complainant's contention has no force at all.

e) Section 45 (4) of the Insurance Act, 1938 (as amended on 26/12/14) read with guidelines letter dated 28/10/15 of IRDAI, stipulates that in case of repudiation on the ground of suppression of material fact (and not on the ground of fraud), the premiums collected under the policy at the time of revival to the date of repudiation shall be paid to the insured or legal representative etc. along with the accrued benefits prior to its revival within a period of 90 days of from the date of repudiation. In its first repudiation letter dated 07/11/17, the insurer communicated that entire liability under the policy was repudiated. However, through its letter dated 02/04/18, the insurer communicated that the ZOCRC awarded an Ex-gratia of Rs. 13,035/-. According to the insurer, premiums were paid up to February 17 quarterly due. This being so, the insurer is bound to refund a sum of Rs. 43,450 (being the 10 instalments of premiums paid under the policy from November 14 to February 17) to the complainant. During hearing, the insurer's representative stated that the claim was repudiated on the ground of fraud since the repudiation letter alleged that there was intention to deceive the insurer while suppressing the material facts. This Forum, however, pointed out that in-as-much as the insurer didn't produce any document to prove the aspect of "fraud", the premium collected under the policy up to the date of repudiation has to be refunded to the complainant.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's decision to repudiate the liability under Policy no. 747795693 is justified and does not warrant any interference.

However, insurer is directed to refund the entire premium of Rs. 43,450 collected from the date of commencement of the policy together with interest as applicable under Rule 17(7) of the Insurance Ombudsman Rules, 2017.

The complaint is, therefore, not allowed.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: B.JEYACHITRA Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0376

AWARD NO: IO/CHN/A/LI/0124/2018-19

1.	Name & Address of the Complainant	Ms B.Jeyachitra W/o (late) H.Ramakrishnan No. 1/67, Horasolai, Nihung Post, Kothagiri Nilgris District-643 217	
2.	Policy No. Sum Assured DOC of risk Type of Policy Mode of payment Instalment Premium Policy Term Premium Paying term	763159811 Rs. 2,00,000 28/07/2009 Jeevan Saral Monthly (SSS) Rs. 817.00 12 years 12 years	763181204 Rs. 1,00,000 28/01/2013 Jeevan Anand Monthly (SSS) Rs. 1019.00 48 years 12 years

	Date of revival **Date of death of LA** **Duration of policy @ 10/10/17(from DOR)** **First Unpaid Premium (FUP)** **Status of the policy @ 10/10/17**	**29/04/2017** **10/10/2017** **5 Months & 11 Days** **28/10/17 (Monthly)** **In-force**	**31/03/2017** **10/10/2017** **6 Months & 9 Days** **28/10/17 (Monthly)** **In-force**
3.	**Name of the Life Assured**	**H.RAMAKRISHNAN**	
4.	**Name of the insurer**	**Life Insurance Corporation of India,** **DO, Coimbatore**	
5.	**Date of Repudiation**	**By DO: 10/04/18 & 04/04/18** **By ZO: 09/08/18**	
6.	**Reason for repudiation**	**Suppression of history of previous illness**	
7.	**Date of registration of the Complaint**	**07/09/18**	
8.	**Date of receipt of Annexure VI-A**	**20/09/18**	
9.	**Nature of complaint**	**Non-settlement of claim**	
10.	**Amount of claim**	**Rs. 2,00,000 plus all premiums paid plus Loyalty addition, if any**	**Rs. 1,00,000**
11.	**Date of Partial settlement**	**Insurer offered to settle Rs. 37,792/- under Policy No. 763181204 & Rs. 49,036/- under Policy No. 763159811. The complainant, however, has not accepted the same.**	
12.	**Amount of relief sought**	**Rs. 3,00,000/-**	
13.	**Complaint registered under**	**Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017**	
14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**	
15.	**Representation at the hearing**		
	a) For the complainant	**Complainant was absent**	
	b) For the insurer	**Shri R.Sathyanarayanan,** **Manager (Claims), LIC of India, DO, Coimbatore**	
16.	**Complaint how disposed**	**By Award**	
17.	**Date of Award**	**14/01/2019**	

18) Brief Facts of the Case:

The Deceased Life Assured (DLA), (late) H.Ramakrishnan, the complainant's husband, took two policies on his own life from LIC of India, herein the insurer. The first one (No. 763159811) was taken in the year 2009 whilst the second one (No. 763181204) was taken in the year 2013. Both the policies were issued under non-medical scheme of the insurer. Due to non-payment of premiums within the days of grace, both the policies lapsed. The policies were revived subsequently on 29/04/17 (policy no. 763159811) and 31/03/17 (policy no. 763181204). Thereupon, within a very short period, the policies resulted in to death claim on 10/10/17. While so, the complainant who is the nominee under both the policies, staked her claim under the policies. The insurer after processing the claim, vide its letters dated 04/04/18 (in respect of policy no. 763181204) & 10/04/18 (in respect of policy no.

763159811), informed the complainant that no history of previous illness was mentioned, as evidenced by the rating sheet of the Divisional Office of the insurer and as a sequel thereto, repudiated all the liabilities under both the policies. However, under policy no. 763181204, the insurer offered to pay Rs. 37,792/- being the paid-up value accrued under the policy as on 31/03/17 and Rs. 49,036/-, being the paid-up value accrued under the policy no. 763159811 as on 29/04/17. Not satisfied, the complainant submitted an appeal to the Zonal Office Claims Review Committee (ZOCRC) of the insurer which while upholding the repudiation decision, offered to refund the premiums paid at the time of revival under both the policies, in addition to the Paid-up value offered already by the DODRC. Still aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

In her complaint, the complainant has simply narrated the events that led to the repudiation of claim. She has not adduced any grounds for re-consideration of the ZOCRC's decision. The complainant has added that she has two daughters and hence, has the responsibility to get them married. The complainant didn't attend the hearing despite being informed about the hearing schedule well in advance. She, however, has sent a letter enclosing the communication dated 19/01/17 received from the insurer regarding launching of campaign for revival of the lapsed policies. The complainant has stated that the policies were revived following the insurer allowing certain concessions in health requirements and discount in late fee, wherever applicable, in reviving the policies during the said revival campaign.

b) Insurers' argument:

The cause of death was heart attack. As per the discharge summary dated 23/09/15 of Kovai Medical Centre & Hospital, the final diagnosis was Diabetic Retinopathy with Nephropathy with chronic kidney failure. On 11/09/15, the DLA underwent renal transplantation and prior thereto, he was undergoing haemodialysis since 26/07/13. The medical records clearly show that the DLA was suffering from ailment which he suppressed at the time of revival. The Divisional Medical Referee (DMR) opined that the undisclosed ailment, viz. renal transplantation is co-related to the cause of death. Hence, the Divisional Office Disputes Redressal Committee (DODRC) repudiated the claim for "fraud" and treated the revival "Null & Void". The revival papers were mis-placed by the branch. The revival was done on the strength of Declaration of Good Health (DGH), Full Medical Report (FMR) and Fasting Blood Sugar (FBS) Report. Had Diabetes Retinopathy with nephropathy with CKD and history of

dialysis been disclosed (at the time of revival), then additional reports would have been called and the cases referred to Central Office Underwriting Section (CUS) for its decision regarding revival. The ZOCRC considered the complainant's appeal and decided to uphold the decision to repudiate. However, it ordered for refund of premiums paid at the time of revival.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Policy documents dated 31/07/09 & 31/01/13
b) Rating sheet (Form No. CBE/323/PS) dated 21/03/17
c) Discharge Summary of Kovai Medical Center and Hospital (KMCH) Limited, Coimbatore
d) Employer certificate dated 09/01/18
e) Repudiation letters dated 04/04/18,10/04/18 & 09/08/18
f) Complaint dated 31/08/18 to the Forum
g) Annexure VI-A dated nil submitted by the complainant
h) Self Contained Note (SCN) dated 24/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions made by the insurer during the hearing and the documents submitted by the complainant and the insurer, it is observed as under:

a) The case of the insurer, as per the letter dated 04/04/18 in respect of policy no. 763181204, is that no history of previous illness was mentioned as per the rating sheet of the Divisional Office and as a consequence, all the liabilities under the policies were repudiated since suppression of material facts which had a bearing on granting of risk was clearly done with (an) intent to deceive the Corporation (herein the insurer).

