BHOPAL

BHOPAL OMBUDSMAN CENTRE
Shri Anoop Parashar…V/s The New India Assurance Co. Ltd. Bhopal
Order No.: BPL/GI/08-09/08 Case No.: GI/NIA/0408/16

Order dated: 12/06/2008

Brief Background

Mr. Anoop Parashar is covered under Group **Mediclaim** policy issued to LIC of India for their employees obtained from The New India Assurance Co. Ltd., Mumbai under which claim was lodged with the Respondent.

As per the Complainant his wife Smt. Neeta Parashar was slipped during cleaning process of the house on 13.04.07 and she was dashed with wall as a result of which there was severe bleeding from her teeth. She contacted to nearby Dr. Prakash Dixit who treated her and advised to contact some dentist for the problem. There was no facility of Dentist at Pathakheda, the place of complainant's posting so he contacted Dr. G.D. Agrawal of Bhopal on 10.08.07 that advised Flap Surgery due to infection in teeth. The treatment was continued and finally in September 2007 the attending doctor confirmed the patient as fit. There was no hospitalization for the treatment. The complainant placed his claim with the Respondent who rejected the claim based on exclusion clause 4.7 of Mediclaim Policy. Aggrieved with the decision of the Respondent, he approached this office for necessary settlement of his claim.

The Respondent in its reply-dated 10.04.2008 stated that the Complainant had lodged a claim for the treatment of a disease arising out of the dental treatment. The Policy signed by the LIC and New India having exclusion clause reads as under:-

"Dental treatment or Surgery which is a corrective, cosmetic or aesthetic procedure, including wear and tear, root canal treatment, tooth extraction, unless arising from disease or injury/accident and which requires hospitalization for treatment. "

The Respondent further mentioned that as per Para 2.3 of the MOU is specific in respect of hospitalization for minimum period of 24 hours are admissible. The claim

was repudiated as the treatment was arising out of disease "Chronic Period entities" which does not attract hospitalization and disease does not include in the scope of the policy. Attending Dental Surgeon did not mention about the accidental history. The disease name itself indicates that the patient is a chronic patient of Period entities.

Observations:

As per the prescription dated 13.04.07 of Dr. Prakash Dixit of Sarni who disclosed that the complainant's wife Smt. Neeta Parashar fall at Floor at home during work and there was mild tears of gums bleeding by month (gums). He further advised for consultation with a Dentist. However, the complainant consulted Dr. G.D. Agrawal who had done Flap surgery in U/2 left segment. Exclusion clause No. 4.7 shown by the Respondent is irrelevant and set aside as the Respondent itself mentioned in their letter dated April 10, 2008 that the said MOU has been made more flexible to get maximum benefits to the LIC employees. Since the patient was suffering from Chronic Period entities and it is related to her earlier injury/accident, the Respondent is liable to pay admissible claim as per Group Mediclaim Policy.

Decision:

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. Since the attending doctor himself advised for Flap Surgery U/2 left segment, the Respondent is directed to settle the admissible claim as per medical papers submitted by the Complainant within 15 days from receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

CHENNAI

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1496/2007 – 08

Mr.C.H. Raj

vs

The New India Assurance Co. Ltd

Award 03 dated 22.05.08

The Complainant Sri C.H. Raj had covered his mother in law Mrs. Bharathi Srinivasan under the group mediclaim policy with New India Assurance Co. Ltd through Citi Bank. She was hospitalized during 2006 for acute LV failure. Her claim was rejected by the insurer since the same was pre existing.

The insured was having the policy since 8 years. As per the attending doctor, she was suffering from heart disease since 11 years and hypertension since 20 years. The insured also admitted the fact of pre existing disease but only requested for considering the claims relating to pre existing diseases.

From the records, it is clear that the insured was suffering from the abovesaid ailments even before taking the policy for the first time. As per condition 4.1 of the mediclaim clause all pre existing diseases present when the cover incepts for the first time are expressly excluded from the scope of the policy and hence the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.08.1457/2007 – 08

Ms.S. Sooriyakumary

Vs

The Royal Sundaram Alliance Insurance Co. Ltd

Award No.07 dated 29.05.08

The insured obtained a three year Health Shield policy from the insurer as customers of Standard Chartered Bank. The insured underwent FESS/SMR Inferior Turbinoplasty (B) sides under general anesthesia. Her claim was rejected by the insurer on the grounds of pre existing condition.

The insurer contended that deviated nasal septum is a complication of the pre-existing conditions of headache and nose block. It is not an established medical opinion that all chronic headaches and nose block lead only to DNS. The hospital records mention that headache and nose block only are preexisting. No mention had been made regarding the preexistence or otherwise of deviated nasal septum prior to inception of the policy. It is also a fact that DNS need not be the only reason for a headache or nose block, since it could be caused by allergies of various kinds, climatic changes, ear ailments etc.

Since no opportunity was given to the insured at all to reveal any information about her health while taking the policy and proposal form not obtained, the insurer is not justified in rejecting the claim on grounds of misrepresentation, mis-description or non-disclosure of any material fact. The insurer could not prove with clinching evidence that insured had DNS problem before inception of the policy. The insurer is directed to process and settle the claim as per the applicable terms and conditions of the policy.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1453/2007 – 08

Mr. J. Arivazhagan

vs

The New India Assurance Co. Ltd

Award No.014 dated 30.05.08

The insured was covered under Group Mediclaim Scheme for the employees of LIC. He was hospitalized for severe pain in the left leg below the hip. The insured's claimfor Rs.12,524/- was rejected by the insurer on the grounds that the hospitalization was only for a follow-up as per the Discharge summary.

The insured got admitted in the hospital due to discomfort he felt during the night and the doctor also advised him to get admitted for the same.. The insured was not comfortable to take the treatment as an out-patient and preferred hospitalization in view of the CVA the insured suffered in 2003. The insurer also sought an opinion from an orthopaedician, who felt that hospitalization was not warranted in this case. It is to be noted that the insurer had settled the claim for hospitalization earlier for the same ailment.

In view of the doctor's opinion on both the sides, an amount of Rs.5,000/- is awarded as ex-gratia and the complaint was allowed partly.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1520/2007 – 08

Mr.Mr. Sushil Kumar Chordia

vs

United India Insurance Co. Ltd

Award No.022 dated 15/07/2008

The Complainant had covered himself and his spouse Smt. P. Jeeva under the Group Mediclaim policy of LIC. During the policy period, the insured lodged a claim for maternity expenses in respect of his wife. The insurer settled the claim for Rs.31,015/- whereas the insured claimed Rs.76,321/- and sum insured being Rs.60,000/-. The insurer settled the claim for 15 days of hospitalization only as per the medical opinion obtained by them whereas the claim was for 80 days of hospitalization. Not satisfied with the settlement, the insured requested for settlement of the remaining amount of Rs.28,985/-.

The long duration of hospitalization was due to the fact that the patient conceived after 10 years and suffering from complications like diabetes and urinary infection. The TPA contended that this was a case of Oligohydramniosis and IUGR and there was no acute condition warranting admission and active treatment. Since rest cure was excluded, the TPA settled the claim for 15 days hospitalization only which was reasonable and disallowed 65 days of room charges and nursing charges.

Hence Ombudsman concurred with the stand of the insurer restricting the expenses to 15 days hospitalization only and taking into account the special circumstances that the patient had severe Oligohydramniosis for which treatment was given an exgratia of Rs.3000/- awarded in addition to the partial settlement of claim by the insurer.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1540/2007 – 08

Mrs. V. Porkodi

vs

The New India Assurance Co. Ltd

Award No.027/2008 – 09 dated 22.07.08

The complainant, an LIC employee and her family are covered under Group Mediclaim Policy for LIC employees issued by New India Assurance Co Ltd with a Sum Insured of Rs.60,000/- . During the course of the policy period, her son Master Chadhur Bala was admitted to Vikram Hospital, Coimbatore for ENT surgery. The insurer settled the claim for Rs.30,000/- (approx) whereas the amount claimed was Rs.49,709/-. The insurer restricted the claim because they felt the reasonable expenses would not exceed Rs.30,000/- for this type of surgery .
The point to be considered is whether the decision of the insurer to restrict the claim to Rs 30,000/- on the grounds of reasonable expenses is in order.

In the instant case it is seen that Vikram Hospital, which has charged Rs 67,000 in Sept. 2005 for a similar operation, has charged Rs 47,000/- for the present operation. It appears that the institution has passed on to the insured, the rationalization of the cost of the various procedures. Medical management without sacrificing a patient's health care treatment and without affecting the clinical freedom of the service providers has to be learnt and practiced at one level. But at the same time, the interest of the large numbers of silent premium payers has also got to be safeguarded. It is reiterated that the insurers and the service providers like TPAs have a duty to educate the insuring public about their rights as well as obligations and also to draw their attention to any prevalent unfair trade practices in the local area. The insured also has a duty to inform the insurer about any planned surgery or hospitalisation and obtain their counsel before they actually incur such heavy expenditure, so that situations such as these are avoided in future.

A sum of Rs 10,000/- as Exgratia in addition to the settlement of Rs.30,000/- already made is awarded subject to the other terms and conditions of the policy.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1016/2007 – 08

Mr. R. Balasubramanian

Vs

United India Insurance Co. Ltd

Award No.029 dated 28.07.08

The complainant was covered under Tailormade floater Mediclaim Policy issued to retired employees of United Bank of India . During the policy period, the spouse of the retired employee underwent spinal chord surgery. The insurer, considering the Sum Insured as Rs 1.00 lacs, settled the claim at 20% of the Sum Insured ie for Rs.20,000/- allowed for Normal Surgery as per the terms of the policy. The insured took up the matter with the insurer stating that he had paid the premium for the Sum Insured of Rs.3,00,000/- and as such he was eligible for 20% of Rs 3.00 lacs ie Rs 60,000/-.