With regard to policy no. 763159811, the insurer, vide its letter dated 10/04/18, contended that no history of previous illness was mentioned in the DGH and medical reports, as per the rating sheet of the Divisional Office. The letter further states that the DLA at the time of revival of the policy, didn't disclose the fact that he underwent renal transplantation with D3 Stenting on 11/09/15, as evidenced by KMCH discharge summary for admission dated 11/09/15. It is further mentioned in the said letter that "this suppression of material facts which had a bearing on granting of risk, was clearly done with (an) intent to deceive the Corporation (herein the insurer) and hence, decided to repudiate all the liabilities under the policies".

b) In repudiating liability under the policies, the insurer relied upon the Discharge Summary of KMCH in respect of treatment rendered to the DLA from 11/09/15 to 23/09/15 (pre-revival period). The discharge summary mentions the final diagnosis as “Diabetic Retinopathy with Nephropathy with chronic kidney failure on maintenance Haemodialysis-renal allograft recipient”. The Discharge Summary records the “past history” as “chronic kidney failure on maintenance Haemodialysis”. The discharge summary further mentions that the DLA was started on maintenance Haemodialysis since 26/07/13 and the DLA underwent renal transplantation (with DJ stenting) on 11/09/15.

c) Perusal of the above hospital record reveals that even prior to revival of the policies, the DLA was suffering from chronic kidney failure for which he had been undergoing Haemodialysis since 26/07/13. The hospital record further reveals that the DLA undergone renal transplantation on 11/09/15 which was prior to the revival of the policies.

d) It is pertinent to mention herein that the complainant herself admitted in her appeal dated 30/04/18, addressed to the Zonal Manager of the insurer, the fact of her deceased husband’s hospitalisation at KMCH from 11/09/15 to 23/09/15 for kidney disease and also, the surgery undergone by him during the said hospitalization.

e) i) The repudiation letters dated 04/04/18 & 10/04/18 didn’t refer to the relevant clause of the policy documents which empowered the insurer to call the policies in question. Also, with regard to policy no. 763181204, there is no reference in the repudiation letter about the DLA’s suffering from kidney failure and the renal transplantation undergone by him prior to the revival of the policy. Moreover, both the letters are silent as to the stage when the suppression (of material facts) happened, viz. whether while proposing for assurance or reviving the policy. Furthermore, repudiation letter dated 04/04/18 in respect of policy no. 763181204 is silent about the “material/s” relied upon by the insurer in repudiating the claim. The only defence taken by the insurer under both the policies was that “no history of previous illness mentioned, as per the rating sheet of the Divisional office”. By not mentioning the details of suppression and also, the material relied upon in the repudiation letter dated 04/04/18 in respect of policy no. 763181204, the communication dated 04/04/18 failed to meet the requirements of Section 45 of the Insurance Act, 1938.

ii) Rating sheet is an internal document of the insurer facilitating the competent authority to take a decision regarding revival of the policy or otherwise. This being so, action of the insurer in making a reference to such an internal document in the repudiation letters is unwarranted. In the SCN, the

insurer has stated the ground of repudiation as “Fraud”. Notwithstanding this, there is no allegation of “fraud” in the repudiation letters.

iii) Regarding revival, the insurer, in its SCN, furnished only the date of revival. There is no information as to the date of lapse and also, number/details of dues collected at the time of revival. In the SCN, the insurer has stated that the revival was done on the strength of DGH, FMR (Full Medical Report) and FBS report with Divisional Office’s decision at ET (Existing Terms).

iv) Nevertheless, the insurer didn’t produce copies of the aforesaid documents but instead, stated that “revival papers were mis-placed by the branch”. As the revival papers, especially DGH, are the base documents (along with hospital records) for repudiating liability under the policies, it is the foremost duty of the insurer to produce at least copy/ies of the DGH so as to enable this Forum to satisfy itself that the complainant indeed suppressed the material information and gave mis-statements to the relevant questions in the DGH, while reviving the policies. This Forum being of Quasi-Judicial in nature, adjudicates the complaints/disputes solely based on the documents submitted by both the parties. Of course, the submissions made during hearing are also taken cognizance of by this Forum provided new extenuating facts are brought in by the parties, backed by documentary evidence/s. Whileso, submission of DGH which is the basic document wherein the insurer alleged that the DLA suppressed the material facts and also, made mis-statements, is *sine qua non* for accepting the allegation of the insurer. In the absence of “DGH”, it is not feasible for this Forum to conclude that the DLA made mis-statements and also, suppressed material facts at the time of revival of the policies notwithstanding the fact that the hospital records clearly prove pre-revival illness of the DLA.

v) While so, the insurer’s action in declaring the revival “void” and admitting the claim only to the extent of Paid-up value accrued under the policies on the date of lapse plus refund of premiums paid at the time of revival is not in order.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by the insurer during the course of hearing, this Forum is of the view that the Insurer’s decision to repudiate the liability under the Policies (No. 763159811 & 763181204) is not justified and hence, warrants interference.

The insurer is, therefore, directed to settle the claim of the complainant for Rs. 3,00,000 as per terms and conditions of the respective policies and in addition pay “interest”, as envisaged in Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

The complaint is, therefore, allowed.

24) The attention of the complainant and 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 30 days of the receipt of the Award and shall intimate the compliance 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 IRDAI 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 Insurer.

Dated at Chennai on this 14th day of January 2019

(M.VASANTHA KRISHNA)

INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: PRESIDENT/SECRETARY, VT658, KILPENNATHUR TEACHERS EMPLOYEES CO-OP THRIFT & CREDIT SOCIETY Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0312

AWARD NO: IO/CHN/A/LI/0126/2018-19

1.	**Name & Address of the Complainant**	**The President/Secretary** **VT 658 Kilpennathur Teachers Employees** **Co-op Thrift & Credit Society,** **Kilpennathur Post,** **Thiruvannamalai District**
2.	**Policy No.** **Type of Policy** **Basic Sum Assured** **DOC of policy** **DOC of risk** **Mode of payment**	**737054803** **Anmol Jeevan-2** **Rs. 7,00,000/-** **27/01/2015** **27/01/2015** **Yearly**