The point to be considered is whether the action of the insurer in reducing the sum insured from Rs 3.00 lacs to Rs 1.00 lac at the time of renewal and thereby restricting the claim is in order.

If the decision of the insurer to restrict the sum insured to Rs 1.00 lacs had been communicated to the insured in time, he may perhaps have decided to avail of the treatment at some other more affordable hospital. The insurer has treated the insured as a new comer to the scheme only at the time of claim processing. At the time of renewal the insurer raised no objection. The insured also delayed the renewal much after the stipulated time given by the insurer. In the circumstances, taking into account that the wife of the insured had undergone a major surgery, ie of the spinal chord, **Rs 20,000/- is awarded as Ex Gratia** in addition to the sum of Rs 20,000/- already settled by the insurer.

DELHI

Group Mediclaim Policy

Delhi Ombudsman Centre

Case No. GI/128/OIC/08

In the matter of Shri R.K.Bansal

Vs

Oriental Insurance Company Limited

ORDER

The complaint was heard on 20.08.2008. The Complainant, Shri R.K.Bansal, was represented by Shri Naresh Bansal. The Insurance Company was represented by Shri Rajesh Gupta, Deputy Manager.

Shri R.K.Bansal has lodged a complaint with this forum on 17.05.2008 that as per the arrangement between Punjab National Bank, his then employer and the Oriental Insurance Company Limited , an employee can avail medical benefits up to Rs.5 lakhs during his lifetime. This benefit starts after the employee is retired from Punjab National Bank services. This Rs.5 lakh include Rs.50000/- which the employee shall get even without paying any premium. On 23.06.2006, he had paid Rs.27366/- as premium by cheque NO.579053 dated 23.06.2006 along with duly filled in proposal form. He had received its receipt. He also received miscellaneous provisional cover note. He did not receive the policy even after close follow up with the insurance company. Since his renewal premium payment had become due, he paid Rs.27366/- vide cheque No.797907 dated 20.07.2007 along with the covering letter dated 20.07.2007. In this letter also, he requested the company to issue him the original policy bond. He did not receive any response from the Insurance Company. He retired from Punjab National Bank on 31.07.2007. During follow up with the Company, it was informed that the renewal premium cheque NO.797907 dated 20.07.2007 given by him was dishonoured in September, 2007. From the pass book, this can be observed that sufficient balance in his OD A/C. was available from 20.07.2007 to 31.08.2007. He personally met Divisional Manager of the Company and explained that sufficient balance was available in his account for more than one month but cheque was presented quite late in his account. So, he may be given an opportunity to give another cheque to pay the renewal premium and also to issue him the policy bond. But no proper response was there. He also represented through letter dated 12.12.2007 and 23.01.2008. In March,2008, he received policy document but regarding his paying renewal premium there was no response. He, then took up with the grievance cell of the Company vide his letter dated 23.04.2008 for accepting his renewal premium and enable him to start getting the medical benefits. He received a letter dated 05.05.2008 informing him that they are taking up with the concerned officials. However, there has not been any reply from the Insurance Company. He requested the Forum that the Insurance Company be directed to accept his renewal premium and confirm to him that he would get all the benefits under the mediclaim scheme as per terms and conditions of the policy.

At the time of hearing, the representative of Shri R.K.Bansal reiterated the details mentioned in his complaint letter dated 17.05.2007. He further contested that when he had issued the cheque there was sufficient funds in his bank and the Insurance Company had presented the cheque on 06.09.2007. On enquiry by the Forum from the representative of the Insurance Company, why the cheque was presented late, the representative of the Insurance Company informed the Forum that since they received a large number of cheques, there is always a delay in submitting the same to the bank for being deposited. Further, the Forum enquired from the representative of the Company that the normal practice is that once the cheque is dishonoured, the Insurance Company normally sends a dishonour advice along with future course of action to be taken by the insured. Whether any such advice has sent or not?

The representative of the Company informed that no such advice was issued to Shri R.K.Bansal. The representative of the Company however drew the attention of the forum towards the Memorandum of Understanding (MOU) signed between the Insurance company and the PNB where it is stated that if the premium

was not received within 6 months, then the policy shall automatically lapsed and no benefits shall accrue under the policy thereafter. Since Shri Bansal had not deposited the premium within 6 months of the premium due, the policy had been lapsed.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri R.K.Bansal had written a letter to the Insurance Company on 20.07.2007 to accept the renewal premium along with a cheque No.797907 for Rs.27366/-. The cheque was dishonoured on account of insufficient funds in September,2007. However, at the time of issuance of the cheque, there were sufficient funds. After the cheque was dishonoured, Shri Bansal had not taken up the matter with the Insurance Company and the policy got lapsed. The Insurance Company informed the Forum that they are unable to accept the premium since the policy stands lapsed and as per condition 28 of the policy, premium could be paid within 6 months from the due date. Shri Bansal has not deposited the premium even after he was aware that the cheque has been dishonoured. The Insurance Company should have sent the cheque dishonoured advise to Shri R.K.Bansal along with the future course of action which they have not done so, hence there has been deficiency in service. In view of Insurance Company being at fault, I pass the Award that the policy could be renewed in continuation provided (i) Shri Bansal and other members who are covered under the policy be medically examined by Company's doctor and any disease which may be present will be excluded. The cost of medical examination will be borne by Shri Bansal. (2) No medical expenses will be paid by the Insurance Company for the period the policy has lapsed. (3) Shri Bansal will have the option to renew the policy up to 01.10.2008 (4) He will have to pay 8% interest on the premium from 20.07.2007 till the date of payment.

HYDERABAD

Office of Insurance Ombudsman
Hyderabad
Complaint No. G 11.04.396

AWARD NO.2 Dated : 30.04.2008

Sri H V Dayal Vs. United India Insurance Co.Ltd.,

Brief Facts: Sri H V Dayal was insured under a Group Health Insurance policy issued by United India to the account holders of Indian Overseas Bank. The sum insured was Rs. 2,50,000/- and the period of insurance was from 31.01.2007 to 30.01.2008. He was admitted to Hospital on 21.07.2007 where angioplasty was done and he was discharged on 26.07.2007. He incurred an expenditure of Rs. 2, 90,975/- and lodged a claim for Rs. 2, 50,000/- whereas it was settled for Rs.1,30,000/-.

Decision: The insurers contended that Sri Dayal had insurance in the previous year for Rs. 1,00,000/- with a cumulative bonus of Rs. 30,000/-. They stated that the insured had ailments of IHD, DM and Stable angina since 2006 and for the policy given from 21.01.2007 these would be pre-existing diseases and therefore the claim was settled as per previous policy limits. The complainant stated that he went abroad after taking overseas medical insurance policy in April 2007. For this insurance, he had undergone ECG and his health was fine. He contended that he had chest pain only 2 weeks prior to his hospitalisation. The original discharge summary records the duration of illness as two weeks. The photocopy said to be procured by the insurers' investigator recording the duration of 2 years is not on hospital letter head, nor had the insurer sought any clarification from the hospital for this discrepancy. It was held that the original documents should be relied upon and the insurers were not justified in restricting the claim to previous sum insured. They were directed to release balance claim of Rs.1,20,000/-

KOLKATA

Delay in settlement

Kolkata Ombudsman Centre

Case No. 378/14/004/NL/09/2007-08

Smt. Payel Guin

Vs.

United India Insurance Company Ltd.

Order Dated: 16.04.2008

Facts & Submissions:

This petition is in respect of delay in settlement of a claim under Group Mediclaim policy issued to Chowranghi Health Care Club by the United India Insurance Company Ltd.

The petitioner Smt. Payel Guin in her petition dated 21.09.2007 stated that she was hospitalised from 14.05.2007 to 16.05.2007 in Radharani Nursing Home for delivery. She was covered by a group mediclaim policy No. 030600/48/06/87/00002506 from 14.09.2006 to 30.08.2007 with maternity benifit and it was a second year policy. She submitted a bill for Rs.7,331/- to the insurance company on 05.06.2007 but in spite of reminders she did not get any response from the insurance company. Then finding no other alternative she approached this forum for redressal of her grievance seeking relief of Rs.7,331/-.

The insurance company wrote a letter dated 03.04.2008 and stated that their TPA has wrongly repudiated the claim. In fact, they advised the TPA to immediately arrange the payment of the claim to the complainant.

Decision :

Since the grievance of the complainant has been satisfactorily redressed and the insurance company has promised to pay the claim, we find that no further intervention is called for. Hence the petition is dismissed.

-----O------

Kolkata Ombudsman Centre

Case No. 421/14/002/NL/10/2007-08

Shri Kallol Polley

Vs.

The New India Assurance Company Ltd.

Order Dated: 19.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Individual Mediclaim policy issued by the New India Assurance Company Ltd.