	Instalment Premium **Policy Term/Prem. Paying term** **Date of death of LA** **Duration of policy from DOC** **Status of the policy** **First unpaid premium** **Total Premiums paid**	**Rs. 2,436/-** **15/15 years** **01/04/16** **1 Y 2 M & 4 D** **In-Force** **27/01/17 (Yly)** **Rs. 4,872/-**
3.	**Name of the Life Assured** **Name of the Assignee**	**G.VEERARAGHAVAN** **VT 658 Kilpennathur Teachers Employees Co-op Thrift & Credit Society**
4.	**Name of the insurer**	**Life Insurance Corporation of India, DO, Vellore**
5.	**Date of Repudiation**	**By DO: 31/03/17** **By ZO: 23/09/17** **By CO: 29/03/18**
6.	**Reason for repudiation**	**Non-settlement of death claim**
7.	**Date of registration of the complaint**	**21/08/18**
8.	**Date of receipt of Annexure VI-A**	**06/09/18**
9.	**Nature of complaint**	**Repudiation of claim on account of suppression of material facts in the Proposal form**
10.	**Amount of Claim**	**Rs. 7,00,000 (Sum Assured)**
11.	**Date of Partial Settlement**	**The Zonal Office Claims Redressal Committee (ZOCRC) of the insurer offered to pay Rs. 4,872/- being the refund of premiums paid. The assignee is yet give its consent to receive the same.**
12.	**Amount of relief sought**	**Rs. 7,00,000 (Sum Assured)**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules 2017**
14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Shri A.Seetharaman (Secretary of the Complainant Society)**
	b) For the insurer	**Shri N.G.Vijai,** **Admn. Officer (Claims), LIC of India, DO, Vellore**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

In January 2015, the Deceased Life Assured (DLA), (late) G.Veeraraghavan, took a policy (No. 737054803) from LIC of India, herein the Insurer. The policy was issued under medical scheme of the insurer. Within 15 months from the date of commencement of risk, the policy resulted into (death) claim on 01/04/16. Thereupon, VT 658 Kilpennathur Teachers Employees Thrift & Credit Society, the complainant herein, who is the assignee under the policy, staked its claim under the policy. The insurer, vide its letter dated 31/03/17, informed the complainant that liability under the policy was repudiated on account of suppression of material facts in the proposal at the time of proposing for insurance. There upon, the Zonal Office Claims Review Committee (ZOCRC) of the insurer examined

the appeal preferred by the assignee, herein the complainant. While upholding the repudiation decision, the ZOCRC, however, recommended for refund of premiums amounting to Rs. 4,872/-. Not satisfied, the assignee preferred second appeal to the Central Office Disputes Redressal Committee (CODRC) of the insurer which upheld the repudiation decision and also refund of premiums. Aggrieved, the complainant has filed this complaint. Based on the notice of assignment given by the DLA, on 21/04/15 the insurer assigned the policy in favour of VT 658 Kilpennathur Teachers Employees Thrift & Credit Society. This being so, this complaint has been preferred by the Secretary & President of the said Society.

19) Cause of Complaint:

a) Complainant's argument:

In its complaint, the Society, herein the complainant, states that it has 137 members comprising Government teachers and workers and the DLA was one of its members and as a collateral security for the loan (of Rs. 5 lakhs) granted to the DLA by the Society, the DLA took the subject life policy and assigned it in its favour. The Society says that the policy was issued after medical examination by one of the medical examiners of the insurer. The DLA is survived by his aged mother and son, aged 9 years and they are finding it difficult to settle the loan amount of Rs. 7 lakhs, the Society further adds. The assignee has requested for settlement of the full claim so that legal action need not be pursued against the legal heirs of the DLA.

b) Insurers' argument:

The life assured, aged 36 years, died of Cardiogenic shock due to liver failure. Case sheets of JIPMER, Pondycherry and Stanley Hospital, Chennai reveal that the DLA was an alcoholic for 10 years and Diabetic for 5 years. The DLA was diagnosed to have suffered from ethanol related de-compensated chronic liver disease, Hepatic Encephalopthy. DLA didn't disclose his alcoholic habit and also Diabetes at the time of taking the policy. Hence, claim was repudiated.

20) Reason for Registration of Complaint: This is a case of repudiation of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Proposal form dated 25/01/15
b) Policy document dated 30/01/15
c) Out-patient Records of JIPMER Hospital, Puducherry
d) Repudiation letters dated 31/03/17, 23/09/17 & 29/03/18

e) Complaint dated 18/06/18 to the Forum
f) Annexure VI-A dated Nil submitted by the complainant
g) Self Contained Note (SCN) dated 24/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions of both the parties made during the hearing and the documents submitted, it is observed as under:

a) The case of the insurer, as per repudiation letter dated 31/03/17, is that the answers given by the DLA to Q nos. 11 (e), (d), (h) & 11 (i) of the of the proposal form dated 25/01/15 were false as evidenced by the proposal form. The case of the insurer is that the suppression of material facts which had a bearing on granting of risk was clearly done with intent to deceive the Corporation and hence, liability was repudiated in terms of provisions of Section 45 of the Insurance Act, 1938.

b) In its repudiation letter dated 31/03/17, the insurer quoted the following 4 questions of the proposal form dated 25/01/15 where under the DLA alleged to have given false replies. The details are:

11 (e) Are you suffering form or have you ever suffered from Diabetes, Tuberculosis, High Blood Pressure, Low Blood Pressure, cancer, Epilepsy, Hernia, Hydrocele, Leprosy or any other disease? **No**
11(d) Are you suffering from or have you ever suffered from ailments pertaining to Liver, Stomach, Heart, Lungs, Kidney, Brain or Nervous system? **No**
11 (h) Do you use or have you ever used alcoholic drinks, narcotic or any other drugs? **No**
11 (i) What has been your usual state of health? **Good**

c) i) In repudiating the liability under the policy, the insurer relied upon the case sheets (OPD) of JIPMER Hospital, Pondicherry, Discharge summary of Stanley Medical College and Hospital, Chennai and Claim Form-B. These records were perused and following are our observations:

- Case sheets of JIPMER Hospital, Pondicherry reveal that the DLA was treated there as an out-patient on 10/11/15, 13/11/15 and 17/11/15, all in post-proposal period. The case sheets contain notings like, “known case of alcoholic for 4-5 years”, “DM on OHA (Oral Hypoglycaemic Agent)”, “Patient increased taking alcohol since 30 days”, “Alcoholic Hepatitis(?), “To stop alcohol”, “Chronic alcoholic for 10 years”, “Daily taking Brandy 200 ml/day”, “DM (?) six months back” & “case of alcoholic hepatitis with Type 2 DM referred for UGI scopy”.

- In the discharge summary of Stanley Medical College and Hospital which relates to the period of treatment of the DLA from 03/03/16 to 09/03/16 (post-proposal period), "Chronic alcoholic-10 years", against Personal history. "Ethanol related Decompensated chronic liver disease-Hepatic Encephalopathy (recovered)" is mentioned as the diagnosis.
- Claim Form-B (Medical attendant's certificate) dated 18/06/16 mentions primary cause of death as "Respiratory distress" and secondary cause as "DCLD/PHT/huge Ascites". The said certificate mentions that the DLA was suffering from the above diseases for 1 year.

ii) The above hospital records prove the following: *Prior to his proposing for insurance, the DLA was a known case of alcoholic. Regarding Diabetes Mellitus, it is mentioned that the DLA was on OHA but there is no mention as to how long he was suffering from it. As regards DCLD (De-compensated Liver Disease) too, there is no information as to the exact period from when the DLA was suffering thereto. Of course, Claim Form-B mentions that the DLA suffered from DCLD/PHT/Ascites for 1 year. Since it was issued in June 16, it may be inferred that the DLA was suffering from the said diseases since June 15 which was subsequent to the issuance of the policy.*

iii) The hospital records clearly prove that the DLA was an alcoholic even prior to his proposing for assurance. Whileso, it is patent that the DLA while replying to Q no. 11 (h)-"Do you use or have you ever used alcoholic drinks, narcotics or any other drugs"-not only suppressed the fact of his taking alcohol but also, made mis-statement by giving "No" as answer thereto. The insurer's stand that the DLA gave false replies to Q Nos. 11 (e) & 11 (d) is not backed by any hospital record and hence, its contention is not correct. To Q no. 11 (i), the DLA replied with an "yes" and not "Good" as mentioned in the repudiation letter dated 31/03/17.