The petitioner, Shri Kallol Polley in his petition dated 06.10.2007 stated that he was covered under a mediclaim policy No. 512800/48/05/79275 for the period from 15.01.2006 to 14.01.2007. There was a previous complaint requesting grant of cashless facility with this forum when he was admitted to Kamineni Hospitals, Hyderabad with complaint of intolerable neck and back pain with difficulty in walking for 3 days, and he was denied cashless facility. The cashless facility was denied by the insurance company because admission to the hospital was only for primary investigation and evaluation of suspected disease which attracted exclusion clause 4.10 of the mediclaim policy. Obviously the insurance company could grant the cashless facility only when the ultimate claim was payable for the policy. By an order dated 07.02.2007, the Hon'ble Insurance Ombudsman held that the complaint was against refusal of grant of cashless facility and not against repudiation of claim and therefore, agreed with the action taken by the insurance company. Subsequently the petitioner lodged a claim for Rs.20,997/- with the insurance company on 21.05.2007 which had not yet been paid. He sent reminders to the insurance company, but he did not get any reply from them. Therefore, he approached this forum for monetary compensation of Rs.20,997/-.

Decision :

Since the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The policy condition 4.10 excluded any reimbursement of expenditure on investigations and tests which were not required for diagnosis of any ailment or disease and which could be done on OPD basis.

In this case the investigations and tests have been done to find out the reason for severe back pain and he was admitted to the hospital on 20.03.2006 and was discharged on 22.03.2006 as per the advice of the doctor.

The Discharge Summary clearly stated that the patient was having Cervical Spondylosis, the tests and investigations done were for diagnosing such a disease. Therefore, according to us the condition 4.10 could not be invoked.

Under these circumstances, Hon'ble Ombudsman did not have any other alternative but to hold that the reasons given by the insurance company for taking decision of repudiation of the claim were not tenable. Therefore, he directed the insurance company to settle the claim as per policy terms and conditions and pay the same.

-----O------

Kolkata Ombudsman Centre

Case No. 378/14/004/NL/09/2007-08

Smt. Payel Guin

Vs.

United India Insurance Company Ltd.

Order Dated: 16.04.2008

Facts & Submissions:

This petition is in respect of delay in settlement of a claim under Group Mediclaim policy issued to Chowranghi Health Care Club by the United India Insurance Company Ltd.

The petitioner Smt. Payel Guin in her petition dated 21.09.2007 stated that she was hospitalised from 14.05.2007 to 16.05.2007 in Radharani Nursing Home for delivery. She was covered by a group mediclaim policy No. 030600/48/06/87/00002506 from 14.09.2006 to 30.08.2007 with maternity benifit and it was a second year policy. She submitted a bill for Rs.7,331/- to the insurance company on 05.06.2007 but in spite of reminders she did not get any response from the insurance company. Then

finding no other alternative she approached this forum for redressal of her grievance seeking relief of Rs.7,331/-.

The insurance company wrote a letter dated 03.04.2008 and stated that their TPA has wrongly repudiated the claim. In fact, they advised the TPA to immediately arrange the payment of the claim to the complainant.

Decision :

Since the grievance of the complainant has been satisfactorily redressed and the insurance company has promised to pay the claim, we find that no further intervention is called for. Hence the petition is dismissed.

-----O------

Kolkata Ombudsman Centre

Case No. 405/14/004/NL/09/2007-08

Shri Rajiv Keshri

Vs.

United India Insurance Co. Ltd.

Order Dated: 08.04.2008

Facts & Submissions:

This petition was in respect of delay in settlement of maternity benefit claim under Group Mediclaim policy issued to M/s Avianca Multicare Society by United India Insurance Company Ltd.

The petitioner, Shri Rajiv Keshri in his petition dated 21.09.2007 stated that he was insured with United India Insurance Company Ltd. under Group Mediclaim policy with M/s Avianca Multicare Society for the period 14.07.2006 to 13.07.2007 for a sum insured of Rs.1 lakh including maternity benefit upto Rs.25,000/-. He preferred a maternity claim in respect of his wife Smt. Priyanka Keshri on 15.02.2007. On 14.08.2007 he received a letter dated 17.07.2007 from M/s Family Health Plan Ltd., the TPA of the insurance company asking for clarification from United India Insurance Company Ltd. that whether to consider this policy as renewal policy or not. The complainant also mentioned that his policy was a renewal policy under Group insurance with all the same benefits including maternity benefit without any break. He went to United India Insurance Company Ltd. but did not get any proper reply. Hence he approached this forum for monetary compensation of Rs.25,000/- plus 18% interest per annum for late payment and litigation cost of Rs.10,000/- and Rs.5,000/- for mental harassment and agony.

The insurance company stated in their self-contained mentioned that under maternity scheme minimum waiting period should be 9 months from inception of the policy upto date of admission. If admission related to child birth had taken on or after 20.04.2008, the claim will be admissible, otherwise will not be payable as per policy condition.