iv) Principle of utmost good faith (Uberrimae fidei) is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in absolute good faith or belief or trust. ***The person getting insured must willingly disclose to the insurer his/her complete true information regarding the subject matter of insurance.*** As a corollary, the insurer's liability gets void if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

d) i) The policy resulted into claim on 01/04/16 which is subsequent to promulgation of "The Insurance Laws (Amendment) Ordinance, 2014" on 26/12/14. The said Ordinance substituted new Section 45 in the Insurance Act, 1938 and subsection 45 (4) thereof empowers the insurer to call a policy in to question within a three year window on the ground of suppression of material facts concerning the life

expectancy of the insured provided the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured, ***the grounds and materials on which such decision to repudiate the policy is based.*** In other words, the repudiation of claim within 3 year window is sustainable provided the communication of the insurer contains grounds of repudiation and also, the materials which formed the basis for repudiation.

ii) Admittedly the insurer called the policy, issued on the life of the DLA, within three year window for "suppression of material facts". More so, a communication in writing was also sent to the assignee on 31/03/17. Furthermore, the insurer quoted the relevant questions of the proposals (and also the replies/answers) where under the DLA is alleged to have given false replies. After quoting the relevant questions and replies, the insurer in its repudiation letter dated 31/03/17 stated as under:

"***We may, however, state that all the aforesaid answers were false as can be seen from the following document, viz. proposal form enclosed. This suppression of material facts which have had a bearing on the granting of risk, was clearly done with intent to deceive the Corporation. Hence, it has been decided to repudiate all the liabilities and in terms of provisions of Section 45 of the Insurance Act, 1938".***

iii) Nonetheless, the communication is silent about grounds of repudiation, viz. "material facts" which were suppressed, and also, the "materials relied upon by the insurer". The communication dated 31/03/17 states two things, viz. "answers given by the DLA to the 4 questions of the proposal form" were false whilst another being "suppression of material facts which will have a bearing on the granting of insurance, was done with intent to deceive the Corporation".

iv) As mentioned above, the communication, as envisaged in Section 45 of the Insurance Act, 1938, should, however, clearly state the facts which were suppressed by the DLA while answering the 4 questions and also, the materials, viz. hospital/other records, relied upon by it in support of its stand regarding suppression. In the SCN, the insurer stated that the DLA was alcoholic for 10 years and Diabetic for 5 years, as per the case sheets of JIPMER Hospital & Stanley Hospital. But, unfortunately this vital information was not mentioned in the repudiation letter dated 31/03/17, thus making the repudiation decision unsustainable. In other words, the repudiation letter is defective for non-compliance of the provisions contained in the Section 45 (4) of the Insurance Act, 1938.

e) To sum up, the hospital records reveal that the DLA was an alcoholic before his taking the policy which fact, he failed to disclose in the proposal form dated 25/01/15. The repudiation letter being the primary document which conveys the decision of the insurer, should conform to the provisions contained in the Section 45(4) of the Insurance Act, 1938, in-as-much-as the claim arose subsequent to the amendment made on 26/12/14. Nevertheless, by not mentioning (in the repudiation letter) the material facts which were alleged to have been suppressed by the DLA in the proposal form and also, the materials relied upon by the insurer in repudiating the claim, the repudiation letter dated 31/03/17 is defective. While so, this Forum concludes that the insurer's action in repudiating the liability under policy no. 737054803 is not in order given the fact that the insurer failed to meet the requirements of Section 45 (4) of the Insurance Act, 1938 in repudiating the policy.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's repudiation of liability under Policy (no. 737054803) is not in accordance with Section 45 of the Insurance Act and hence, warrants interference.

The insurer is, therefore, directed to settle the claim of the complainant for Rs. 7,00,000 for the eligible amount as per terms and conditions of the policy and in addition pay interest, as envisaged in Rule No. 17(7) of the Insurance Ombudsman Rules, 2017.

The complaint is, therefore, allowed.

24) The attention of the complainant and 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 30 days of the receipt of the Award and shall intimate the compliance 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 IRDAI 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 Insurer.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

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: P.TAMILARASI Vs LIFE INSURANCE CORPORATION OF INDIA
REF: NO: CHN-L-029-1819-0336

AWARD NO: IO/CHN/A/LI/0127/2018-19

1.	**Name & Address of the Complainant**	**Ms P.Tamilarasi** **W/o (late) D.Prabhu** **No. 5-41, SJN Rice Mill,** **V.Pudur village,** **R.K.Pet Post, Pallipat Taluk-631 003**
2.	**Policy No.** **Sum Assured** **DOC of risk** **Type of Policy** **Mode of payment** **Instalment Premium** **Policy Term** **Premium Paying term** **Date of death of LA** **Duration of policy @ 10/10/17** **First Unpaid Premium (FUP)** **Status of the policy @ 10/10/17** **Gap premium, if any**	**732624064** **Rs. 5,00,000** **30/05/2014** **New Jeevan Anand** **Monthly (SSS)** **Rs. 1787.00** **26 years** **26 years** **17/10/15** **1 year 4 months & 17 days** **October 15 (monthly)** **In-force** **1 (July 14)**
3.	**Name of the Life Assured**	**D.PRABHU**
4.	**Name of the insurer**	**Life Insurance Corporation of India, DO, Vellore**
5.	**Date of Rejection of claim**	**By BO: 25/09/17 (No reason given for rejection of claim). Appeal dated 07/06/18 was submitted to CRM, SZO. But, again BO only sent a letter dated 21/07/18 informing that the claim could not be admitted, as SSS ex-gratia is not applicable.**
6.	**Reason for rejection**	**As there existed one gap premium at the time of death, nothing is payable as SSS ex-gratia is not applicable to the new plans.**
7.	**Date of registration of the complaint**	**28/08/18**
8.	**Date of receipt of Annexure VI-A**	**06/09/18**

9.	**Nature of complaint**	**Non-settlement of Death claim**
10.	**Amount of Claim (Insurer has not even produced copy of the policy document. This information has been taken from the insurer's official website)**	**Death benefit, defined as sum of Sum Assured on Death and vested Simple Reversionary Bonuses and Final Additional bonus, if any, shall be payable. Where, Sum Assured on Death is defined as higher of 125% of Basic Sum Assured or 10 times of annualized premium. This death benefit shall not be less than 105% of all the premiums paid as on date of death.**
11.	**Date of Partial Settlement**	**Not applicable. Entire claim rejected**
12.	**Amount of relief sought**	**Rs. 5,00,000/- plus Bonus**
13.	**Complaint registered under**	**Rule No. 13 (1) (b) of the Insurance Ombudsman Rules, 2017**
14.	**Date of hearing & Place of hearing**	**24/10/18 & Chennai**
15.	**Representation at the hearing**	
	a) For the complainant	**Ms P.Tamilarasi (Complainant)**
	b) For the insurer	**Shri N.G.Vijai, Admn. Officer (Claims), LIC of India, DO, Vellore**
16.	**Complaint how disposed**	**By Award**
17.	**Date of Award**	**14/01/2019**

18) Brief Facts of the Case:

In May 2014, the Deceased Life Assured (DLA), (late) D.Prabhu, the complainant's husband, took a policy on his own life from LIC of India, herein the insurer. The instalment premium was Rs. 1,787/-, payable at monthly rests under Salary Savings Scheme (SSS). Thereupon, within 17 months of commencement of risk, the policy resulted into death claim on 17/10/15. While so, the complainant who is the nominee under the policy, staked her claim. The insurer after processing the claim, vide its letter dated 25/09/17, informed the complainant that the claim was not admitted, as intimated by its Divisional Office (DO) Claims department. Thereupon, the complainant, vide her letter dated 04/05/18, requested both the Branch as well as the Divisional offices to inform the reason for non-admission of the claim. As there was no response thereto, she sentt a letter dated 07/06/18 to the Customer Relations Department of the insurer's Zonal office. In response thereto, the complainant received two letters from the Branch office (dated 11/07/17 & 21/07/18) stating that SSS Ex-gratia claim is not applicable for new policies and hence, nothing was payable under the policy as July 14 due premium remained as "gap" (unpaid) at the time of death of the life assured. Aggrieved, the complainant has filed this complaint.

19) Cause of Complaint:

a) Complainant's argument:

The complainant states that she submitted claim forms to the insurer in the month of November 15. She further states that 22 months after her submitting the forms, she received a letter dated 25/09/17

from the insurer's Branch office stating that nothing was payable under the policy. Her contentions are: a) The insurer took almost 22 months to intimate non-admission of claim which is against IRDAI Regulations. b) Had the authorization letter (to the employer of the DLA) been sent on time, the employer would have deducted the July 14 due premium from his salary. c) SSS ex-gratia not being applicable for new policies is a lame excuse. d) The insurer failed to communicate either to the employer of the DLA or DLA himself about existence of "gap" premium. In fact, intimation regarding gap premium was received only after the life time of the DLA. e) The employer recovered the July 14 gap premium while settling the terminal benefits of the DLA and also, remitted it to the insurer. f) Had the insurer decided the claim within the timelines prescribed by the IRDAI, the question of non-applicability of "SSS ex-gratia" would not have arisen.

b) Insurers' argument:

The insurer's contention is that nothing is payable under the policy in accordance with the provisions contained in the circular letter dated 20/05/16 which stipulates that SSS ex-gratia is not applicable to new plans. The DLA's employer admitted that the gap premium for July 14 due was not paid to the insurer and it was recovered only from the final settlement made by it and subsequently remitted to the insurer. The insurer submitted copy of the letter dated 09/03/17 of the DLA's employer regarding deduction of July 14 premium from the terminal benefits of the DLA and copies of correspondences (2 Nos.) dated 07/07/18 & 19/07/18, exchanged between the BO & DO regarding the complaint preferred by the complainant to the CRM department of the insurer.

20) Reason for Registration of Complaint: This is a case of rejection of claim and hence, comes within the scope of Rule 13 (1) (b) of the Insurance Ombudsman Rules, 2017.

21) The following documents were submitted to the Forum for perusal.

a) Cover page of the Policy document dated 12/06/14
b) Policy status report
c) Claim Forms-A, B & B-1
d) Letters dated 25/09/17, 11/07/17 & 21/07/18 of the insurer addressed to the complainant
e) Letters dated 04/05/18 & 07/06/18 of the complainant addressed to the insurer
f) Letter dated 09/03/17 of the employer (Brakes India Private Limited)
g) Default Notice dated 07/01/16 of the insurer
h) SSS Demand Invoice for July 2014 dated Nil
i) Circular letter dated 20/05/16 of the insurer (ref: CO/CRM/1023/23)
j) Complaint dated 30/07/18 to the Forum
k) Annexure VI-A dated Nil submitted by the complainant
l) Self Contained Note (SCN) dated 25/09/18 of the insurer

22) Result of hearing with both parties (Observations & Conclusion): Based on the submissions of both the parties made during the hearing and the documents submitted, it is observed as under:

a) The case of the insurer, as per letter dated 21/07/18 (addressed to the complainant and copy received by this Forum from the insurer through mail on 03/10/18) is that July 14 due premium under the policy was not paid and remained as "gap" & more so, "SSS Ex-gratia" is not applicable for new plans and hence, nothing was payable under the policy.

b) i) As per the cover page of the policy document which was produced to this Forum by the complainant, it is noted that the risk under the policy commenced on 30/05/14 whereas the policy was issued on 12/06/14. The SCN is silent about number of instalments of premium collected towards initial proposal deposit while taking the policy. The general practice, however, is to collect two instalments of premium as initial proposal deposit in respect of new proposals under SSS. While so, the initial deposit collected by the insurer would have been adjusted for May 14 & June 14 dues.

ii) In respect of premium dues commencing from July 14 and onwards, the insurer, as per its Manual provisions, is required to send "Demand Invoice" (both for new and existing policies) to the Paying Authority (PA), viz. Employer, by the second week of the relevant month. In other words, for premiums due in the month of July 14 in respect of the policies issued on the lives of the employees/officers of the PA concerned, the insurer shall have to send the "Demand Invoice" to the PA in the second week of July 14. According to the insurer, the demand invoice for the month of July 14 was sent to the DLA's employer (Brakes India Limited, Sholingar) on 04/07/14. Perusal of the demand invoice for the month of July 14, reveals that the new policy number (taken by the DLA), instalment premium and also, name of the policyholder, herein the DLA, were duly included therein.

c) As regards July 14 premium which remained as "gap", it is to be examined whether the insurer complied with its Manual provisions concerning follow-up of such "gap" premiums.

i) "Conditions & Privileges" of the said plan, viz. "New Jeevan Anand" (Table No. 815), downloaded from IRDAI's official website, is silent about aspects concerning "SSS gaps vis-à-vis its impact on settlement of death claim". The insurer has not submitted full set of the policy document to this Forum.

ii) Manual No. 14 (Policy Servicing Department-Salary Savings Scheme) deals with administrative aspects of the SSS policies serviced by the various offices of the insurer. *S no. 19, captioned, "Premium default intimation (gap intimation)" of the said Manual stipulates that* ***premium default intimation to the policyholders for stray defaults should be sent immediately as individual***

premium notices are not sent to the individual policyholders under SSS. *It further states that, "prompt intimation would serve to remind the policyholder for paying the overdue premium or result in prompt action to trace the amount if already paid through the employer".*

iii) It is the stand of the complainant that Ranipet BO of the insurer failed to communicate to her deceased husband and also his employer regarding the gap premium during his life time. ***The complainant further states that the Premium default intimation (gap intimation) in respect of July 14 due was received only after the demise of her husband***.