Further according to the evidence available from the documents submitted to the Ombudsman, it was found that National Insurance Company Ltd. Insured Club Asian Venture Group in which the complainant was a beneficiary member for the period 20.07.2005 to 19.07.2006 and later the beneficiary (complainant) became member of M/s Avianca Multicare Society which was insured with United India Insurance Company Ltd. by an MOU dated 10.07.2006. The certificate issued by the Club

Asian Venture Group covered maternity benefit and later it was changed to M/s Avianca Multicare Society as per the certificate maternity benefits were covered but with a rider of waiting period of 9 months.

The insurance company had also given their company's consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

Decision:

As per the insurance company's argument maternity benefit had to be provided to the new members only after a waiting period of 9 months and accordingly the TPA of the insurance company on the ground of policy condition rejected the claim of complainant's wife as being a fresh entrant to M/s Avianca Multicare Society. However, on going through the certificate issued in the name of United India Insurance Company Ltd., it was found that the previous policy No. 101000/46/03/8500528 had been mentioned and the complainant was of the opinion that mentioning of that member had to communicate continuation of the policy cover. Hon'ble Ombudsman also found that there was no written information given to the beneficiary members of the new society that they would be treated as fresh members and the previous policy continuation would not be allowed. In the absence of such communication the individual beneficiary member was naturally under the impression that the cover granted in the new policy was in continuation of the old policy. The insurance company should take into consideration the policy condition that had not been informed to the beneficiary as vital before repudiation of the claim. The policy condition simply informed that there was a waiting period of 9 months and did not mention whether the previous policy cover continuous to the new policy under a new insurance company.

If one took into consideration the policy condition being applicable to a fresh entrant would permanently bar a person from claiming the maternity benefits for two children if the beneficiary member had continuous policy but changed the membership of the Club and the Club in turn changed the insurance company under an MOU. The changes that took place between the Clubs and the insurance company due to any reason specially due to load of premium and consequent change in policy conditions could not be detrimental to a member beneficiary who relied on them and took insurance cover continuously for 2 to 4 years and plans to claim maternity benefit for two children during the 4 years of insurance cover. This condition on which the insurance company relies goes against all canons of natural justice.

Therefore, Hon'ble Ombudsman was unable to agree with the arguments of the insurance company in support of repudiation of maternity benefit claim. No reasonable beneficiary member would like to forego the existing benefit of maternity cover by changing over to another insurance company. Here in this case it was clear that the beneficiary member suffered due to lack of communication from the present insurance company.

In view of the above, Hon'ble Ombudsman directed the insurance company to pay the maternity claim as per the sum insured depending on whether it was a normal delivery or a caesarian delivery.

-----O------

Kolkata Ombudsman Centre

Case No. 423/14/004/NL/10/2007-08

Shri Ajay Poddar

Vs.

United India Insurance Company Ltd.

Order Dated: 30.04.2008

Facts & Submissions:

This petition was against delay in settlement of a claim under Group Mediclaim policy issued to M/s Avianca Multicare Society Ltd. by the United India Insurance Company Ltd.

The petitioner Shri Ajay Poddar in his petition dated 03.10.2007 stated that his father Shri Hariprasad Poddar was covered under a Group Mediclaim Policy No. 030200/48/87/06/00001560 for the period from 18.08.2006 to 17.08.2007. He submitted a claim for treatment of his father for Rs.43,081/- to the insurance company but the claim was not paid. In spite of reminders to the insurance company he did not get any reply. He, however on enquiry from Family Health Plan Ltd., the TPA of the insurance company came to know that his father's file was kept on hold as policy terms and conditions restrict the admission of the claim for the person beyond the age of 59 years. He then approached this forum for a monetary compensation of Rs.43,081/- plus interest @ 12% P.A and Rs.10,000/- as harassment and mental agony charges.

This office received a copy of the insurance company's letter dated 01.04.2008 addressed to the Family Health Plan Ltd. advising them to proceed with the settlement of the claim as the condition of 59 years of age did not apply to this policy.

Decision:

From the evidence available on records, this office found that the insurance company had directed their TPA M/s Family Health Plan Limited to settle the claim as per their letter dated 01.04.2008. Since the grievance of the complainant had been satisfactorily redressed, Hon'ble Ombudsman did not find any need for further interference. Hence the petition is dismissed. The claim of interest was not exigible.

-----O------

Kolkata Ombudsman Centre

Case No. 422/14/004/NL/10/2007-08

Shri Navin Dugar

Vs.

United India Insurance Company Ltd.

Order Dated: 30.04.2008

Facts & Submissions:

This petition was against delay in settlement of a claim under Group Mediclaim policy issued to M/s Avianca Multicare Society Ltd. by the United India Insurance Company Ltd.