The said default intimation, a copy of which is produced by the complainant to this Forum, is dated 07/01/16 whereas the complainant's husband breathed his last on 17/10/15. Through the said default intimation, the DLA was informed not only about the gap premium (July 14) but also, regarding non-remittance of 3 instalments of premiums due from 28/10/15 to 28/12/15 which had fallen due subsequent to his death. The complainant's husband expired on 17/10/15 whereas the claim forms, as per the complainant, were alleged to have been submitted to the insurer in the month of November 15 itself.

iv) Even though the insurer informed this Forum, vide its mail dated 12/10/16, that premium default letter (intimation) was sent (to the PA, viz. DLA's employer) along with Demand list for August 14, the insurer didn't produce copy of such intimation. Since the complainant has submitted copy of a premium default intimation dated 07/01/16, there is no need to place reliance on insurer's version that it was sent in August 14 itself.

d) i) As regards non-applicability of Chairman's relaxations for SSS Ex-gratia claims for new plans, the complainant's grievance is that had the insurer decided the claim within the stipulated time lines, as prescribed by the IRDAI, the question of non-applicability of Chairman's relaxations for SSS Ex-gratia claims would not have arisen.

ii) According to the complainant, she submitted claim forms to the insurer in the month of November 15. Along with her complaint, she produced copies of Claim form-A (undated), Claim Form-B dated 28/11/15, Claim Form-B1 dated 26/11/15, Claim Form-C (undated) & Claim Form-E (undated). Nonetheless, she has not produced any acknowledgement (to this Forum) from the insurer to that effect. Although there is no information in the SCN as to when it received death intimation from the complainant and also the date of receipt of last requirement for its considering the claim, the insurer's

representative, during hearing, informed that the claim forms were received by it only in September 16.

iii) Regulation 14 (2) (i) of IRDAI's Protection of Policyholders' Interests Regulations, 2017 dealing with "Claims Procedure in respect of a Life Insurance Policy", envisages as under:

"A death claim under a life insurance policy shall be paid or be rejected or repudiated giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and required clarifications. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate the same at the earliest and complete such investigation expeditiously, in any case not later than 90 days from the date of receipt of claim intimation and the claim shall be settled within 30 days thereafter".

iv) In the case on hand, the life assured expired on 17/10/15 and the claimant, herein the complainant, is claiming that she submitted the claim forms in the month of November 15 itself whereas it was September 16, as contended by the insurer. There is no mention in the SCN whether the claim warranted investigation. That being the case, the insurer shall have to pay or reject or repudiate the claim within 30 days from the date of receipt of all requirements. Nevertheless, the insurer communicated its decision to the complainant (for the first time) only on 25/09/17 which was well beyond the timelines prescribed by the IRDAI and hence, the insurer's action would amount to clear violation of IRDAI (Protection of Policyholders' Interests) Regulations, 2017. The Central office's letter regarding applicability of Chairman's Relaxation Rules, 1987 and SSS ex-gratia is dated 20/05/16 and even after receipt of such instructions, the insurer didn't take any immediate decision and instead, conveyed the decision only after expiry of around 12 months.

v) In rejecting the claim under the policy, the insurer relied upon letter dated 20/05/16 of its Central office, clarifying that the instructions contained in its circular dated 23/04/13 regarding applicability of Chairman's Relaxation Rules, 1987 in the matter of "SSS Ex-gratia claim" cannot be extended to policies issued under New Plans (like 807, 812 & 165) which are guided by "IRDAI's (Product) Regulations, 2013", "File & Use of the relevant plan" and "The Insurance Laws (Amendment) Act, 2015.

vi) Regarding "SSS Ex-gratia" claim, this Forum referred to the "Manual for Policy Servicing Department-Claims" issued by the insurer and notes that the insurer, in order to mitigate hardship to the claimants in respect of claims where there is no legal liability to make payment, is considering

payment by way of Ex-gratia claims under SSS policies with default in premia. To be more specific, if a policy results into a claim where there are defaults in premium and the policy has not acquired claim concession, viz. at least three full years premiums not paid, nothing would become payable. However, the insurer is considering ex-gratia payment of full sum assured under such cases (called SSS Ex-gratia claim), subject to deduction of unpaid premiums with late fee and of the premiums to complete the policy year of death provided there is no terminal default and the total number of defaults, whether continuous or intermittent, do not exceed six. "SSS Ex-gratia claim" provides for payment of Accident Benefit also and benefits are allowed irrespective of the period for which the premiums have been received.

vii) In the case on hand, premiums were paid only for 1 year & 6 months (from May 14 to September 15 with one gap) and more so, total number of defaults (gaps) was just one which, however, is not terminal default. As three full years premiums were not paid, the policy didn't acquire "Paid-up value" and as a consequence, the policy is not eligible for claim concession. This being so, this claim satisfies all the conditions stipulated for consideration under "SSS Ex-gratia" claim, in the normal course.

viii) However, relying upon the instructions contained in the Central office letter dated 20/05/16, the insurer took a stand that nothing was payable under the policy since the policy was issued under New Plan which was introduced on or after 01/01/14. The operative/relevant para of the Central office circular dated 20/05/16 is re-produced hereunder:

"As regards applicability of Chairman's Relaxation Rules, 1987 and SSS ex-gratia for policies issued under new plans introduced on or after 01/01/14, it is informed that the same cannot be extended to policies issued under new plans which are guided by "IRDAI's Product Regulations of 2013", "File & Use of the relevant Plan" and "The Insurance Laws (Amendment) Act, 2015"

ix) The crux of the Central office letter dated 20/05/16 is that SSS ex-gratia cannot be extended to policies issued under new plans introduced on or after 01/01/14. The said communication was issued in May 16 by the insurer's Central office but there is no information as to from which date the revised instructions shall apply. To be specific, the said circular letter is silent as to whether the revised instructions shall apply to death claims which arose prior to issuance of the said letter also. Be that as it may, this Forum could not find any sound logic in such a decision and hence, instructed the insurer's representative who attended the hearing, to explain the rationale behind such decision by its Central Office. The complaint was heard on 24/10/18 and even at this point of time of issuing this

Award, no explanation has been received from the insurer. This Forum regrets very much regarding non-responsiveness attitude of the insurer.

e) Since the policy was issued under Salary Savings Scheme (SSS), and as per Clause no. 22 which is imposed on all fresh policies issued under SSS, the instalment premium will be deemed to fall due on 20th day of each month irrespective of the due date mentioned in the policy schedule. According to the insurer, barring July 14 due premium, all instalments of premiums (since inception of the policy) that fell due on the date of death of the deceased life assured remain paid and adjusted. As per the Status report of the policy, submitted by the complainant, the last premium that fell due before the date of death of the life assured, viz. September 15 due, was adjusted on 26/10/15. While so, the next instalment of premium had fallen due on 20th October 15 but before that, the life assured died on 17/10/15. As such, the policy was in full force on the date of death of the life assured.

Condition 2 of the policy further envisages that if the death of the life assured occurs within the grace period but before the payment of the premium then due, the policy shall be valid and the benefits shall be paid after deduction of the said unpaid premium as also the unpaid premium falling before the next anniversary of the policy.

In view of the above provisions, it, therefore, manifest that the policy was in full force as on the date of death of the complainant's husband and hence, the policy is eligible for all benefits, however, subject to deduction of October 15 due premium and also instalments of premiums due from November 15 to April 16. As mentioned above, none of the conditions and privileges printed in the policy document deals with aspects concerning "SSS gaps vis-à-vis its impact on settlement of death claims". As a corollary, the insurer's contention that nothing was payable under the policy since July 14 due remained as "gap" at the time of death of the life assured" is at variance with the "conditions and privileges" governing the policy.

f) Based on the documents submitted and submissions made by the parties, this Forum is of the view that the insurer's action of rejecting the claim is not in order and hence, calls for intervention by this Forum in view of the following findings. The insurer miserably failed to comply with its own manual/administrative provisions in not immediately sending the default intimation regarding July 14 gap premium to the DLA. Had it been done, there was every likelihood of deduction and payment of the said due premium to the insurer but unfortunately that didn't happen. This Forum fully concurs with the SSS Manual provisions that *Premium default intimation (gap intimation) to the policyholders for stray defaults should be sent immediately as individual premium notices are not sent to the*

individual policyholders under SSS and "prompt intimation would serve to remind the policyholder for paying the overdue premium or result in prompt action to trace the amount if already paid through the employer". As per the records submitted to this Forum, the default intimation was sent to the DLA only after his life time which does not speak well of the insurer. Barring July 14 due premium, all premiums due under the policy including the terminal due were paid and status of the policy was "in-force", as evidenced by the Status report. Last but not least, the material which was relied upon by the insurer in rejecting the claim, viz. Circular letter dated 20/05/16, does not expressly state that the revised instructions shall also apply to death claims which arose prior to issuance of the said circular letter. While so, this Forum concludes that the insurer's action in rejecting the death claim under policy no. 732624064 is not in order.

g) The Forum would like to place on record the following observations for the information of the insurer and also, for necessary corrective action. The Self Contained Note (SCN) received from the insurer is not only brief but bereft of vital facts of the case. No documentary evidence was let into this Forum in support of its decision. The letter dated 20/05/16 of its Central office which was the basis for rejecting the claim was not even sent to this Forum along with the SCN. It was subsequently received only on request made by this Forum. Furthermore, despite specific request made on 28/08/18, the insurer didn't forward to us copy of the proposal form and also, that of the policy document. The SCN is silent as to when risk under the policy commenced, when the claim arose, when the office received death intimation, when the office received last necessary document for considering the claim, the reason for the inordinate time taken by the insurer in conveying its decision to the complainant, etc. This Forum records its strong displeasure about the insurer's casual approach to the preparation of SCN.

23)

AWARD

Taking into account the facts and circumstances of the case & the submissions made by both the parties during the course of hearing, this Forum is of the view that the Insurer's decision to reject the death claim under Policy (no. 732624064) is not justified and hence, warrants interference.

The insurer is, therefore, directed to settle the claim of the complainant for Rs. 5,00,000 for the eligible amount as per terms and conditions under the policy along with interest, as envisaged in Rule No. 17(7) of the Insurance Ombudsman Rules, 2017.

The complaint is, therefore, allowed.

24) The attention of the complainant and 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 30 days of the receipt of the Award and shall intimate the compliance 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 IRDAI 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 Insurer.

Dated at Chennai on this 14th day of January 2019.

(M.VASANTHA KRISHNA)
INSURANCE OMBUDSMAN
STATE OF TAMIL NADU & PUDUCHERY

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN, STATE OF STATE OF ASSAM,ARUNACHAL,MIZORAM, MANIPUR ,NAGALAND,TRIPURA, MEGHALAYA,

(UNDER RULE NO:16(1)/17 OF THE INSURANCE OMBUDSMAN RULES, 2017)

OMBUDSMAN- SHRI K B SAHA

CASE OF NORKAY ATHOKPAM V/S Bajaj Allianz Life Insurance Co. Ltd.

COMPLAINT REF:NO: GUW-L-006-1819-0195

AWARD NO. IO/GUW/A/LI/0126/2018-2019

1.	**Name & Address Of The Complainant**	NORKAY ATHOKPAM Top Mayai Leikai Porompat Baruni Road, Near T.Y.C. Club, PO/PS:Porompat Imphal East, Manipur
2.	**Policy No.** **Type Of Policy** **Policy term/Policy Period**	0307250064, 0336632248 Life DOC 7/10/2013 & 01/08/2017 DOD 05/09/2017
3.	**Name of the insured**	Athokpam Helendro

4.	**Name of insurer**	Bajaj Allianz Life Insurance Co. Ltd.
5.	**Date Occurrence of Loss/claim**	09/04/2018
6.	**Details of Loss:**	Non receipt of Death Claim
7.	**Reason For Grievance**	According to Rule 17(6) of the Insurance Ombudsman Rules, 2017
8.	**Date of receipt of the Complaint**	15-Nov-2018
9.	**Amount of Claim**	0.00
10.	**Date of Partial Settlement**	
11.	**Amount of Partial Settlement**	0.00
12.	**Amount of relief sought**	0
13.	**Complaint registered under Rule no: of RPG rules**	Rule 13(1)(b) – any partial or total repudiation of claims by an insurer
14.	**Date of hearing** **Place of hearing**	10-JAN-2019 Guwahati
15.	**Representation at the hearing**	
	a)For the Complainant	**Mr.Nokay Athokpam**
	b)For the Insurer	Mr. Sandeep Dutta gupta
16.	**Complaint how disposed**	Through hearing
17.	**Date of Award/Order**	10-Jan-2019
18.	**Brief Facts of the Case**	The death claim was rejected by the insurer due to submission of fake death certificate.
19.	**Cause Of Complaint**	Repudiation of death claim
	Complainant's Argument:	The complainant has mentioned in his application that they have no knowledge about fake death certificate. While they have collected the original the date of death and other items are same. So they have no any bad intention to produce a fake death

		certificate.
	Insurer's Argument:	The insurer had come to know after receiving RTI reply that the death certificate submitted by the claimant is a fake one and on the basis of this they had repudiated the death claim.
20.	**The following documents were placed for perusal.**	1) Complaint letter 2) Death certificates 3) SCN
21. Result of hearing with both parties(Observations & Conclusion)		**I have gone through all the documents on record. I have also carefully heard both the parties. The death certificate issued on 08/11/2017 by the Registrar (Births & Deaths) Imphal East –II, C.D Block Manipur in the name of Athokpam Helendro. The copy of this death certificate submitted by the claimant to the insurer for death claim payment. Since during investigation the insurer has come to know that the said death certificate is a fake one , so the complainant himself filed a police complaint and asked for a genuine death certificate of Athokpam Helendro. The complainant has submitted the another death certificate issued by the Sub-Registrar(Births & Deaths) Top Dusara Gram Panchayat KCD block Impha dated 07/05/2018**

Decission

Taking into account facts & circumstances of the case and the submissions made by both the parties during the course of hearing,it is clear that there are two death certificates on the same person issued by the different authority.It requires a criminal investigation which is beyond the jurisdiction of Insurance Ombudsman. The complaintis closed allowing the complainant leave of approach other appropriate Forum/Court for redressal.

Dated at Guwahati on10th day of January 2019

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INSURANCE OMBUDSMAN
GUWAHATI

PROCEEDINGS BEFORE - THE INSURANCE OMBUDSMAN, LUCKNOW

(UNDER RULE NO: 16(1)/17 OF THE INSURANCE OMBUDSMAN RULE 2017)

Smt. Asha Maurya …….…….……. Complainant

V/S

Life Insurance Corporation of India ……..……Respondent

COMPLAINT NO: LCK-L-029-1718-0117 Order No. IO/LCK/A/LI/0006/2018-19

1.	**Name & Address of the Complainant**	**Smt. Asha Maurya** **Post Teliyarganj** **Allahahabad (UP)**
2.	**Policy No:** **Type of Policy** **Duration of policy/DOC**	**314945857** **Jeevan Tarang policy (with Profits)** **28.08.2013**
3.	**Name of the insured** **Name of the policyholder**	**Lt. Akhilesh Kumar Maurya** **Lt. Akhilesh Kumar Maurya**
4.	**Name of the insurer**	**Life Insurance Corporation of India**
5.	**Date of Repudiation of DAB**	**10.11.2016**
6.	**Reason for repudiation/Rejection**	**Murder not an accident but planned & intentional**
7.	**Date of receipt of the Complaint**	**01.05.2017**
8.	**Nature of complaint**	**Repudiation Of Accidental Benefit amount**
9.	**Amount of Claim**	**10,00,000/-**
10.	**Date of Partial Settlement**	**---**
11.	**Amount of relief sought**	**10,00,000/-**
12.	**Complaint registered under Rule**	**Rule No. 13(1)(b) of Ins. Ombudsman Rule 2017**
13.	**Date of hearing/place**	**On 16.01.2018 at 11.15 am at Lucknow**
14.	**Representation at the hearing**	
	a) For the Complainant	**Smt. Asha Maurya(complainant)**

	b) For the insurer	**Mr. Sukhbir Kumar (A.O.)**
15.	**Complaint how disposed**	**Dismissed**
16.	**Date of Award/Order**	**16.01.2019**

17. Smt. Asha Maurya (Complainant) has filed a complaint against the decision of Life Insurance Corporation of India (Respondent) alleging repudiation of Accidental benefit claim.