The petitioner, Shri Navin Dugar in his petition dated 03.10.2007 stated that his mother Smt. Shashi Kala Devi Dugar was covered under a Group Mediclaim Policy No. 030200/48/87/06/00001995 for the period from 07.10.2006 to 06.10.2007. He submitted a claim for treatment of his mother for Rs.10,865/- to the insurance company but the claim was not paid. Inspite of reminders to the insurance company he did not get any reply. He, however on enquiry from Family Health Plan Ltd., the TPA of the insurance company came to know that his mother's file was kept on hold as policy terms and conditions restricted the admission of the claim for the person beyond the age of 59 years. He then approached this forum for a monetary compensation of Rs.22,820/- (Rs.10,865/- claim amount + 18% interest and harassment Rs.10,000/- for mental agony etc.

This office received a copy of the insurance company's letter dated 01.04.2008 addressed to the Family Health Plan Ltd. advising them to proceed with the

settlement of the claim as the condition of 59 years of age did not apply to this policy.

Decision :

From the evidence available on records, this office found that the insurance company had directed their TPA M/s Family Health Plan Limited to settle the claim as per their letter dated 01.04.2008. Since the grievance of the complainant had been satisfactorily redressed, Hon'ble Ombudsman did not find any need for further interference. Hence the petition is dismissed. The claim of interest was not exigible.

-----O------

Kolkata Ombudsman Centre

Case No. 423/14/004/NL/10/2007-08

Shri Ajay Poddar

Vs.

United India Insurance Company Ltd.

Order Dated: 30.04.2008

Facts & Submissions:

This petition was against delay in settlement of a claim under Group Mediclaim policy issued to M/s Avianca Multicare Society Ltd. by the United India Insurance Company Ltd.

The petitioner Shri Ajay Poddar in his petition dated 03.10.2007 stated that his father Shri Hariprasad Poddar was covered under a Group Mediclaim Policy No. 030200/48/87/06/00001560 for the period from 18.08.2006 to 17.08.2007. He submitted a claim for treatment of his father for Rs.43,081/- to the insurance company but the claim was not paid. In spite of reminders to the insurance company he did not get any reply. He, however on enquiry from Family Health Plan Ltd., the TPA of the insurance company came to know that his father's file was kept on hold as policy terms and conditions restrict the admission of the claim for the person beyond the age of 59 years. He then approached this forum for a monetary compensation of Rs.43,081/- plus interest @ 12% P.A and Rs.10,000/- as harassment and mental agony charges.

This office received a copy of the insurance company's letter dated 01.04.2008 addressed to the Family Health Plan Ltd. advising them to proceed with the

settlement of the claim as the condition of 59 years of age did not apply to this policy.

Decision:

From the evidence available on records, this office found that the insurance company had directed their TPA M/s Family Health Plan Limited to settle the claim as per their letter dated 01.04.2008. Since the grievance of the complainant had been satisfactorily redressed, Hon'ble Ombudsman did not find any need for further interference. Hence the petition is dismissed. The claim of interest was not exigible.

-----O------

Total repudiation

Kolkata Ombudsman Centre
Case No. 633/11/003/NL/01/2007-08

Shri Abhijit Roy

Vs.

National Insurance Company Ltd.

Order Dated : 29.07. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim under Group Madiclaim policy issued to Golden Multi Services Club Limited by National Insurance Company Ltd. on the ground that the disease fell under 1st year exclusion clause.

The petitioner Shri Abhijit Roy stated that he along with his wife was covered under Group Mmediclaim policy for the period from 01.10.2004 to 30.09.2005. He was hospitalized in Kothari Medical Centre, Kolkata from 16.06.2005 to 21.06.2005 with pain in abdomen and vomiting 3 to 4 times since that day. He was diagnosed with Hiatus Hernia with GERD. He submitted a claim for Rs.24,836.31 to the insurance company which was repudiated by the TPA of the insurance company under first year exclusion clause. He represented to the insurance company stating that the disease suffered by him was Hiatus Hernia with GERD and not hernia, so it should not be treated under the first year exclusion clause. But his appeal was not considered by the insurance company, hence he approached this forum for redressal of his grievance seeking monetary compensation of Rs.24,836.91 plus interest @ 15% thereon w.e.f. 19.08.2005 plus expenses of about Rs.2,000/- plus compensation for mental agony & torture etc.

The insurance company did not send the self-contained note after repeated correspondences.

Decision:
On going through the evidence it was found that the Discharge Summary clearly indicated the diagnosis after investigation tests as Hiatus Hernia and GERD. It was true that the expenses on Hiatus Hernia are not reimbursable as per the policy condition. Hon'ble Ombudsman opined that the expenditure incurred for diagnosing GERD being a gas related disease and had to be paid under the policy condition.

Keeping in view the above analysis Hon'ble Ombudsman proposed to grant an ex-gratia payment of Rs.12,500/-being proximately the expenses referable to GERD. However, this office confirmed the repudiation of the claim with regard Hiatus Hernia which was excluded as per terms and conditions of the mediclaim policy. However, interest was not exigible as the insurance company took a decision of repudiation on the available material in their possession.