18. Brief facts of the case-The complainant has stated that the above policy was taken by her husband from respondent company. RIC had paid basic Sum Assured under the policy but accidental benefit claim was repudiated stating that murder of DLA was pre-planned/ intentional and not an accident. According to the complainant her husband was Lekhpal and was posted at Soraon Tahsil in Allahabad District. After duty when her husband was returning to home, he was murdered in the way at Saray Bahar Mod, on 29.09.2015 at 06.30 PM. The murder was unexpected and is an accident. Her husband had no criminal history. Being aggrieved with decision of the respondent, she had approached the Insurance Ombudsman for payment of Accident Benefits.

The respondent in their SCN/reply have stated that above policy was issued on the life of late Akhilesh Kumar Maurya for Sum Assured of Rs. 10,00,000/- on 28.08.2013.Death claim under the policy was admitted and paid to the nominee. Accidental benefits were denied because the cause of death was preplanned and intentional murder.

19. The complainant has filed complaint letter, Annx. VI A and correspondence with respondent while respondent have filed SCN with enclosures.

20. Efforts for mediation failed, I have heard both the parties at length and perused papers filed on behalf of the complainant as well as the Insurance Company.

21. Claim of double accident benefit was repudiated on the ground that murder was pre-planned / intentional and not an accident. The representative of the respondent have argued that murder of complainant's husband was due to enmity with pattidar, election of Lekhpal Sangh and work assigned them in region. Complainant has opposed the above argument and argued that her husband was not having any criminal history and murder was sudden and accidental.

FIR no. 571/2015 was lodged on 29.09.2015 by Smt. Asha Devi w/o Late Akhilesh Kumar Maurya in which it is

mentioned that **"** मेरे पति की हत्या के पीछे तहसील में हुए लेखपाल संघ का चुनाव व नियुक्ति के छेत्र में लेखपाल के पद के कार्यो को सम्पादित किये जाने में हुई रंजिश व पैत्रक गाँव बबुल्लापुर थाना नवाबगंज जिला प्रतापगढ़ के पट्टीदारो की अदावत से हो सकती है जिनके बारे मे मेरे पति अक्सर मुझसे कहते व परेशान रहते थे" . The same is also repeated in her statement given to IO. From FIR & statement it is clear that the murder was due to enmity. It is also clear that insured was murdered with firearm. This shows intention to the act of felony to kill any person and hence, murder is not an accidental murder. In First appeal no. 204/1999 Prithvi Raj Bhandari Vs. Lic of India Hon'ble National Consumer Disputes Redressal Commission has propounded that dominant intention of the act of felony to kill any person is not an accidental but is a murder simplicitor. Hence, this case is a case of intentional murder. As the murder of insured was intentional and not accidental, hence double accidental benefits are not payable and respondent has rightly repudiated the claim of DAB.

22. In view of the above facts and circumstances, I come to the conclusion that the respondent has not erred in rejecting the Accidental benefits claim under policy no. 314945857. Therefore, I am of the opinion that there is no reason to interfere with the decision of the respondent company and hence, the complaint is liable to be dismissed.

23. The complaint filed by Smt. Asha Maurya is dismissed herewith.

24. Let copies of Award be given to both the parties.

Dated : January 16, 2019 (G.S. Shrivastava)

Place : Lucknow 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-L-029-1819-0169
Award No: IO/MUM/A/LI/OO /2018-19
Complainant: Ms Nazia Shaikh
Respondent: LIC of India

Name and address of the complainant	Ms Nazia Shaikh/Mumbai

Policy No.	927869404
Name of Insured, DOB, Age at proposal	Mr Firoz Akhtar Shaikh 1.4.1978/38
Name of the Insurer	LIC of India
DOC	31.3.2016
Date of Death	3.9.2016
Premium paying term	25, 16 years
Premium, Mode	Rs.10125/- Monthly
Sum Assured	Rs.25,00,000/-
Date of first complaint to GRO	13.1.2018
Date of receipt of the complaint at OIO	3.9.2018
Nature of Complaint	Death claim repudiated
Amount of relief sought	Death claim
Rule of Insurance Ombudsman Rules, 2017 under which the complaint was registered	13(1) (b)
Date of hearing/ place	27.11.2018 / Mumbai
Representation at the hearing	
a) For the complainant	Ms Nazia Shaikh
b) For the Insurer	Mr Mohan Gnaniah
Complaint how disposed	By issuing the Award
Date of Award	31.1.2019

Contention of the complainant:

The complainant stated that her husband purchased the above policy for Rs.25 lakhs. He expired in a rail accident. She approached the Company for the claim amount but the same was rejected under the Suicide Clause. She also approached the Zonal Office of the Company and was informed that her claim stands repudiated. She has requested the Ombudsman to help her get her claim amount.

20. Contentions of the Respondent:

The Respondent contended that the Deceased Life Assured purchased the above policy on 31.3.2016 for sum assured of Rs.25 lakhs with Date of Commencement as 3.9.2016 with Monthly mode of premium payment. The DLA died on 3.9.2016 (within 5 months) as he was hit by a train, while **crossing railway line** between Mira Road and Bhayandar stations at **1.15 am.** There is no justification for the DLA to be at the spot at that time of the night. The policy holder's office is exactly opposite Mira Road station. He had gone to his office by his car, which
should have been used to come back home specially at that late hour of the night. Accident took

place about 100 meters away from Mira Road station. On the basis of the above facts, the early death claim was regretted under Suicide Clause under the policy.

21. <u>Observations and conclusions</u>:

The forum observed that the above policy was purchased by the deceased life assured for sum assured of Rs.25 lakhs, with date of commencement of risk as 31.3.2016 and died on 3.9.2016. He met with an accident and died as he was hit by a train while crossing the railway line between Mira Road Station and Bhayandar station at **1.15 am.** Though it is illegal to cross the tracks and there was no railway pass or ticket on the deceased life assured's body, the Respondent's have not been able to prove that death was not an accident but suicide. In absence of evidence from the Respondent and considering the fact that the Life Assured died due to rail accident injury, the complaint is tenable and the award as follows:

AWARD

The Forum directs the Respondent to pay the Death Claim of Rs.30 lakhs under policy no. 9253229031 immediately on receipt of requirements. The Sum Assured under the policy is Rs.25 lakhs and the complainant is entitled to receive DAB, total amounting to Rs.50 lakhs. However, the jurisdiction of this Forum being Rs.30 lakhs as per Ombudsman Rules, 2017, the forum is restricting the awarded amount to Rs.30 lakhs.

It is particularly informed that in case the award is not agreeable to the complainant, it would be open for her, if she so decides to move any other Forum/Court as she may consider appropriate under the law of the land against the Respondent insurer.
The attention of 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 31st day of January, 2019

(Milind Kharat)
INSURANCE OMBUDSMAN, MUMBAI