-----O------

Kolkata Ombudsman Centre
Case No. 727/11/002/NL/03/2007-08

Shri Devasis Mukherjee

Vs.

The New India Assurance Company Ltd.

Order Dated : 29.08. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim due to investigation performed but not prescribed by an M.D. Doctor under Group mediclaim policy.

The petitioner, Shri Devasis Mukherhee stated that he along with his family members were covered under Group Mediclaim Policy. His father Shri N.C.Mukherjee was having some problem in Lumber and Knee joint and visited an M.D doctor (Dr. A.K.Roy) first and Dr. Roy Advised to consult an MS (Ortho) for correct investigation and treatment. According to his advice Dr. Sunil Thakur was consulted and as per his advice investigation (CT Scan) was done. He submitted a claim for Rs.3,500/- to the insurance company which was repudiated by them stating that investigation was not prescribed by an MD Doctor. He represented to the insurance company to review but his appeal was rejected and therefore he approached this forum for a monetary compensation of Rs.3,500/- + interest etc. if payable.

The insurance company did not send their self-contained note along with consent.

Decision:

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

As M.S degree was equivalent to M.D degree the advice for admission by an M.S doctor should be sufficient for the insurance company to process the claim. As the reason that the patient was not advised by M.D doctor could not be sufficient ground for repudiation of the claim, the arguments of the insurance company were held to be untenable. Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim as per terms and conditions of the policy.

-----O------

Kolkata Ombudsman Centre
Case No. 743/11/004/NL/03/2007-08

Shri Khages Chandra Acharyya

Vs.

United India Insurance Company Ltd.

Order Dated : 22.09.2008

Facts & Submissions :

This petition was against repudiation of claim under Group Mediguard Insurance Policy issued by United India Insurance Company Ltd. on the ground of "pre-existing disease" as per exclusion clause No. 4.2.

The petitioner, Shri Khagesh Chandra Acharyya stated that he along with his family members were covered under Mediguard Insurance policy for the period 05.05.2007 to 04.05.2008. His son Shri Tamoghna Acharyya had Lasik Surgery for correction of myopia on both of his eyes on 13.01.2007 at Implant's Better Sight Centre Pvt. Ltd. Kolkata by Dr.Sudip Chaudhuri. He submitted a claim for Rs.12,626.20 to the insurance company which was repudiated by the insurance company on the ground of pre-existing disease and also for the reason that operation was cosmetic surgery. His appeal was not considered by the insurance company and therefore, he approached this forum for redressal of his grievance seeking monetary relief of Rs.12,626.20.

The insurance company in their self-contained note dated 16.05.2008 stated that the claimant was suffering from Myopia which was in the knowledge of the insured while taking the cover of the above policy. Dr. Sudip Chaudhuri the operating doctor certified that the claimant was having minus 4DS power in 1996 which was increased to minus 14 DS and minus 13 DS in right eye and left eye respectively. Therefore, myopia in this case was held to be pre-existing disease and hence the claim was repudiated.

Decision:

From the records available it was clear that the myopia was existed before the inception of the policy in 1997. However, if the same had been mentioned in the proposal form the insurance company would have to pay the claim. Since the proposal form was not traceable and it was a Group Insurance Policy given by the employer to the employee, this office was unable to come to a conclusion whether the complainant had disclosed the existence of myopia before the inception of the policy. Therefore to meet the ends of justice, Hon'ble Ombudsman opined that certain amount of ex-gratia could be paid. Therefore, giving benefit of doubt to the complainant he directed the insurance company to pay an amount of Rs.7,000/- as an ex-gratia payment towards the expenses incurred on operation done for correcting myopia.

-----O------

OFFICE OF THE INSURANCE OMBUDSMAN (GUJARAT)
2nd Floor, Ambica House, Nr C.U. Shah College, Ashram Road, Ahmedabad-380014
Phone: 079-27546840, 27545441 Fax: 079-27546142

SYNOPSES OF AWARDS YEAR: 2008-09

FROM 01.04.2008 TO 30.09.2008

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0375-08

Ms.Bharti M.Patel Vs. United India Insurance Co.Ltd.

Award dated 30.07.08

The insured was covered under Group Mediclaim by the employer. Claim lodged for hospitalization for illness was repudiated.

The complainant pleaded that she was admitted for Diarrhea, Vomiting and Fever. The Respondent pleaded that the hospital Aditya Nursing Home gave the treatment for Falciperum Malaria which is wrong and doubtful. The penal Physician of the Respondent opined that there is neither history nor follow-up finding patient's condition, noting on hospital record, medicine given etc leads to doubts for genuineness of claim.

The evasive replies to the Respondent's query by attending physician giving single letter for six claims of same group insurance members arises doubts. In consistency between ailment and treatment is different.

The case was dismissed.

END OF SYNOPSIS-APRIL'08 TO SEPT'08